Financing In Flux: Succeeding In The Era Of Value-Based Contracting

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I. What Drives Current Trends In Financing Models
II. Emerging Value Based Contracting Models
III. Key Competencies Needed In Shifting From FFS To Value-Based Contracts
IV. Example From The Field
   • Daniel Fishbein, Ph.D., Vice President, Corporate Business Development, Jefferson Center for Mental Health
The Growth Of Risk-Based & Performance-Based Initiatives

• 20 states implemented new Medicaid managed care initiatives in 2012; 35 states implemented new initiatives in 2013, including:
  ◦ Expansions of managed care into new regions
  ◦ Enrollment of new eligibility groups
  ◦ A shift from a voluntary to a mandatory enrollment model for specific populations
  ◦ New or expanded use of managed long-term care
  ◦ Medical/Behavioral integration models
  ◦ Shifting financing model from ASO to Risk
  ◦ Self-directed care pilots
  ◦ New performance-based contracting

• On January 31, 2013, CMS announced that over 500 organizations will begin participating in its Bundled Payments for Care Improvement initiative.
Medicaid Enrollment In Comprehensive Risk-Based Managed Care Continues To Rise

Number and share of Medicaid enrollees in comprehensive risk-based managed care:

<table>
<thead>
<tr>
<th>Year</th>
<th>Number</th>
<th>Share</th>
</tr>
</thead>
<tbody>
<tr>
<td>2003</td>
<td>17.3m</td>
<td>39.7%</td>
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<tr>
<td>2004</td>
<td>18.0m</td>
<td>40.5%</td>
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<tr>
<td>2005</td>
<td>18.9m</td>
<td>41.6%</td>
</tr>
<tr>
<td>2006</td>
<td>19.3m</td>
<td>42.3%</td>
</tr>
<tr>
<td>2007</td>
<td>20.1m</td>
<td>45.1%</td>
</tr>
<tr>
<td>2008</td>
<td>21.1m</td>
<td>44.8%</td>
</tr>
<tr>
<td>2009</td>
<td>23.5m</td>
<td>46.5%</td>
</tr>
<tr>
<td>2010</td>
<td>26.7m</td>
<td>48.9%</td>
</tr>
<tr>
<td>2011</td>
<td>29.1m</td>
<td>51.0%</td>
</tr>
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What Drives Current Trends In Financing Models
Two Mega Market Forces In Health & Human Services

As health reform moves ahead, with “bending the cost–curve” as its theme, two mega market forces are driving strategy in health and human services:

I. Coordinated Care Organizational Models
II. Pay–for–Performance/Risk–based Payment Models
Achieving The Triple Aim Of Health Care

- Improving the patient experience of care (including quality and satisfaction)
- Improving the health of children and families
- Reducing the per capita cost of health care
“Bend the cost curve” is the theme

Focus on complex high-cost consumers

Entering the “consumer-centric” era

“Value-based purchasing” is the new model
Coordination Of Care & Integrated Services A New Payer Focus

Integration Of Primary Care & Behavioral Health
Coordination of behavioral health services and primary care services to improve consumer services and outcomes

Integration Of Primary Care & Chronic Disease Management
Coordination of services to manage and address multiple chronic disease states within or parallel to primary care

Coordination More Important Than Integration
75% Of U.S. Health Care Spending Focused On Chronic Illness

- Services to support chronic illnesses contribute to 75% of the $2 trillion in U.S. annual spending

- Patients with co-morbid chronic conditions costs 7x as much as patients with one chronic condition

Nine Highest-Cost Chronic Conditions

1. Arthritis
2. Cancer
3. Chronic pain
4. Dementia
5. Depression
6. Diabetes
7. Schizophrenia
8. Post traumatic conditions
9. Vision/hearing loss
Individuals With Behavioral Health Conditions Frequently Have Co-occurring Physical Health Conditions

