

Understanding Alternative Payment Arrangements: Innovation in Service Delivery

Presentation to Indiana Council of
Community Mental Health Centers



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Agenda

I. Introduction

II. Level Setting

III. Discussion Question

IV. Government Role

V. Getting Ready for APAs

1. Leadership
2. Risk
3. Finance
4. Clinical staff
5. IT

VI. Conclusion

Introduction

Introduction

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Senior Associate, *OPEN MINDS*



Areas of Expertise

- Financial management of health and human service organizations – both service provider systems and health plans
- Health information management and management electronic medical recordkeeping systems
- Technology selection and implementation
- System integration including computerizing clinical workflows

Professional Highlights

- Chief Operating Officer for Community Care Behavioral Health
- President, Askesis Development Group, Inc.
- Vice President, Technology Strategy, UPMC Insurance Services Division
- President, U Squared Interactive



Provider owned 501(c)(3) company

Funded by provider owners to respond to a behavioral health carve out

Licensed as a insurance company by Pennsylvania

Accepts full risk and ASO

NCQA and URAC accreditation

Started out with only FFS models; implemented a large number of APAs by the time that I left
(Some worked and some did not)

Level Setting

Indiana Experience

- You already have experience with an APA because your MRO program is, in fact, an APA
- The problem with successful APAs is that, while phase one generally provides savings opportunities, later phases have more limited opportunity.
- Once you have removed \$80 million out of a system, how much in savings is left?
 - Opportunity is to use MA expansion to move state or local dollars to Federal match dollars. But have to be careful that cornerstones of the system don't get worn away.
 - Since services are based on level of need, what happens when you've managed existing consumers of services to the lowest level and the next generation comes in to get care?

Alternative Payment Arrangement (APA)

A method for reimbursing a provider of health care services that is other than a Fee for Service (FFS) methodology.

But when CMS and payers talk about APAs, they define them as either:

- Saving money on total spend or
- Improving quality/outcomes of a population

So the definition that we will use today is:

A payment arrangement that is created to incentivize either dollar savings and/or improve quality (or outcomes) of care delivered to a targeted population.

Managed Care Continues To Grow As Dominant Contracting Model

Segment	Total U.S. (Million)	Percent U.S.	Managed Care Enrollees (Million)	Managed Care Percent
Medicare	53.8	16.8%	15.6	29.0%
Medicaid*	54.0	16.9%	36.2	67.0%
Military	4.9	1.5%	4.9	100%
Commercial	165.2	51.6%	164.4	99.5%
Uninsured	42.0	13.1%	0.0	0.0%
TOTAL	319.9	100%	221.1	69.1%

*Exclusive of dual eligible beneficiaries

The Competing Goals Of APA

The payer is hoping that the arrangement will lead to overall savings

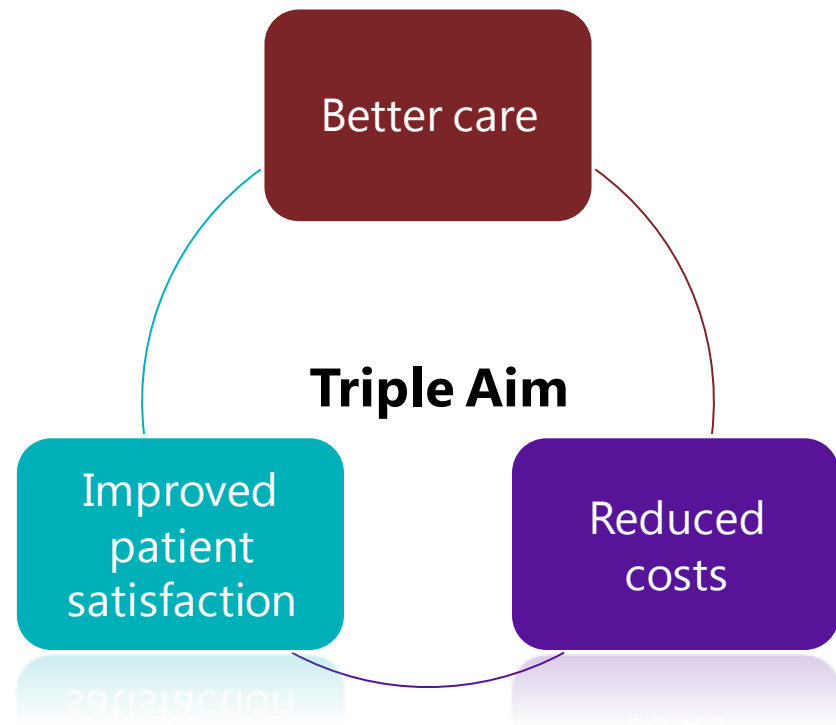
The provider is hoping that their efficiencies can allow them to recognize excess revenue

Everyone is hoping that the effectiveness of services are improved

- Outcomes
- Quality
- Population health
- Burden of health problems on associated spending

Competition Among Health Plans Has Sharpened The Focus On Value

- Health plans responsibility is at the “population” level
- Looking to increase value by improving the consumer care experience, improving consumer health, and reducing costs across their population
- This is often referred to as “Triple Aim”



APAs are Seen as an Answer

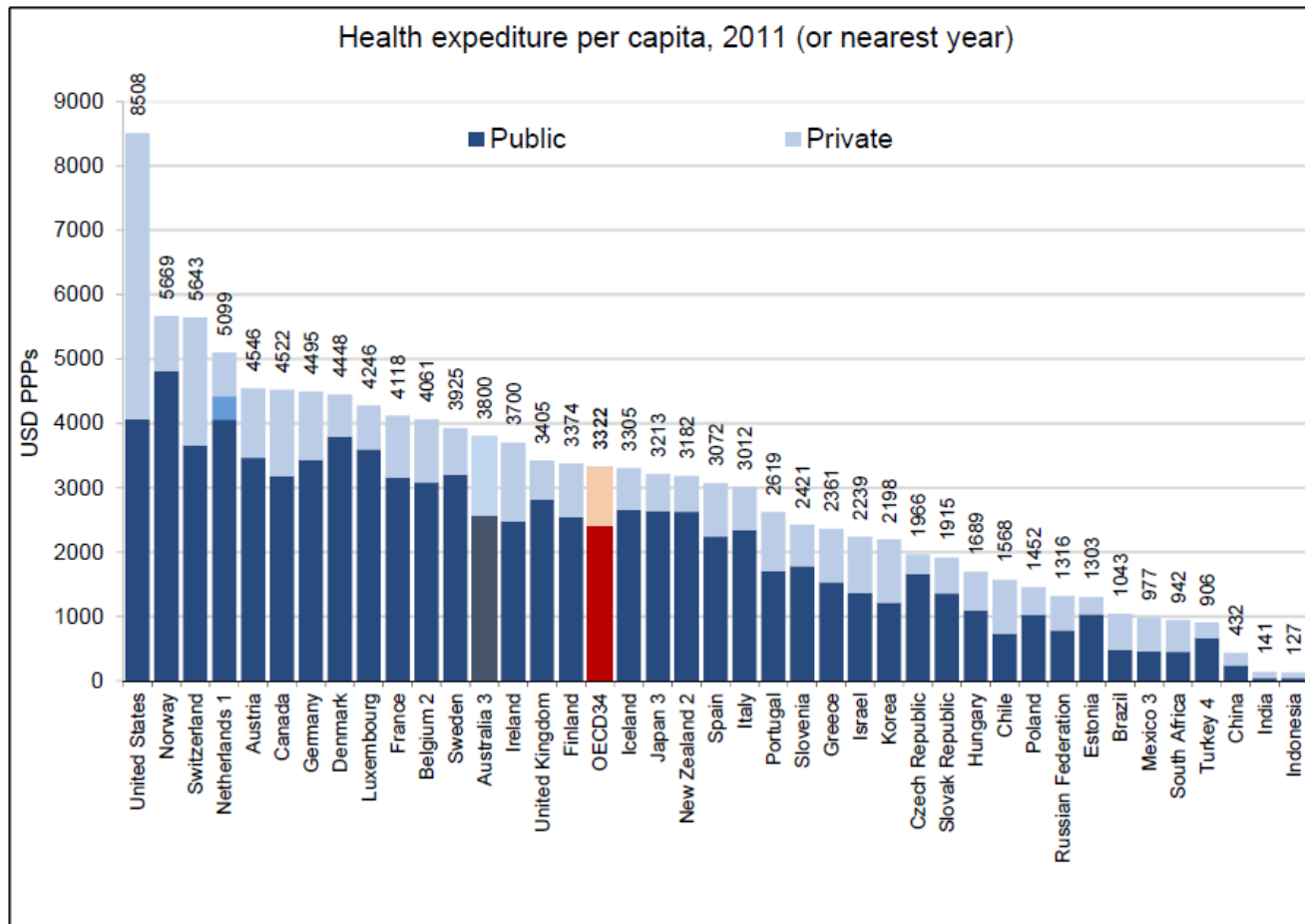
Health spending is high

- Trends are moving in the wrong direction
- Aging society
- People living longer
- People living with chronic disease

