Morning Session 1, Day 1: Aligning Financial Models and Purchasing Methods

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Overview of session

- The importance and challenge of aligning business models with purchasing methods
- An overview of purchasing methods
- An overview of financial models/strategies
- Discussion: the alignment of models and purchasing methods

The need to align financial and mental models with markets

- Senge: “Mental models are deeply ingrained assumptions, generalizations, or even pictures or images that influence how we understand the world and how we take action.” *The Fifth Discipline*, P. 8
- Often unconscious, unchosen
- Models not aligned are a barrier to continuing success when purchasing methods change.

Endless examples of misalignment in human events . .

- If I knew then what I knew now, . . .
- Housing bubble of 2007, tech bubble a few years earlier
- Car guys – customers want performance and style (not reliability)
- Military history
- Etc. etc. etc.

Two explanations for persisting in models that become counterproductive.

1. Ladder of mental models, Rick Ross, *The Fifth Discipline Fieldbook*, page 242.

- Our beliefs are *the* truth.
- The truth is obvious.
- Our beliefs are based on real data.
- The data we select are the real data.

Explanation 2: “The owl of Minerva only flies at dusk.”

- Hegel, *Philosophy of Right*, 1820, referring to not understanding the spirit of the times until after things change.
- Difficult to see what’s important in the midst of complex change.
- Easy to find fault using 20/20 hindsight.

Misaligned business models are a source of BH provider distress as systems change.

- Humility: past success may commit us to newly dysfunctional models.
- Important to identify and evaluate unexamined assumptions.
- Learn from those experienced in similar changes elsewhere.

Broad categories of BH purchasing

- Traditional
  - Expense-based reimbursements
  - Fee-for-service
- Performance-based contracting
  - Pay-for-performance (P4P)
  - Case-rates, bundled purchasing
  - Capitation/population based

Expense-based reimbursements from state BH authority

- Transaction: Grantee submits expense and other required reports, state pays.
- Payment is for capacity, service delivery assumed.
- Important to the development of capacity, service enhancements and maintenance.
- Potential cross-subsidies and low productivity
- Can fund capacity while providers receive FFS.

The transaction of funding program costs may reinforce:

- Internal programs as the focus of planning.
- Provider perception “It’s our money.”
- BHA as a funding entity for providers
- History and political advocacy may be central to allocations.

Fee-for-service, in Alaska as Medicaid replaces some DBH

- Transaction: provider paid for services to individual patients.
- State purchases services on behalf of covered populations instead of funding organizations.
- Purchasers consider adequacy of services within communities over legacy funding.

More shifts inherent with FFS

- Incentive is for volume, a factor driving up healthcare costs.
- FFS Rewards:
  - Efficiency.
  - Productivity.
  - Access, such as patient-centered preferences for hours of operation.
- Reduces cross-subsidies which may be a shock to system.
- Requires more expensive billing system.

Performance-based contracting

- Financial incentives for quality and sometimes cost containment.
- Require highly effective performance management system and reporting.
- Encounter reporting remains critical.
- In most of healthcare, driven by a desire to correct FFS incentive to increase cost.

P4P

- Incentives paid for achieving some performance level, such as a threshold or improvement.
- Requires reliable performance management systems.
- In commercial systems, often paid from a pool created from a “holdback.”
- Delaware example of P4P that increase productivity and results.
- Oklahoma: pool for defined outcomes on several dimensions.

Shared Risk: Case rates/bundled rates

- Single payment for a service or services over a period or episode of care.
- Often include services from various provider types, organizations.
- May be for a defined time or the completion of an episode or level of care.
- May also incorporate P4P for quality.

More on case rates/bundled rates

- Retains fee-for-service incentives for access.
- Adds powerful incentive to contain costs.
- Saves provider needs for continuing stay authorization.
- Does NOT reduce encounter reporting which is needed for accountability and rate calibration.
- Provider processes and culture aimed at maximizing volume and revenue become problematic.

Shared risk: capitation, population-based

- Paid amounts/covered lives, usually per month.
- Responsible for a set of services delivered to contracted standards, such as timeliness.
- Inherent incentives for efficiency
- Provider processes to maximize revenue problematic.
- Pre-payment, helps cash flow,
- Quality measures, appeals, and other safeguards important

Market position, models, and shared-risk

- Provider assumption of shared risk through bundled/case rates or capitation/population based requires the provision of comprehensive core services.
- Contracted providers must either provide the services themselves or subcontract to other providers to deliver them.
- Internally delivered has great advantages:
  - Far less costly
  - Market share, a motive for accepting such contracts
  - Clinical coordination
- Niche or specialty providers at a major disadvantage.