- 29% of Adults with Medical Conditions Also Have Mental Health Conditions
- 68% of Adults with Mental Health Conditions Also Have Medical Conditions

Comorbid Chronic Physical & Behavioral Disorders Increase Annual Medicaid Costs By 75%

<table>
<thead>
<tr>
<th>Condition</th>
<th>No Behavioral Health Disorder</th>
<th>With Mental Illness And/Or Addiction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma/COPD</td>
<td>$8,000</td>
<td>$24,598</td>
</tr>
<tr>
<td>Congestive Heart Failure</td>
<td>$9,488</td>
<td>$24,927</td>
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<tr>
<td>Coronary Heart Disease</td>
<td>$8,788</td>
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<tr>
<td>Diabetes</td>
<td>$9,498</td>
<td>$36,730</td>
</tr>
<tr>
<td>Hypertension</td>
<td>$15,691</td>
<td>$35,840</td>
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</table>
Problem With Current “System Of Care” For Consumers With Chronic Conditions

- Multiple specialists (and multiple prescriptions)
  - Consumers with 5 or more chronic conditions see 16 physicians a year with 37 office visits
  - Fill 50 prescriptions per year
- Poor follow-up from ER visits and hospitalizations
  - 20% of Medicare hospitalizations are followed by readmission within 30 days
  - Among <65 Medicaid patients, 10% were readmitted within 30 days

Readmissions add $15 billion in annual Medicaid and Medicare payments
Payer Focus: Reducing The Health Care Costs Of 5% Of Consumers

5% of U.S. population account for half (49%) of health care spending
- $11,487 per person

50% of population account for only 3% of spending
- $664 per person
For The 95%: Primary Care–Focused Models Spend Less Via Consumer Engagement

- Management via ACOs, medical homes, and primary care
- Specialist role is secondary
- Focus on prevention and wellness
- Consumer self-care and consumer convenience is key
- Web presence (optimization, reputation, etc.) critical for consumer referrals
- Health information exchange a requirement

Services for 95% of consumers via primary care–directed models
For The 5%: Intensive Coordinated Care Models Spend Less By Investing More

• Coordination of medical, behavioral, and social service needs by specialty group within larger system
  ◦ Health homes
  ◦ Waiver-based HCB programs
  ◦ PACE programs
  ◦ Specialty care management programs

• Assumption of performance risk (with or without financial risk)

Specialty coordinated care systems for ‘high needs’ consumers -- new ‘carve out’ model
Emerging Value-Based Contracting Models
Musical Chairs In Health & Human Services

The competition for control of patient care coordination

- Patient coordination = control of patient referrals
- Patient coordination by consumer type, not service type (the ‘new’ carve-out)
- Patient coordination goes to organizations accepting value-based (risk and/or P4P) reimbursement

Fewer ‘roles’ in the emerging system
Value-Based Purchasing (Pay-For-Performance & Risk-Based Reimbursement)

1. Increase transparency of performance
   ◦ Increase ‘pressure’ for improvement
   ◦ Facilitate consumer-directed care

2. Link professional, service provider organization, and care manager reimbursement to desired performance
   ◦ Improved access to care
   ◦ Increased care integration and coordination
   ◦ Person-centered planning and recovery focus

3. Control costs of care
   ◦ Financial incentives to help consumers become and remain healthy for longer periods of time
   ◦ Increase lower-cost interventions for ‘not yet seriously ill’ population
   ◦ Reduce unnecessary use of high-cost services
Service Delivery Models Moving To Value-Based Financing: More P4P & Risk-Based Reimbursement

**FFS Financing**

- Payer maintains risk for unit cost and quantity of services used
- Consumers request services
- Provider organizations deliver services and are reimbursed based on volume

**Value-Based Financing**

- Payer contracts with provider organizations to deliver services to a population for a fixed amount of dollars
- Consumers request services
- Provider organizations determine type and amount of service, delivers service, and manage pool of dollars
Transition of the Model

Optum Provider Contracting Changes

In selected provider arrangements, we will be transitioning and supporting financial risk, accountability and utilization management practices.

