You Can’t Act If You Don’t Know: Understanding New Contracting Models
Really knowing is good. Not knowing, or refusing to know, is bad. . .

Acting without knowing takes you right off the cliff.

— Ray Bradbury, *Something Wicked This Way Comes*
Agenda

I. Current Trends In Performance Measurement
II. From Performance Measurement To Pay-For-Performance (P4P) & Risk-Based Contracting
III. Examples Of P4P & Risk-Based Reimbursement Contracts
IV. Strategies To Prepare For & Manage P4P & Risk-Based Contracts
I. Current Trends In Performance Measurement
Drivers Of Performance Measurement & Performance-Based Contracting

1. Government budget deficits – and desire to get the most from available dollars
2. Policy focus of moving from lowest cost per unit to ‘value’ of service
3. Increased interest in transparency of performance of health care systems, provider organizations and professionals
   ◦ Increase ‘pressure’ for improvement
   ◦ Facilitate consumer–directed care
4. “Death” of FFS
Objectives Of P4P In Behavioral Health

- Link professional, service provider organization, and care manager reimbursement to desired outcomes and quality improvements
  - Improved access to care
  - Increase care integration and coordination
  - Person-centered planning and recovery focus
- 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
<table>
<thead>
<tr>
<th>More Organizations Are “Rating” Performance In Health Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMS Quality Initiatives</td>
</tr>
<tr>
<td>National Committee for Quality Assurance (NCQA)</td>
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<tr>
<td>National Quality Forum (NQF)</td>
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<tr>
<td>Substance Abuse and Mental Health Services Administration (SAMHSA)</td>
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<tr>
<td>The Joint Commission</td>
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<tr>
<td>Center For Excellence in Assisted Living</td>
</tr>
<tr>
<td>Care management organizations (HMOs, MCOs, PPOs, ACOs, etc.)</td>
</tr>
<tr>
<td>Consumer–driven open–source rating organizations</td>
</tr>
</tbody>
</table>
## 1. Centers For Medicare & Medicaid Services Quality Initiatives

<table>
<thead>
<tr>
<th>CMS Program</th>
<th>Enrollment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare</td>
<td>47,672,971 (15% of population)</td>
</tr>
<tr>
<td>Medicaid</td>
<td>50,314,600 (20% of population)</td>
</tr>
<tr>
<td>CHIP</td>
<td>7,705,723 (3% of population)</td>
</tr>
</tbody>
</table>
Current CMS Quality Initiatives

- Medicare Quality Care Finder
- Star Quality Rating System
- Physician Quality Reporting System
Launched in August 2011

Find & Compare...

Doctors, Hospitals, Plans and Suppliers

- Get contact information for hospitals, doctors, nursing homes, home health agencies, dialysis facilities, and drug and health plans.

- Compare information about the quality of care and services these providers and plans offer.

- Get helpful tips on what to look for when comparing and choosing a provider or plan.

Select a compare tool from the left to get started

Additional Resources
- Medigap Policy Search
- Long-Term Care Planning
- Formulary Finder
- Medicare Supplier Directory

Contact Medicare
- 1-800-MEDICARE (1-800-633-4227)
- 1-877-486-2048 (TTY)

Learn about the Affordable Care Act
Measures In Medicare Quality Care Finder: Hospital Compare

1. Process of care measures
2. Outcome of care measures
   ◦ Hospital readmission rate compared to national average
   ◦ Hospital mortality rate compared to national average
3. Use of medical imaging
4. Patients' hospital experiences
   ◦ Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)
5. Patient safety measures
   ◦ Serious complications and deaths
   ◦ Hospital acquired conditions
6. Medicare payment and volume
Medicare Quality Care Care Finder – Comparing Three Hospitals In Louisiana

Bars below tell the percent of patients at each hospital who reported that YES, they were given information about what to do during their recovery at home.

Were patients given information about what to do during their recovery at home?

- Average for all Reporting Hospitals in The United States: 82%
- Average for all Reporting Hospitals in Louisiana: 82%
- BATON ROUGE GENERAL MEDICAL CENTER: 76%
- EARL K. LONG MEDICAL CENTER: 80%
- WOMANS HOSPITAL: 87%
Medicare Quality Care Finder – Comparing Three Hospitals In Pennsylvania

How often did nurses communicate well with patients?

These results are from patients who had overnight hospital stays from January 2010 through December 2010.

Patients reported how often their nurses communicated well with them during their hospital stay. "Communicated well" means nurses explained things clearly, listened carefully to the patient, and treated the patient with courtesy and respect.

How often did nurses communicate well with patients?

- Average for all Reporting Hospitals in the United States: 76%
- Average for all Reporting Hospitals in Pennsylvania: 76%
- HAHNEMANN UNIVERSITY HOSPITAL: 79%
- PENNSYLVANIA HOSP OF THE UNIV OF PA HEALTH SYS: 71%
- THOMAS JEFFERSON UNIVERSITY HOSPITAL: 77%
These results are from patients who had overnight hospital stays from January 2010 through December 2010.

If patients were given medicine that they had not taken before, the survey asked how often staff explained about the medicine. “Explained” means that hospital staff told what the medicine was for and what side effects it might have before they gave it to the patient.

Bars below tell the percent of patients who reported that staff "always" explained about medicines before giving it to them.

How often did staff explain about medicines before giving them to patients?

- Average for all Reporting Hospitals in The United States: 61%
- Average for all Reporting Hospitals in Pennsylvania: 59%
- HAHNEMANN UNIVERSITY HOSPITAL: 69%
- THOMAS JEFFERSON UNIVERSITY HOSPITAL: 61%
- VIRTUA MEMORIAL HOSPITAL OF BURLINGTON COUNTY: 60%
Graph 14 of 22 How often the home health team taught patients (or their family caregivers) about their drugs.

This information comes from the Home Health Outcome and Assessment Information Set (OASIS) C during the time period July 2010 – June 2011.

How often the home health team taught patients (or their family caregivers) about their drugs.

