

# How Health Care Payment Reform Can Support Population Health

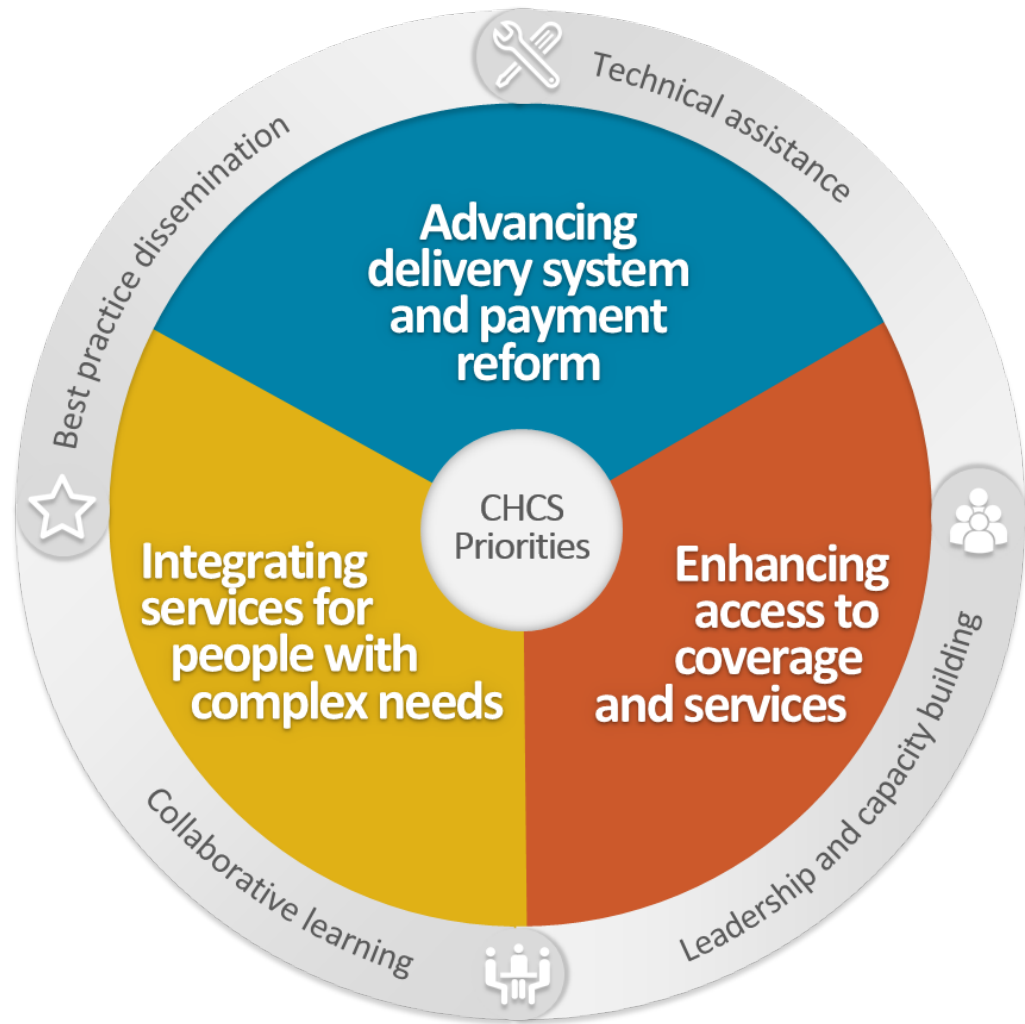
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Center for Health Care Strategies

# About the Center for Health Care Strategies

A non-profit policy center dedicated to improving the health of low-income Americans



# Select CHCS Initiatives

## Access to Coverage and Services

- Affinity Group for U.S. Charity Care Programs
- Ensuring Health Coverage and Access for Justice-Involved Individuals

## Delivery System and Payment Reform

- Advancing the CDC's 6|18 Initiative: State Medicaid & Public Health Collaboration
- Medicaid Accountable Care Organization Learning Collaborative
- State Innovation Model Technical Assistance

## Services for People with Complex Needs

- Advancing Trauma-Informed Care
- Complex Care Innovation Lab
- Promoting Youth Substance Use Disorder Prevention Strategies in Medicaid
- Transforming Complex Care

## Leadership and Capacity

- Medicaid Leadership Institute
- State Medicaid Academies



# Three Key Takeaways

- Population health is difficult to pay for in a fee-for-service environment
- Alternative Payment Models (APMs) present flexibility that enables a population health focus
- States can help health care providers and managed care organizations address population health by supporting APM development



# Agenda



- Our current fee-for service health care model
- Alternative Payment Models (APMs)
- Implementing APMs to support population health strategies
- Q&A

# Our Current Fee-for-Service Model

Or

“Why everything costs so much”

