

SUMMARY REPORT: RATES AND ACCOUNTABILITY HSC TECHNICAL ASSISTANCE WORK GROUP – 3/21/11

A workgroup of human service advocates and providers has examined how to reshape human service funding in Illinois to adequately cover provider cost, increase care coordination, measure performance outcomes and hold providers accountable for meeting outcome measures. The workgroup included experts in the following areas: mental health, substance abuse, domestic violence, developmental disabilities, child care, and home- and community-based services for older adults. The purpose of the workgroup's final report is to provide an overview of the current conditions and trends surrounding provider compensation and how, and whether, the current system incentivizes various types of service provision and outcomes. The workgroup developed a set of recommendations for moving toward an outcomes-based reimbursement system.

The State of the Current System

1. Unlike the majority of public services provided by the State of Illinois, the State itself does not provide many human services directly. Rather, the state contracts with private and non-profit providers, as well as local governments, to deliver a large variety of human services.
2. Nearly all human service providers are paid on a fee-for-service (FFS) basis. Many programs and services formerly funded on a grant basis were converted to fee for service over the last several years to capture Medicaid match and to increase accountability. While FFS ensures that only services actually delivered can be billed to the state, it creates a negative incentive. It incentivizes providers to deliver as many services as they can to as many individuals, or as many services to any one individual, and does not encourage care management and coordination. In most cases, and except where care coordination is specifically contracted, care coordination is simply not reimbursed or incentivized. Accordingly, the current fee structure fosters neither short-term nor long-term individualized care planning or service efficiencies.
3. In many fields, state FFS rates were set years ago. With no regular inflation-based adjustment, the rates now bear little relation to the actual cost of providing the service.
4. Accordingly, rates paid are significantly lower than the cost of providing the service, leaving providers to subsidize the true cost of quality services by raising additional funds from non-governmental sources such as individual donors, corporations and foundations.
5. In some fields, rates for programs are not differentiated to reflect the variation in costs presented by the level of client need and risk factors. For instance, services for the most significantly impaired disabled individuals are often reimbursed at the same amount for programs delivering care to those with far fewer cognitive or physical challenges.

6. The state generally reimburses providers for only a narrowly defined set of services that focus more on meeting immediate rather than longer-term needs. Because only a limited set of services is reimbursable, there is little opportunity for service innovation.
7. In most cases, the state does not pay for case management services that would facilitate greater coordination of care across providers and reduce duplication of services. For instance, the state requires many domestic violence programs to coordinate care for clients but provides no funding for it. The state cannot expect providers to deliver services in excess of what they are paid to do, particularly when the reimbursement for the contracted service does not even cover that cost. Despite the lack of reimbursement for case management, the state is putting tremendous pressure on providers to do more of it.
8. On many contracts, the current FFS system does not provide sufficient reimbursement for essential operational expenses such as administration, capital investment or program evaluation. These costs are legitimate provider costs that should be taken into account for any reimbursement structure.
9. Because reimbursement rates are below actual provider cost, providers are unable to offer competitive wages and benefits to their employees. In turn, providers and their clients experience high degrees of employee turnover, which imposes costs on the agencies and reduces the quality of client services provided. In some settings, this results in the ability to pay only lower-skilled workers. Even for the dedicated individuals who are drawn to these positions despite the low compensation, career opportunities are limited because of the low pay.
10. The current FFS system does not utilize provider quality or performance measures sufficiently across all services. In some cases where quality incentives do exist, such as in QRS ratings in child care, they are implemented ineffectively.
11. Illinois has a higher rate of institutionalization than most states for individuals suffering from mental illness, developmentally disabilities, or the effects of aging. Some individuals living in large facilities may be cared for and may wish to live in small group homes or in their own homes with the support of home and community based services, and for some this may result in lower costs to the state.

Trends and Implications of the current system

1. Illinois faces an unprecedented budget crisis that has been developing for over a decade. Human services have received a disproportionate amount of funding cuts over the last several years. Cumulatively, the imperative to reduce direct state expenditures for services has affected providers in many fields through the loss or reduction of

service contracts, rationing of services of many types in many areas, long-frozen reimbursement rates and payment delays. Inflation has meant that over this period many providers have faced a rate decrease year after year in real terms.

