

Provider Readiness for Operating in Alternative Payment Environments



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Background

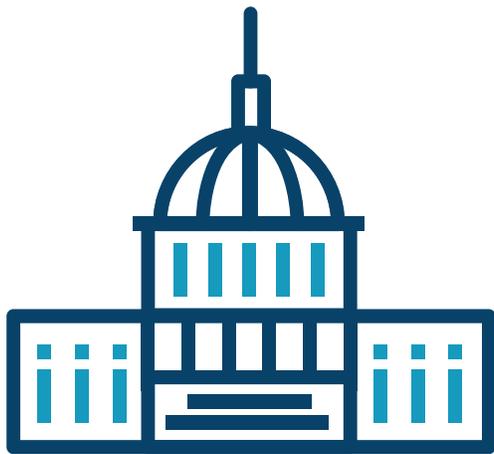
In 2010, the Affordable Care Act (ACA) set the stage for sweeping changes across the healthcare landscape and later long-term services and supports with its “Triple Aim.” The Triple Aim intends to improve the US healthcare system by:

1. Enhancing the experience of care
2. Improving the health of populations
3. Reducing the per-capita costs of health care

To achieve these goals, the ACA included several provisions targeting how healthcare is organized, delivered, and paid for with a focus on testing new models of delivery and focusing on the value of care versus volume.¹

Across the healthcare industry, improved outcomes and quality-of-life are key drivers of healthcare initiatives. As a result, healthcare payment systems, including Medicaid, are increasingly moving away from fee-for-service (FFS) models and shifting toward paying for value and outcomes which offer the potential for improvements in efficiency, quality, and flexibility in service provision.²

In a report published by ANCOR in 2019, the National Association of Medicaid Directors’ defined Alternative Payment Models (APMs) as strategies that change the way Medicaid providers are paid - moving away from FFS payments to methods of payment that incentivize value. The report also identifies Value-Based Payment (VBP) models as those models in which a state Medicaid program holds a provider or a managed care organization accountable for the costs and quality of care that they provide or pay for.³



1 - www.commonwealthfund.org/publications/issue-briefs/2015/may/affordable-care-acts-payment-and-delivery-system-reforms

2 - ANCOR.org; Value-Based Payment Models in I/DD Services

3 - ANCOR; Advancing Value & Quality in Medicaid Service Delivery for Individuals with Intellectual & Developmental Disabilities, January 2019

Alternate Payment Method Continuum

It is important to understand that the shift away from the traditional fee-for-service model of providing and paying for care is happening in several ways and can generally be categorized under what is known as the Alternate Payment Method Framework. Developed by the Health Care Payment Learning & Action Network,⁴ this model illustrates the four categories of payment and delivery models.

HCP LAN APM FRAMEWORK

|  |  |  |  |
|---|--|---|---|
| <p>CATEGORY 1 FFS - No Link to Quality & Value</p> | <p>CATEGORY 2 FFS - Linked to Quality & Value</p> | <p>CATEGORY 3 APMS Built on FFS Architecture</p> | <p>CATEGORY 4 Population-based Payment</p> |
| | <p>A</p> | <p>A</p> | <p>A</p> |
| | <p>Foundational Payments for Infrastructure & Operations (care coordination fees and payments for HIT investments)</p> | <p>APMs with Shared Savings (shared savings with upside only)</p> | <p>Condition-specific, Population-based Payment (per-member per-month payments and payments for specialty services, e.g. oncology or mental health)</p> |
| | <p>B</p> | <p>B</p> | <p>B</p> |
| | <p>Pay for Reporting (bonuses for reporting data or penalties for not reporting data)</p> | <p>APMs with Shared Savings and Downside Risk (episode-based payments for procedures and comprehensive payment with upside and downside risk)</p> | <p>Comprehensive Population-based Payment (global budgets or whole/partial premium payments)</p> |
| | <p>C</p> | <p>C</p> | <p>C</p> |
| <p>Pay for Performance (bonuses for quality performance)</p> | | | <p>Integrated Finance & Delivery System (global budgets or whole/partial premium payments in integrated systems)</p> |
| | | <p>3N Risk-based Payments NOT Linked to Quality</p> | <p>4N Capitated Payments NOT Linked to Quality</p> |

Category 1 is traditional FFS; Category 2 is based in FFS but links quality & value to enhanced payments or penalties; Category 3 offers APMs built on a FFS system and incorporate an element of risk-sharing between the funder and the provider; and Category 4 eliminates the FFS system and is based entirely on condition-specific and/or population-based payments. This category provides capitated funding or global budgets based on population attributes or specific conditions.

