Bringing medicine, patients and community-based services together.

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changing the shape of health care

Setting Rates for CBO Services

Sandy Atkins, VP

Partners in Care Foundation

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Thanks to our funders for helping us be trailblazers

With gratitude to the
John A. Hartford Foundation
& the Archstone Foundation

What to call “person”?

- Client? – health plan is our client
- Person? – we’re all people
- Patient? – some find this offensive
- Participant? – we use this for classes
- Member? – works for health plans only
- Recipient? – they may not receive anything
- Consumer? – at least it’s unambiguous

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What is our pricing experience?

- 25 contracts with 13 healthcare entities
  - Waiver continuation for duals – required (6)
  - Waiver-like for wait list and not-quite-eligible (3)
  - HomeMedsPlus: In-home assessment and short-term care coordination
    - 2 physician groups, Medicaid plan, Medicare Advantage plan, Exchange plan
  - Care transitions
    - Medicaid plan, Medicare Advantage, CMS (x3)
  - Evidence-based self-management
    - Commercial/Public Employees, Medicare Advantage
- FY2012-13: Breakeven
- FY 2014-15: Positive $1 million

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The evolution of a pricing model: Cost

- Find a program in the agency that fully allocates all costs, both direct and indirect
  - Grants usually do not allocate full costs
  - For us it was our waiver program
- Derive a % of variable direct program costs for:
  - Administrative support & other fixed direct cost
  - Indirect cost
- Apply % to direct program costs
- Overestimate <u>everything</u> so there's room to negotiate

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Assumptions/Experience

- Customer's comparison usually not correct– e.g., home health – we need product differentiation
- Offer at high end of reasonable rate
- Know ROI (if you have info) for various prices - **VALUE**
- You're probably competing against "DIY" (do it yourself; build v. buy)
- First year of contract often a pilot
  - Volume will be low!!
  - Pain will be short lived if we set the wrong price
  - Learning and building a résumé may be worth losing $ in the short run
  - Insist on DATA

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Types of cost

- Direct variable costs
  - Change based on anticipated # of clients/patients/ participants
- Direct fixed costs
  - Difficult to gauge for small/pilot programs
  - % allocation of program costs based on similar programs
  - Can also use for breakeven analysis approach
- Indirect costs – *% of cost vs. % of price*
- Margin – no margin, no mission
- Something new: Network management costs

Overestimate Everything!

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What are the variable direct costs?

- Staff to deliver program
  - Time study - Budget hours high; know how low to go
  - Budget salaries high…But know your lowest reasonable cost
  - Consider inefficiencies built into old ways of doing business
  - LCSW required to sign off on each assessment
    - 15 minutes of an existing staff member until volume is sufficient to hire
  - Program variations lead to time/cost variations
    - Service plan to Health Plan CM vs. arrange services vs. long-term CM
    - **Service plan startup $:** first mos. high due to previously unmet needs
    - **Population:** Frail, high-moderate risk, Medicare, Medicaid, Exchange
- Mileage & parking: High avg. distance at fed mileage rate
- Pharmacist review
- Materials/handouts for classes, coaching, etc.
- This is early work – many unanticipated expenses

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Time Study

Intake
Call consumer to establish service
Visit for assessment – including driving time
Data Entry: Transfer handwritten assessment into software *(Try to avoid!!)*
Convert assessment into care plan
Case conference
Formalize care plan and communicate with client/consumer
PER PROBLEM: Establish services with vendors – phone calls, authorization, etc.
PER PROBLEM: Arranging referred services, coordination, etc.
Notify consumer/family about services/scheduling
Communication between Hospital/Plan & Coach
HomeMeds follow-up with pharmacist, prescribers, consumer/family/caregiver
Quality assurance – check w/ consumer about services received
Troubleshooting and exceptional services
Teaching, motivating, and helping client execute POLST/advance directive
What else – billing?

Fixed direct costs

- Ghulyhg#iurp#ehqfkpdun#surjudp#zlwk#ixoo# doorfdwlrq#ri#wkh#frvw#î rxu#zdlyhu
- Ryhuvljkw2vxshuylvlrq
  - Eh#uhdolvwlf#î iru#d#slorw#|rx#suredeo|#fdqýw#diiruj#d# surmhfw#pdqdjhu#lq#wkh#sulfh
- Dgplq#vwdii/#vwxghqw#vwlshqgv/#hwf1
- IW#v|vwhp#vshflilf#wr#wkh#surjudp2vhuylfh
- Surjudp#vxssolhv/#frs|lqj/#jhqhudo#dgplq/#hwf1
- Fhoo#skrqh2preloh#krwvsrw

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Indirect Costs

- These are real costs
  - **HR** – Staff will be hired and managed
  - **Finance** – more billing
    - Case rate involves many more transactions than grants
  - IT, communications, security **infrastructure**
  - **Rent**: More people=more space
  - **Insurance**
    - Coverage limits doubled; new cyber policy required
  - **Admin staff**

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Network Costs in Subcontract Mode

- **Legal** related to network contracts & network management
- **Sales**/**Marketing**/Contract Negotiations Staff & Consultants
- **Credentialing, Quality Assurance**, **Oversight** of Network Providers
- **LCSW** oversight and review
- **Insurance** Differential or $ directly attributable to network contracts
- **Billing** Cost (Finance Staff)
- **Accreditation/Training** Requirements
- Member/patient **satisfaction surveys,** metrics, analysis
- Medicare/Medicaid **billing #**
- **Software** (Clinical/Billing/Client Management)
- **Contact Center, intake, assigning cases to network members**
- **Project management**
- **Customer relations** with plans – coordination
  - Weekly meetings, quarterly meetings, etc.

