The National Payment and Delivery System Reform Landscape

States Acting as Purchasers and Advancing Transformation

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Presentation Overview

1. Regulating vs. Purchasing
2. The Problems Created by Fee-for-Service Payment
3. Innovation Examples from Across the U.S.
4. How Other States Have Succeeded in the Operationalization of Payment Reforms
5. How “Readiness" was Determined by States as They Used Adopted Payment Reforms

Regulation: The Traditional Public Sector Strategy for Health Care

- Traditional Medicaid programs have issued regulations defining performance expectations for providers.
- These performance expectations are viewed as minimum requirements.
- The role of the Medicaid program is then to assess compliance with those minimum requirements.
- Public employee benefit programs have differed a little, but also focus on *contractual compliance*.

Regulatory Compliance Activity

- Compliance activity is typically focused on monitoring, e.g., were reports submitted on time? were telephones answered on time?
- Audits are performed to make sure that rules haven't been broken.
- Non-compliant contractors are fined or otherwise penalized.
- Is this approach likely to promote innovation, transformation and improved value?

Purchasing

- Ensuring minimum requirements are met *is* important…

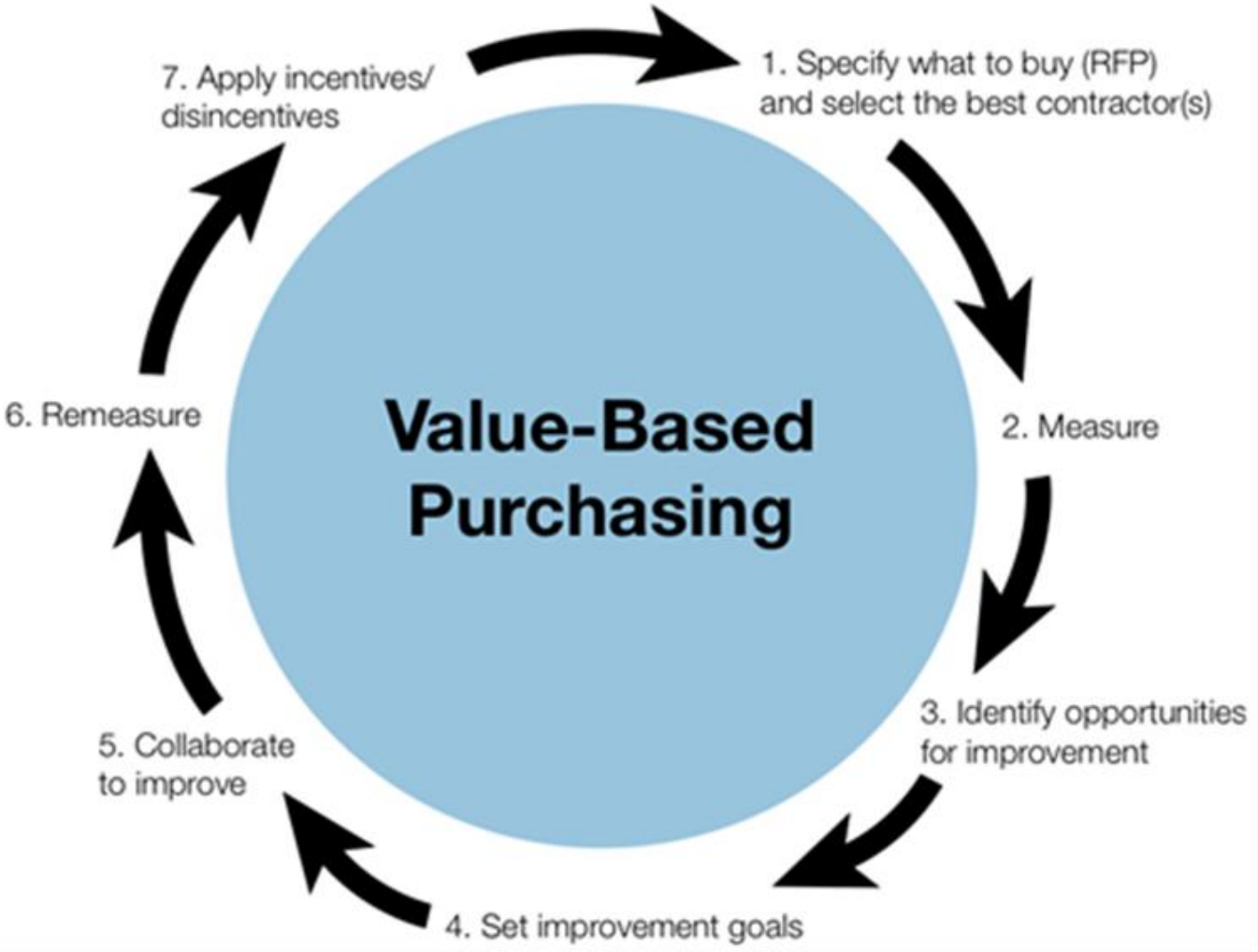
  …but all it ensures is minimal performance.

