

THREE CASE STUDIES

Innovative Financing and Payment Models for Care of People with I/DD

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Editor's Note

This paper is one of three analyses commissioned by Institute for Exceptional Care (IEC) and presented at a three-day workshop titled "Optimizing Care Systems for People with Intellectual and Developmental Disabilities," presented by the National Academies of Sciences, Engineering, and Medicine (NASEM) in December 2021. Learn more about IEC and find the entire series and more background on this project at www.ie-care.org.

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EXECUTIVE SUMMARY

Health outcomes are poor for people with intellectual and developmental disabilities (I/DD). The complexity of the U.S. healthcare system is magnified for patients with I/DD and their families, who often navigate a complicated web of providers and services (both inside and outside healthcare) in order to have their needs met. Further, people with I/DD face stigma in the healthcare system and do not always have access to providers who are qualified to care for them appropriately.

Policymakers have attempted to address similar challenges in the broader U.S. healthcare system—care that does not deliver value, poor quality outcomes, and poor coordination of services—through alternative financing and payment models that incentivize higher quality and lower total costs. However, few of these models have been applied to the I/DD population.

Institute for Exceptional Care, a nonprofit that aims to transform the system of care for people with I/DD to get them the supports and care they need to thrive, engaged Aurrera Health Group to develop three case studies exploring payment and financing innovations in services and care for people with I/DD. For the purpose of these case studies, we define financing as "the mechanism for allocating the funds available to pay for care" (e.g. legislative appropriation, patient and employer premiums, and patient cost-sharing) and payment as "the mechanism for reimbursing providers or suppliers for services and equipment" (e.g. fee-for-service claims payments, per-patient-per-month capitated payments, and bonus payments tied to quality incentives). Through these case studies of innovations that do exist in this space, we hope to identify promising models, identify gaps, and highlight the opportunity that exists to improve care through different financing and payment structures.

Each of the three case studies below includes the following information about the organization:

- Organizational overview
- Payment/financing innovation
- Theory of change
- Outcomes
- Lessons learned
- Sustainability and scalability

Several promising themes emerged across the payment and financing innovations that we explored.

Opportunity for Creativity

Because the broader value-based care/alternative payment model market has largely not targeted care for people with I/DD, the financing and payment innovations in I/DD care are not limited to the categories that have become standard in the broader market (such as accountable care organizations, advanced primary care models, and episodic bundled payment models). One organization interviewed by Aurrera Health Group remarked that working in I/DD care—considered by many to be a niche space—has given them the opportunity to be creative in negotiating payment structures, unencumbered by the rules and norms that have come to govern healthcare payment for the broader U.S. population.

Accommodation of the Payment Model to the Care Model

Many of the payment innovations for I/DD care were designed to support a particular care model, such as a team-based series of appointments with multiple specialists conducted during a single office visit. This framing of payment models as secondary to care models differs from the theory behind many alternative payment models that have been tested for non-I/DD populations; the latter often emphasize the importance of setting the correct incentives but do not assume or dictate a particular care model. Because the I/DD financing and payment innovations are first and foremost enablers of care models, the organizations that have negotiated these innovative arrangements typically have thoughtful, patient-centered care models.

Early Evidence of Reduced Hospital Costs

Although most of the payment and financing innovations that we explored did not have peer-reviewed studies or formal evaluations of their impact on total cost of care, a number of organizations shared that they have some evidence for reducing hospital costs. They also noted that a reduction in total cost of care may not necessarily be an appropriate standard for the I/DD population, which has historically been underserved in healthcare.

METHODS

To produce these case studies, Aurrera Health Group completed an environmental scan of organizations that have financing or payment innovations related to care and services for people with I/DD, conducted detailed interviews with 11 organizations, and selected three of those organizations to feature at a workshop with the National Academies of Sciences, Engineering, and Medicine (NASEM) titled “Optimizing Care Systems for People with Intellectual and Developmental Disabilities” in December 2021.