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Negotiating Price

- Surprisingly little pushback
- For waiver-like, purchase of service was issue
  - Plans want short-term CM, i.e., 30 days
  - But…cost highest in first 3 months, amortized over average 5 years in waiver
  - Capped @ $150
- One contract called “pilot”
  - Asking price granted for 100 patients
  - Review & revise when we know effort & population

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Before you sign that contract…

- *Grq´w#vhwwoh#rq#sulfh#*xqwlo#|rx#vhh#ilqdo#whup v#ri# frqwudfw® wkh|#riwhq#dgg#dv#wkh|#jr
  - Pruh#lqvxudqfh/#IW#dxglw/#olfhqvhg#vwdii/#sw1#vdwlvidfwlrq/# hwf1
- *Grq´w#vhwwoh#rq#sulfh#*xqwlo#|rx#nqrz#wkh#yroxph
  - Orz#yroxph#@#kljk#dgplq#shu#fdvh
  - Yroxph0edvhg#sulflqj#+pruh#yroxph#@#orzhu#',
  - Rwkhu#lqfhqwlyhv#iru#pruh#uhihudov#iurp#sodq2jurxs
  - Gdwd#v|vwhp#)#fulwhuld#iru#dxwrpdwlf#uhihudov
  - Xs0iurqw#sd|phqw#ru#dgydqfh#iru#vwduwxs
  - Uhylhz#udwhv#diwhu#h{shulhqfh

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Basic Pricing Model

- Irup xodv#uhfdoxodwh#e|#fkdqjlqj# dvvxp swlrqv
  - Uhdo0wlp h#gdwd#nqwu|#yv1#frs|lqj
  - Gxudwlrq#rqh0wlp h/#63/#93/#<3#gd|v/#iruhyhu,
  - Vdodulhv/#iiiruw#hiilflqf|½,
  - Krp hP hgv#skdup dflvw#yv1#Sodq#skdup dflvw
  - P lqv
  - Z kr#z loo#p sdnp hqw#vhuylfh#sodqB
    - Sodq2Sudfwlfh#Fdvh#P dqdjhu#ru#FER #
  - &#sduwflsdqw#lq#vhdl0p dqdjhp hqw#hgxfdwlrq

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Future

- Split payment for pt. contact, engagement & delivery
- Shared savings – start with cost or <cost
- PMPM (per member per month) – not yet…
  - Need to know more about population & work involved
  - Agree to evolve the amount with experience
- Data still slim for determining ROI/Value

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Simple/Simplistic ROI Analysis

Use the data you have…

Let the customer do more if they want to

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What is ROI?

- Return on investment
  - ROI is not the only element in **VALUE**
- ROI = Net savings / Total cost (i.e., investment)
  - ROI = (Total savings - Total cost)/Total Cost
- Normal output is % - Think interest rate, e.g., 58% ROI.
- Alternative is expressed as a ratio
  - Savings to Total Invested—1.58:1, i.e., a *return* of $1.58 per $1.00 invested, or a *gain* of $0.58 for each dollar spent
  - Don't be surprised if the health plan's standard is something like 2:1 – as high as 3:1

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ROI Model: Costs

- = Your Price, i.e., what they pay you
- If your contracting partners want to claim a cost, that's up to them.
  - One assumes that they're not adding any staff to do the referrals
  - There may be up-front costs, e.g., legal or to connect IT systems, but should be insignificant over time (if there's enough volume)

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Determine N and comparison

Name of Payer	n=
Intervention	253
Comparison (Baseline or non-intervention)	69
Enter # in Intervention Group	253
Enter # in Comparison Group*	69

- Typical comparison group would be people who met referral criteria but who didn't receive intervention
- For baseline comparison, use the same N for each group

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Start with Assumptions/Facts

Enter # in Intervention Group	1,000
Enter # in Comparison Group*	1,000
Enter # of Admissions/Uses – Intervention (or % rate)	100
Enter # of Admissions/Uses – Comparison (or % rate)	180
Enter value per admission (or ER use, or SNF use)	$16,000
Enter your price per intervention (“Cost”)	$500

**Comparison group n is the same as intervention group if it is a baseline comparison*

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Model Auto-calculates

"Name of Payer"	n=	# Used	% Utiliz. rate	# avoided	$ saved @ $X per Use	Total Cost	Net Savings	ROI
Intervention	1000	100	10.0%	60	$960,000	$500,000	$460,000	92.0%
Comparison (Baseline)	1000	160	16.0%					
			37.5%	Reduction in Utilization Rate				

Used = # Readmits, # ER visits, # SNF days, etc.
Avoided = Same categories

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Where to get cost & utilization data

- From the targeted healthcare entity
  - What's your average cost per ER visit, /readmit?
- From your state Quality Improvement Organization (QIO)
  - Geographic average – e.g., SoCal is 99th percentile
- For CCTP, from CMS Quality Management Reports (QMRs)
- Patient self-report
  - Call within 30 days – Ask if they've been to ER or stayed overnight in hospital or SNF
- CMS & state healthcare planning agency
  - CA Office of Statewide Health Planning & Development (OSHPD)
- Google search, Kaiser, Commonwealth, CA Healthcare Foundation
- State & National Health Interview Survey Research data – e.g., Stanford for Chronic Disease Self-Management
- Colleagues already contracting - outcomes

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Happy to Help!

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