

LMES AND PROVIDERS WORKING TOGETHER SUCCESSFULLY

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- Perspectives from working in 33 states (and as a provider)

Overview

- Funding methods in the context of NC: grants, unit cost reimbursement (UCR), and risk.
 - Note: there are many variations of each and performance incentives can overlay any of these.
 - Advantages, disadvantages of each.
- The opportunity for providers and LMEs to work together using non-Medicaid state (IPRS) funding

Themes

- All funding methods have perverse incentives.
- Applications of methods should address:
 - Strategic objectives.
 - The problems the system chooses to manage.
 - Context: capacities, history.
 - The surprisingly severe problems from varied transaction requirements.

Why utilization control and expense issues are different for SA

- Over-utilization risk is lower for SA clients because they:
 - Are ambivalent about treatment.
 - Do not enter treatment without needing it.
 - Often want lower doses of treatment than are needed.
- SA cost-containment problems are almost always the provider delivering inappropriate care or care at too high a cost.
- Research shows a positive relationship between treatment duration and outcomes.

Grants (“expense based” or “non-UCR”)

- *Grants purchase capacity, not services.*
- Usually 1 / 12 per month for projected costs.
- Usually have productivity and cost/unit standards.

Advantages of grant funding

- Good for starting up services and organizations, covers start-up costs.
- Might be an option for services with low volumes when the capacity to provide is important.
- Supports stability.
- Most providers prefer grants to fee-for-service.

Disadvantages of grant funding

- Reinforces sluggish and inefficient performance.
 - Can be \$ on the stump at midnight.
 - Programs may compete for staff on staff-centered dimensions.
 - In some systems, providers profit by deferring hires.
- Political capital needed to move funds from unproductive providers to productive providers.
- Masks cross-subsidies to other payers.
- Brings purchaser into the details of providers' business.

Unit cost reimbursement (UCR)

- *The purchasing of services.*
 - Often referred to “fee-for-service.”
- Examples:
 - \$22.00/15 minutes of behavioral health counseling
 - \$131.93/IOP day
- Public SA systems usually contract for an annual allocation
 - Example: \$131.93/day not to exceed \$300,000/per year
 - Helps stabilize the system, supports more expensive services.

Advantages of UCR

- Powerful incentive to provide high volumes of care which means incentives to:
 - attract, engage, and retain clients.
 - be efficient and productive.
- Funds are earned as services are delivered so funds do not subsidize inefficiency.
- Resolves cross-subsidies.

Disadvantages of UCR

- Higher transaction costs.
- Can stress providers, especially at its introduction.
- Reinforces volumes of inappropriate (as well as appropriate) care.

Risk/Partial risk

(Not immediately relevant to NC and not widely used.)

- Types of “capitation” or “case rates”
- May pay/covered life/month for a population.
- May pay a fixed amount/period for all or a type of service.
- Supports efficiency but may reward under-serving.