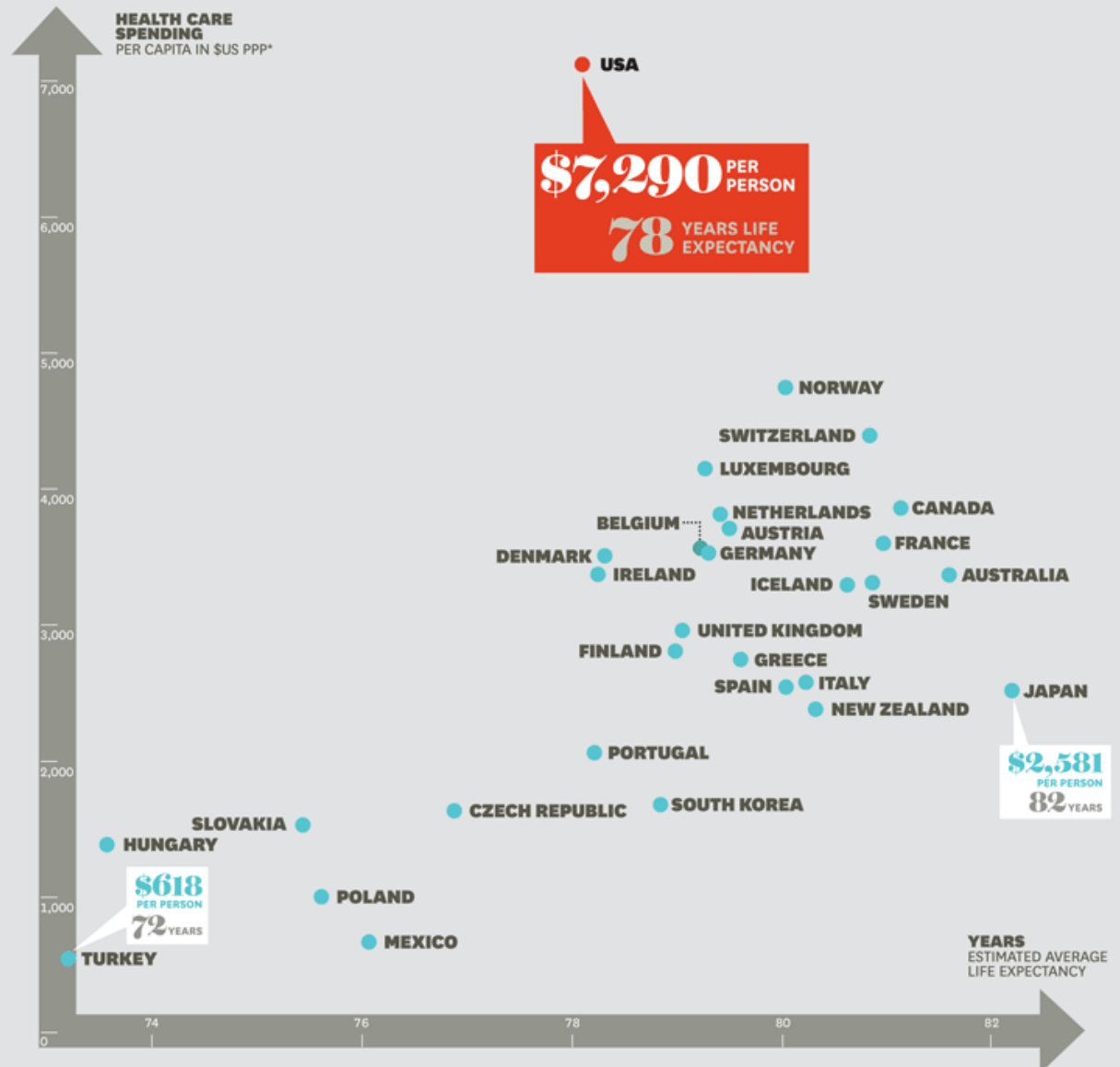
System is not designed to keep people healthy

Incentives are not in place to keep people healthy

The Spend for Medical Services (per capita)



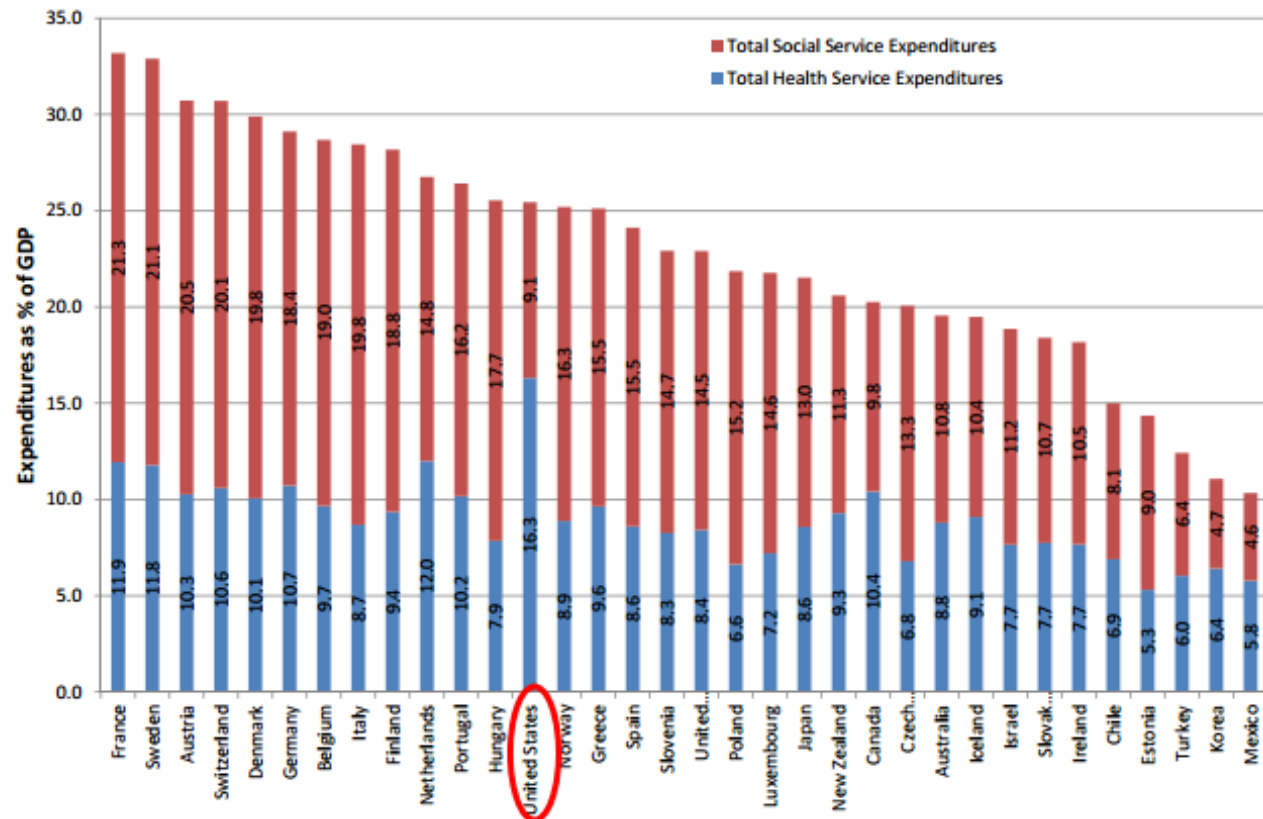
OECD (Organization for Economic Co-operation & Development) Country Comparisons



Source: Harvard Business Review, Spotlight on Fixing Health Care, "Fixing Health Care on the Front Lines", Richard J.J. Bohmer, April 2010.

