Transitioning to a Sub-Capitation (At Risk) Model
Presentation Overview

Understanding the Changing Environment

Understanding Changing Payment Models

Network Management Keys For Success

Shifting Mindsets for Success
Activity 1: Organizational Readiness Quick Check

• Assessing organizational readiness

Do you track readmission rates across all providers in your network?

Do you know how your providers compare against one another in terms of critical metrics?

Do you know the average cost of care by type for consumers, and the cost of care by provider?
Group Exercise

• Assessing organizational readiness

Do you know which providers have implemented EHRS, and do you coordinate information?

Do you partner with providers in terms of technology, systems and reporting?

Do you know the key providers in your network and have a relationship with them?
Group Exercise

• Assessing organizational readiness

Do you have any joint QI projects with your providers?

Have you developed or implemented any innovative care programs with providers?

Do you know provider consumer satisfaction ratings?
Group Exercise

- Can you demonstrate that you deliver high quality at a lower cost?

- How does your quality of care vs. cost performance stack up against other MCOs (state and national)?

- Have you implemented quality dashboards to constantly monitor baselines and progress?

- Can you identify your key outliers in terms of cost and do you have a plan to address?
How many no answers did you have?
Which no answer will be the most challenging for you to address and why?
Now Let’s Dive Into the Details

- We are now going to go a bit deeper and take a look at some significant shifts when it comes to value, population health, and reimbursement.

To ensure success, it is critical that MCOs lay the foundation for collaboration with their providers, and have plans in place for both population health management and the integration of data and IT systems.
UNDERSTANDING CHANGING PAYMENT MODELS
Financial Ramifications

- Financial ramifications of healthcare reform will be significant and will go well beyond the level of Federal Reimbursement for Medicaid eligibles.
- The industry is seeing significant shifts across the following areas which will have a global impact on the financial stability of payers and providers:
  - Movement from fee for service (value based purchasing)
  - Quality Based Payments
  - Financial Penalties tied to Readmissions
  - Financial Penalties tied to Acquired Conditions
  - Decrease in Disproportionate Share Hospital (DSH) Payments
The Future of How Healthcare Will Be Financed

• Beginning in 2014 coverage for newly eligible adults will be fully funded by the federal government for three years.

• When this funding ceases, State payments that are filtered through to providers are expected to significantly decrease.

• This funding will phase down to 90% by 2020, but many providers may see a reduction in payments before then via several detailed financial changes that we will discuss in a moment.

Providers will need to migrate from the FFS Model, it should be the imperative of the Managed Care Organization to assist in this transition in order to achieve alignment.
As the volume of those receiving healthcare increases, the way that providers deliver care – and their accountability – is shifting dramatically from fee for service to “at risk” delivery models.
The Shift From Fee For Service

• New fee for value (rather than fee for volume) service delivery models which are being explored include:
  • Bundled payments
  • MCO/ACO Organizations
  • Value Based Purchasing; and
  • Fixed reimbursement costs (PMPM)
• New models will put providers at significant risk by tying reimbursement to both outcomes, and cost of care

Up to $500 Billion dollars in clinical risk will shift from payers to providers under healthcare reform, constituting 20% of the current costs managed in the U.S. Healthcare System
Transitioning Payment Models

- **Fee for Service**
  - Negotiated payment based on volume of service

- **Performance-based fee for service**
  - Negotiated payment for volume plus additional incentives for managing costs, quality, patient experience

- **Shared Savings**
  - Shared savings if interim costs are less than target

- **Risk Sharing**
  - Shared savings and shared losses

- **Full capitation**
  - All savings/losses are assumed by provider

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Pay for Performance

- Value based purchasing programs have been established which will tie a percentage of payments to hospitals/providers to performance on a number of quality measures.
- Quality measures and reporting requirements which are needed are likely to incur high internal costs for hospitals/providers and without careful balance there is the potential that payment increases will not offset these expenditures.