- To view one's activities as being those of a purchaser is to adopt a significantly *different perspective*.

- Purchasing is about setting expectations and about achieving ever greater value.

- Purchasing is about a highly interactive relationship with contractors that is based on collaboration and accountability. It is active – not passive!

MCO Value-Based Purchasing Cycle



Fee-for-Service (FFS) Payment

- For many years, using both regulatory and purchasing approaches, Medicaid programs and employer purchasers (public and private) have been buying health work on a piecework basis.
- What do you get when you pay per piece?
- You get lots and lots of pieces.
- **Payment drives care delivery.**

FFS: not only rewarding volume, but rewarding volume of highly priced services

- FFS payment provides a financial incentive to:
  - Provide more of those services which are paid most handsomely – e.g., cardiology, orthopedics
  - Introduce new services that generate higher fees than longer-standing services

FFS: not creating incentives for providers to do “the right thing”

- Fee-for-service payment…
  - Does not incentivize coordination across providers
  - Does not promote whole-person care
  - Does not reward quality
  - Can actually reward poor quality (no warranties here!)

FFS: creating disincentives for providers to do "the right thing"

- FFS payment provides a financial *dis*incentive to:
  - Deliver services that generate comparatively lower remuneration – e.g., primary care, psychiatry
  - Provide services for which there is no FFS compensation – e.g., patient outreach, care coordination, treatment plan development, e-visits, web visits

Are there benefits to FFS payment? Yes.

- FFS payment does motivate providers to provide patients with access to services and to provide needed (*and* unneeded) services.
- FFS payment volume does motivate technology firms, pharma and others to develop new services and medications that might alleviate pain and suffering, and delay death.

Atul Gawunde on Fee-for-Service Payment and Unnecessary Care

"It isn't enough to eliminate unnecessary care. It has to be replaced with necessary care. And that is the hidden harm: **unnecessary care often crowds out necessary care**, particularly when necessary care is less remunerative."

"If doctors are rewarded for practicing more conservative medicine, some could end up stinting on care…**Right now we're so wildly over the boundary line in the other direction**…Waste is not just consuming a third of health-care spending; it's costing people's lives."

Gawunde A. "Overkill" *The New Yorker*, May 11, 2015

State Innovation Models

- CMS, through its SIM grants, is actively encouraging efforts to change payment and improve care delivery – the two concepts are linked.
- States, in varying degrees of collaboration with insurers and employer purchasers, are actively testing multiple new payment models.
- Let's now review the primary payment models and a few examples of innovation in action across the nation.

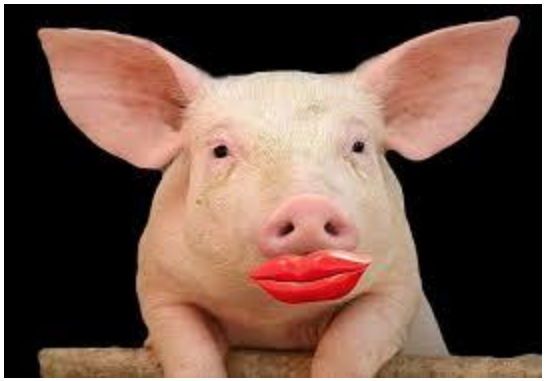
Alternative Payment Models

There are four primary alternatives to FFS payment:

1. Incentive Bonus
2. Supplemental Per Capita Payment
3. Episode-based Payment
4. Total Cost of Care
    - by specialty
    - by sub-population
    - for all, or nearly all

1. Incentive Bonus

- Provides a financial reward for good performance on quality and/or efficiency.
- Built on top of FFS payment.
- Unlikely to change FFS volume incentive alone, but may motivate some focused performance improvement efforts.