The three case studies below are a product of the detailed interviews with the organizations and discussion at the NASEM workshop. They include Lee Specialty Clinic (an interdisciplinary clinic serving people with I/DD in Louisville, Kentucky), the Utah Neurobehavior HOME Program (an integrated payer/provider system serving patients with a developmental disability and a co-occurring mental health or behavioral health diagnosis in Salt Lake City, Utah), and the Penn Autism Clinic (a clinic contracted by the University of Pennsylvania employee health plan to conduct intake, assessment, and care planning for health plan dependents with autism in Philadelphia, Pennsylvania).

CASE STUDY: LEE SPECIALTY CLINIC

Organizational Overview

Lee Specialty Clinic is an interdisciplinary clinic that provides a range of clinical services—including primary care, dental care, podiatry, ophthalmology, physical therapy, nutrition, audiology, and other specialties—as well as crisis management and care management to people with I/DD age 13 and up. It serves approximately 1,400 patients, many of whom live several hours away from the Louisville, Kentucky clinic. The clinic combines multiple services into a single visit, when possible, in order to provide interdisciplinary care and maximize convenience for patients and families who travel long distances to receive care. The State of Kentucky appropriated the funding to build Lee Specialty Clinic in 2008, and it began seeing patients in 2014.

The clinic is a unique provider type [created](#) by the Kentucky Cabinet for Health and Family Services: an Intermediate Care Clinic, which is very different from Intermediate Care Facilities (ICF). ICFs are residential facilities for people with I/DD that provide clinical services only to their residents. In contrast, Intermediate Care Clinics (ICC) like the Lee Clinic are non-residential clinics that provide services to people with I/DD regardless of their place of residence. Lee Clinic was the first ICC in Kentucky, and its founders were heavily involved in the establishment of the new provider type. Today there are two other ICCs in the state.

Payment/Financing Innovation

Lee Specialty Clinic includes innovations in both financing and payment. The State of Kentucky appropriates funding for contracts to run the ICCs in the state. Lee Specialty Clinic leadership has bid and won two six-year contracts (the first starting in 2014 and the second starting in 2020), each of which has a renewal process every two years. The state provides a flat rate of funding under each contract and requires a minimum number of patient visits.

Under the contract, Lee Specialty Clinic is able to see patients with any type of insurance coverage as well as uninsured patients. The clinic submits claims for reimbursable services to patients' insurers and passes through any reimbursement received to the state in order to partially offset the contract amount. Total claims reimbursement typically only offsets between 25 percent and 30 percent of the total contract amount.

Quick Stats

Type of entity:	Interdisciplinary Clinic
Eligibility criteria:	People with intellectual or developmental disabilities age 13 and up
Definition of I/DD:	Primarily rely on self-identification; may run clinical tests if there is uncertainty
Number of people served:	1,000-1,200 patients per year
Covered services:	Primary care, dental care, specialty clinical services
Insurance restrictions:	All insurance (and uninsured) accepted

The financing innovation is that the Kentucky legislature appropriates general funds to directly cover services for all eligible patients, regardless of insurance coverage status or type—typically, financing is separate for different types of insurance coverage and comes from a combination of federal or state appropriations, premiums, and patient cost-sharing.

Additionally, the funding for ICC contracts, though state-based, is not done through Medicaid (so is not subject to Medicaid laws and regulations). The payment innovation is that the clinic receives a guaranteed budget that covers the cost of its full scope of services, rather than the fee-for-service reimbursement it would receive from different insurers for a subset of reimbursable services if this unique payment arrangement did not exist.

Theory of Change

By covering the full cost of the clinic's services, the funding mechanism for Lee Specialty Clinic provides flexibility for the clinic to tailor services to the unique needs and goals of individual patients and their families. For example, while the clinic might not be permitted to bill an insurer for multiple different services in a single day if it were subject to typical payment mechanisms, under its innovative payment structure it is able to arrange for patients to receive multiple services in one day without foregoing payment. It also receives enough funding to cover services that are not reimbursable by many insurers, such as crisis management and nutrition guidance.