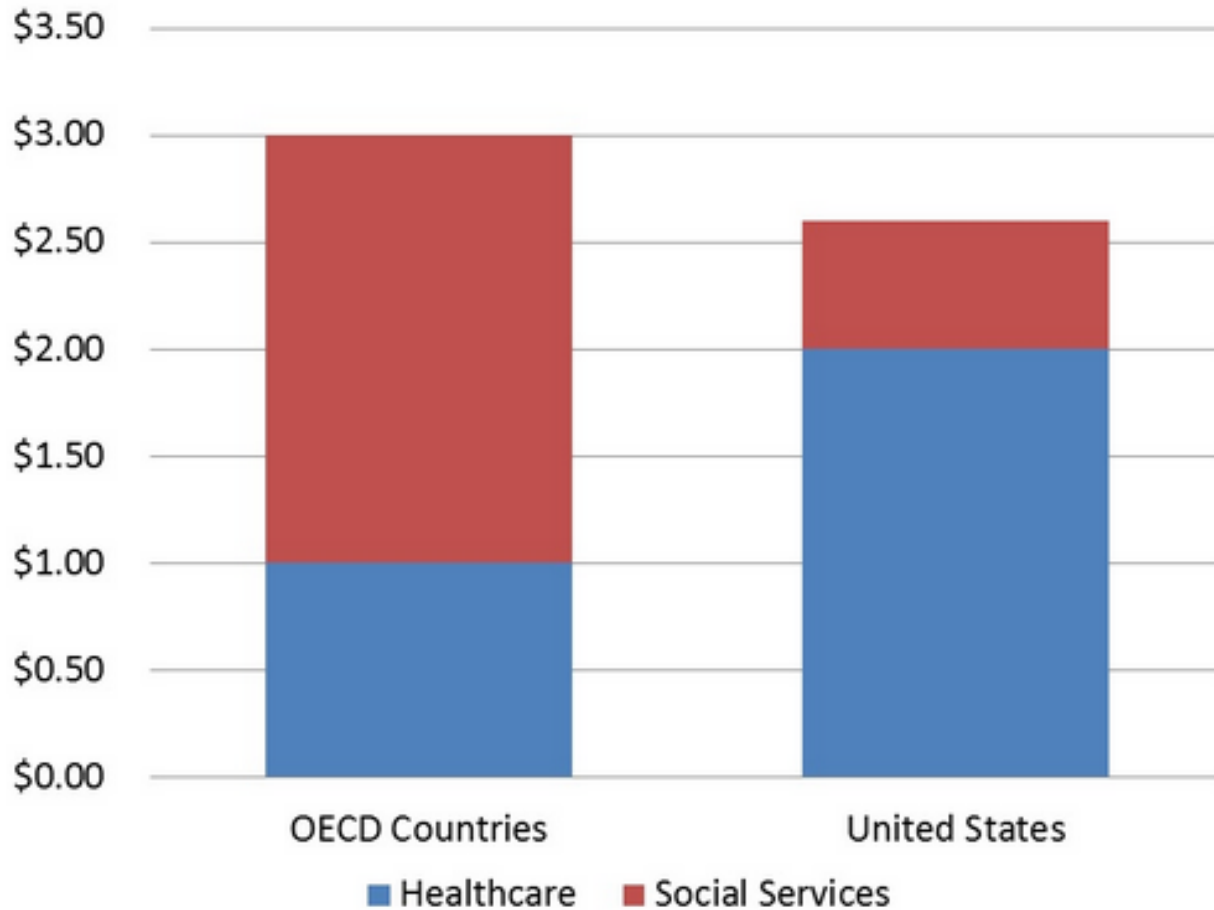
Adding In Social Services

Total health care investment in US is *less*



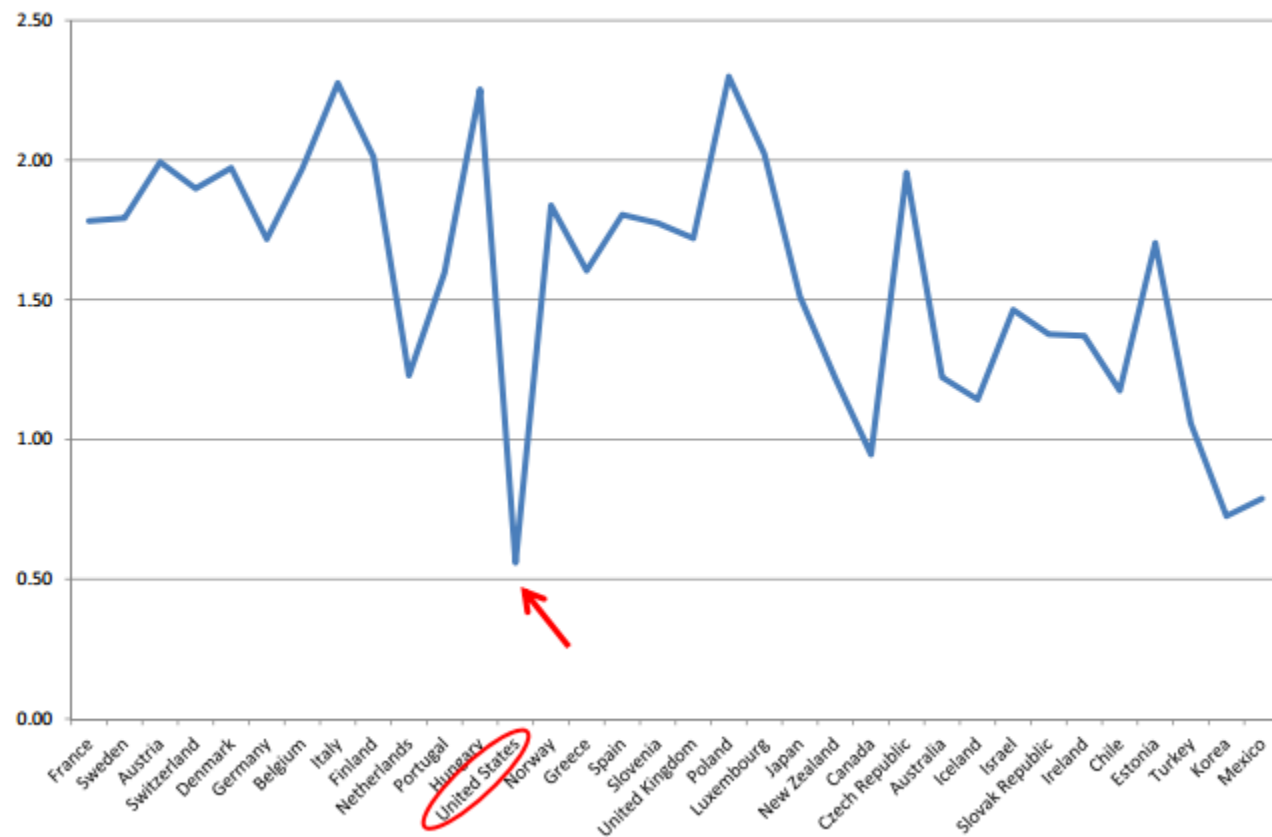
In OECD, for every \$1 spent on health care, about \$2 is spent on social services
In the US, for \$1 spent on health care, about 55 cents is spent on social services


What are the implications?



From The Same Source

Ratio of social to health spending is different





Question:
What do you think are the
implications for our field?



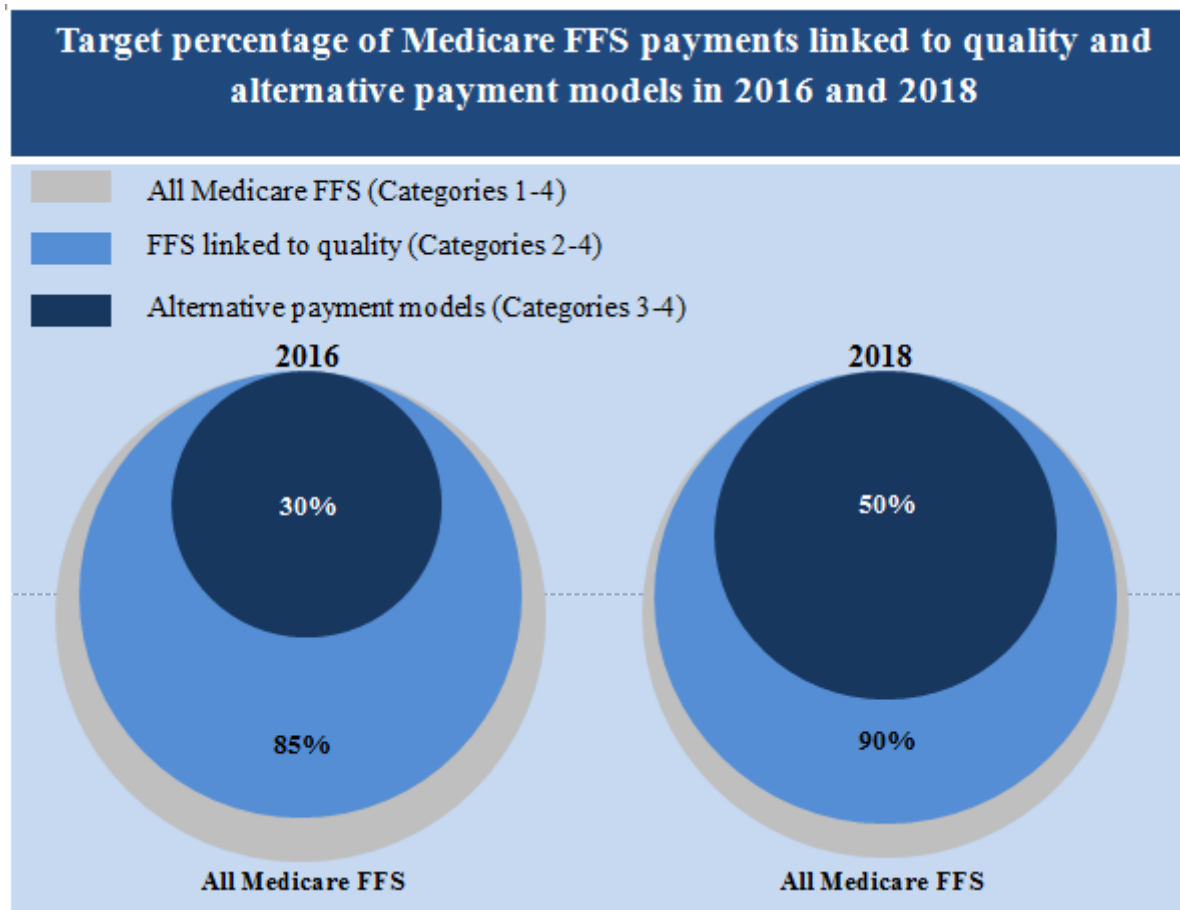
Government Support/Involvement

What is the number 1 thing that providers want from APAs?