4 - <https://hcp-lan.org/apm-refresh-white-paper/#1466615468036-18abb176-bf37>

Current Trends

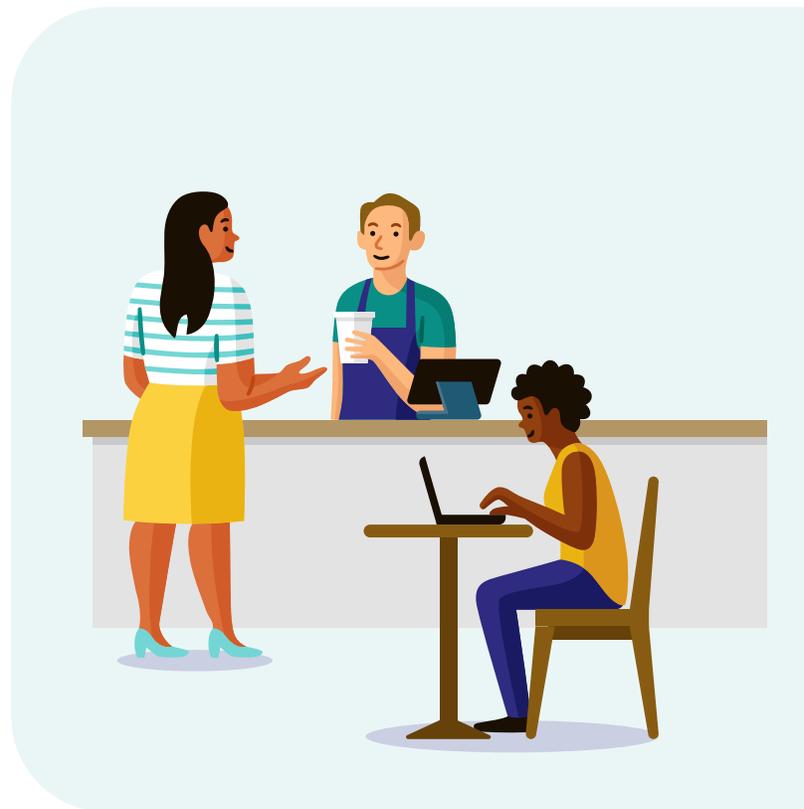
Currently most VBP initiatives in the I/DD LTSS space are tied to enhanced employment outcomes. This initiative tends to be used in behavioral health services. Several states are implementing enhanced payments for better outcomes, often with a predetermined threshold that must be met to qualify for the enhanced payment. These initiatives fall into Category 2 of the APM Framework.

Value Based Purchasing, Specifically in LTSS

So why are CMS and others looking to develop purchasing programs like this? In the current FFS paradigm, providers bill for units of service with little to no correlation to quality of service or the outcomes for the person.

In a 2019 report,⁵ value-based reimbursement was found to be a component of Medicaid managed care programs in 28 out of 40 states including recent additions – California, Colorado, District of Columbia, Kansas, Louisiana, and Wisconsin.⁶ Funders and payers are trying to ensure they are getting quality supports by restructuring payment methods to focus on positive outcomes. They want to apply the old adage “you get what you pay for.”

To achieve this objective, states are increasingly incorporating VBP methodology on top of established FFS billing systems. While the objective is laudable, this practice can further complicate an already challenging billing system. If lost revenue and missed opportunities result from the discrete benchmarks or thresholds that determine enhanced payments, it can be frustrating to providers. Generally there are two types of VBPs, those structured to incentivize the provider and those structured to penalize the provider.



5 - RevCycle Intelligence; More States Require Value-Based Reimbursement in Medicaid, October 2019

6 - www.openminds.com/market-intelligence/executive-briefings/the-vbr-mandate-medicaid-requirements-on-the-increase/

Incentive Payments

In the incentive model, providers are offered enhanced payments for achieving a certain level of quality or another specific outcome. For example, a contract may offer a \$10,000 bonus for reaching a threshold of 95% of “x” activity, but if the provider only reaches 92%, they do not collect any of the incentive. The provider may perceive this as a disincentive to participate or even demoralizing for getting no portion of the reward for nearly reaching the threshold.