The funding was designed to support a care model that emphasizes interdisciplinary care, under the theory that patients, especially those with I/DD, receive better care when different specialists coordinate and learn from each other. For example, a developmental medicine physician may work with a dentist to determine whether a patient who hits himself in the face might be communicating dental pain.

Both providers may, in turn, communicate with the psychiatrist to ensure that the patient is not improperly placed on psychiatric medications to address what might appear to be self-injurious behavior. This type of interdisciplinary collaboration is intended in part to address diagnostic overshadowing, a common problem in I/DD care in which providers over-ascribe a patient's symptoms or behaviors to their I/DD rather than to the root cause (which may be unrelated to I/DD).

Outcomes

Lee Specialty Clinic conducts regular patient satisfaction surveys using a proprietary survey and has consistently achieved patient satisfaction scores in the range of 95% or more. Clinic leaders shared that common clinical quality measures such as Healthcare Effectiveness Data and Information Set (HEDIS) measures are not as meaningful for the I/DD population (though they are still relevant), but that some measures of success that the clinic tracks for individual patients include a reduction in polypharmacy, decrease in operating room and hospital utilization, lower aggression, corrected diagnoses, improvement in chronic conditions, improvement in social function, and lower utilization of emergency services.

Provider Education

Lee Specialty Clinic extends its reach beyond the clinic itself through a teaching program that invites medical, nursing, dental, dental hygiene, and health professional students in a dozen other disciplines to do rotations in the clinic to learn how to provide optimal care to people with I/DD.

Lessons Learned

Many of the lessons that clinic leadership shared regarding the payment model emphasized the need for better data. While they have reason to believe that the total healthcare costs of patients who use the clinic are lower than they would be absent the clinic, they do not have adequate data systems to conduct a formal study or evaluation to confirm that belief.

Clinic leaders stressed that better data, along with an earlier strategic vision for how to leverage demonstrated total cost of care savings into political will to expand the program, would have made it easier for the clinic to scale after achieving initial operational success. The clinic has a large waiting list, so cost-effectiveness data would help to facilitate greater investment into the necessary infrastructure to meet the demand.

Clinic leaders also highlighted the importance of flexibility in the care model, especially a willingness to constantly readjust and reorient to the needs and goals of specific patients. They shared a belief that provider training in this type of flexible and patient-oriented care model would improve a provider's ability to care for any patient, including those without I/DD.

Sustainability and Scalability

When evaluating sustainability and the opportunity to scale or replicate this financing and payment innovation, we considered whether there are any unique conditions—regulation, competency, or capacity—that make each case more or less suited to replication or expansion.

In the case of Lee Specialty Clinic, leaders noted that other states would be equally capable of passing legislation to create and fund similar clinics, but that doing so would require effective advocates to collaborate with effective legislators at an advantageous time. The legislation enabling Lee Specialty Clinic was the result of a collaboration between clinic leadership, Louise Underwood (a parent advocate), and Jimmie Lee (a State Representative for whom the clinic is named). Other states would also need a clinical team with relevant expertise ready and willing to provide services under a similar payment arrangement.

CASE STUDY: UTAH NEUROBEHAVIOR HOME PROGRAM

Organizational Overview

The Utah Neurobehavior Health Outcomes Medical Excellence (HOME) Program, based at University of Utah Health, is an integrated payer/provider system serving patients with a developmental disability and a co-occurring mental health or behavioral health diagnosis. University of Utah Health administers HOME Medicaid, a managed Medicaid plan that covers both medical and mental/behavioral health services.

The HOME clinic, which employs primary care providers, psychiatrists, occupational therapists, case managers, and applied behavioral analysis (ABA) therapists, plays a central role in providing and coordinating care for patients covered by the HOME Medicaid plan. The plan also covers out-of-network services (such as specialist care, durable medical equipment, and home health) upon referral from the clinic.

