Value Based Payment Strategies: Design, Implementation, and Success

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Rob Houston
Senior Program Officer
Center for Health Care Strategies
About the Center for Health Care Strategies

A non-profit health policy center dedicated to improving the health of low-income Americans.
Relevant CHCS Initiatives

- **Medicaid ACO Learning Collaborative**
  Working with six states to share ideas and best practices and help design/implement Medicaid ACO programs

- **State Innovation Models (SIM) Initiative**
  Provide technical assistance for CMMI project to design and test state-based models for multi-payer payment and delivery system reform

- **New York DSRIP PPS Learning Collaborative**
  Convene and administer learning network among state and performing provider systems
Agenda

- Introduction to Value Based Payment (VBP) and Delivery System Reforms
- VBP Approaches and state examples
- The New York VBP Roadmap
- Policy Implications for Ohio
What is Value Based Payment?

- **Value Based Payment (VBP)** - Broad set of performance-based payment strategies that link financial incentives to providers’ performance on a set of defined measures of quality and/or cost or resource use

- VBP Goals
  - Improve quality/outcomes
  - Lower costs
  - Improve patient experience

- Impetus for VBP can come from the federal government, state governments, health plans, or providers
What VBP is not...

- Many delivery system reforms are confused as VBP models, but these are separate things
  - A VBP model is part of a delivery system reform effort

- Things often called “VBP models” that are not:
  - Managed Care Organizations
  - Accountable Care Organizations
  - Episode of Care models
VBP Proliferation

• HHS Goals
  ► 85% of Medicare payments tied to quality or value by the end of 2016; 90% by 2018
  ► 30% to Alternative Payment Models (APMs) by 2016 and 50% by 2018

• New York VBP Roadmap
  ► New York is leaning on its DSRIP program to shift 80-90% of Medicaid payments to VBP by 2020

• Accountable Care Organizations
  ► 744 ACOs have been established, most shared savings/ models
  ► Serve 23.5 million individuals nationwide (7% of the U.S. population)
# HCP LAN Alternative Payment Models Framework

## Category 1: Fee for Service — No Link to Quality & Value

<table>
<thead>
<tr>
<th>Fee-for-Service</th>
<th>A: Foundational Payments for Infrastructure &amp; Operations</th>
<th>B: Pay for Reporting</th>
<th>C: Rewards for Performance</th>
<th>D: Rewards and Penalties for Performance</th>
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<tbody>
<tr>
<td></td>
<td>Traditional FFS</td>
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<td></td>
<td>DRGs Not Linked To Quality</td>
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## Category 2: Fee for Service — Link to Quality & Value

<table>
<thead>
<tr>
<th>Reward Category</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>A</td>
<td>APMs with Upside Gainsharing</td>
</tr>
<tr>
<td>B</td>
<td>APMs with Upside Gainsharing/Downside Risk</td>
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## Category 3: APMs Built on Fee-for-Service Architecture

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## Category 4: Population-Based Payment

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<th>Reward Category</th>
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<tbody>
<tr>
<td>A</td>
<td>Condition-Specific Population-Based Payment</td>
</tr>
<tr>
<td>B</td>
<td>Comprehensive Population-Based Payment</td>
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VBP Accountability Continuum

Level of Financial Risk

Degree of Care Provider Integration and Accountability

- Fee-for-Service
- Performance-Based Programs
- Primary Care Incentives
- Performance-Based Contracts
- Condition or Service Line Programs
- Bundles & Episodes of Care Programs
- Shared Savings
- Shared Risk
- Capitation

Accountable Care Programs
The Five Most Common VBP Approaches

- Care coordination fees
- Pay-for-performance (P4P)
- Bundled payments
- Shared savings/risk
- Capitation/global payments
• Providing upfront payment, usually on a per member per month (PMPM) basis, to perform care coordination activities

• Payments are typically used to pay for technological elements and personnel

• No real accountability beyond receiving payment
Pay-for-Performance (P4P)

• **Rewards**
  - Providers receive a bonus payment for measurable performance in quality, patient satisfaction, resource use, and/or cost (e.g., hospital readmissions from nursing homes)

• **Penalties**
  - Providers receive a withhold/clawback of payment based on performance
  - Providers receive lower or no payments for events and procedures that are harmful and avoidable
Care Coordination + P4P Example: Colorado