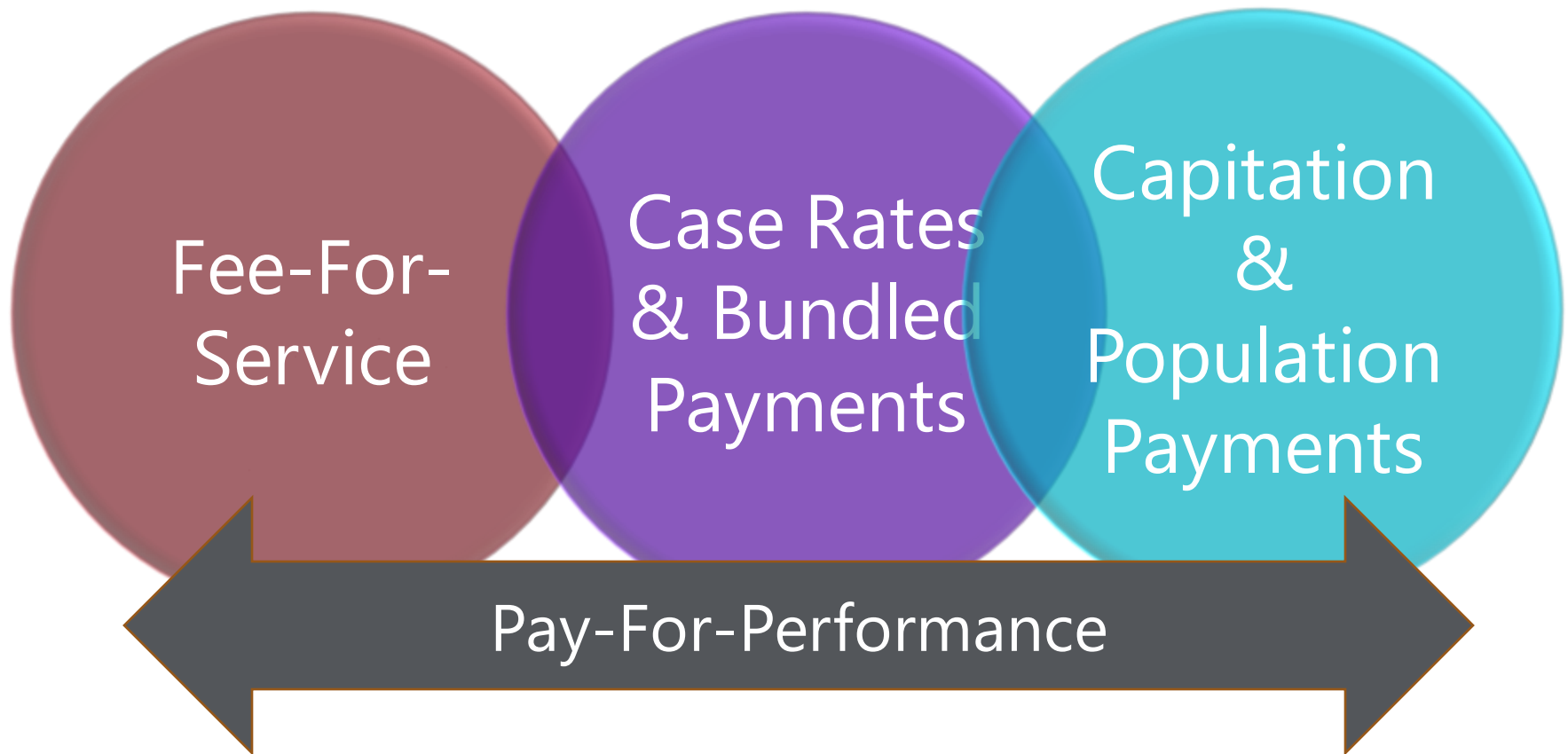
Relief from regulations!



Medicare Targets-50% By 2018



The Transition From Pay-For-Volume To Pay-For-Value-CMS View



CMS Rules Vs. States Autonomy

CMS rules with which the states must comply make flexibility harder in APA maintenance

- Example: Bundled program that includes multiple levels of care within the program but that requires that encounter records follow the standard billing format (837)
- So admin expenses are not lower for the provider org

But..APAs are Here to Stay (Until the next solution is proposed)

What are the implications for your organization?

- Finance needs to retool itself and its skills.
- You'll need a deeper understanding of your cost structures and cost drivers
- You need to get your staff ready
- You need to figure out how much cash on hand you have
- And have a plan to stay afloat if your cash is low

There is some hard work but, since you've had the MRO program in place, you may have done some of it already.

Getting Ready for APAs: Leadership Staff



Get Your Staff On Board

Today's healthcare organizations were built for high volume and serious illness, not for prevention and health

- What is the focus of YOUR organization and how do you change it, if needed?
- Can you promise anything that will lead to improved outcomes?
- What is the effect of your providing the services that you provide?
 - And how do you know that you get that effect?
- Can you state your value in a few simple sentences?
- How are your utility departments set up (e.g., finance and IT)

Inventory of capability for management of APA

Exercise

Why are we better?

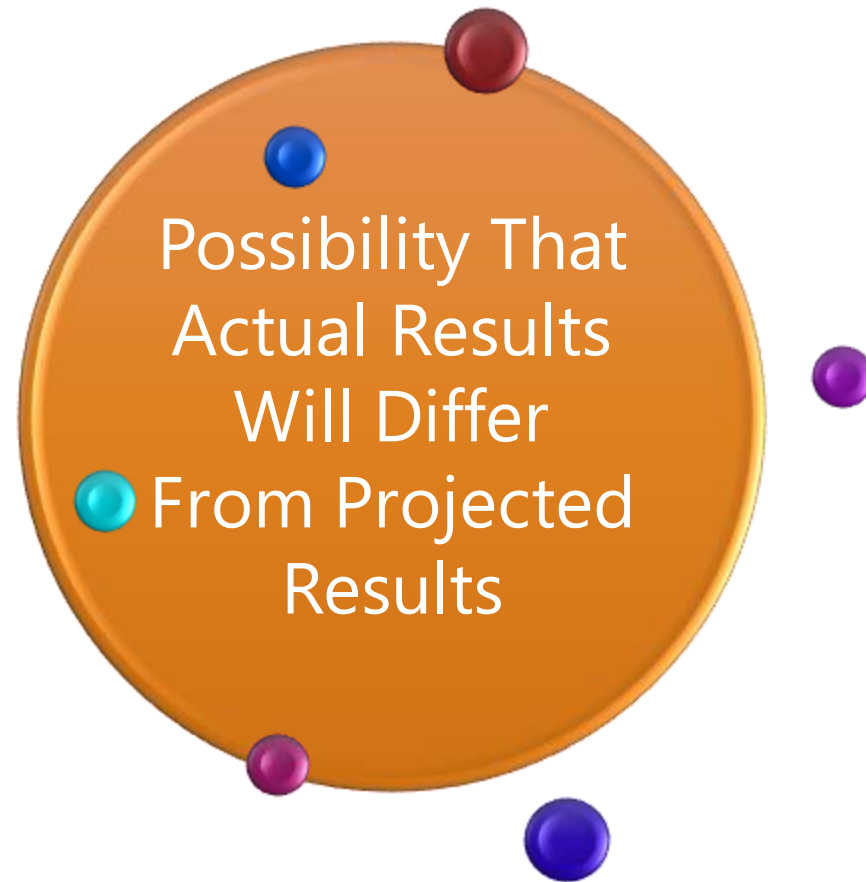
- Positioned to manage cash flow issues
- Excellence in clinical care
- Seamless transitions from level of care to level of care
- Effectively uses data to plan and act
- Measurable outcomes
- Staff competence
- Others

Your goal is to determine the vision statement for your organization

Getting Ready for APAs: Risk



Risk Is. . .