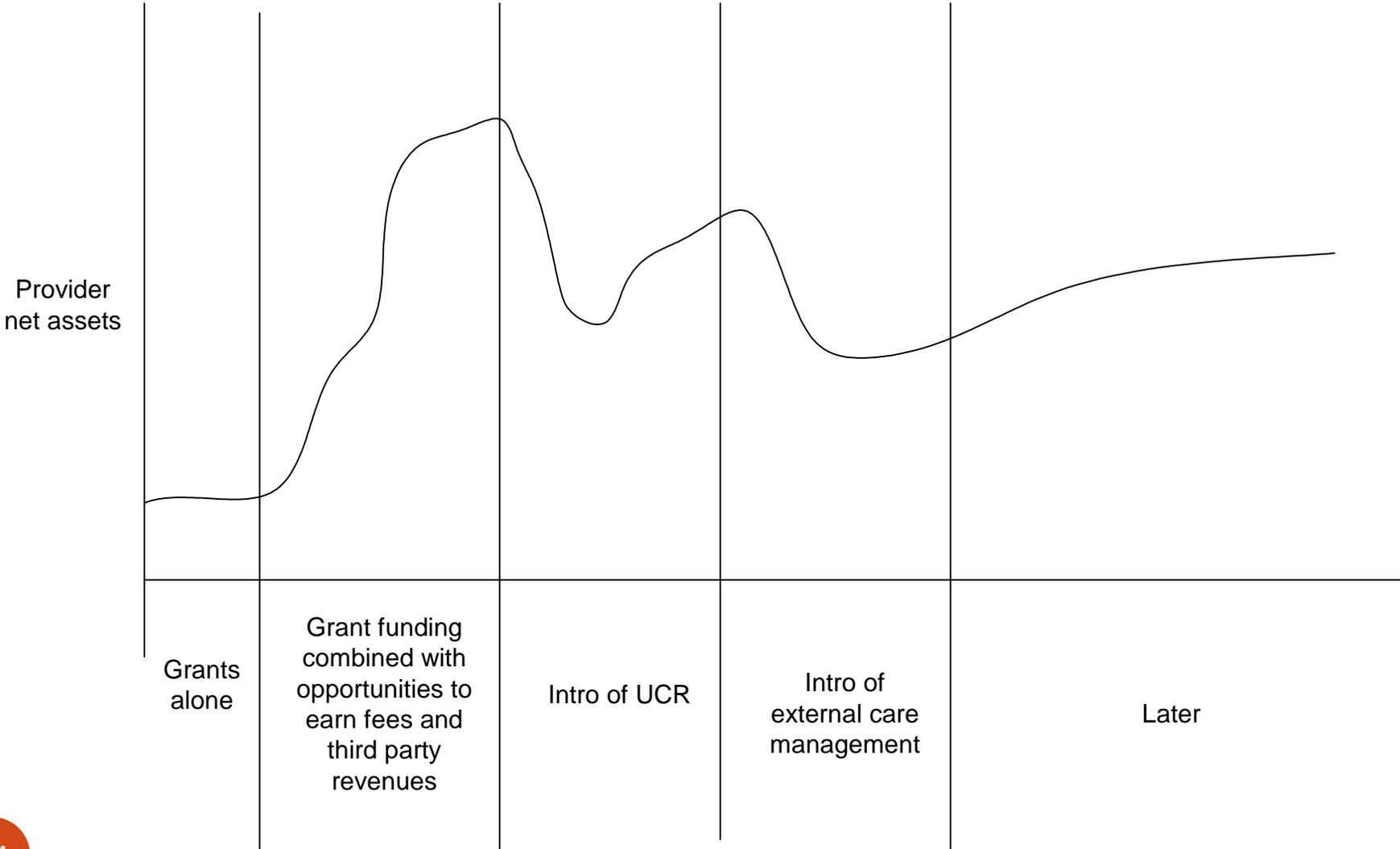
How some systems developed SA services

- Started with grant funding.
- Eventual concern with sluggish performance.
- Introduced UCR.
- Provider losses during transition because of time needed to:
 - improve:
 - access, engagement, and retention.
 - productivity and efficiency.
 - billing systems.
 - resolve cross-subsidy issues.