Patients of all ages are eligible for the HOME Program if they have a developmental disability and a mental health or behavioral health diagnosis, live within a seven-county catchment area around Salt Lake City, and enroll in the HOME Medicaid plan. The clinic uses an interdisciplinary care model that encourages its primary care providers and psychiatrists to collaborate on patient care and coordinate medications.

Payment Innovation

The Utah Neurobehavior HOME Program includes innovations in both financing and payment. Prior to the establishment of the Neurobehavior HOME Program, medical and mental health/behavioral health coverage were separate for patients enrolled in Medicaid. Pediatricians and health plan leaders at the University of Utah approached the Utah Department of Health with a proposal to combine financing for both services into a single health plan that targeted enrollees with developmental disabilities and a mental health/behavioral health diagnosis.

The integrated plan began as a pilot with 100 patients in 2000, expanded to 300 patients after its first year, and was expanded into a permanent program after three years due to findings of cost savings and improved quality of care.

Quick Stats

Type of entity:

Integrated payer-provider network

Eligibility criteria:

People of all ages with intellectual or developmental disabilities and a mental health/behavioral health diagnosis

Definition of I/DD:

The definition used by the Division of Services for People with Disabilities, with the exception that the HOME program does not see people who sustained a traumatic brain injury when they were over the age of 22 and whose only source of disability is that traumatic brain injury

Number of people served:

1,316 patients as of 2020 audit

Covered services:

Primary care, psychiatric care, ABA, and other therapy

Insurance restrictions:

Medicaid enrollment and selection of Medicaid HOME plan required

The State of Utah pays the Medicaid HOME plan a capitated, per-member, per-month amount. The HOME clinic tracks encounters within its network but does not submit claims to the HOME plan; providers outside the network submit claims to the HOME plan and receive reimbursement at Medicaid fee-for-service rates. Each year, the HOME Program submits a cost report to the Utah Department of Health containing information about encounters, claims, salaries, and quality data.

The Department of Health contracts with an actuary to use those data to calculate a combined rate for medical and mental health/behavioral health coverage, following federal guidance. The HOME Program has an opportunity to negotiate the rate with the Department of Health, drawing on information such as quality outcomes (though the capitated payment is not directly tied to quality or cost outcomes).

Theory of Change

The payment and financing structure behind the Utah Neurobehavior HOME Program is intended to support better integration of medical and mental health/behavioral health services by a) combining the financing for both into a single Medicaid plan that has access to claims and encounter data for both sets of services and b) co-locating both sets of services at a single clinic to encourage collaboration between providers.

The goal of integration is to ensure that all of a patient's medical and mental health/behavioral health needs are met, and that the treatment plans (including medication) do not conflict with or contra-indicate each other. It also provides both medical and mental health/behavioral health providers with additional insights that may improve their ability to care for patients; for example, a psychiatrist can inform a primary care provider if a patient's difficulty managing diabetes is related to depression, which may affect the primary care provider's strategy for improving diabetes management.

Additionally, the integration of a Medicaid health plan with a provider network is intended to give the clinic flexibility in providing optimal care for patients with different needs. Because the payment to the Medicaid health plan from the state flows to the same legal entity that owns the clinic, and the clinic therefore does not rely primarily on claims reimbursement, the clinic is able to use funds flexibly to support non-reimbursable activities such as case management and medication management.

Cross-Model Comparison

Another example of the integration of physical and mental health/behavioral health benefits is North Carolina Medicaid. As the state transitions its Medicaid program to managed care, it is integrating mental health benefits (which had previously been under managed care) and physical health benefits (which had been under traditional, fee-for-service Medicaid) together under Medicaid managed care plans. The state will have three types of managed care plans, one of which specifically targets people with behavioral health needs or I/DD.