Financial Risk is Part of an APA

Have you done an analysis
of cash on hand

How well do you
understand your cash flow

- Can you negotiate pre-payments for the APA with a true up occurring later?

Do you have a “finance”
function or simply an
accounting function

Determine how much risk
you are willing able to take

- Remember that the higher the risk, the higher the reward...but the higher the risk!

To Manage Risk...

You need to understand the actual cost of delivering a service

- Activity-based cost management
 - An understanding of the activities that cause cost
- Target costing
 - Understanding the range of rates within your market
 - Developing a plan to track this range within your own organization
- Value engineering
 - Once cost drivers are identified, then processes can be reengineered to get closer to the market range

Getting Ready for APAs: Finance

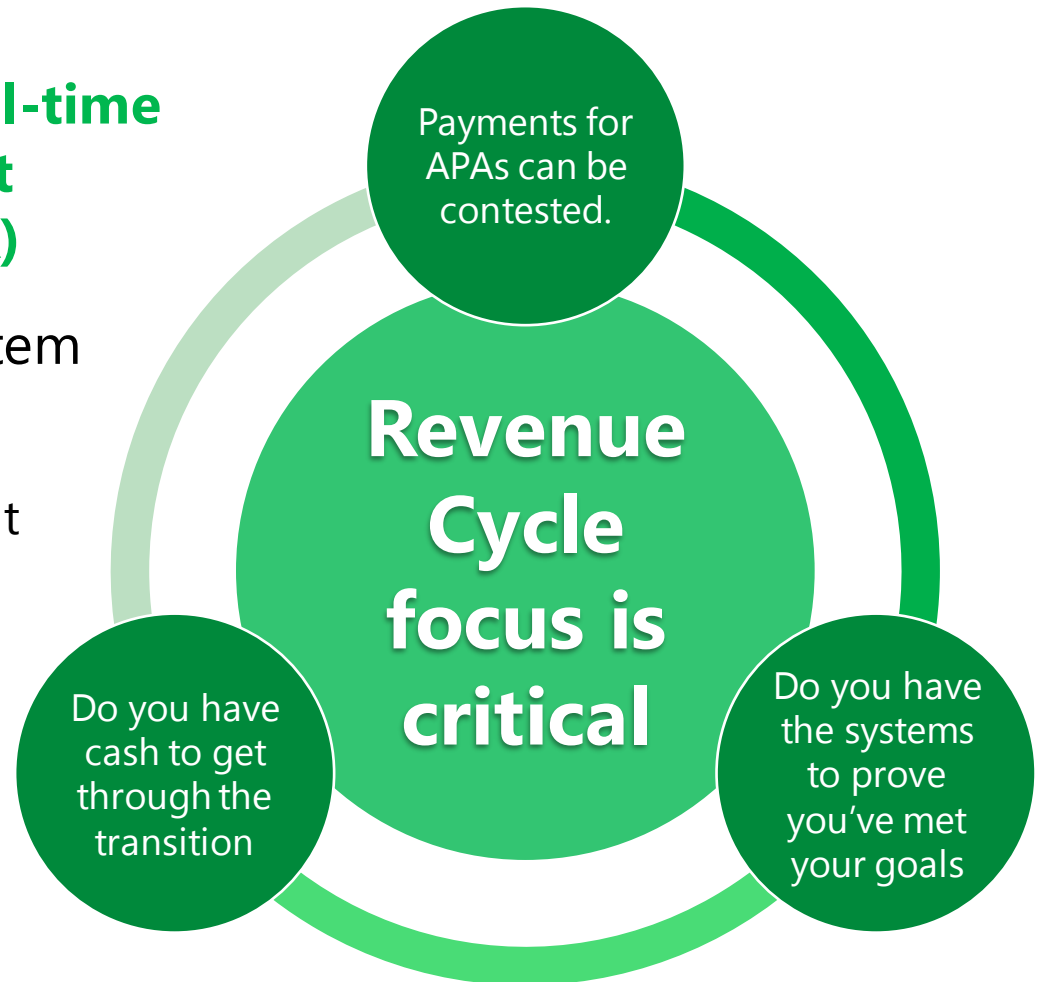


Financial Risk Management System

Key element is routine real-time clinical utilization and cost reporting (including IBNR)

Overall cost accounting system

- Cost per unit of treatment
- Cost per course of treatment
- Cost per patient



Key Financial Concept 1: Medical Expense Ratio

Ratio between costs incurred for services and premiums received

- Total premium received in month: \$100,000
- Total cost for services + IBNR: \$90,000
- MER = (\$90K / \$100K) = 90%

$$\text{Total premium received in month} \div \left(\text{Total cost for services} + \text{IBNR} \right) = \text{Medical Expense Ratio}$$

Key Financial Concept #2:

IBNR = Incurred But Not Reported

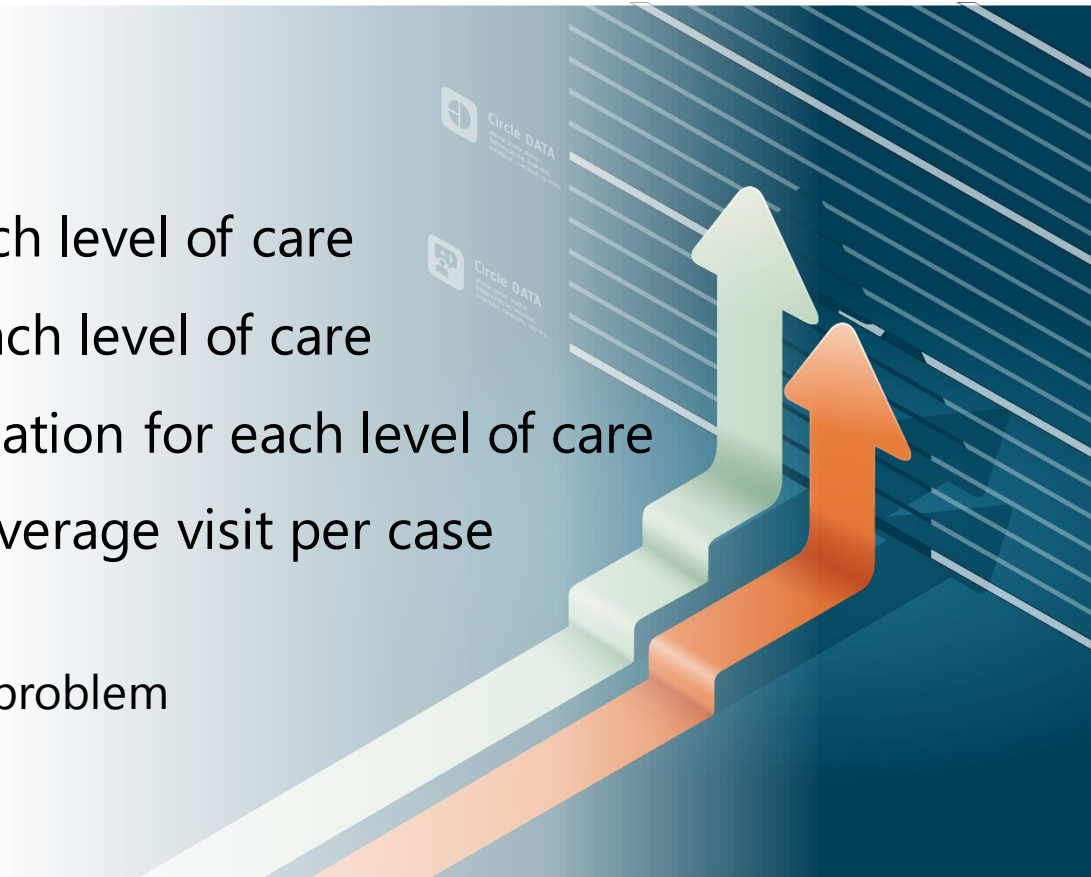
Outstanding claims for services that:

- Have not been received
- or
- Have not been captured by the authorization system

An accrual for these claims necessary to accurately report claims expenses for given period.

Risk Metrics of the Payer

- IBNR
- Total days/visits per 1000
- Days/visits per 1000 for each level of care
- Admissions per 1000 for each level of care
- Gross costs per 1000 population for each level of care
- Average length of stay or average visit per case
 - In aggregate
 - By diagnosis and presenting problem
 - By age group
 - By level of care



And Now For Some Math

Actuarial processes needs to be learned.

You pay for insurance in case something catastrophic happens and the insurance company prices you by using actuarial assumptions that determine how likely that is to happen.

If I am older, then the likelihood that I will need care is higher.
If I am younger, then it's lower.

But when you are looking at a population of people,
then you need to think about volatility.

Generally the larger the number in your population, the lower the volatility.

Basic Statistics

Example 1

For 500 people, I am trying to figure out their average score on some standardized assessment that has a rate between 1 and 10.