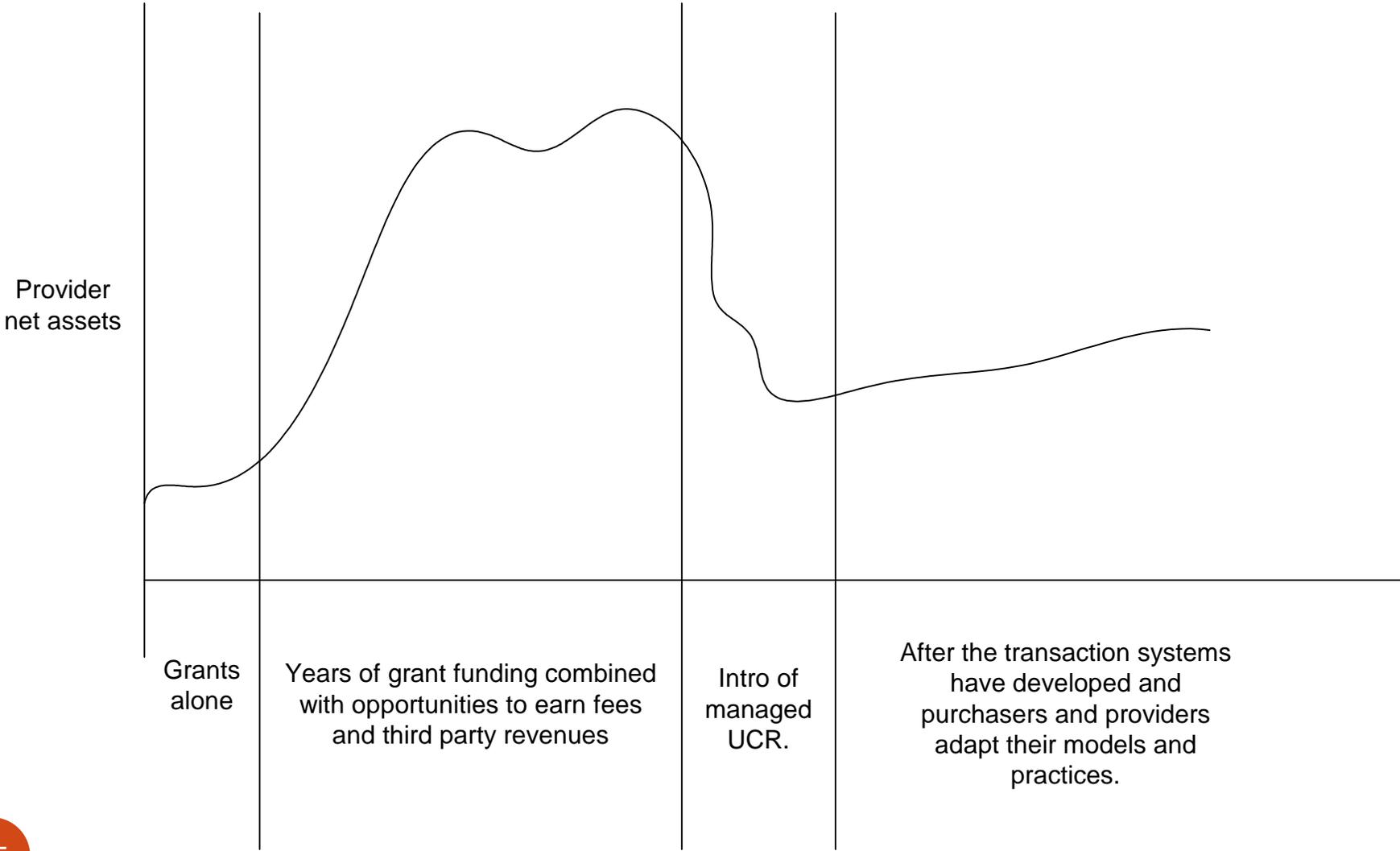
Notes re: externally managed access

- Advantage: Placement decisions can be based on client variables alone.
- Business implication: provider does not control revenue stream.
- Lower than projected utilization usually leads to provider losses.
- This has been a contributor of provider stress.

Representation of the trends in community-based provider net assets with the distinct introductions of unit cost reimbursement (UCR) followed by externally managed care.



Representation of the trends in community-based provider health with the introduction of managed unit cost reimbursement.



Observations re: some causes of stress among NC's SA providers

- Spin-offs have had low net assets to cushion transitions.
- Inexperience with externally managed fee-for-service.
- Some providers took enormous risks by expanding rapidly without contractual protections and substantial reserves.
- Low productivity among some providers, probably related to workforce issues.
- Some LMEs may inhibit access with features of externally managed systems.

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- Unlike MH, most public SA funding is non-Medicaid IPRS.
- LMEs can recapitulate the grant-to-UCR transition using IPRS.
 - Case-by-case, contract using non-UCR *temporarily* as services develop or providers stabilize.
 - Requires LMEs to be able to specify improvements and track progress.
 - Most will need support to know how to do so.
- Relational contracting to resolve lower than expected utilization with externally-managed access.