When a hospital meets quality standards payment is increased by a % for the fiscal year following the period.

When a hospital does not meet a standard, the payment amount is decreased by a % for the fiscal year following the period.

Providers will need to meet **all** standards across a number of conditions or face payment reduction.
The ACA has established a bundled payment pilot program which is aimed at integrating care across hospitals, providers, and post acute care providers during and episode of care. When appropriately applied, bundled payments serve to allow one fixed cost for all providers who are involved in a single episode of care. Bundled payments are highly dependent upon care coordination between providers, and allow for added transparency and predictability related to health care cost as well as alignment of incentives providing for the best outcomes of the patient in the most efficient manner possible.
Bundled Payments

- Risks results when providers do not appropriately negotiate the bundled payment for an episode of care (which is often caused by lack of appropriate data concerning the patient population, and failure to account for critical variables)
- Risk has also occurred when all providers have not been able to appropriately coordinate care and track cost putting them at a financial deficit for the provision of some episodes of care
What is “At Risk”

- “At risk” payments are paid on a per person basis and put the provider “at risk” for maintaining cost of services or paying the difference.
- Physicians accept members of the plan for a certain set price per member.
- It makes no difference how often the member is seen.
<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Global Capitation – PMPM</td>
<td>Payments for services to cover the total risk for all items and services that are furnished to enrollees who have selected or been assigned to the physician practice professional services</td>
</tr>
<tr>
<td>Partial Global Capitation – PMPM</td>
<td>Payments for services provided by the practice itself in addition to payments for all physician, laboratory, diagnostic and other outpatient services</td>
</tr>
<tr>
<td>Practice Capitation – PMPM</td>
<td>Payments for services provided by the physician practice itself</td>
</tr>
<tr>
<td>PMPM Case Management Payment</td>
<td>i.e. primary care physicians involved in patient-centered medical homes</td>
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The amount of the “at risk” payment will be determined in part by the number of services provided and will vary from health plan to health plan, but most “at risk” payment plans for primary care services include the following:

- Preventive, diagnostic, and treatment services
- Injections, immunizations, and medications administered in the office
- Outpatient laboratory tests done either in the office or at a designated laboratory
- Health education and counseling services performed in the office
- Routine vision and hearing screening
Key Provider Impacts: Financial Strain

- Provider organizations will face significant financial strain in the next 5-7 years,

- Increased administrative cost due to quality and reporting requirements
- Clinically complex residents
- Preferred provider networks
- Payment reductions
- Increased hospital integration
- Value based care requirements
Market Pressure from Provider Risk

- Provider organizations will need to align themselves with newly emerging, industry prevalent thinking and determine a way to address cost containment in order to remain viable.
- MCOs need providers to successfully make this shift in order to retain a successful network.

Healthcare cost alignment

- Government/State
- Payers (MCO/Insurance)
- Providers/Hospitals
The main issues of concern currently surrounding healthcare are reducing costs and increasing quality.

The current fee-for-service system focuses on volume and quantity.

Physicians, hospitals and other providers gain more reimbursement based upon providing more services.

This adds fuel to the fire in terms of inflation of health care costs with no direct correlation to the level of quality.

“At risk” and value based payment models are an effective way to create accountability throughout the continuum of care and align cost with quality.
Creating a Value-Based Payment System

1. Organize into Integrated Practice Units
2. Measure Outcomes and Costs for Every Patient
3. Move to Bundled Payments for Care Cycle
4. Integrate Care Delivery Across Separate Facilities
5. Expand Excellent Services Across Geography
6. Build an Enabling Information Technology Platform
Reform Driven Change

- Increased financial risk
- Operational efficiency imperative
- Collaboration is key to success
- Technology investments
- Increased quality (that you can measure)
- Elevated regulatory risk
- Community based care and services
- Post-acute

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Value Based Payments

- Encourage use of evidence based medicine
- Reduce fragmentation, duplication and inappropriate use of services
- Encourage effective management of chronic disease
- Accelerate the adoption of health information exchange
- Empower and engage consumers
Performance based payments will drive change

Different practice arrangements will be accommodated

Multidisciplinary team members will be recognized

Accountability will be across multiple levels and sites of services

Plan will be budget neutral

Focus will be to change FFS and there will be a short term and long term strategy
Healthcare reform and payment reform are happening.