Outcomes

The Utah Neurobehavior HOME Program tracks patient satisfaction through a Primary Care Medical Home (PCMH) Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey and typically receives scores in the 90th percentile. They also report emergency department utilization, hospital readmissions, length of stay, and rate of follow-up visits following a hospital stay to the Department of Health annually. Once every three years, the Department of Health requires that the HOME Program conduct a detailed quality improvement project that is audited by a third party; the most recent project tracked HbA1c levels in patients with prediabetes.

Lessons Learned

Utah Neurobehavior HOME Program staff identified their affiliation with a large health system as an important structural feature of their program. In particular, the health system employs staff with expertise in government programs and reimbursement who are critical in negotiations with the Department of Health regarding payment rates to the Medicaid HOME plan. Because University of Utah Health has many specialists and services available, the clinic is also able to refer patients to providers with whom they have relationships and share an electronic health record.

Staff also shared operational lessons related to access. Since patients of the clinic have a mental health or behavioral health diagnosis, the clinic had originally required that their first visit be with a psychiatrist. However, limits to psychiatrist availability created a bottleneck that led to a multi-year waitlist. The clinic changed their care flow to allow patients to first see primary care providers, with an understanding that the psychiatrists on staff would make themselves available to any new patients with a significant and urgent need. Additionally, the clinic has made efforts to simplify its patient intake packet to remove barriers to access, especially for patients whose preferred language is not English.

Sustainability and Scalability

While the Utah Neurobehavior HOME Program is stable and has operated for over 20 years, staff indicated that they would be interested in expanding its reach if certain barriers were not present. First, because the clinic's affiliation with University of Utah Health is central to the design of the program, they are unable to expand geographically to locations where the health system does not have a presence. Additionally, this financing and payment structure is currently limited to Medicaid; the clinic receives reimbursement from Medicare and commercial insurance for its few patients who have dual enrollment, but it is not able to accept patients who are not enrolled in Medicaid at all.

To scale the model in its current form to other states, there would need to be an integrated payer-provider system willing to follow a similar model, and the state would need to be willing to contract with them. Many of the lessons learned from the Utah Neurobehavior HOME Program would be relevant, such as the importance of affiliating with a large health system or other well-resourced entity in order to have access to its resources.

CASE STUDY: PENN AUTISM CLINIC

Organizational Overview

Penn Autism Clinic provides intake and assessment services to people with autism who are dependents of University of Pennsylvania employees covered by the University’s self-insured health plan.

The clinic does not provide ongoing treatment; rather, its staff develops behavioral health treatment plans to support the goals of patients and their families, monitor the progress of those treatment plans through quarterly reports submitted by treating providers, accompany families to Individualized Educational Plan (IEP) meetings, and connect patients and families to additional resources.

Through its health plan, the University of Pennsylvania requires that patients with autism receive a behavioral health assessment from the clinic in order to have other treatments for autism covered. This requirement acts as a version of utilization management—an umbrella term for mechanisms that health plans use to place requirements around the type of care that providers may deliver—however, it is unusual in that most utilization management activities occur within the health plan rather than through an independent clinic.

The health plan also requires that other providers follow the treatment plan developed by the clinic and submit regular progress reports to the clinic. The clinic is staffed by one full-time psychologist, who conducts the assessments and develops treatment plans, and one half-time social worker, who provides wraparound services and supports to families, such as attending IEP meetings.

Payment/Financing Innovation

Penn Autism Clinic has an innovative payment mechanism. Although the clinic does receive claims reimbursement for some of its services through a traditional fee-for-service payment arrangement, most of its payment is in the form of a budget allocated by the University of Pennsylvania in its capacity as a self-insured employer. It is this payment that allows the clinic to provide critical yet usually unbillable services, especially through its social worker. The clinic and the university negotiated the initial budget based on the clinic’s estimate of the expected cost, and they revisit the amount annually as part of the university’s budgeting process. The full-time psychologist’s salary is tied to productivity measures similar to relative value units.