- Colorado’s Accountable Care Collaborative established seven Regional Care Coordination Organizations (RCCOs) charged with improving care coordination
- RCCOs receive upfront care coordination payments between $8 and $10 and a P4P bonus for performance on quality metrics
- RCCOs receive data and analytics support from the State Data and Analytics Contractor (SDAC)
- Program has saved $77 million in net savings over four years
Bundled Payments

- Providers receive an inclusive bundled payment for a specific scope of services to treat an “episode of care” with a defined start and end point
  - Incentivizes coordination across physicians, hospitals, nursing homes, etc. to provide care at or below the payment level
  - Payment contingent on quality performance
  - Popular episodes include:
    - Knee/hip replacement
    - Pre-natal care
    - Diabetes
Arkansas Medicaid currently provides bundled payments for 15 episodes of care, including total hip/knee replacement, perinatal care, and ambulatory URI.

Each episode has a Principal Accountable Provider (PAP) selected by payers who acts as a “quarterback” for care coordination between providers for the episode.

PAP receives shared savings payment if costs of an episode are lower than “commendable” or “acceptable” levels and meets quality standards.

Reduced Medicaid spending growth by 50%
- 6% annual growth to 3%
- 73% of Medicaid PAPs improved costs or remained in a commendable or acceptable range during first phase of the program.
Shared Savings/Risk

- Providers that succeed in keeping costs below a total cost of care benchmark keep a percentage of the savings
  - Payment contingent upon quality performance
  - Incentivizes quality and cost improvements across all services included in the total cost
  - Utilized primarily in accountable care organizations (ACOs)
    - But increasingly being explored in PCMH, health homes, and super-utilizer initiatives
Shared Savings Example: Minnesota

- Integrated Health Partnerships (IHPs) build on existing patient-centered medical home (PCMH) initiative and are modeled on the Medicare Shared Savings Program.

- Two-track approach:
  - “Virtual” providers participate on an upside-only basis, receiving 50% of shared savings.
  - Fully integrated providers bear two-sided risk, and shared losses are gradually incorporated.

- Providers can choose to participate, but MCOs must share savings with ACOs.

- Program saved $76.1 million in 2 years and all IHPs have improved quality.
Global or Capitated Payments

- Providers receive a PMPM payment to cover a wide range of services
  - Providers bear full financial risk for patients
  - Incentivizes investments in care coordination, quality improvement, and efficiency across the full continuum of care
  - Utilized with advanced ACOs, hospitals, and multi-specialty provider groups
Global Payment Example: Maryland

- All Maryland hospitals receive an all-payer per capita global budget for hospital expenditures
  - Rates are case-mix adjusted
  - Limits per capita spending growth to 3.8% annually over five years
  - Uses 3M quality metrics to track quality performance
- Approved via CMMI waiver in January 2014
- Includes initiatives to reduce Medicare readmissions reduction and potentially preventable conditions
- Estimated to save Medicare $330 million over 5 years
- Program is exceeding expectations
  - 1.47% growth rate and $116M Medicare savings in Y1
Pathways to Implementing Medicaid VBP

- State plan amendment
- Waivers (e.g., 1115 demonstration)
- Modifications to health plan contracts
- Memorandum of understanding (e.g., between hospitals and providers)
- Charters (e.g., between health plans)
Delivery System Reform Incentive Programs (DSRIP) – A Rising Vehicle for Implementation

- Safety net hospital payments tied in part to successful implementation of transformation initiatives
- Improvement projects are well-defined and tailored to state-specific issues
- Payment is contingent upon achieving a set of process and outcomes measures, specific to each project
The New York VBP Roadmap

- Commissioned as part of NY’s $6 Billion DSRIP Program
- Roadmap Goals
  - Shift 80-90% of Medicaid Payments to providers to VBP by 2020
  - Increasing shift to higher risk levels (APMs)
  - Reduce avoidable hospital use 25% by 2020
- Majority of payments will still be made through managed care
- Roadmap will be updated periodically
Choose Your Own (VBP) Adventure

- The NY VBP Roadmap focuses on flexibility and innovation
- It does not require MCOs and providers to participate in a specific VBP arrangement
  - Rather, providers and MCOs “choose their own adventure” by agreeing to pursue one or more “VBP Approaches”
### VBP Roadmap Matrix

- **VBP Options**
  - All care for total population
  - Integrated primary care
  - Acute and chronic bundles
  - Total care for subpopulation