If providers can negotiate a sliding scale approach to the incentive, they are better positioned to receive some compensation for

partial attainment of the goal versus none. This type of VBP structure must include an incentive payment generous enough, and also reasonably attainable, to motivate providers to meet or exceed the benchmark.



Payment Withholds

The withhold model focuses on funding a provider at a percentage less than the established rate for a specific service unless benchmarks are met. In this example, a payer may offer a provider a payment of 90% of the established rate for the service and then propose to pay the additional 10% when certain benchmarks are achieved. This method is particularly challenging in the I/DD LTSS sector as providers often report that states offer rates that are not enough to cover the cost of service provided. Many states have gone for years without rate increases or have only provided increases specifically earmarked for

personnel salaries. In this case, many providers contend that the implementation of the withhold payment model is detrimental to providers who are already underpaid, noting that they do not have the ability to “float” the full cost of services until the target is met.



The other challenge facing both versions of VBP is that there is not a widely agreed upon set of discrete quality measures in the long-term services and supports sector at this time. Unlike with healthcare delivery, people’s satisfaction with the services and quality of life is far more difficult to standardize and measure. There are several national organizations working to identify and quantify indicators of quality LTSS and individual satisfaction, but this conversation will likely continue for some time.

Managed Long-Term Services and Supports

Within the MLTSS model, Value Based Payment strategies are often included to drive improved outcomes for populations served, as described above. Payers may seek to incentivize performance and consumer outcomes with the use of a carrot (enhanced payments based on certain performance indicators or quality outcomes being met) or a stick (payment withholds pending the service provider meeting a certain threshold or outcome measure).

In a 2017 report by Truven Health Analytics,⁷ it was found that twenty-four states had implemented MLTSS since 2012. Of these twenty-four states, only ten include people with I/DD in their MLTSS program. These states include Arizona, Arkansas, Iowa, Kansas, Michigan, North Carolina, New York, Pennsylvania, Tennessee, and Wisconsin. Generally, we see states implementing a MLTSS program in the aging and behavioral health sectors but shying away from including people with

I/DD. This group has typically been carved-out for several reasons, but primarily because the population represents a high need, high cost segment of Medicaid recipients. Additionally, we find that MCOs have had limited experience with this population and have not had robust models for projecting cost trends or service coordination needs.

We are starting to see MCOs willingness to take on the I/DD population increasing, and in several cases, states are looking to carve-in this group, particularly in dual-eligible pilot programs. The dual-eligible population (those people who have I/DD and are both Medicare and Medicaid eligible) have heightened coordination needs and are ripe for integrated care programs which can maximize the funding infrastructure, minimize the service gaps, and deliver a potentially seamless service to a sometimes fragile population with potential cost savings.



7 - <https://www.medicaid.gov/medicaid/managed-care/downloads/ltss/mltssp-inventory-update-2017.pdf>

How to Ready Your Organization for APM / Value-Based Changes

“Provider organizations regardless of the state they operate in need to at minimum begin readying their organization for VBR.”⁸ As you think about the possibility or the likelihood of a shift to alternative payment methods, a lot is unknown. This can be a stressful time for any business but there are things you can do to prepare for this changing paradigm.



Understand the Current Environment & Develop a Strategic Plan

Fee-for-service (FFS) payment structures have previously rewarded volume of services. While most providers are committed to providing quality services, the FFS payment model does not incentivize providers for these improvements. The shift to Value Based Payment (VBP) structures takes a different approach, which focuses better outcomes, lower costs and improved individual & provider experience. Providers that understand VBP models, and have prepared for a payment model environmental shift, will position themselves favorably opposed to providers who have not made the same effort. With both the Incentive and Withhold payment models, it is important that providers are intimately familiar with the contracts they hold with the Managed Care Organization (MCO).

8 - <https://www.openminds.com/market-intelligence/executive-briefings/the-vbr-mandate-medicaid-requirements-on-the-increase/>



Understanding Your Value-Proposition

Providers may consider opportunities to reduce costs. One option to achieve reduction of costs is to review spending variation across geographic areas for the same services with the same quality results. Standardizing care delivery by reducing variation may allow providers to reduce costs and improve outcomes. It is also beneficial to build a detailed understanding of the managed care contract the state holds with the MCO. If you are clear on what is expected of the MCO, you are better equipped to provide them solutions and refine your value-proposition.