Quick Stats

Type of entity: Clinic contracted by health plan for utilization management

Eligibility criteria: People under the age of 26 who have autism or suspected autism and are covered by the University of Pennsylvania employee health plan

Definition of I/DD: Autism diagnosis or suspected diagnosis

Number of people served: About 150 patients a year

Covered services: Intake and assessment, care plan development, IEP support

Insurance restrictions: Coverage by the University of Pennsylvania employee health plan required

Theory of Change

The problem that Penn Autism Clinic is trying to solve with its model is three-fold:

- There are diverse needs among people with autism, and a single provider may not have all the resources and knowledge to appropriately treat a heterogeneous group of autistic patients. The clinic applies its broad expertise to treatment plans to assist providers as they care for patients.
- Care for people with autism consists of a lifetime of varying supports and services, not a one-time cure. As a result, families may be susceptible to fraudulent claims of the effectiveness of various treatments. The clinic provides patients and families with an unbiased opinion of what treatment plan will support their goals. It also provides assurance to the health plan that the services recommended are high value and evidence based.
- Providers and schools have a financial incentive to maximize and minimize services, respectively, and parents are sometimes put in the role of negotiator between the provider and the payer. The clinic, which does not have a financial stake in the level of service provision, is able to provide a treatment plan that both the provider and the payer agree to, without the need for parent advocacy.

Outcomes

Penn Autism Clinic translates care plan goals into quantifiable measures that it tracks quarterly through reports submitted by the providers following their care plans. The clinic also measures patient satisfaction through the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey and a proprietary survey. Annual survey results routinely are positive, with 96-99% of respondents rating their satisfaction with the clinic as “extremely high.”

Although lower total cost of care is not an explicit goal of the clinic, claims data have indicated that patients who use the clinic have lower total cost of care than those who do not. For several years, the University of Pennsylvania implemented the program for employees of its health system but not for employees of its university; the data demonstrating lower cost of care for patients enrolled in the clinic are derived from a comparison of the two groups. The average difference in cost between the groups was approximately \$8,000 per patient per year.

Cross-Model Comparison

The Mass General Down Syndrome Program has an initiative that similarly provides expert guidance on care plans to other providers. The clinical leaders of the program developed an online platform (dsc2u.org) that generates a screening checklist that patients with Down Syndrome can bring to their primary care providers who may not have expertise in Down syndrome. This app extends the program's expertise beyond the geographic limitations of the program's physical clinic.

Lessons Learned

Since Penn Autism Clinic occupies a unique position between a commercial payer and a provider, they have learned the importance of developing a clear, concise description of the clinic's role and value when introducing it to people who are not familiar with it. They have also emphasized the need to tailor that description to particular groups; families will understand the value of the clinic differently than a commercial payer that is potentially interested in contracting with the clinic.

Clinic leaders also noted the challenges that arise from separate funding streams for different services used by people with autism. The budget for the clinic is sufficient to allow its staff to attend IEP meetings with parents, and clinic leaders noted the importance of schools in serving children with autism. However, the separation of funding for schools and healthcare means that this type of collaboration is atypical.

Sustainability and Scalability

Penn Autism Clinic leaders noted that evidence of higher quality and lower costs is not sufficient to motivate expansion of their payment model beyond the University of Pennsylvania employee health plan. The University of Pennsylvania staff who approached the clinicians with the idea for the clinic were aware of their department's reputation and expertise in autism, and they had an institutional relationship with those clinicians. Other potential partners, though convinced of the value of the clinic and its ability to lower costs and improve quality, do not have that existing relationship.

The key to expansion for the clinic is not just having a value proposition but also having a payer partner that is in a position to prioritize contracting with the clinic over other potential uses of time, energy, and political capital.

Another key to Penn Autism Clinic's creation was the presence of an academic department with significant expertise and ongoing research in autism. Payers interested in employing clinicians for a similar utilization management function would need to identify clinicians who have the expertise to develop care plans and who are trusted by patients and families to base those care plans on clinical evidence rather than just cost savings.