- **Average for all Reporting Agencies in The United States**: 87%
- **Average for all Reporting Agencies in Pennsylvania**: 90%
- **Abington Memorial Hospital Home Care**: 100%
- **Abramson Home Care**: 97%
- **Amedisys Home Health**: 82%
<table>
<thead>
<tr>
<th>Nursing Home</th>
<th>Overall Rating</th>
<th>Health Inspections</th>
<th>Nursing Home Staffing</th>
<th>Quality Measures</th>
<th>Fire Safety Inspections</th>
<th>Penalties and Denials of Payment Against the Nursing Home</th>
<th>Complaints and Incidents</th>
<th>Nursing Home Characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ANGELA JANE PAVILION</strong>&lt;br&gt;8410 ROOSEVELT BLVD&lt;br&gt;PHILADELPHIA, PA 19152&lt;br&gt;(215) 708-1200</td>
<td>★★★★★ 5 out of 5 stars</td>
<td>★★★★★ 5 out of 5 stars</td>
<td>★★★★ 4 out of 5 stars</td>
<td>★★★★ 4 out of 5 stars</td>
<td>6 Fire Safety Deficiencies</td>
<td>0 Civil Money Penalties 0 Payment Denials</td>
<td>1 Complaints 0 Incidents</td>
<td>Program Participation: Medicare&lt;br&gt;Number of Certified Beds: 49 Certified Beds&lt;br&gt;Type of Ownership: For profit - Partnership&lt;br&gt;Continuing Care Retirement Community: No&lt;br&gt;Located in a Hospital: No</td>
</tr>
<tr>
<td><strong>BETHANY VILLAGE RETIREMENT CENTER</strong>&lt;br&gt;5225 WILSON LANE&lt;br&gt;MECHANICSBURG, PA 17055&lt;br&gt;(717) 766-0279</td>
<td>★★★☆☆ 3 out of 5 stars</td>
<td>★★★★★ 5 out of 5 stars</td>
<td>★★★★ 4 out of 5 stars</td>
<td>★★★★ 4 out of 5 stars</td>
<td>7 Fire Safety Deficiencies</td>
<td>1 Civil Money Penalties 0 Payment Denials</td>
<td>1 Complaints 1 Incidents</td>
<td>Program Participation: Medicare and Medicaid&lt;br&gt;Number of Certified Beds: 69 Certified Beds&lt;br&gt;Type of Ownership: Non profit - Corporation&lt;br&gt;Continuing Care Retirement Community: Yes&lt;br&gt;Located in a Hospital: No</td>
</tr>
<tr>
<td><strong>CHESTNUT HILL LODGE HEALTH AND REHAB CTR</strong>&lt;br&gt;8833 STENTON AVENUE&lt;br&gt;WYNWOOD, PA 19033&lt;br&gt;(215) 836-2100</td>
<td>★☆☆☆☆ 1 out of 5 stars</td>
<td>★☆☆☆☆ 1 out of 5 stars</td>
<td>★★★★ 3 out of 5 stars</td>
<td>★★★★ 3 out of 5 stars</td>
<td>9 Fire Safety Deficiencies</td>
<td>0 Civil Money Penalties 0 Payment Denials</td>
<td>7 Complaints 0 Incidents</td>
<td>Program Participation: Medicare and Medicaid&lt;br&gt;Number of Certified Beds: 200 Certified Beds&lt;br&gt;Type of Ownership: For profit - Corporation&lt;br&gt;Continuing Care Retirement Community: No&lt;br&gt;Located in a Hospital: No</td>
</tr>
</tbody>
</table>
Medicare Star Quality Rating System

• The Medicare Star Quality Rating System was enacted with federal health care reform to improve the quality of care provided by private Medicare plans.

• The system compares how well Medicare Advantage plans perform based on 50 quality measures assessed across five categories:
  ◦ Staying healthy
  ◦ Managing chronic conditions
  ◦ Customer services
  ◦ Pharmacy services
  ◦ Member satisfaction
Examples Of Measures In Medicare Star Quality Rating System

• Performance measures that are derived from plan and beneficiary information collected in administrative data and data from three surveys:
  ◦ Healthcare Effectiveness Data and Information Set (HEDIS)
  ◦ Consumer Assessment of Healthcare Providers and Systems (CAHPS)
  ◦ Health Outcomes Survey (HOS) – and administrative data
### Geisinger Gold Classic 3 $0 Deductible Rx (HMO) (H3954-100-0)

**Organization:** Geisinger Gold

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<thead>
<tr>
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<tbody>
<tr>
<td>$13.90 Drug: $13.90 Health: $0.00</td>
<td>$13.90 Health Plan Deductible: $1,300 In-Network Drug Copay/Coinsurance: $1.10 - $3.30</td>
<td>Doctor Choice: Plan Doctors Only Out of Pocket Spending Limit: $1,500 In-Network No Gap Coverage</td>
<td>All Your Drugs on Formulary: N/A Drug Restrictions: N/A</td>
<td>$2,100</td>
<td><img src="image" alt="4.5 out of 5 stars" /></td>
<td><img src="image" alt="4.5 out of 5 stars" /></td>
<td><img src="image" alt="4.5 out of 5 stars" /></td>
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### FreedomBlue PPO HD Rx (PPO) (H3916-025-0)

**Organization:** Highmark Inc.

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<tbody>
<tr>
<td>$0.00 Drug: $0.00 Health: $0.00</td>
<td>$0.00 Health Plan Deductible: $0 In-Network Drug Copay/Coinsurance: $1.10 - $3.30</td>
<td>Doctor Choice: Any Doctor Out of Pocket Spending Limit: $2,700 In-Network $4,500 In and Out-of-Network No Gap Coverage</td>
<td>All Your Drugs on Formulary: N/A Drug Restrictions: N/A</td>
<td>$2,200</td>
<td><img src="image" alt="3.5 out of 5 stars" /></td>
<td><img src="image" alt="3.5 out of 5 stars" /></td>
<td><img src="image" alt="3.5 out of 5 stars" /></td>
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### Advanta Elite (PPO) (H5522-008-0)