Consider Service or Process Changes that Will Yield the Best ROI

The shift to value-based or other alternative payment structures will likely involve shifting your service delivery model to encompass care management or care coordination principles, which allow providers to deliver services more efficiently while maintaining quality and achieving the outcomes that your payments may now be tied to. Many provider agencies are mirroring what payers and even some acute care providers do by embedding care management into their organizations. This could include recruiting and hiring care managers from other fields with experience in the processes and principles of service delivery, or even establishing a Care Management department within your organization.



Consider Partnerships that May Strengthen Your Organization

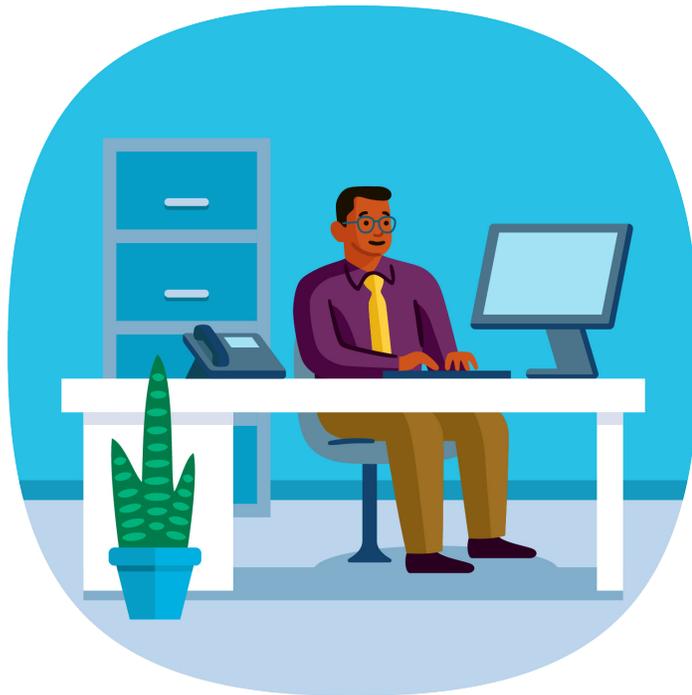
Providers who can align themselves with other stakeholders who share the same shared goal of value have a shared benefit of more efficiently delivering services. One way to gain market share is to develop a Clinically Integrated Network (CIN) or Accountable Care Organization (ACO). CINs and ACOs are similar in respect to the philosophy behind how they operate, however, the similarities end there. CINs typically serve commercial and privately insured beneficiaries while ACOs generally serve Medicare beneficiaries. CINs are allowed much more flexibility in how they operate than ACOs. Although there are differences in the amount of financial risk that an ACO or CIN is allowed to take, ultimately if a cost savings is established there is opportunity for either type of network to benefit financially. Coordination of care is the key to an improved individual and provider experience, enhanced quality of care, and reduced cost of care. One of the most important tools that a provider can have to effectively coordinate care is a robust IT platform, particularly when partnering with other groups.



Invest in Data Systems that Can Streamline Internal Processes

Many alternative payment models include incentives for providers to collect and report data. To capitalize on this, your agency may need to enhance its data collection and reporting capabilities by implementing an electronic health record. It is important to reduce the administrative burden of data collection so that frontline staff are not spending valuable time on this task. Many of the reporting requirements in alternative payment models go beyond spreadsheets and require an investment in systems. A platform that is both easy-to-use and provides comprehensive and sophisticated reporting tools, can prove to be an invaluable investment for your organization. In managed care payment models, there will be multiple payers—each with their own contracts and fee schedules—instead of a single payer with most of the revenue stream. Management of the revenue cycle becomes more important as claims need to be filed accurately so that they are paid upon the first submission. Having an platform that can handle various reimbursement model requirements and support the analytics to manage the cost and quality of service delivery is an essential investment.

Providers seeking to stay one step ahead of the emerging quality framework should consider how to best quantify the usage of resources and identify the quality of I/DD services and supports provided to its individuals.



Investments in people, processes, and technology can help demonstrate the impact of services, and can definitively prove or disprove previous assumptions that were long on hunches and short on data.