Findings:

- Mean score = 6.579
- If my 501st person has a score of 9, my mean goes to 6.584

Example 2

N=10 for the same assessment

Findings:

- Mean score = 5.800
- If my 11th person has a score of 9 my mean changes to 6.100

The smaller your population the more volatility, the more that one outlier is going to have a significant effect.

Another Example

There are 700,000 people with ESRD in the U.S. and 242 million adults. So if you are insuring the whole population of the U.S., your chance of having someone in your population with ESRD is 0.28%.

- When the actuaries are determining if rates are adequate, they use these kinds of prevalence measures.
- If you have 1 million covered lives, you are expecting that you will have about 2,800 people with ESRD and if you have one or two more, you don't have a big financial program.
- But if you have 10,000 or 5,000 covered lives and you have two extra ESRD members, you can lose lots of money.

CSNP Example

Program to enroll dually-eligible persons into a condition-specific special needs plan (an MA and MC program that is overseen by MC).

Each participating clinical program (Intensive or Targeted Case Management) was part of a gain sharing model. No downside risk, but, based on financial performance, were eligible to share savings (and increased revenue) with the health plan.

It was determined that once each participating program reached 300 people then, based on the management fee that they were being paid, the programs would be assured of making money.

One person in one program was diagnosed with stage 4 cancer, and that program lost all risk sharing opportunity.

Risk Bands

Think of risk bands the way that you think about standard deviation in statistics.

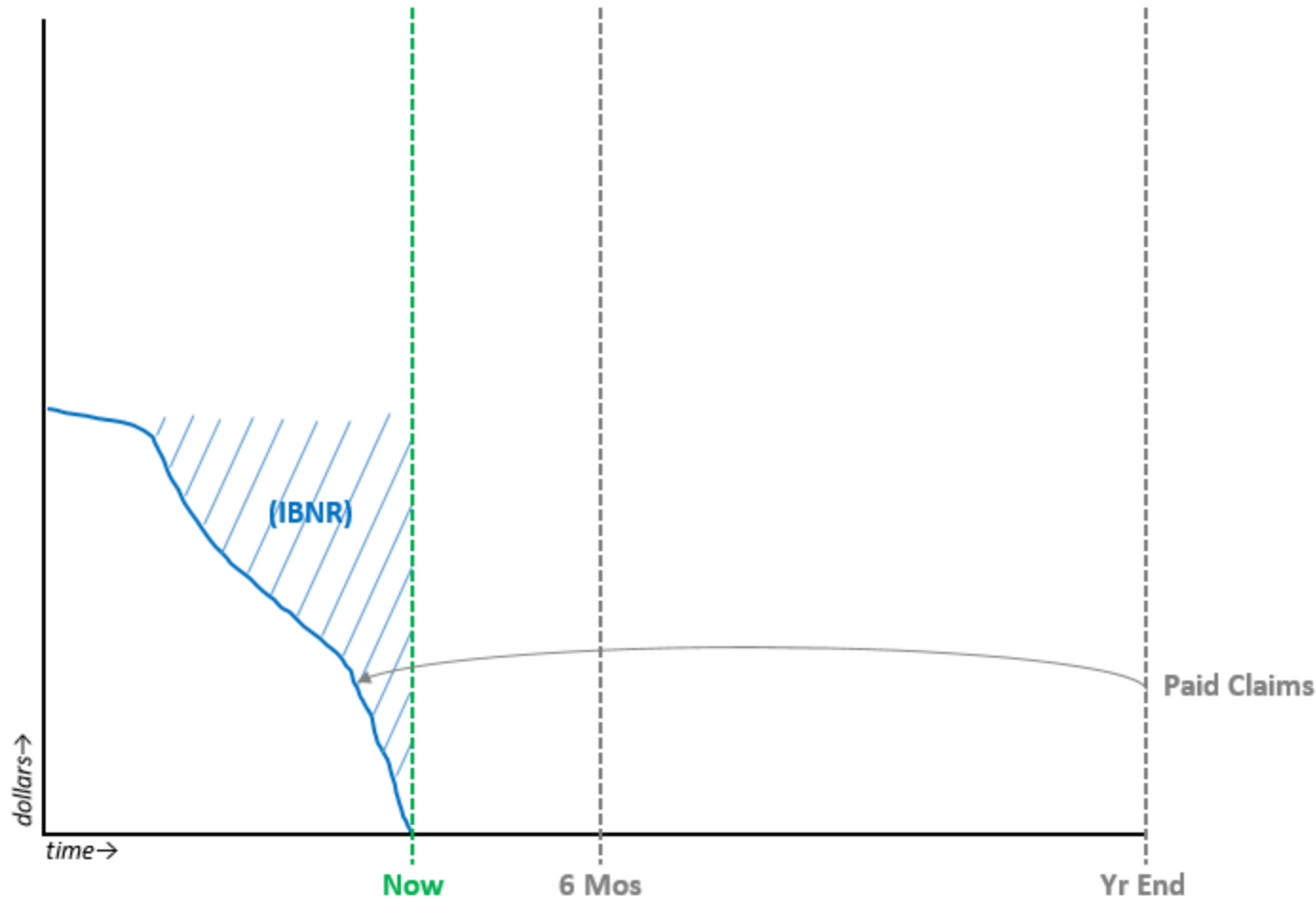
- Standard deviation (SD) is a quantity calculated to indicate the extent of deviation within a set of data.
- Risk bands then are the range of estimates of expenditure that the actuary will provide.
- As with SD, the larger the number in the population, the tighter the risk bands
- It's important to understand both the size of the risk band and also the absolute dollar that is being proposed in any APA.

Steps To Determine “Current Spending”

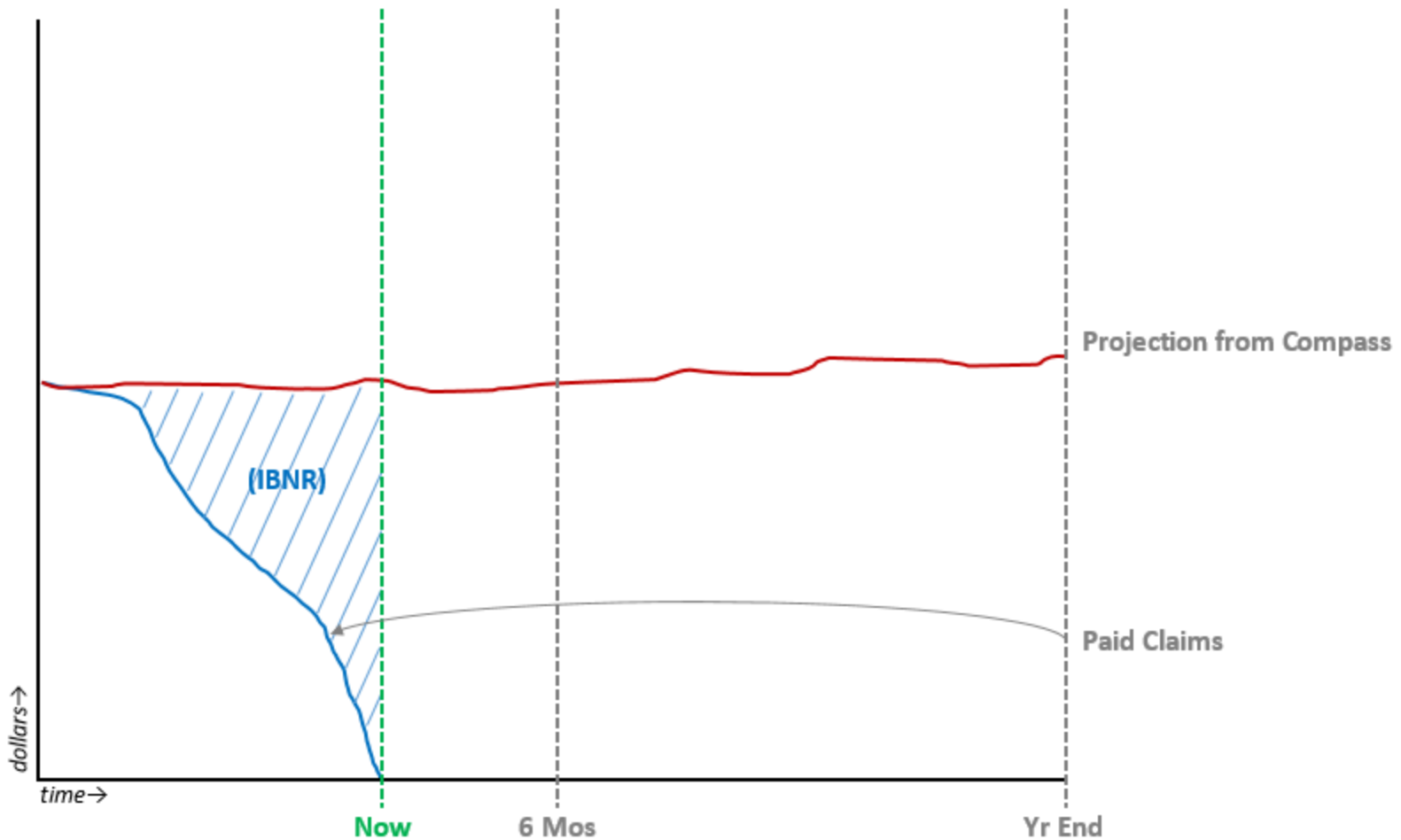
1. The next few slides come from the principal of Compass Health Analytics in Portland Maine. Compass provided economic and actuary services to my past employer.
2. Define: “Incurred But Not Reported” or IBNR
 - The dollar amount the MCO assumes it will pay in the future for services already rendered but for which claims have not yet been submitted by providers
 - Authorizations and historical paid claim patterns are used to calculate this figure