**Organization:** HealthAmerica

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</thead>
<tbody>
<tr>
<td>$0.00 Drug: $0.00 Health: $0.00</td>
<td>$0.00 Health Plan Deductible: $0 In-Network Drug Copay/Coinsurance: $1.10 - $3.30</td>
<td>Doctor Choice: Any Doctor Out of Pocket Spending Limit: $6,400 In-Network $10,000 In and Out-of-Network No Gap Coverage</td>
<td>All Your Drugs on Formulary: N/A Drug Restrictions: N/A</td>
<td>$2,450</td>
<td><img src="image" alt="3.5 out of 5 stars" /></td>
<td><img src="image" alt="3.5 out of 5 stars" /></td>
<td><img src="image" alt="3.5 out of 5 stars" /></td>
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</table>
Physician Quality Reporting System

• PQRS is a Congressionally created mandate for physicians to provide quality data to CMS
• The program is voluntary – but provides incentive payments to eligible physicians (EPs) and other professionals who satisfactorily report data on quality measures for covered services
• CMS provides a 1% incentive payment in 2011 and 0.5 percent incentive payments in 2012 – 2014 for successfully reporting PQRS measures
• Penalties will begin in 2015 for those who do not satisfactorily submit quality data
• CMS proposes to include 198 measures individual EPs can report in 2011
  ◦ Claims–based reporting measures
  ◦ Registry–based reporting measures
  ◦ New individual measures
  ◦ EHR–based reporting measures
Examples Of Measures In Physician Reporting System: Major Depressive Disorder

- **Antidepressant Medication During Acute Phase for Patients with MDD** – Percentage of patients aged 18 years and older diagnosed with new episode of MDD and documented as treated with antidepressant medication during the entire 84-day (12-week) acute treatment phase
- **Diagnostic Evaluation** – Percentage of patients aged 18 years and older with a new diagnosis or recurrent episode of MDD who met the DSM-IV criteria during the visit in which the new diagnosis or recurrent episode was identified during the measurement period
- **Suicide Risk Assessment** – Percentage of patients aged 18 years and older with a new diagnosis or recurrent episode of MDD who had a suicide risk assessment completed at each visit during the measurement period
Examples Of Measures In Physician Reporting System: Substance Use Disorders

- Counseling Regarding Psychosocial and Pharmacologic Treatment Options for Alcohol Dependence — Percentage of patients aged 18 years and older with a diagnosis of current alcohol dependence who were counseled regarding psychosocial AND pharmacologic treatment options for alcohol dependence within the 12-month reporting period

- Screening for Depression Among Patients with Substance Abuse or Dependence — Percentage of patients aged 18 years and older with a diagnosis of current substance abuse or dependence who were screened for depression within the 12-month reporting period
## 2. National Committee For Quality Assurance

<table>
<thead>
<tr>
<th>NCQA Quality Initiatives</th>
<th>NCQA Accreditation Programs</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Healthcare Effectiveness Data and Information Set (HEDIS)</td>
<td>• Health plan and new health plans</td>
</tr>
<tr>
<td>• Health Plan Report Card</td>
<td>• Managed behavioral healthcare organizations</td>
</tr>
<tr>
<td></td>
<td>• Disease management programs</td>
</tr>
<tr>
<td></td>
<td>• Wellness and health promotion programs</td>
</tr>
<tr>
<td></td>
<td>• Accountable care organizations</td>
</tr>
<tr>
<td></td>
<td>• Patient–centered medical homes (recognized practice)</td>
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</tbody>
</table>
NCQA’s HEDIS Measures

- HEDIS is a tool used by more than 90 percent of America's health plans to measure performance
- Creates a standard data set when comparing performance of health plans
- 75 measures across 8 domains of care

**HEDIS Measures Relevant To Behavioral Health**

<table>
<thead>
<tr>
<th>Measure</th>
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</thead>
<tbody>
<tr>
<td>Antidepressant medication management</td>
</tr>
<tr>
<td>Follow-up care for children prescribed attention-deficit/hyperactivity disorder medication</td>
</tr>
<tr>
<td>Initiation and engagement of alcohol and other drug dependence treatment</td>
</tr>
</tbody>
</table>
Proposed New HEDIS® Measures for SMI Consumers

**Use of antipsychotic medications**

The percentage of members 25–64 years of age with a diagnosis of schizophrenia who remained on an antipsychotic medication for at least 80% of their treatment period.

**Definition**

An average of 65.7% of the individuals maintained continuous treatment with an antipsychotic for at least 80% of the time. The range across the states was 48.3% to 84.6%.

**Follow-up after hospitalization at seven and 30 days**

The percentage of members 25–64 years of age with a diagnosis of schizophrenia who had an outpatient visit, intensive outpatient encounter, or partial hospitalization following discharge from a hospitalization for schizophrenia.

**Follow-up**

An average of 36% of individuals received follow-up care at seven days and 69.7% received follow-up care at 30 days. The range across the states was 8.3% to 66.1% for seven days, and 25.6% to 88.5% for 30 days.

**Cardiovascular screening**

The percentage of members 25–64 years of age who were diagnosed with schizophrenia or bipolar disorder and prescribed any antipsychotic medication, and who received a cardiovascular health screening during the measurement year.

**Screening**

An average of 43.9% of individuals received cardiovascular health screening. The range across the states was 6.9% to 63.3%.
Proposed New HEDIS® Measures for SMI Consumers

**Diabetes monitoring**

The percentage of members 25–64 years of age who were diagnosed with schizophrenia and with diabetes, and received both an LDL–C test and an HbA1c test during the measurement year.

An average of 57.3% of individuals received LDL–C test and an HbA1c test. The range across the states was 9.1% to 81.6%.

**Cardiovascular monitoring**

The percentage of members 25–64 years of age with a diagnosis of schizophrenia and a diagnosis of cardiovascular disease, who received a cardiovascular health monitoring test during the measurement year.