Compensation Continuum
(Level of Financial Risk)

- Small % of financial risk
  - Fee-for-service
- Moderate % of financial risk
  - Performance-based Contracting
  - Bundled and Episodic Payments
- Large % of financial risk
  - Shared Savings
  - Shared Risk
  - Capitation
  - Capitation + Performance-based Contracting

No Accountability  →  Moderate Accountability  →  Full Accountability

- a. 100% case by case UM
- b. Utilization stats review supplemented by case review
- c. Data management and system modifications to achieve targets
- d. Internal ownership of performance using data management

Basic Q and U measurements  →  Max quality process and outcomes driven measurements

Passive involvement  →  Provider engaged  →  Provider active in management  →  Assumes accountability

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Payers (whether a government or an employer) want **predictability in costs**. Risk-based contracting reduces financial responsibility to payers – but pushes that responsibility onto care management organizations and provider organizations.
Fee–For–Service

Provider pays an established fee for a defined service

- Clearly defined package of services to be provided
- Quality standards can be established for defined services

Fee schedule an issue

Varying degrees of ‘management’
What Factors Affect FFS Risk?

- Risk of controlling cost per unit of service
  - Wages of direct care staff
  - Overhead/administrative costs
  - Staff productivity
  - Volume of consumers served
  - Length of stay/average visits per case
  - Acuity/service needs of consumer

- Risk of managing performance metrics (if P4P)
Case Rates

Payment of a flat amount for a defined group of procedures and services

• Per treatment episode
• Per time period

Based on

• Diagnosis
• Assignment of a patient to a given type of treatment
• Other patient characteristics
What Factors Affect Case Rate Risk?

Definition of the “package” of consumer services over a specific time period

Risk of controlling cost per case

• A function of both number of units used and cost per unit of service
Capitation

An entity (health plan or provider organization) is paid a contracted rate for each member assigned, referred to as "per-member-per-month" (PMPM) rate.

Regardless of the number or nature of services provided.

Contractual rates are usually adjusted for age, gender, illness, and regional differences.

In sub-capitation, responsibility and risk move from plan to provider.
What Factors Impact Capitation Risk?

- Consumer utilization
- Provider payments and facility costs
- Program design & control issues
- Benefit plan coverage provisions

  • Psychological testing, marriage counseling, smoking cessation, court ordered services, sexual dysfunction treatment, obesity/weight reduction, Alzheimer's, ADD, personal growth, etc.
Pay-for-success financing is a new P4P model that directs taxpayer dollars to interventions that have demonstrated success in delivering outcomes.

Pay-for-success financings are contracts that:

- Leverage private capital
- Monetize social impact/outcomes of social services
- Realize costs savings for government
- Connect performance outcomes to financial return
Social Impact Financing

- An intermediary organization raises capital from private investors to fund multi-year delivery of preventative or early intervention social service programs traditionally funded by government agencies on an annual basis.
- If social service providers are successful in achieving contractually agreed targets for performance and achievement outcome metrics, the government pays the investors, through the intermediary, a return on their investment.
- This return on investment is funded from the savings produced in the population receiving the preventative or early intervention services by comparison to a defined population that has not.
- If the outcome targets are not achieved, the government does not pay.
Key Competencies Needed In Shifting From FFS To Risk-Based Contracts
Three Key Competencies For Provider Organizations To Be Successful In A Value-Based Market

1. Develop Administrative Competencies

2. Develop Management Competencies To Accept Value-Based Payment

3. Create Service Program Models
1. Develop Administrative Competencies

- Payer contracting
- Consumer marketing
- Utilization review processes/metric management
- Use of technology
- Managed care compatible documentation/electronic health record
- Knowledge of what services are preferred by payers
2. Develop Management Competencies For Value-Based Payment