Invest in Data Systems that Can Streamline Internal Processes (con't)

Review your systems and processes related to data storage, identify where your data is located on services rendered, service schedules, vitals, notes, financials, among others, is located. Is the data located in a central location? Is it stored electronically or in paper? Do the right people have access to this data? The important thing to realize about data inventory and consolidation is that chances are, providers already have this information. In many cases, organizations are likely already tracking specific data points, in the form of critical incident reporting, medication error reporting, among others. This information can be leveraged to comply with key quality and financial metrics.

The information that you are collecting—is it easy to access and readily understandable? Providers tracking these types of metrics often comment that it can often be time consuming to aggregate and analyze the materials to arrive at the insights associated with the data. Generally, these investments are four-pronged:

1. Database storage and organization
2. Security protocols
3. Front-end user interfaces
4. Interoperability

Investments in a robust health information technology infrastructure, as well as the necessary training and exposure for users, can be a contributing factor in improving outcomes, increasing quality and safety, decreasing cost, and improving research.



Identify Quality Measures You Can Begin to Track Now

If you are not already regularly collecting data for quality measurement submission, there are a number of quality measurement sets that I/DD providers can reference in identifying areas of quality improvement. One such measurement set is the National Core Indicator (NCI) project. NCI is a voluntary effort from public developmental disability agencies to measure and track their own performance. NCI measures capture service outcomes in areas of individual results (including personal experience and employment — choice of job, hours worked, worker satisfaction); health, welfare and rights; system performance; staff stability; and family indicators. The NCI set was recently cited as a resource for states seeking to build meaningful outcomes into managed care programs. Meanwhile, the Council on Quality and Leadership (CQL) provides accreditation, training, certification and consultation to human service organizations and systems to improve quality of life and services for people with I/DD and others. CQL's Basic Assurances and Personal Outcome Measures identify outcomes impacting individual health and safety.

While it is important to understand the landscape and observe what others are doing, you can begin your quality improvement efforts today and demonstrate your value if you are effectively collecting data and identifying the baseline requirements of the standards. I/DD providers have insights on what comprises great care and what to aim for in their own organizations. Start by selecting an achievable list of standards, and then expand on standards and data collected. For example, if absenteeism is a concern, then start tracking related metrics, even in Microsoft Excel.



SPOTLIGHT ON QUALITY MEASURES

An Example of VBP Measures from New York State

As part of New York's Medicaid Payment Reform transition, the state organized Clinical Advisory Groups (CAGs) - clinicians and subject matter experts to help develop quality measure recommendations. Their recommended MLTC VBP Measure Set includes the following measures:

- Percentage of members who did not have an emergency room visit in the last 90 days
- Percentage of members who did not have falls resulting in medical intervention in the last 90 days
- Percentage of members who received an influenza vaccination in the last year
- Potentially Avoidable Hospitalizations (PAH) for a primary diagnosis of heart failure, respiratory infection, electrolyte imbalance, sepsis, anemia, or urinary tract infection
- Percentage of members who remained stable or demonstrated improvement in pain intensity
- Percentage of members who remained stable or demonstrated improvement in Nursing Facility Level of Care (NFLOC) score
- Percentage of members who remained stable or demonstrated improvement in urinary continence
- Percentage of members who remained stable or demonstrated improvement in shortness of breath
- Percentage of members who did not experience uncontrolled pain
- Percentage of members who were not lonely and not distressed

North Carolina Tailored Plans

North Carolina's Behavioral Health IDD Tailored Plans will serve individuals with acute behavioral health conditions including Intellectual and Developmental Disabilities, Substance Use Disorder, and Traumatic Brain Injuries.

The North Carolina Department of Health & Human Services, along with stakeholder input, has identified performance measures that will be used in implementation of value-based payment to providers. The complete North Carolina Quality Measures Set consists of 67 measures which will be used to monitor PHP performance and set priorities for future years. A subset of 32 priority measures are tied to national and state benchmarks and serve as the basis for PHP improvement plans and provider incentive plans. Of the priority measures, 6 withhold measures will be used to financially reward and hold PHPs accountable.