An average of 54.5% of individuals received cardiovascular health monitoring test. The range across the states was 11.7% to 85.7%.

**Diabetes screening**

The percentage of members 25–64 years of age with a diagnosis of schizophrenia or a diagnosis of bipolar disorder, who were prescribed any antipsychotic medication and received a diabetes screening test during the measurement year.

An average of 12.1% of individuals received diabetes screening test. The range across the states was 2.3% to 28.2%.
NCQA’s Health Plan Report Card compares the performance of NCQA–accredited health plans across the country based on HEDIS measures.
Humana Health Benefit Plan of Louisiana: Health Plan Report Card

<table>
<thead>
<tr>
<th>General Information</th>
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<tbody>
<tr>
<td><strong>Plan Type:</strong></td>
</tr>
<tr>
<td><strong>Accredited Product:</strong></td>
</tr>
<tr>
<td><strong>Address:</strong></td>
</tr>
<tr>
<td><strong>Number of members enrolled:</strong></td>
</tr>
<tr>
<td><strong>Website:</strong></td>
</tr>
<tr>
<td><strong>Other Names:</strong></td>
</tr>
</tbody>
</table>

**This health plan serves members in the following state(s):**
Louisiana

**For specific areas covered, please contact the plan directly.**

<table>
<thead>
<tr>
<th>Accreditation Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Accreditation Type:</strong></td>
</tr>
<tr>
<td><strong>Expiration Date:</strong></td>
</tr>
<tr>
<td><strong>Date of Next Review:</strong></td>
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<tr>
<td><strong>HEDIS measures included in results:</strong></td>
</tr>
<tr>
<td><strong>CAHPS measures included in results:</strong></td>
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<thead>
<tr>
<th>Performance Results</th>
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</thead>
<tbody>
<tr>
<td><strong>Accreditation Status:</strong></td>
</tr>
</tbody>
</table>

**Accreditation Star Ratings**
- Access and Service: ★★★★★
- Qualified Providers: ★★★★★
- Staying Healthy: ★★★☆☆
- Getting Better: ★★★★★
- Living with Illness: ★★★★★

# Health Plan Report Card Comparison Function

<table>
<thead>
<tr>
<th>Plan Name</th>
<th>Plan Type</th>
<th>Accredited Product</th>
<th>Accreditation Type</th>
<th>Access and Service</th>
<th>Qualified Providers</th>
<th>Staying Healthy</th>
<th>Getting Better</th>
<th>Living with Illness</th>
<th>Overall Accreditation Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aetna Life Insurance Company (Louisiana)</td>
<td>Commercial</td>
<td>PPO</td>
<td>Health Plan Accreditation</td>
<td>★★★★★</td>
<td>★★★★★</td>
<td>★★★☆☆</td>
<td>★★★☆☆</td>
<td>★★★☆☆</td>
<td>Commendable</td>
</tr>
<tr>
<td>UnitedHealthcare of Louisiana, Inc.</td>
<td>Commercial</td>
<td>HMO/POS Combined</td>
<td>Health Plan Accreditation</td>
<td>★★★★★</td>
<td>★★★★★</td>
<td>★★★☆☆</td>
<td>★★★☆☆</td>
<td>★★★☆☆</td>
<td>Commendable</td>
</tr>
<tr>
<td>Humana Health Benefit Plan of Louisiana</td>
<td>Medicare</td>
<td>HMO</td>
<td>Health Plan Accreditation</td>
<td>★★★★★</td>
<td>★★★★★</td>
<td>★★★☆☆</td>
<td>★★★☆☆</td>
<td>★★★☆☆</td>
<td>Excellent</td>
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</tbody>
</table>
The National Quality Forum (NQF) is a not–for–profit membership organization created to develop and implement a national strategy for health care quality measurement and reporting.

The NQF represents over 375 organizations:
- Public and private purchasers
- Health care professionals
- Provider organizations
- Organizations involved in health care research or quality improvement
- Health plans
- Accrediting bodies
NQF Measurement Domains

1. Ambulatory care
2. Behavioral health/psychiatric
3. Emergency medical services/ambulance
4. Home health
5. Hospice
6. Hospital/acute care facility
7. Imaging facility
8. Laboratory
9. Pharmacy
10. Post acute/long term care
NQF–Endorsed Standard Development Process

• NQF uses its formal consensus development process to evaluate and endorse consensus standards which includes:
  ◦ Performance measures
  ◦ Best practices
  ◦ Frameworks
  ◦ Reporting guidelines

• NQF uses this process to ensure the standards going forward are representative of the health care industry as a whole
NQF–Endorsed Behavioral Health Performance Measures

1. Use and adherence to antipsychotics among members with schizophrenia
2. Depression remission at six months
3. Depression remission at twelve months
4. Utilization of the patient health depression questionnaire
5. Inpatient consumer survey
6. Bipolar disorder and major depression: appraisal for alcohol or chemical substance use
7. Child and adolescent major depressive disorder: diagnostic evaluation
8. Follow-up after hospitalization for mental illness
9. Major depressive disorder: diagnostic evaluation
## NQF Proposed Multiple Chronic Condition Measures

<table>
<thead>
<tr>
<th>High Priority Multiple Chronic Condition Measure Concepts</th>
<th>Corresponding High Priority Illustrative Measures</th>
</tr>
</thead>
</table>
| **Optimize function, maintain function, or prevent decline in function** | • Long-stay nursing home residents with moderate-severe pain  
• Long-stay nursing home residents with depressive symptoms  
• Change in basic mobility or function for post-acute care  
• Functional capacity and HRQL in COPD patients before and after pulmonary rehab  
• Lower back pain: pain and functional status assessment  
• SF-36 and SF-12 surveys |
| **Seamless transitions between multiple providers and sites of care** | • Care Transition Measure—CTM-3  
• Transition record with specified elements received by discharged patients |
| **Access to usual source of care** | • People unable to get or delayed getting needed medical care, dental care or prescription medications  
• Access problems due to cost  
• Children with special healthcare needs with access to medical home |
| **Shared accountability that includes patients, families, and providers** | • Children with effective care coordination and with a medical home |
NQF Proposed Multiple Chronic Condition Measures *(cont)*