NEXT STEPS

In addition to celebrating the successes and strengths of the innovative financing and payment models that have been developed to date, discussions during the NASEM workshop also surfaced elements that are currently missing from financing and payment innovations in I/DD care and aspirations for the future.

Scalability Beyond the Committed Core

The dedication of people who work with I/DD populations has driven the success of the financing and payment models we explored. However, the necessity of having a strong champion limits the degree to which innovative models are able to scale beyond the capacity and geographic regions of those few champions. Similarly, the innovative models that we explored almost exclusively focused on I/DD care as specialty care, rather than as an expertise that could be cultivated more generally among providers who care for a diverse population of patients.

This limitation makes some sense; in order to negotiate their financing or payment model, providers needed to demonstrate that they had a unique care model that could serve people with I/DD well. Additionally, providers for whom people with I/DD represent only a fraction of their patient population may not be interested in an alternative financing or payment model that only applies to that fraction.

However, many facets of the patient-centered care models that the above organizations use to care for patients with I/DD (and the financing and payment models that enable them) would also improve care for patients without I/DD: better coordination and communication across specialists, an emphasis on convenience and the removal of barriers for patients, and diagnostic tools that are accurate across a range of behaviors and abilities.

An aspirational future for I/DD financing and payment models does not need to eliminate specialists with a particular expertise in I/DD care, but more people with I/DD could be served if there were non-specialist options available as well.

Home- and Community-based Services

Although we did interview some state agencies that restructured their Medicaid programs to integrate the administration of medical benefits and home- and community-based services (HCBS) benefits, we did not otherwise hear much discussion about innovations in financing or payment for HCBS or coordination between medical services and HCBS. We also did not encounter innovative solutions to the challenge that many people with I/DD, despite needing the types of supports that HCBS provides, are either not eligible for HCBS or are on waitlists for HCBS.

Data Across Systems

Many of the organizations we interviewed identified a lack of access to comprehensive data as a barrier to proving their value and scaling their innovative financing or payment model. These data limitations included both a lack of comprehensive medical data (for providers who do not have access to all of their patients' claims) and a lack of coordination of data between the various silos that provide services to people with I/DD (e.g., healthcare, HCBS, and schools).

Other panels at the NASEM workshop discussed optimal care coordination models across these silos for people with I/DD; data sharing would be important not only for enabling that care coordination, but also for evaluating financing and payment models that pay for it.

Variety of Models

The models highlighted in these case studies—as well as many other models we explored—are all variations on cost-based reimbursement (arrangements that reimburse providers on the basis of their total cost to operate, rather than reimbursing them for individual services or patients).

Many other types of alternative financing and payment models have been tested in the U.S. healthcare system, and a greater variety of models may appeal to more providers, payers, and government entities. For example, payers may be more interested in offering payment models that hold providers accountable to total cost of care targets, and a greater number of providers may be interested in participating in payment models if there were more accurate risk adjustment methodologies that allowed payment to be varied based on patient acuity.

About the Author

Brede Eschliman, MPH, serves as the Director of Medicare at Aurrera Health Group, where she is focused on expanding Aurrera Health Group's mission-focused policy, strategy, and operations work into the Medicare program. Previously, she was a federal civil servant, most recently as a Medicare Program Examiner at the Office of Management and Budget (OMB) and a team lead at the Center for Medicare and Medicaid Innovation (CMMI) in the Center for Medicare and Medicaid Services (CMS). Earlier, Brede served as the Director of Operations for Community of Hope, a community health center in Washington, DC, and worked in strategic planning for MedStar Health, a large health system in the DC-Baltimore region. In these roles she focused on process improvements ranging from appointment scheduling to revenue cycle overhauls. She received a master's degree in public health from the Yale School of Public Health and a bachelor's degree from Yale University.



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