

COBB MODELS FOR FUNDING TREATMENT SERVICES

Background

Both fee-for-service and capitated managed care systems for purchasing healthcare services have intractable financial conflicts of interest inherent in their designs. In the first, the incentive is to provide more treatment than is necessary and in the latter the opposite—financial incentives for under treating. In neither model of purchasing or funding treatment have logical, objective means of monitoring accountability typically been employed.

To date, most monitoring has been crude (e.g., mortality rates), inconsequential (e.g., what percentage of incoming calls are answered by the third ring), or of questionable validity (e.g., patient satisfaction questionnaires and complaint rates). More recent efforts have attempted to address quality of care for addictions treatment in terms of more relevant measures such as monitoring rates of engagement in treatment once contact is made and retention in terms of completing the recommended care once it has been initiated.

Still, such monitoring does not address the question of whether treatment services are effective, much less, cost-effective. Also, such monitoring has not been linked to the design of treatment services so as to produce optimal or acceptable objective results nor to address the questions about whether services are of sufficient structure, intensity, or duration to yield expected outcomes.

The COBB (Coalition for Outcomes-Based Benefits) was organized to explore funding models and develop the technology and strategies for providing accountable treatment at affordable costs. Accomplishing this goal requires both information and innovation. Information was derived from reviewing the literature on the variables and using available data to explore factors that influence treatment outcomes. Factors influencing outcome expectations include patient characteristics and the relationships with the intensity and duration of treatment services. Development of models also included consideration of various contracting arrangements that would be suitable from the perspectives of payers, providers, and patients.

This work has progressed to the point that two basic models can be proposed. One may be more recognizable as applicable to public sector service and the other to private sector contracting, but in point of fact, either can be used for public or private sector contracting. The distinguishing features of the models are that they can tie financial incentives and penalties to treatment results. In many cases such results are not simply measures of abstinence from substance use, which can be difficult to determine with confidence. Rather the outcome measures may be quite objective and measurable—what proportion of treated employees are still employed a year or two after starting treatment; what proportion of welfare recipients continued to manifest substance use related problems that precluded employment; what proportion of substance related offenders were rearrested or reincarcerated for a substance related offense during a specified period of time.

The following is a brief description of each of the COBB funding models. Each has certain advantages and disadvantages relative to the other. It should be pointed out that the COBB models consider substance dependence as a chronic condition to be treated as any other chronic medical condition. That means that treatment is not to be considered a time limited event, but rather will involve long-term management with indefinite periodic delivery of services as

needed. In contrast, substance abuse may be more of an acute or time delimited problem that can actually be resolved with brief interventions or time-limited services. In either case, the goal is to provide results as defined in the contracting vehicles.

Independent Case Management

The Independent Case Management (ICM) model is less radical in its departure from more commonly used managed care models. It is distinct from the traditional capitated models in that the fee, or cost, of the case management is derived from a funding stream or contract independent from the funding for the actual treatment services. Treatment funds not expended revert back to the payer and are not retained by the management organization. This does not appear to be much different from the managed care models where the managed care company manages funding for a public agency or a self-insured corporation. But there are significant differences in the COBB model from most of the current arrangements.

The first difference is that the care management organization or entity must be a clinical organization, but not a provider. That is, the care management organization must employ professionals of sufficient skills and credentials so as to do the actual face-to-face assessments required for making the proper diagnoses and designing a treatment plan. Case management by remote control via formulas implemented by clerks and phone authorizations without any patient contact are not acceptable. This means that the care management organization must be local and have means of being accessible at the point where individuals are likely to seek care.

The care management organization/entity must be independent of the care providers, in reality as well as name. This means that shell corporate structures in which a provider group owns the care management organization, the care management organization owns the provider programs, or both are owned by a holding company is unacceptable for the ICM model.

Another major distinction is that with the ICM model, the care management entity is accountable for treatment results. Cost is not the only criteria. Do the services authorized by the care managers address problems and result in outcomes that are related to tangible results? The results to be achieved may be abstinence, but in most cases, it will involve other issues related to recovery and of interest to society an those funding treatment services. These issues include employability, commission of crimes, ability to parent, utilization of healthcare resources, etc.

The ICM model assumes that other services beyond basic treatment services will be required. These so called “wraparound” services may include providing for factors to enable treatment (e.g., transportation expense, child care, etc.) or to enhance recovery efforts (e.g., vocational counseling, social skills training, etc.). Investments in the wraparound services may not only be cost-effective, but essential in long-term gains.

Financial bonuses for exceeding expectations in terms of outcomes given service expenses and financial penalties for failure to perform can be built into the contracting framework. Over time, expectations can be adjusted based on history within a location and on experiences in other geographical areas.

ICM models have been in operation in the United States for a number of years with the delivery of services to recipients of TANF (Temporary Assistance to Needy Families) funds. The results have been that more individuals needing services were identified and more services were provided for the same level of funding. In England, similar models are in pilot stages of development.

Accountability Based Contracting

Accountability Based Contracting (ABC) models provide a strategy by which either a care management organization or provider network go at varying levels of risk for provision of all services from case finding to primary treatment to maintenance care. One way of conceptualizing the ABC model is as an augmented case-rate system. The provider/management organization would contract with the payer to provide those components of the continuum of care required to achieve a desired result. An example may be the easiest way to appreciate this model.

An employer with 10,000 workers in a specified geographic area might be served by a provider or provider network. Of this workforce, epidemiological data suggests that approximately 600 will have a substance use disorder. Actuarial data also suggests that only 30 of those 600 are likely to enter treatment in any given year and perhaps as few as 15 of the 30 will be able to remain employed by the company. The others will have relapsed and been found positive in random testing or otherwise will have been terminated or quit working for the company.

In this example, the goal may be to more precisely estimate the prevalence of substance use disorders, increase penetration of services to 10% of the afflicted workforce (60 individuals), and achieve a retained employability rate of at least 65% (40 workers). The provider/case management organization is to provide a bid for doing so. Such a bid would involve employee assistance services if the company does not have an internal EAP or coordinating with the established EAP for case finding strategies, provide primary treatment services, and maintenance care. A variable in the contract may be a case rate fee for each case identified so that the provider is not penalized for being more successful than anticipated in identifying and treating afflicted employees. Employees who leave the company for reasons other than cause should not be part of the equation since they may leave for better jobs elsewhere on achieving recovery. A bonus might be agreed upon if at least 75% of employees are retainable post-treatment.

In such a scenario, the provider/manager must be capable of delivering effective yet efficient services in order to be competitive. In addition, ongoing care would need to be accessible over the period of the contract for those individuals diagnosed as dependent, because they are likely to require periodic services to avoid relapses.

Competitive bidding in the ABC models will require knowing the characteristics of the workforce, the implications of those characteristics for treatment outcome expectations, and the likely results given various levels and intensity of services. At a general level, these are obtainable from the scientific literature and data available to the COBB. With a given workforce, these parameters can be refined over time.

A public sector ABC model might involve a similar bidding situation for treating individuals arrested for driving under the influence or for inmates with addiction problems released from state penal institutions. The objective would be to reduce the anticipated substance related rearrest rates. In this scenario, the bidding entity would again need to evaluate the characteristic of the target population, determine likely service needs, and costs related to services that would be likely to achieve the desired targets.