<table>
<thead>
<tr>
<th>High Priority Multiple Chronic Condition Measure Concepts</th>
<th>Corresponding High Priority Illustrative Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient clinical outcomes (e.g. mortality, morbidity)</strong></td>
<td>• Health outcomes—mortality and morbidity</td>
</tr>
</tbody>
</table>
| **Avoid inappropriate, non-beneficial end-of-life care** | • Hospice patients who didn’t receive care consistent with end-of-life wishes  
• CARE mortality follow back survey of bereaved family members  
• Inappropriate non-palliative services at end of life  
• Preventable ED visits |
| **Transparency of cost (total cost)** | • Average annual expenditures per consumer unit for healthcare  
• Consumer price indexes of medical care prices  
• Personal health care expenditures, by source of funds |
| **Shared decision-making** | • Persons whose healthcare providers always involved them in decisions about their healthcare as much as they wanted |
Joint Commission Accreditation Programs

Accreditation programs in key areas:

- Ambulatory health care
- Behavioral health care
- Critical access hospitals
- Home care
- Hospital
- Laboratory services
- Long term care
- Office–based surgery
Joint Commission Performance Measures For Behavioral Health

• Hours of physical restraint use
• Hours of seclusion
• Multiple antipsychotic medications at discharge – overall rate
• Multiple antipsychotic medications at discharge with appropriate justification – overall rate
• Post discharge continuing care plan – overall rate
• Post discharge continuing care plan transmitted – overall rate
Center For Excellence In Assisted Living (CEAL)

• Non-profit collaborative of 11 national organizations, has published recommendations for nine domains for assessing person-centered home and community-based services (HCBS) attributes and assisted living indicators
• The project was undertaken with Commonwealth Fund support and the recommendations have been submitted the Centers for Medicare and Medicaid Services (CMS), which is in the process of identifying person-centered attributes and indicators for its Medicaid HCBS programs
CEAL Performance Measurement Domains

1. Core values and philosophy reflect personhood; respect and dignity; autonomy, choice and independence; and privacy
2. Relationships and sense of community reflect and support belonging
3. Governance/ownership values, policies, and practices incorporate and operationalize person-centered principles
4. Leadership systems demonstrate understanding of person-centered principles and support staff empowerment
5. Workforce practices for staff and volunteers support person-centered principles
6. Meaningful life and engagement is supported by soliciting resident preferences and offering them relevant choices
7. Service delivery and schedules support resident preferences
8. Environment, or the facility spaces and visitor policies
9. Accountability on the part of the facility to use resident and staff feedback in quality improvement processes
II. From Performance Measurement To Pay-For-Performance (P4P) & Risk-Based Contracting
From Performance Measurement To Pay–For–Performance

• With better performance measurement, payers able to move systems to P4P and risk–based contracting
• Pay–for–performance (P4P) is a term that describes health care payment systems that offer financial rewards to organizations (can be care management organizations, provider organizations, or professionals) that achieve, improve, or exceed their performance on specified quality, cost, and other benchmarks
• Most approaches adjust aggregate payments on the basis of performance on a number of different measures
• Payments may be made at the individual professional, service provider, provider group, or care management system level
Growing Use Of Pay–For–Performance

• Over 100 P4P initiatives nationwide sponsored by health plans, employer coalitions, and public insurance programs.
• P4P initiative examples include:
  ◦ Medicaid Behavioral Health Managed Care Systems
  ◦ Bridges to Excellence
  ◦ CMS Medicare Star Quality Rating System
  ◦ CMS Value–Based Purchasing Initiative
Three Types of Risk-Based Financing & Reimbursement Options Are Emerging (Can Be With P4P Provisions)

1. Fee-for-service
2. Case rates, episode-based payments, or bundled payment rates
3. Capitation (and subcapitation)
Fee–For–Service

- Provider paid 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 consumers
- Other?
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
Case Rate Type: Episode-Based Payments

• Payment by episodes of care
• Episodes of care have two major dimensions:
  ◦ a clinical dimension, including what services or clinical conditions comprise the episode
  ◦ a time dimension that reflects the beginning, middle and end of an episode
• Commonly includes a number of treating professionals
Case Rate Type: Bundled Payment Rates

• Definition: Bundling patient costs into a single payment irrespective of the kinds and quantities of the services provided.
Case Rate – Reimbursed Programs

• Types of case rates
  ◦ Single service per episode
  ◦ Single service over specific time period
  ◦ “Package” of consumer services over specific time period – single, multiple, or entire consumer populations

• Case rate contracting
  ◦ Risk of controlling cost per case
  ◦ A function of both # of units used and cost per unit of service
## Wide Range Of Case Rates