- Decision support tools such as data-informed dashboards
- Customer service
- HIE abilities
- Specialized financial management systems
- Provider and claims payment systems
- Referral capabilities
- Ability to analyze the competition and use market intelligence
3. Create Service Program Models

- Programs that have proven outcomes and are delivered in the community
- Services that keep the consumer out of emergency room care and hospitalization
- Program models that can service large groups of consumers
- Integrate mental health with physical health and substance abuse
- Program costs that are market driven
Top 5 Things MCOs Are Looking For Today

- Care that is integrated with medical care and other behavioral health service levels
- Careful assessment and planning process, with appropriate diversion, step-down, and aftercare
- Integrate MCO care criteria within provider P&Ps, staff training, and operations
- EMR to tailor, track, coordinate and adjust client care (+electronic claims)
- Demonstrated outcomes, quality, and compliance
Top 5 Things Consumers Are Looking For Today

- Engagement
- Integration with health and social services
- Self-help resources
- Convenience and affordability
- Performance
Do you have the management competencies needed to succeed with these new contracts?

- Payers are moving beyond FFS to value-based purchasing
- Models and technologies exist for improving quality of service and reducing costs
- Preference will go to the organizations that can adapt to the new payer priorities and consumer preferences
Example From The Field:
Jefferson Center for Mental Health
Dan Fishbein, Ph.D.
Vice-President, Corporate Business Development
Jefferson Center for Mental Health
Wheat Ridge, Colorado

One Center’s Experience With Capitation
Jefferson Center for Mental Health

- West Metro Denver serving a three county catchment
- Private not-for-profit
- $40 million annual revenues
- Has grown to over 500 employees
- Blends mission driven with:
  - Entrepreneurial
  - Diversified
Colorado Medicaid Behavioral Health Carve-Out

- Created 1995
- Initially many agencies, called MHASAs
- 2004 Colorado consolidated into regions called BHOs
- Jefferson Center was a MHASA
- For BHO transition, Jefferson formed a JV LLC with CMHC in Boulder called Foothills Behavioral Health (a managed care organization)
Colorado Medicaid Behavioral Health Carve-Out

- 2008 FBH felt affiliation with national MCO needed
- FBHP formed by adding Value Options
  - Each CMHC 1/3, VO 1/3
  - Governance includes stakeholder’s council
- Rebid every 4 years (approximately)
- CO agency HCPF
- Full risk capitation
- Rates vary by population subgroup
  - 2010 varied $4 to $27 non-SSI, $25 to $172 SSI
  - Also vary by BHO region
Colorado Medicaid Behavioral Health Carve-Out

- Utilization data ("encounters") sent to the state
- Focus on penetration and utilization
- Overall penetration 2010 11.9%
  - Jefferson penetration has run as high as 19%
  - Quality Indicators monitored by BHOs and reported to the state
  - Expansion into integrated care
  - Bringing substance abuse treatment into the BHOs
Jefferson Center & The Carve-Out

MedCap program uses programs and resources throughout the entire Center

A wrap around IPN network from community added for choice and to ensure access

BHOs contract with facilities and various alternative programs

Jefferson has staff and structure to extend and support admin functions of the BHO (UM, QI, etc.)
Jefferson Center & The Carve-Out

Jefferson Center has a defined sub-cap with FBHP

Cost of care for members in our catchment comprises the sub-cap

Certain costs are paid by FBHP (ER; IPN network costs)

Periodic reconciliation process, always nonadversarial
# Jefferson Center & The Carve–Out

17 years since program started—a learning curve, steeper in the initial years

| Evolution of structure and processes to serve a population under capitation |
| Central Intake—telephone triage, entry portal |

| Access/Emergency 24 hour crisis coverage—ERs |

| Onsite F2F crisis evaluation and intervention |
Jefferson Center & The Carve-Out

Access nurse coverage and emergency psychiatry

Jefferson Hills creates a children’s CSU type unit

Real time clinics

Transition specialists

Hospital liaisons

UM manager
Wait! There’s more!