2. Supplemental Per Capita Payment

- Provides a PMPM investment to support otherwise non-reimbursed services (e.g., high-risk patient care mgt) and/or infrastructure development and operations (e.g., quality measurement and reporting).
- Common in Patient-Centered Medical Homes and Health Homes contracts.
- Built on top of FFS payment.
- Volume incentive is less of a concern with primary care, but the payment model does not promote accountability for quality or cost management.

3. Episode-based Payment

- A **fixed dollar amount** that covers a set of services for a defined period of time.
- Payment is typically administered on a FFS basis with **retrospective reconciliation** to an episode budget. There are examples of prospective ("bundled") payment in use, however.
- Most often providers share in savings generated ("shared savings"), but are sometimes held accountable for losses too ("shared risk").
- Quality is typically a component of payment – either influencing gain/loss distribution, or as a separate bonus.

4. Total Cost of Care Payment

- **Defines a budget on a *per-capita* basis** for a broad population of patients for whom the provider assumes clinical and financial responsibility.
- Populations can be defined based on **enrollment** (e.g., PCP selection) and/or on **attribution** (e.g., assigned to the provider based on visit history).
- Can be for limited services (e.g., primary care), a subpopulation *or* for total cost of care for all.
- Providers share in savings only or also share in risk.
- Quality is typically incorporated into the model.

State Examples

1. Incentive Bonus
2. Supplemental Per Capita Payment
3. Episode-based Payment
4. Total Cost of Care
   - by specialty
   - by sub-population
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Incentive Bonus Example: Massachusetts Medicaid

- Massachusetts initiated a hospital-based P4P program in 2008/9 to measure and incentivize hospital quality for non-elderly patients in its Medicaid PCCM.
- Hospitals initially received incentive payments based on their scores for quality indicators related to care for pneumonia and surgical infection prevention.
  - Measures for pneumonia care include the timing and selection of antibiotics and smoking-cessation counseling.
  - Measures for surgical infection prevention include the selection and preventive use of antibiotics during and 24 hours after surgery.

Massachusetts Medicaid (cont'd)

- Expanded this hospital P4P program to heart attack, heart failure, and maternal and neonatal care in 2010.
- Today, allocates a maximum of *$50M annually* for hospital supplemental P4P payments.
- In 2012 introduced financial penalties for hospitals related to potentially preventable readmissions.
- The 2014 contract includes terms for incentive payments for 18 measures in the following areas:
    - Maternity (4)
    - Community-acquired pneumonia (2)
    - Pediatric asthma (3)
    - Surgical care infection (3)
    - Health disparities (1)
    - Care coordination – inpatient (3)
    - Emergency department measure set (2)

Supplemental Payment Example: Missouri Medicaid

- Section 2703 of the ACA provided states with the new option of creating a “health home” program within Medicaid for high-risk beneficiaries with complex care needs.
- Missouri implemented the first Medicaid health home program in the U.S. in 2012.
- Separate mental health and primary care health homes.
- Currently paying $62.47 PMPM to primary care health homes (far above other models in the US, e.g., OR $10-$24 PMPM).

Missouri Medicaid (cont'd)

- CMHC health homes are Community Mental Health Centers providing community psychiatric rehabilitation services under the Medicaid Rehabilitation Option with sufficient capacity to sustain a viable health home.
- State assesses health homes on multiple performance measures and on impact on utilization and cost.
- For its 27 CMHC health homes, MO reported 12.8% reduction in inpatient admissions and 8.4% reduction in ED visits after the first year.