# Our Current Fee-for-Service Model

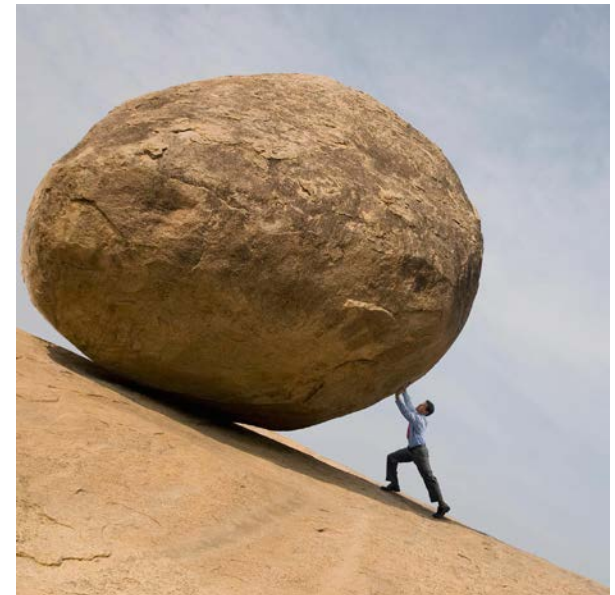
- If you have a need for a health care service – you pay a health care provider for it!
  - » Usually, this transaction is facilitated by health insurance
- Advantages of this model
  - » It's simple!
  - » You don't pay for anything you don't want or need!
    - *(sort of...)*
  - » When insurance is involved, many services just require a low co-pay or are free!





# Disadvantages of Fee-for-Service

- Incentivizes volume of services rather than value of services
  - » Payment is not based on quality of services
  - » If providers want to make more money, they perform more services
  - » “Incorrectly assumes that health is produced when we pay for health care”  
– Kindig and Milstein
- Leads to the highest-cost health care system in the world and worse health outcomes than most of the developed world





# How Fee-for-Service affects Population Health

- Since the model only pays for “health care services,” things that are not considered a “health care service” are not reimbursable
  - » Services rarely involve something non-medical or preventative that could make a big difference in the health of a patient or population
    - Home asthma remediation
    - An air conditioner
    - Supportive housing
    - Walkable neighborhood



# “The Doorbell Story”

- Flexible payment models allow creative solutions



# Alternative Payment Models

Or





“Provider Risk = Provider Flexibility”

# Alternative Payment Models

- Alternative Payment Models (APMs) are designed to move away from Fee-for-Service and toward value-based payment (VBP)
  - » Aligns provider payment with patient outcomes, performance of evidence-based processes, and patient experience
  - » Incentivizes cost reduction
- APMs also require providers to take on some form of financial risk
  - » “Upside Risk”
  - » “Downside Risk”
  - » “Full Risk”







# HCP LAN Alternative Payment Model Framework

			
<p><b>CATEGORY 1</b> FEE-FOR-SERVICE - NO LINK TO QUALITY AND VALUE</p>	<p><b>CATEGORY 2</b> FEE-FOR-SERVICE – LINK TO QUALITY AND VALUE</p> <p><b>A</b></p> <p><b>Foundational Payments for Infrastructure and Operations</b> (e.g., care coordination fees and payments for HIT investments)</p> <p><b>B</b></p> <p><b>Pay-for-Reporting</b> (e.g., bonuses for reporting data or penalties for not reporting data)</p> <p><b>C</b></p> <p><b>Pay-for-Performance</b> (e.g., bonuses for quality performance)</p>	<p><b>CATEGORY 3</b> APMS BUILT ON FEE-FOR-SERVICE ARCHITECTURE</p> <p><b>A</b></p> <p><b>APMs with Shared Savings</b> (e.g., shared savings with upside risk only)</p> <p><b>B</b></p> <p><b>APMs with Shared Savings and Downside Risk</b> (e.g., episode-based payment for procedures and comprehensive payment with upside and downside risk)</p>	<p><b>CATEGORY 4</b> POPULATION-BASED PAYMENT</p> <p><b>A</b></p> <p><b>Condition-Specific Population-Based Payment</b> (e.g., per member per month payments, payments for specialty services, such as oncology or mental health)</p> <p><b>B</b></p> <p><b>Comprehensive Populations-Based Payment</b> (e.g., global budgets or full/percent of premium payments)</p> <p><b>C</b></p> <p><b>Integrated Finance and Delivery System</b> (e.g., global budgets or full/percent of premium payments in integrated systems)</p>
		<p><b>3N</b> Risk-Based Payment NOT Linked to Quality</p>	<p><b>4N</b> Capitated Payments NOT linked to Quality</p>

Source: *Alternative Payment Model (APM) Framework: Refresh for 2017*. The MITRE Corporation. 2017. Available at: <http://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf>.