What can you do with the hand you’ve been dealt?
NETWORK MANAGEMENT: KEYS FOR SUCCESS
Network Management Keys For Success

- MCOs should not only know what their “ideal” provider looks like, but should communicate this information to their network.
- Know who is in your network now, identify key providers, and understand where they are in terms of readiness for the switch from a FFS model.
- Provide educational outreach to your network informing them on why “at risk” payments create alignment for everyone.
- Establish dedicated IT work groups to inform providers of the systems that you use, reports that you require, and identify opportunities for data integration.
Consumer Expectations

- Customer Expectations
  - Demand for value and accountability
  - Need for transparency
  - Customers must not merely be satisfied, they must be delighted
  - Emphasis on and access to unique prevention services
Ideal Provider

• Low/no readmissions
• Meaningful use of EHR
• Demonstrated patient centered approach to care
• Cost of care is low in comparison to peers with comparable quality
• High Quality

Top of class in provider comparisons
High patient satisfaction ratings
Innovative care delivery approaches
Good community reputation

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What Providers Need to Demonstrate in Relation to Value

- That they have examined care delivery to reduce cost and improve value
- That they can quantify value of their organization
  - How do they compare to other comparable organizations in the network?
  - Do they measure, track and communicate how they create value within their organization?
  - Does this align with the MCO definitions of value?
What Providers Need to Demonstrate in Relation to Value

- Do providers have critical or innovative partnerships with other providers?
- How robust are the providers quality measures
  - Providers will need to work toward predictive modeling, process, and outcomes measures – become part of the conversation
- Understand the need for health information and plan to facilitate integrations and collaboration
  - Tracking, quality, claims, cost, care transitions, and disease management will be critical
  - For providers who are just beginning to implement IT systems provide information on what you use, how data can be shared, what your expectations are, and which systems “play well together”
Elimination through natural competition

Have large, robust network

MCO Driven Network Pruning

Limited network to select providers
Activity 3: Exploration of Network Management Strategies

How do you currently manage your network?

What are the pros and cons of this approach?

Is your current strategy putting you at risk in the future?
SHIFTING MINDSETS FOR SUCCESS
Shifting Mindsets for Success

- MCOs need to be keenly aware of healthcare industry pressures on providers and how this will impact them as payers.
- Provider failure = MCO failure

Provider Risk
- Emphasis on effective treatment which is cost efficient

Payer Viability
- At risk payers dependent upon providers to realize cost savings and quality metrics

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Shifting Mindsets for Success

• Payers, providers, the government and consumers are moving toward a healthcare delivery system which is more closely connected than ever, and in which the emphasis is shifting from volume to value.
• Population health management will be critical as a component for remaining economically viable.
• Data and metrics will be the new centerpiece of management of care and quality.
Shifting Mindsets for Success

- The emphasis on value in the new reform environment cannot be overstated.
- MCOs need to be clear on how they define value, what they measure, and how they integrate data systems with providers.
- Emerging purchasing agreements which are value based will pose a unique opportunity for the MCOs to improve care, control spend, and realize the goals of reform.
Change Implementation Strategies

- Generate a sense of urgency
- Build a coalition throughout the system (MCO and providers)
- Create and share a vision for process and outcome improvement
- Instigate success recognizing lessons learned
- Communicate and recognize short term wins
- Empower partnerships to identify and eliminate obstacles
- Sustain change by emphasizing new patient management techniques and treatments
- Highlight network standouts
- Duplicate provider success throughout the network by replication of transition

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