<table>
<thead>
<tr>
<th>State/Initiative</th>
<th>Financing &amp; Approximate Rates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Connecticut Continuum of Care Model</td>
<td>Case rate, about $48,000 for 15 month, plus bonus tied to performance</td>
</tr>
<tr>
<td>Delaware CPS Low Risk Intervention</td>
<td>Case rate with 2 providers, $1250–$1500, with a $250 bonus (other providers FFS)</td>
</tr>
<tr>
<td>Delaware</td>
<td>$4,239 per child per service month</td>
</tr>
<tr>
<td>Family Builders</td>
<td>Case rate $3,500</td>
</tr>
<tr>
<td>Florida District 13</td>
<td>Case rate of $15,200 FY98, now capitated</td>
</tr>
<tr>
<td>Foster Care</td>
<td>Case rate $14,022 for 1–year reunification</td>
</tr>
<tr>
<td>Indiana</td>
<td>$2,000 annually (SED), $2,500 annually (substance abuse)</td>
</tr>
<tr>
<td>Indiana Child Welfare Demonstration</td>
<td>Case rate of no more than $9,000 per child. $20.4 million for 24 months</td>
</tr>
<tr>
<td>Kansas Family Preservation</td>
<td>Case rate $3,719 for 1 year</td>
</tr>
<tr>
<td>Maryland Baltimore City</td>
<td>Case rate for 3 years, not yet established, not more that $3500 per month</td>
</tr>
<tr>
<td>Massachusetts Commonworks</td>
<td>Leads have case rate of $4,447</td>
</tr>
<tr>
<td>Michigan–Michigan Families</td>
<td>Case rate of $1,500 per month per case for IV–E eligible, plus other state and local $</td>
</tr>
<tr>
<td>Ohio Hamilton County Creative Connections</td>
<td>Case rate $3130.29 per member per month</td>
</tr>
<tr>
<td>Oklahoma Children's Service Initiative</td>
<td>No risk Year 1, up to $3000 per family, with up to $400 in goods; case rate Year 2, perhaps $400 per month for up to 6 months</td>
</tr>
<tr>
<td>Permanency–Focused Reimbursement</td>
<td>Performance–based: $1,700 initial, $14.95 per day, $1,500 for meeting permanency goal or TPR, Bonus of $750 for good outcome at 6 months post–placement</td>
</tr>
<tr>
<td>South Carolina Privatized Adoption</td>
<td>FFS, performance–based schedule of payments, maximum of $13000 per child; $15,700 per sibling group</td>
</tr>
<tr>
<td>Texas Project PACE</td>
<td>Fixed daily rate of $72.40 per day, regardless of level of care. Case rate possible in later years</td>
</tr>
<tr>
<td>Wisconsin</td>
<td>$2,200 per child per service month (Dane County)</td>
</tr>
</tbody>
</table>
What Contracting Factors Affect Successful Management Of Case Rates?

• Cost per case is function of:
  ◦ Patient population
  ◦ Average utilization per patient
  ◦ Unit cost

• Specific factors in case rate development:
  ◦ Control of assignment of cases
  ◦ Estimates of acuity and demand in population
  ◦ Limitation of range of services provided
  ◦ Ability of individuals to opt in/out – when and how
  ◦ Referral process for inpatient/residential services
Capitation (& Subcapitation)

• 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
Factors With Impact On Capitation Rates

• Consumer Utilization and Cost History
  • Number of enrollees, historical costs for two years, ALOS by age/diagnosis, total days by diagnosis, modality, case ratios, provider payments and facility costs

• Program Design Issues
  • Coverage, copayments and copayment differentials, out of pocket expenses, coverage maximums, “carve outs”, EAP, UR policy, provider restrictions, policy on pre-certification and emergency cases

• Benefit plan coverage provisions
  • Psychological testing, marriage counseling, smoking cessation, court ordered services, sexual dysfunction treatment, mental retardation coverage, obesity/weight reduction, AIDS, Alzheimer's, ADD, personal growth, etc.
Unit cost of care for each level of service

- Direct costs of each level of care
- Indirect/overhead costs of care
- Estimated administrative costs

ALOS/AVPC by diagnostic category of each level of care
III. Examples Of P4P & Risk-Based Reimbursement Contracts
CMS Hospital Value-Based Purchasing Initiative: FFS With P4P

- CMS value-based purchasing proposed rules link hospital payment to delivery of “high quality care”
  - Measures are a subset of those CMS adopted for its existing Medicare Hospital Inpatient Quality Reporting Program
- Payments based on whether a hospital meets or exceeds proposed performance standards or shows greatest improvement from previous year – score based on clinical process measures and consumer experience measures
- Medicare will cut payments to hospitals one percent and set that money aside for a bonus pool.
  - Bonus payments of $850 million in the first year
  - Bonus pool would increase to two percent of Medicare payments in October 2016
  - Bonus amounts not yet determined
CMS Value-Based Purchasing: Proposed Measures On Clinical Process

• 70% of score: Clinical process of care measures, based on Medicare hospital inpatient quality reporting program measures

• Five categories include:
  ◦ Acute myocardial infarction
  ◦ Heart failure
  ◦ Pneumonia
  ◦ Healthcare–associated infections
  ◦ Surgeries
CMS Value-Based Purchasing: Patient Experience Measures

- 30% of score: Patient experience, based on hospital consumer assessment
- Eight categories include:
  - Nurse communication
  - Doctor communication
  - Cleanliness and quietness of the hospital
  - Responsiveness of hospital staff
  - Pain management
  - Communications about medications
  - Discharge information
  - Overall rating
CMS Hospital Quality Demonstration Project (HQID): FFS With P4P

- Three-year pilot to incentivize hospitals to deliver highest quality of care.

- Focused on hospital quality performance in the following clinical areas: pneumonia, heart bypass, heart attack, heart failure, and hip and knee measures. In these five areas, hospitals participating in this project “raised overall quality by 11.8% in two years.”

- CMS awarded incentive payments of $8.7 million to 115 top-performing hospitals, representing the top 20% of hospitals in each of the project’s five clinical areas.

- Extended through 2010 to allow CMS to test new ways to measure quality and new incentive models.

- Hospitals are rewarded for meeting a defined quality threshold or demonstrating improvements to achieve them.
Bridges To Excellence: FFS with P4P

- Physicians and physician organizations in Albany, Boston, Cincinnati, and Louisville
- Measure categories assessed:
  - Diabetes care measures
  - Heart/stroke care
  - Physician office care—implementing information management systems
- Bonus structure:
  - Per member per year (PMPY) bonus for meeting requirements for certification in physician recognition programs in each measure category
  - $80–$100 PMPY for diabetes patients
  - $50 average PMPY for meeting physician office criteria
Prometheus Payment Model Of Episode-Based Payments

- Launched in 2006 by the Robert Wood Johnson Foundation Prometheus Payment Models are used at four pilot locations:
  - Crozer–Keystone Health System—Philadelphia, Pennsylvania
  - Health Partners—Minneapolis, Minnesota
  - Spectrum Health—Grand Rapids, Michigan
  - Employers Coalition on Health—Rockford, Illinois
- A bundled reimbursement for all health care services delivered in response to a particular health issue or for a package of treatment services that can be defined by diagnosis, time, or locale
- Prometheus packages payment around a comprehensive episode of medical care that covers all patient services related to a single illness or condition
Bundled payments ‘combine’ FFS payment – and replace FFS payment – by creating a single payment amount (the ‘bundle’) irrespective of the kinds and quantities of the services provided.