# APMs are...

			
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# What Makes APMs So Flexible?

- APMs are based on patient Total Cost of Care – how much all a patient’s medical services cost during a year
  - » If the cost of medical care is lower than the projected total cost of care – providers get to keep a portion of that savings
  - » Therefore, high-value interventions that improve quality or reduce costs but are not considered medical services could be paid for through anticipated savings
- Some APM models under a global budget arrangement allow for “flexible services”





# How Providers Can Pay for Population Health

- County-based Accountable Care Organization composed of a medical center, community health center, MCO, and the county public health department
- Offers medical, behavioral health, and social services for residents of Hennepin County and financed through a “braided” global budget mechanism
- A portion of savings achieved below its capitated amount is placed in a “reinvestment fund,” which can be used to pay for non-covered services for patients
  - » Currently focused on housing support



# Implementing APMs to Support Population Health Strategies

Or

“How States can help get the job done”

# 4 APM Implementation Strategies

- Participation in existing CMS programs
- Payment arrangements between managed care organizations (MCOs) and providers
- Create a State-based APM program
- CMS Waivers
  - » Section 1115 Research & Demonstration Projects - Includes Comprehensive waivers, Delivery System Reform Incentive Payment (DSRIP) waivers
  - » Section 1915(b)(3) Managed Care Waivers - Use cost savings to provide additional services to beneficiaries



# Pros and Cons of APM Implementation Strategies

Approach	Easy to Implement	State could incentivize providers to participate	State can design model to target specific outcomes	State can offer “flexible services”
Existing CMS Programs	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MCO-provider APM Arrangements	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Create State-based APM program	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
CMS Waivers	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

# Ohio Already Has a Good Foundation

- Patient Centered Medical Home (PCMH) model is widespread
  - » Emphasizes care coordination
- Episodes of Care model has opportunities for flexibility in its payment model
  - » Shared savings/risk model (LAN Category 3B)
- CPC+ Program establishes prospective payment methodology for Track 2 practices
- Medicaid Managed care contracts have VBP targets
  - » 50% of net payments to providers need to be “value-oriented” by 2020.



# State-Based Model Example - Minnesota

- Created Integrated Health Partnerships (IHPs) – Accountable Care Organization (ACO) entities responsible for total cost of care of attributed population
- “Track 2” IHPs receive population-based payment + Upside and Downside performance risk
- Medicaid MCOs are required to contract with IHPs
- IHPs can earn higher “upside” if they contract with community partners that help provide support for housing, food security, social services, and education, among other services
- 21 IHPs saved over \$216M over four years



# 1115 Waiver Example - Oregon

- Created Coordinated Care Organizations (CCOs) – regional health plan-like entities to serve Medicaid beneficiaries
  - » Most have a monopoly on their geographic market
- The 16 CCOs are paid via a global budget
- Waiver allows CCOs to cover “health-related services”
  - » **Flexible Services** – cost-effective services offered to an individual member to supplement covered benefits (e.g., non-durable medical equipment; air conditioners, temporary housing)
  - » **Community benefit initiatives** – community-level interventions focused on population health and health care equity (e.g., a farmer’s market in a “food desert,” a local workforce training program)
- Saved \$1.3 Billion over four years





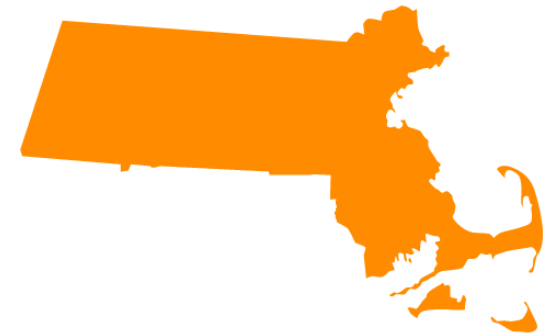
# 1115 Waiver Example - New York

- DSRIP waiver includes “Value-Based Payment Roadmap”
  - » Requires 80% of Medicaid payments to providers to be through an APM by 2020
  - » Certain VBP arrangements must include a Community-Based Organization (CBOs)
- Performing Provider Systems (PPSs) include many CBOs
  - » Many DSRIP quality metrics target areas CBOs can help improve
- Requires providers in certain VBP arrangements to implement at least one intervention to address from a social determinants of health “menu”



# 1115 Waiver Example - Massachusetts

- DSRIP waiver requires the state's newly-established ACOs to contract with Community Partners (CPs)
- The 17 ACOs work with CPs to provide “flexible services”
  - » Community transition services
  - » Home- and community-based services
  - » Services to maintain a safe and healthy living environment
  - » Physical activity and nutrition
  - » Experience of violence support



# Remember the Three Key Takeaways

- Population health is difficult to pay for in a fee-for-service environment
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# Question & Answer



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