- **VBP Risk Levels**
  - 0 – Foundational payments
  - 1 – Upside only risk
  - 2 – Upside/downside risk
  - 3 – Full risk

<table>
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<tr>
<th>Options</th>
<th>Level 0 VBP</th>
<th>Level 1 VBP</th>
<th>Level 2 VBP</th>
<th>Level 3 VBP (only feasible after experience with Level; requires mature PPS)</th>
</tr>
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<tbody>
<tr>
<td>All care for total population</td>
<td>FFS with bonus and/or withhold based on quality scores</td>
<td>FFS with upside-only shared savings when outcome scores are sufficient</td>
<td>FFS with risk sharing (upside available when outcome scores are sufficient; downside is reduced when outcomes scores are high)</td>
<td>Global capitation (with outcome-based component)</td>
</tr>
<tr>
<td>Integrated Primary Care</td>
<td>FFS (plus PMPM subsidy) with bonus and/or withhold based on quality scores</td>
<td>FFS (plus PMPM subsidy) with upside-only shared savings based on total cost of care (savings available when outcome scores are sufficient)</td>
<td>FFS (plus PMPM subsidy) with risk sharing based on total cost of care (upside available when outcome scores are sufficient; downside is reduced when outcomes scores are high)</td>
<td>PMPM Capitated Payment for Primary Care Services (with outcome-based component)</td>
</tr>
<tr>
<td>Acute and Chronic Bundles</td>
<td>FFS with bonus and/or withhold based on quality scores</td>
<td>FFS with upside-only shared savings based on bundle of care (savings available when outcome scores are sufficient)</td>
<td>FFS with risk sharing based on bundle of care (upside available when outcome scores are sufficient; downside is reduced when outcomes scores are high)</td>
<td>Prospective Bundled Payment (with outcome-based component)</td>
</tr>
<tr>
<td>Total care for subpopulation</td>
<td>FFS with bonus and/or withhold based on quality scores</td>
<td>FFS with upside-only shared savings based on subpopulation capitation (savings available when outcome scores are sufficient)</td>
<td>FFS with risk sharing based on subpopulation capitation (upside available when outcome scores are sufficient; downside is reduced when outcomes scores are high)</td>
<td>PMPM Capitated Payment for total care for subpopulation (with outcome-based component)</td>
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Nationwide Effects of NY VBP Roadmap

- Renewed interest in DSRIP in other states
  - “Set the standard”
- Incorporation of VBP threshold percentages in state managed care contracts
- Higher bars and increased flexibility in VBP program design
Implications of VBP Efforts in Ohio

• Leveraging existing efforts in PCMH, episodes of care, and health homes

• Leveraging existing provider efforts
  ▶ Pediatric ACOs
  ▶ Efforts targeting SUD populations

• Focusing on social determinants of health
  ▶ Accountable Health Communities
  ▶ Population health initiatives
CMMI’s Accountable Health Communities

- Evaluation-heavy initiative to test the efficacy of linking health to “health-related social needs” such as housing, food insecurity, utility needs, interpersonal violence, and non-medical transportation
- $1M - $4.5M grants to 44 AHCs
- 3 Tracks
  - **Track 1** – Awareness: Increase beneficiary awareness of available community services through information dissemination and referral
  - **Track 2** – Assistance: Provide community service navigation services to assist high-risk beneficiaries with accessing services
  - **Track 3** – Alignment: Encourage partner alignment to ensure that community services are available and responsive to the needs of beneficiaries
Accountable Communities of Health in Medicaid

- Designed to address social determinants of health outside the medical realm
  - Focus on bringing together providers and community-based organizations to achieve common goals
  - Many different models being pursued:
    - **Minnesota** – 12 project-based initiatives
    - **Washington** – 2 cross-sector and regionally-based ACHs advise state agencies (will expand to 9)
    - **Vermont** - emerging model is a population health-focused model that may include a payment component
Linking Payment to Social Determinants of Health

- One of the biggest potential opportunities to reduce costs and incentivize whole-person care
  - However, CMS does not currently pay for many services that may generate positive health impacts, such as the social determinants of health
  - Linking VBP to new initiatives (such as AHCs/ACHs) or providing VBP models that purport such activity (such as global payments) could help to bridge the gap between health care and social and community-based services
For More Information

Contact me for more information:

rhouston@chcs.org