2. Illinois, like many states, has maximized federal revenue by ensuring that as many social service programs as possible are funded through Medicaid. As Medicaid has become an increasingly important part of Illinois social services, its rules and rates have increasingly defined how much providers are paid and for what. If these federal matching dollars had been set aside for special human service funds, this could have increased the total resources available to human services, enabling providers to increase their array of services to the Medicaid-eligible population while still providing some services to the non-Medicaid-eligible. However, in most cases Medicaid matching dollars are a revenue source for the State's General Fund, and are not set aside for human services. Thus, despite the influx of federal dollars due to Medicaid conversion, the human service sector did not see increased funding for quality and service improvements, or the preservation of funding for some Medicaid-ineligible persons.
3. If implemented well, the ACA provisions for health information exchanges could facilitate greater coordination of care and compensate providers for "meaningful use" of new systems.
4. The State has begun a Medicaid pilot program for integrated, managed care. A major goal of the program is better coordinated care, which has the potential to reduce overall program costs. While the pilot has the potential to improve access to preventative care and needed specialty services, there is also concern that costs will simply be reduced through restricted access to services without significant benefit to clients. In addition, managed care approaches may encourage greater care coordination and incent more holistic outcomes, but they also place more financial risk on the provider with respect to clients with less predictable service needs. The human services industry should carefully monitor the Medicaid Integrated Care pilot for what works, and what does not, in terms of the appropriate balance between care coordination and the proper utilization of services.
5. Across the fields of aging, physical and developmental disabilities and mental health, there is a movement toward serving more people either in their homes or other community settings, rather than in larger institutions. In order for this movement to be successful in Illinois, the payment system will need to incentivize providers to create the needed service settings.
6. With the new state-level budgeting for outcomes, there will be increased pressure on state agencies and, therefore, their contracted providers, to measure and be accountable for outcomes of their work in order to continue to receive financial support for their programs. At this time, only the broadest outline of how the new system might operate has been created.

Recommendations

How, exactly, payment and accountability systems would best operate varies across different service fields. General principles for payment and accountability that tend to be common to fields are as follows:

1. Providers across all of the human services domains must be paid for the full cost of the services they provide, including the specific service contracted for, care coordination, administrative and capital costs.
2. Reimbursement rates should be reviewed at least annually by an independent third party to determine how they will be updated to reflect actual costs.
3. Systems and incentives that support and invest in coordination of care should be developed and expanded. Better-coordinated care holds promise for reducing overall governmental care expenditures as it reduces duplication of service and has greater potential for clients to successfully access multiple care systems to meet their needs.
4. Payment systems should incentivize services provided in less costly community-based settings rather than larger institutional and urgent care settings, yet rate systems should be embedded in a framework that meaningfully supports client choice. Rebalancing service between large institutional and community-based care would be facilitated by stronger payments to community care providers that have the effect of incentivizing them to develop greater capacity. This includes the ability to provide better compensation to their workers, thereby improving quality and reducing turnover, which benefits all consumers.
5. Payment systems should incorporate performance and outcomes measures including broad, long term outcomes, and program-specific outcomes.
6. Contracting should incent quality and efficiency. Depending on the setting, this could include
 - a. Tying contract renewal to minimum performance
 - b. Tying full contract payment to performance
 - c. Providing bonuses when high performance measures are achieved
 - d. As a general principle, systems where “money follows the person” are the preferred mechanism for allocating state payments to providers. The chief advantages of following this method are 1) consumers are able to exercise choice in which providers or services to utilize and 2) the method incentivizes providers to deliver quality in order to retain market share.

7. The service system needs to set goals for client outcomes for which providers are accountable and that align with outcomes for which state agencies are held accountable.
8. Outcomes need to be developed through a process that includes the recommendations of elected officials, state agencies, service providers, subject matter experts, and consumers.
9. Outcomes may be defined in a number of ways. At the highest level they may include items such as maximizing the number of children prepared to learn, ensuring human capital sufficient to make the state economically strong, or reducing crime. Other outcomes may be narrower, such as maintaining a high quality of life for a severely disabled person or reducing the likelihood of recidivism for a re-entering offender. Outcomes will need to be consistent with state and federal mandates.
10. Where possible, outcomes should be defined with the goal of reducing the future demand for services.
11. Provider payments need to be sufficient to cover costs but need to be tied to accomplishment of outcomes. In some instances, those outcomes may be substantially within the control of the service provider. In other instances, achievement of the outcome may require quality service provision by multiple providers. In the latter instance, payment incentive mechanisms must be developed that incent providers to work together, but that reward quality provided by individual service providers. In all cases, consumer characteristics and service mix must be taken into consideration for provider compensation such that clients requiring more complex or more volume of services are compensated for those costs.