CMS recently issued applications for health systems interested in receiving bundled payments:

- The initiative will permit bundle payment across provider sites for multiple services given during an episode of care.
Bundled Payment Models

Model 1
- **An acute care hospital stay only** – for all MS–Diagnosis Related Groups (DRGs); the bundle includes all inpatient hospital services

Model 2
- **The acute care stay plus associated post–acute care** – for targeted clinical conditions based on MS–DRGs for an inpatient hospital stay; the bundle includes inpatient and physician services, related post–acute care services, related readmissions, and other services to be defined in the application

Model 3
- **Post–acute care following discharge** – for targeted clinical conditions based on MS–DRGs for an inpatient hospital stay; the bundle includes post–acute care services, related readmissions, and other services to be defined in the application

Model 4
- **Single prospective bundled payment for inpatient stays only** – for targeted clinical conditions based on MS–DRGs for an inpatient hospital stay; the bundle includes inpatient and physician services and related readmissions
Geisinger Health System’s ProvenCare Bundled Payment Model

- Launched bundled payments in 2006
- Bundled payment for all non-emergency coronary artery bypass surgery procedures, including preoperative evaluation, all hospital and professional fees, and management of any complications (including readmissions) within 90 days of procedure
- Lowered hospital costs by 5%; reduced average length of stay by 0.5 days; reduced complications by 21%; and reduced readmissions by 44%
Cuyahoga County Children’s Services Case Rate

2,600 children in specialized foster or higher levels of care (episode of care case rate)

- Lead agency model: Public agency contracts with a private organization to be responsible for coordinating or providing all necessary child welfare services
  - Lead agency can provide services directly or can subcontract with other local service providers to form a service provider network
- $53,000 per child for 12 and under and $56,000 for children up to 14 years
- Covers the period of custody to permanence + 9 months (12 for children that are adopted)
- 50% of children must achieve permanence in 12 months. Payment schedule is 18 equal monthly payments for each child
- Payments made even if permanency is achieved earlier. If child remains stable for 9 months, dollar obligation ends
- If child re-enters care, the contractor takes responsibility for care at the original rate
Pennsylvania’s DPW Welfare To Work: Incremental Case Rates

Pennsylvania Department of Welfare pays contractors for reaching milestones in individual cases

<table>
<thead>
<tr>
<th>Measure</th>
<th>Definition</th>
<th>Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participation</td>
<td>Client completes an assessment</td>
<td>$1,000</td>
</tr>
<tr>
<td>Placement</td>
<td>Client obtains unsubsidized employment</td>
<td>$1,000</td>
</tr>
<tr>
<td>Medical Benefits</td>
<td>Client obtains employment that includes medical benefits</td>
<td>$400</td>
</tr>
<tr>
<td>Job Retention</td>
<td>Client remains employed for 12 months</td>
<td>$1,600</td>
</tr>
</tbody>
</table>
Missouri Health Home Payment & Performance Measures: Capitated Care Management

- The Missouri CMHC health homes receive $78.74 per member per month
- Pay–for–performance funding based on CMHC performance against six benchmarks
  1. Completion rate of metabolic screenings
  2. Enrollment and outreach percentage of clients in The Disease Management 3700 Project (DM 3700)*
  3. Completion rate for CPS adult and youth status reports
  4. Completion rate for Mental Health Statistics Improvement Program (MHSIP) adult consumer surveys
  5. Cyber access patient history utilizations
  6. CMHC behavioral pharmacy management (BPM) benchmark report
Michigan Medicaid PIHPs: Behavioral Health Capitation

- Michigan Medicaid mental health services are financed on PMPM basis
  - Services are provided through 18 regional PIHPs, which are community mental health service programs (CMHSPs) or regional affiliations of CMHSPs
- PMPM ranged from $57 to $143 during the reporting period of October 1, 2006 through March 31, 2007
  - The average PMPM rate was $80
- Medicaid specialty services are provided in a variety of home- and community-based settings to individuals with developmental disabilities, mental illness, serious emotional disturbance, and substance use disorders
Iowa Medicaid Behavioral Health System Measures – P4P In Capitation System Payment

64+ measures with financial penalty or incentive:

1. **Readmission rate** Rate of mental health inpatient readmission by children and adults and overall at 7, 30, and 90 days. Monitor to the following:
   - 7–day readmission for children and adults
   - 30–day readmission by children and adults 15% or less
   - 90–day readmission by children and adults 25% or less

2. **Community Tenure** The average time between mental health hospitalizations shall not fall below 60 days for children and adults.

3. **Involuntary Hospitalization** The percent of involuntary admissions for mental health treatment to 24–hour inpatient settings shall not exceed 15% of all children admissions and 10% of all adult admissions.

4. **Service Array** At least 6% of mental health service expenditures will be used in the provision of integrated services and supports, including natural supports, consumer run programs, and services delivered in the home of the enrollee.
Pay–For–Performance With Medicare Star Quality Rating System: P4P In Capitated System

- Uses Medicare Star Quality Rating System to ‘reward’ good performance in private Medicare Advantage plans
- Rewards to high-performing Medicare Advantage plans
  - Beneficiaries allowed to enroll in 5-star Medicare Advantage plans throughout the year – not wait until open enrollment period
  - Additional financial compensation
    - Plans with three stars or better, will get bonuses of 3 to 5 percent of their total Medicare payments
- Plans that consistently score less than three stars could eventually be out of the Medicare program
  - Proposed regulation released early this year by the Medicare agency
IV. Strategies To Prepare For & Manage P4P & Risk-Based Contracts
The Market Situation. . .