- Intensive program
- HAF House (Hospital Alternative Facility)
- Intermediate residential facilities with variable stays
- How can the Center afford these?
  - Through the flow of capitation revenue
Jefferson Initiatives Related To The Carve-Out

- Defining Episode Of Care
- Groups
- Motivational Interviewing
- Welcome Classes
- Wellness Now
- Meds Only
- Navigation
Jefferson Initiatives Related To The Carve–Out

- Not everything worked well
- Access is a continuing challenge
  - Dedicated intake team
  - Continues with conversion to same–day access
- Not all initiatives stem solely from the carve–out
  - Synergies offer the best options—if you can find and implement them
Advantages, Disadvantages, & Challenges

Productivity paradox
- Your revenue is not linked to service volume

Real (not faux) UM
- Find a really good medical director

Your clinical staff are not just providers—also key in benefit administration
- Covered diagnoses
- Session limits
- Special care about recommending treatment or programs
Advantages, Disadvantages, & Challenges

Blending your service delivery systems serving varied customers with the one serving the huge capitation contract

• Jefferson launched 3rd party program, sought synergy but ended up creating a standalone
• Had to break many business rules which had roots in the carve–out program
As soon as you have your capitation contract, begin planning for when it ends

- Our per-service expense is too high and a vulnerability if either the funding level declines in the capitation, or the program ends and we move to another payment model.
- It seems intuitive your system would evolve to the most cost efficient model and practice, but, in fact, with the financial stress of FFS removed, you may migrate to some inefficient patterns.
Lessons Learned From The Colorado Carve-Out (& Before)

Capitation is not a guaranteed path to easy street

Caps can blow up

Contracts can disappear

- Not always anything you did wrong
- You may not control (or even influence) the decision
Lessons Learned From The Colorado Carve-Out (& Before)

You’re not just providing care

You are also doing benefit administration

High quality account management with contract holder is critical

If there’s an intermediary (like an MCO) you may not have easy access to customer
Lessons Learned From The Colorado Carve-Out (& Before)

Old days: just give us the cap and get out of the way

- The initial RFP in 1995 made clear the revenue was intended to help create a system to serve all
- More recent focus is that Medicaid dollars support Medicaid program

No longer (if it ever was)

- Reporting encounters or claims
- Quality measures
- Contract standards
- Administrative costs connected with the contract are critical (but can be hard to project)
Lessons Learned From The Colorado Carve-Out (& Before)

What is delegated to you under the cap?

• UM
• Appeals (up to a point)
• QI
• Claims payment (this can be really important)

Funding level reflected in the cap

• How did we arrive at the cap?
• What assumptions or decision drivers?
• Save $$$$—race to the bottom
• Hold the line for future increases—set at prior experience
Lessons Learned From The Colorado Carve-Out (& Before)

Your system will be highly stressed when one of two things occurs

- Significant increase in membership
- Significant decrease in membership

Beware the cusp

- Whenever there’s a cap there are boundaries
- Then there are border wars—who is paying
- ER most common and challenging
- Try to define in the contract but never capture all
Lessons Learned From The Colorado Carve–Out (& Before)

Can quality and capitation co–exist?

- Absolutely—in Colorado and at Jefferson
- Broadened the continuum of care
- Drove innovation
- Increased the numbers served
- Brought value to our customers
- Allowed us to focus on our clients AND we don’t have to bring our results and cost of care every quarter to Wall St and market analysts
Remember

With a capitation contract, you’re no longer complaining about the problem...

You’re part of the solution.

Questions?
Dan Fishbein, Ph.D.
VP, Corporate Business Development
Jefferson Center for Mental Health
danielf@jcmh.org
Questions & Discussion
The market intelligence to navigate.
The management expertise to succeed.