IBNR And Current Spending

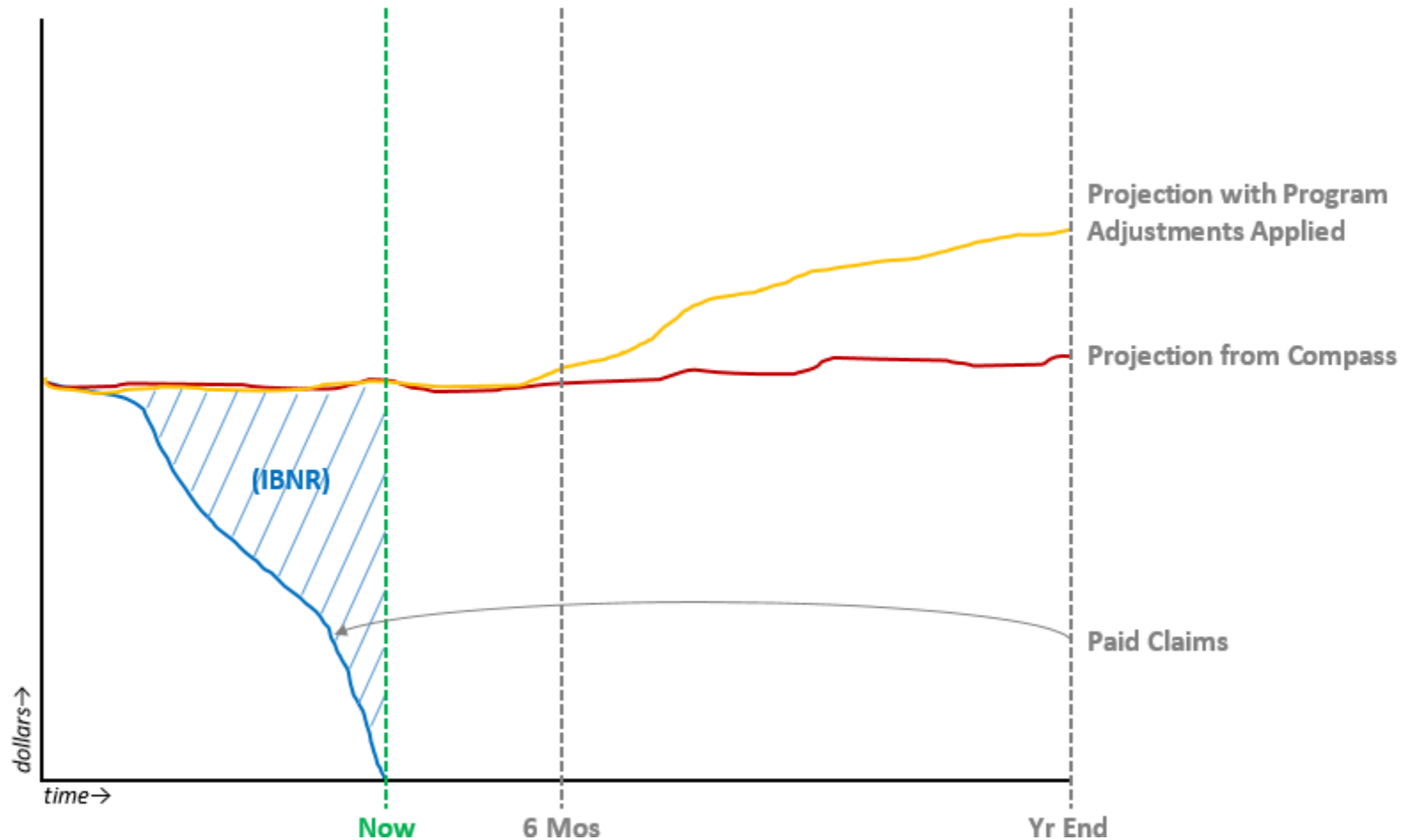
Recent claim data provides a very limited picture, so actuarial calculations help predict true costs in the future



Projected Growth Rate And Current Spending



Program Adjustments And Current Spending



Risk Scale By APA Types

Some examples of common alternative payment methods

Complexity ↑	Risk Model	Revenue Description	Level of Risk	Clinical Volatility	Patient Volume	Complexity
	Capitation: Global	Providers receive a fixed sum, usually prepaid monthly, designed to cover the cost of delivering all or some of the services of the patients within their care, which may be supplemented with incentive payments for achieving quality goals.	High – Full risk for all services agreed to under the capitation arrangement	Low	High	High
	Value based purchasing	Provides financial incentives to hospital and physicians for providing higher quality care at an efficient cost predominantly through clinical protocols and incentives	Medium/High – Combination of fixed payment and Fee for Service payments with incentives/penalties for meeting quality benchmarks and for lowering utilization and costs	High	High	High
	Bundled Payments	Providers receive a fixed payment to cover all of the costs of services delivered during a hospitalization or episode of care (knee replacement or heart failure) or to treat a particular disease for a defined period of time (Diabetic Patient).	Medium – Full risk for specific services. Monitoring of costs and outcomes easier for a subset of the larger population	Low	Low	Medium
	Capitation: Routine Care	Providers receive a fixed sum; usually pre-paid monthly, designed to cover the cost of delivering preventative services of the patients within their care.	Medium/High – Full risk for preventative services agreed to under the capitation arrangement	Low	High	Medium
	Gain Sharing	Hospitals and providers collaborate and share cost savings as a reward for quality and efficiency improvements. Gain sharing targets device and supply usage within a specific service line (e.g., orthopedics or cardiology) whereas shared savings targets specific patient populations (e.g., diabetics or asthmatics).	Low/Medium – The incentive to reduce supply usage in conjunction with a quality outcome leads to efficiency gains. Risk increases in conjunction with the complexity of services rendered (i.e., traumas)	Low	Low	Low/Medium

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Getting Ready for APAs: Clinical Staff



Clinical Focus

The organization should answer the following questions:

How do you know that people receiving services from your organization are improving?

How do you know who is a “good” practitioner within your organization?

Do you know how much of your revenue comes from providing services that are not helping people?

Why should payers pay you more than your competitors?

Movement From Process To Outcomes

Recently behavioral health measures of performance have been process related

- i.e. Appointments within 7 days
- i.e. Treatment plan started with 24 hours of admission
- i.e. Physician sees person at least every 4 months

In physical, measures have been a mixture of outcomes and process

- i.e. No hospital acquired infections
- i.e. Coding of present on admission diagnoses
- i.e. Reduction of pharmacy errors

It is likely that outcomes measures will be the wave of the future.

Antithetical to Status Quo

Clinicians are trained to think about procedures.

Have to retrain to think about process and outcomes

Great article:

<https://hbr.org/2015/10/turning-value-based-health-care-into-a-real-business-model>

Harvard Business Review examples of value based health care in the real world

Need to think about how the interventions that we provide in BH helps save money for the PH. This should be part of your risk contract with payers.

Managing Requires Coordination

Clinical decision support tools across all high risk population treatment

System thinking and systems action

Coordination with non-health social services/physical health and across levels of care

Systematic approach to consumer engagement and improving the consumer health experience

- Have to be better at engagement

Getting Ready for APAs: IT



Getting Ready for APAs

CMHCs have been organized:

- To provide services to individuals
- To report to local authorities
- To support community based services

CMHC information technology has been developed to:

- Support clinical transactions
- Clinical notes
- Billing transactions
- Compliance with state regulations re: treatment planning, documentation, assessment, etc.

Infrastructure Requirements

Necessary elements to manage risk include:

- Technology infrastructure: systems to aid in streamlining administrative operations (i.e., registries, callback systems, data systems)
- Reporting and analytics: data mining to identify areas of risk, including outliers, patient demographics, and risk factors

How is Your Information Department Structured?

Best practice in systems

A. Information systems-

maintenance of applications that are used to support clinical and revenue cycle

B. Information technology-

hardware/software/connectivity/remote access

C. Data management-

ETL, warehousing, reporting, analytics, projections

Importance of Data Management

Number 1 problem that providers have with APAs?