NC measures² are grouped into the following categories:

- Acute Care Behavioral Health Utilization Measures
- Adult Measures
- CMS/SUD Monitoring Protocol Measures
- Innovations Waiver Measures
- Maternal Measures
- Patient and Provider Satisfaction Measures
- Pediatric Measures
- Public Health Measures
- State-University Partnership Learning Network (SUPLN) Measures

¹https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/vbp_library/2017-oct_mlhc_cag_rpt_vbp_recommend.htm

² <https://files.nc.gov/ncdhhs/TP-RFA-Pre-Release-Policy-Paper-Final-01.30.2020.pdf> in Appendix A.



Prepare Your Staff for New Operating Environments

As your state transitions to value-based payments, stakeholders will define new services and new procedures for service delivery, billing, and payment to match. Providers can be prepared to thrive in new operating environments by formalizing new service definitions for the services you intend to provide under a new model. This process should be comprehensive and formally embed the rules and regulations of the new services into your organization. Activities may include flow chart development, timeliness expectancies, reporting, quality measures, facility, supplies and equipment requirements, as well as educational and training resources, qualifications for providers, and salary or contract payment schedules.

A shift to value-based or other alternative payment structures includes not just a shift in processes for your staff, but also a shift in culture, as the industry moves towards emphasizing quality over quantity and focuses on outcomes. Support this culture shift in your organization by embedding the state's goals for the new payment model (e.g. enhanced quality of life for beneficiaries, etc.) in all staff-facing training materials and convenings. This culture shift could also include encouraging staff to place more value on software, data tracking systems, or other technology as a key way to help your organization and the people you support succeed in the new payment and service environment. Consider a one-time investment to kickstart the move towards culture change and a new way of operating, by bringing experts from provider agencies in other states to share lessons learned and the benefits of operating in new or alternative payment models. Or build the capacity of key leaders in or your organization to formally implement change management techniques (through training, consulting, etc.) across your organization.

The time to prepare for alternate payment landscapes is now. Quality data is a vital component of readying your organization to operate in the changing environment.



Develop Dashboards for Key Metrics, Quality Measures, Fiscal Measures

One of the key attributes to look for in a Health IT solution is the capability to present and manipulate data in various formats that can generate insight for the end user. This may include live, customizable dashboards, a robust reporting catalog, transaction logs, error identification and reporting, and proactive system notifications. In addition, identify future-proof software that allows you to generate the types of reports and visualizations that you might not even be thinking about today. Look for solutions that can allow the end user to design, save, and share custom reports and dashboards, be able to join multiple datasets and population cohorts, and filter by demographics, risk-level, clinical data, and more.



This culture shift could also include encouraging staff to place more value on software, data tracking systems, or other technology as a key way to help your organization and the people you support succeed.



Monitor and Make Adjustments as New Systems are Implemented

The transition to alternative payment models is gradual. While providers should be proactive in adjusting service delivery and internal business processes to ensure success in a new payment environment, it's important to stay informed of the adjustments that states and payers will make as they learn from implementing a new payment model. Maintaining positive working relationships with state agencies and payers, which could include dedicating staff to sit on state working groups, goes a long way in ensuring your agency stays aligned with the priorities of the state as it advances new payment models.

In addition, agencies can continue to track and trend data from your own systems (accounting, EHR, business intelligence, etc.) that show your agency's performance in the new environment, and where process or outcomes improvements can be made. This could include identifying and tracking key performance indicators (KPIs) on the financial health and stability of your organization, such as the average aging of claims, accounts receivables, and payments. EHR platforms with robust billing platforms and the ability to interface with external financial systems can help agencies access and understand data on KPIs, including your organization's financial health. Providers should also monitor beneficiary outcomes, as more payment models will be tied to individual outcomes. Software vendors can work with provider agencies to identify reporting needs and build custom reports for trending outcomes or offer ad-hoc query builders to allow providers to monitor and ultimately improve the quality and impact of services.



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A joint publication

The logo for ANCOR features a stylized white graphic above the word "ANCOR". The graphic consists of a curved line that starts with a small circle at its peak, arching over the letters "A" and "N", and ending with a small circle at its base. The word "ANCOR" is written in a bold, white, sans-serif font.The logo for medisked features a stylized white graphic to the left of the word "medisked". The graphic consists of three curved lines that sweep upwards and to the right, resembling a stylized 'S' or a series of overlapping arcs. The word "medisked" is written in a white, lowercase, sans-serif font.

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