- “Managed” types of models are coming to the market for all payers
- Within those models, many different P4P and risk-based contracting models are emerging
- Regardless of the specific models that are adopted, many of the same service delivery system effects are likely

The question – How to develop strategy to respond to the pending system changes?
Beyond FFS: More Case Rates & Capitated Contracts

**FFS Financing**

Payer (or MCO) maintains risk for unit cost and quantity of services used

Consumers request services

Provider organizations deliver services and are reimbursed based on volume

**Beyond FFS Financing**

Payer (or MCO) 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
# Common Financing Options For Behavioral Health Providers

<table>
<thead>
<tr>
<th>Structural Financing Options</th>
<th>Reimbursement Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACO Partner (FFS P4P Or Risk–based)</td>
<td>FFS, FFS with P4P, Case Rate, Episodic/Bundled Payment, Capitation</td>
</tr>
<tr>
<td>Specialty ACO Provider Or Partner</td>
<td>FFS, FFS with P4P, Case Rate, Episodic/Bundled Payment, Capitation</td>
</tr>
<tr>
<td>Medical Home Provider</td>
<td>FFS, FFS with P4P, Risk–based</td>
</tr>
<tr>
<td>Medical Home Partner</td>
<td>FFS, FFS with P4P</td>
</tr>
<tr>
<td>Health Home Provider</td>
<td>FFS, FFS with P4P, Case Rate, Capitation</td>
</tr>
<tr>
<td>Health Home Partner</td>
<td>FFS, FFS with P4P</td>
</tr>
<tr>
<td>Case Rate–reimbursed Specialty Program (By Population)</td>
<td>Case Rate, Episodic/Bundled Payment,</td>
</tr>
<tr>
<td>High–performing Network Provider And/Or “Center Of Excellence”</td>
<td>FFS, FFS with P4P, Case Rate, Episodic/Bundled Payment,</td>
</tr>
<tr>
<td>Network Provider</td>
<td>FFS</td>
</tr>
</tbody>
</table>
Managed Care Systems Require New Administrative Capabilities

<table>
<thead>
<tr>
<th>Provider Organization Administrative Capabilities</th>
<th>Care Management Organization Administrative Capabilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Managed care contracting and referral development</td>
<td>Member and customer service functions with eligibility determination</td>
</tr>
<tr>
<td>Systems to address preauthorization and utilization management requirements, including denials and appeals</td>
<td>Clinical and utilization management system</td>
</tr>
<tr>
<td>Enhanced clinical documentation requirements</td>
<td>Provider relations and network management</td>
</tr>
<tr>
<td>Billing and collections</td>
<td>Claims management and payment system</td>
</tr>
<tr>
<td>Collection of consumer payments – copayments, deductibles, non-covered services, etc.</td>
<td>Financial management system</td>
</tr>
<tr>
<td>Enhanced information systems capabilities to support care authorization, billing, reporting, and HIE</td>
<td>Organizational legal and financial requirements</td>
</tr>
<tr>
<td></td>
<td>Information systems and reporting systems</td>
</tr>
</tbody>
</table>
# Making New Models A Sustainable Reality Takes New Management Practices & Management Discipline

1. Develop vision of future competitive advantage and market positioning

2. Scenario-based strategic plan incorporating alternate future positioning options

3. Detailed plans – marketing, financial, operational, capital, HR, etc. – to implement strategy and future vision

4. Key performance metrics and metrics-based management to track strategy implementation (and allow mid-course adjustments)

5. Optimization of current operations to keep current programs as competitive (and profitable) as possible as long as possible

6. New service model development to support future vision

7. Collaborations as needed to facilitate new market vision
#1: Organizational Vision & Scenario-Based Planning For Managed Care System

1. In the new ‘managed care’ environment, what is the vision of your organization’s role in the future?

2. What are the market scenarios that are likely in your market – and how does that vision “fit” in each?

3. Which structural options are possible within each market scenarios?

4. What are the programmatic options that would work each market scenario?

The market scenarios will likely be driven by the MCOs, their ACOs, the BHOs, and emerging PCMHs.
Creating Your Future Vision

If you don't know where you are going, any road will get you there.
Lewis Carroll
#2: Market Research

1. MCOs and BHOs
2. Their ACOs and other preferred provider relationships
3. Primary care medical homes
4. Health homes

- Existing service provider organizations in network
- Service delivery gaps
- Range of possible contracting opportunities
- Competitive organizations (services, rates, etc.) for contracts and referrals from each
#3: “Feasibility” Analysis For Each Option

- Business model assumptions for possible contracts
  - Breakeven analysis
  - Profit/loss projections
- To create need the following information:
  - Service delivery managed care capabilities required (EHR, reporting, billing and collections, etc.)
  - Care management care capabilities required (care management processes, financial management, MCO IT capabilities, etc.)
  - Services reimbursed
  - Reimbursement rate
  - Service volume
  - Service cost (including deployment of technology)
  - Overhead costs
- Decisions about merger/collaboration needs
  - Breakeven point (volume and time) for model
  - Capital investment requirements and cash needs for start-up
  - Capabilities requirements
  - Contract acquisition requirements
#4. Contract Development & Negotiation

1. Final rate development
2. Terms of agreement
3. Stop loss provisions and arrangements
4. ‘Hold harmless’ period with payer
5. Implementation plan
Financial Management Focus Depend On Reimbursement Model

Fee–For–Service Contracting
• Risk of controlling cost per unit of service

Fee–For–Service Contracting With P4P
• Risk of controlling cost per unit of service
• Risk of managing performance metrics

Case Rate Contracting
• Risk of controlling cost per case
• A function of both # of units used and cost per unit of service

Full–Risk Capitation
• Risk of incidence in population
• Plus cost per case (# of units used and cost per unit of service)
Closing Thought

Great works are 1% inspiration and 99% perspiration. . .
The market intelligence to navigate.
The management expertise to succeed.