Not being able to prove your success/performance

Data collection system

Full mapping of the clinical workflow that you'll need to achieve the performance

Plan for training to achieve the performance

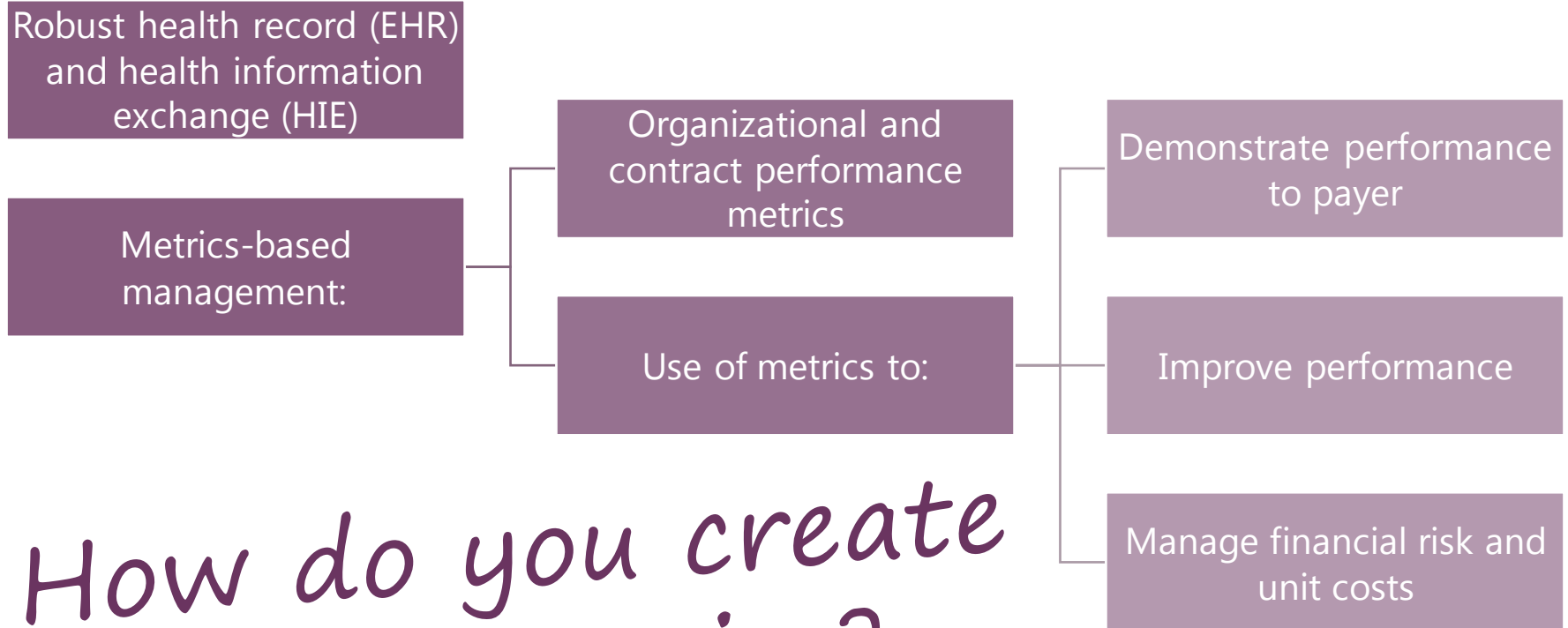
Data reporting system

Data analysis system

OPEN MINDS P4P Tech Capabilities

Functional Area	FFS	FFS P4P	CASE	SUBCAP	CAP
Clinical case management and resource authorization		?	✓	✓	✓
Common patient registration across the continuum of care		?	✓	✓	✓
Common clinical record across entities and levels of care		?	✓	✓	✓
Claims processing, payment, and reporting				✓	✓
Integrating complaints and appeals tracking				✓	✓
Membership eligibility and demographics			✓	✓	✓
Group billing and contract (including capitation and subcapitation) tracking					✓
Integrating financial accounting and reporting			✓	✓	✓
Provider network credentialing and profiling				✓	✓
Member services, including integrated scheduling				✓	✓

Managing Requires Metrics



How do you create your metrics?

Best Practices For Provider Organizations

Understand what the payer is asking for

Determine if you have the systems capability to measure what is needed

- Can you report on it?

Get it in writing from the payer

Clearly communicate with your staff

Be wary of "teaching to the test"...have some way to assure that all the work is being done

Don't count on all the funds in the first year

Summary



Infrastructure Needed

Organizational Legal/Financial Capabilities – licensure, accreditation, financial reserves, reinsurance/risk pool, etc.

Intake, Referral, & Member/Customer Service Functions – web/toll-free 24/7 member access and inquiries, urgent/crisis response, eligibility determination, authorization, referral matching/management, scheduling

Clinical/Utilization Management System – assessment, case planning criteria/ decision support, documentation requirements, administrative process for continued care management, utilization review process, consumer experience/outcome measurement

Billing/Account Reconciliation Capability – billing system for risk-based contracts (case rates, bundled rates, capitation), capability for retroactive reconciliation of premium payments; tracking and billing based on performance measures

Infrastructure (Continued)

Financial Management System – real-time clinical utilization/cost reporting; IBNR reporting; cost accounting system -- cost per unit of treatment, per course of treatment, and per member

Information Systems & Management Reporting – software to support administrative and reporting for clinical case management, provider network management, financial management, operations management, including claims payment & member relations, account management, licensure, accreditation

If paying other provider organizations to deliver services:

- **Claims Management/Payment System** – acceptance of provider claims, system links provider claims to eligibility, service authorization, and network provider information; coordination of benefit (COB) capabilities for claims editing & payment adjudication (including Medicare crossover claims); coinsurance, deductible calculation, & accumulation capabilities; link to IBNR reporting
- **Provider Relations/Network Management** – credentialing, contracting process, sanctioning process, & profiling systems

Strengths/Weakness of APAs

Strengths	Limitations/Risks
Providers have flexibility to determine which services are offered to members	Creates complexity for billing and clinical documentation systems
Persons getting services can transfer to levels of care as needed	Does not protect the consumer from being offered fewer services than needed so that provider can keep more of the case rate.
Makes cash flow/revenue predictable	Does not control for the number of services provided so if acuity is not accurate, provider can expend more effort than he/she is getting paid for.
Limits payer volatility	Can cause losses for provider if not adequately adjusted for risk

Exercises

Bundled Rate

- You are being paid a flat fee that is based on the assumption that it is going to cover all the services that are offered in one of your outpatient programs.
- This rate covers individual, medication management, group, family, crisis, and psychiatry time.

Carve Out

- Behavioral Health carve out which removes the BH spend from the MCOs and creates a requirement to manage a whole population.

Pay For Performance

- You have the opportunity to earn a 20% bonus based on the total that you've been paid by a specific payer if you can reduce the number of readmissions for a specific population for which you are providing ambulatory services

Gain Sharing

- You share 50% of the total savings that the payer realizes on reduction of the overall spending a specific population for which you are providing ambulatory services.

Helpful Hints

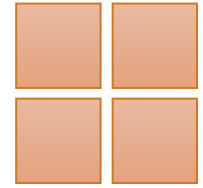
Determining spending is complex. Beware of simplistic answers.

Populations with 100% of people who are users of service will have very high PMPMs and very high costs. Don't be lulled by the total dollars.

Every APA will have ways to game the system (e.g., case rates can see more discharges and then reopening of a case as a new case, population management can see agencies selected the lower risk members of the population and refusing to treat the higher risk members, etc.)

When in doubt, go outside of your organization for expertise.

Building Blocks For Contracting



4 fundamental structures to assure in your Contract:

1. The definition of the services that will be covered by a single payment.
2. The mechanism for controlling utilization and spending.
3. The mechanism for ensuring good quality and outcomes.
4. The mechanism for ensuring adequacy of payment.

No design for an APA is complete until decisions are made about how all of these will be structured, and there are multiple ways to design each.

Things that you MUST do in your contracts:

- Outline the measurement methodology
- Outline the appeal methodology WHEN your results differ from the payer's results

BH APA Cautions



There is not enough money in the pot now, so it is even more difficult to decrease spending

Commercial behavioral health spending has generally been subsidized by MA and local or program funding

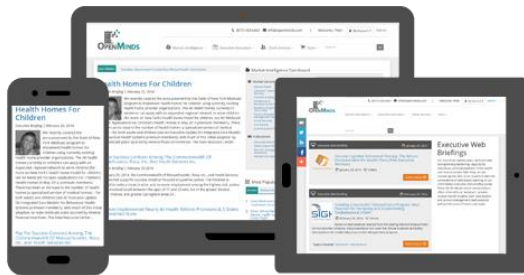
- Reimbursement for outpatient care is generally lower than cost of providing care

This means that the total for care delivery that payers are working with for APAs is lower than the actual spend.

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