Episode-based Payment Example: Arkansas Medicaid and commercial insurers

- Arkansas (Medicaid and two insurers) launched an episode-based payment program in 2012.
- Initial episodes included:
  - ADHD
  - Congestive heart failure admission
  - Joint replacements
  - Perinatal care (non-NICU)
  - Ambulatory URI
- Have added new episode bundles in waves
- Overlapping models in Arkansas approach:
  - Episode-based payment *and* supplemental payment to medical homes/health homes

Arkansas (cont'd)

- Providers share in savings or excess costs of an episode depending on their performance for each episode.
  - Share up to 50% of savings if average costs are below "commendable" levels and quality targets are met.
  - Pay part of excess costs if average costs are above "acceptable" level.
  - See no change in pay if average costs are between "commendable" and "acceptable" levels.

Sources: Arkansas Center for Health Improvement (ACHI) www.achi.net , and www.paymentinitiative.org and presentations by Joseph Thompson MD, MPH, Surgeon General, State of Arkansas, ACHI Director

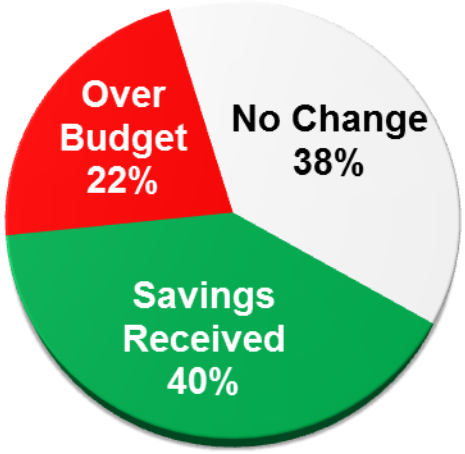
Arkansas (cont'd)

- For each episode, all treating providers **continue to file FFS claims** and are reimbursed according to each payer's established fee schedule.
- The payer identifies the **Principal Accountable Providers** (PAP) for each episode through claims data and calculates average cost per PAP.
- Evolved from voluntary to **mandatory program** and from prospective bundles to retrospective payment.
- For some episodes, providers submit a small amount of **quality information** not currently available through the billing system through the provider portal.

Arkansas (cont'd)

Initial results for URI:

- 40% of providers experienced savings, 22% were over budget, remainder saw no change.



- Anecdotal reports also suggested quality improvements

Total Cost of Care Example: Minnesota Medicaid

- Program termed the “Integrated Health Partnerships (IHP) demonstration.” Part of SIM Test Model grant.
- Started 1-1-13 with six participating delivery systems. Now 16 participants statewide.
- In their first year of participation, delivery systems can share in savings. After the first year, they also share the risk for losses. Delivery systems’ total costs for caring for members are measured against targets for cost and quality.

Minnesota Medicaid (cont'd)

- The IHP model covers both managed care and traditional fee-for-service care.
- The state conducts the procurement and then instructs MCOs to contract with the IHPs.
- One IHP consists of a coalition of 10 urban FQHCs.
- The state reported $61.5 million in savings in 2014, and plans to grow participation from 20% to 50% of program penetration by the end of 2018.

States Mix and Match

- States often use multiple payment models in combination.
- For example, Arkansas combines:
  - Supplemental per capita payment
  - Episode-based payment
  - Total cost of care payment for subpopulations
- Nobody can say definitively which payment model(s) works best, or which payment model works best with what types of providers or services in what type of market. We're still experimenting.

A Few Other State Innovations of Note

- Maryland: Global budgets for hospital services
- Oregon: "CCOs" which emphasize coordination with non-health care community organizations
- Vermont: All-payer model (in development), including:
  - Medicare, Medicaid and commercial insurer capitation payment to one statewide ACO (merger of three existing ACOs) – perhaps mix of shared and full risk
  - ACO will contract with hospitals using fixed revenue budgets for all hospital services and employed specialists
  - ACO will pay primary care providers an enhanced primary care capitation payment
  - Quality incentive pools for all providers

Two Remaining Questions

1. How have other states succeeded in the operationalization of payment reforms?

- It's not been easy.
- States need deep knowledgeable and skilled staff, strong partnerships with select stakeholders, consultant support (to varying degrees) and executive leadership.

2. How was "readiness" determined by states as they used new models or adopted payment reforms?

- Readiness is important in terms of state, payers and providers.
- Readiness often correlates with experience. Less experience can mean a longer lead time – but doesn't always (e.g., Arkansas).

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