Health Care Payment Reform:

State-based Payment Reform Models – Who is Doing What? Is it Working?

Part Two of a Three-Part Series

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June 10, 2014

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Presentation Overview

1. ***Webinar Logistics***
2. State Health and Value Strategies Program
3. Payment Reform Webinar Series
4. Five State-based Payment Reform Models
   - Supplemental Payments
   - Pay-for-Performance
   - Episode-based Payments
   - Population-based Payments
   - Global budgets
5. Questions and Discussion
6. Contact Information and Wrap-Up

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Webinar Logistics

- The recording and slides will be available following the webinar.
  - **www.rwjf.org/en/grants/grantees/state-health-and-value-strategies--shvs.html**
  - An email with this information will also be sent to all webinar participants

- Due to the number of participants, we will not open the telephone lines for questions. Please use the webinar Q&A feature instead to ask questions.

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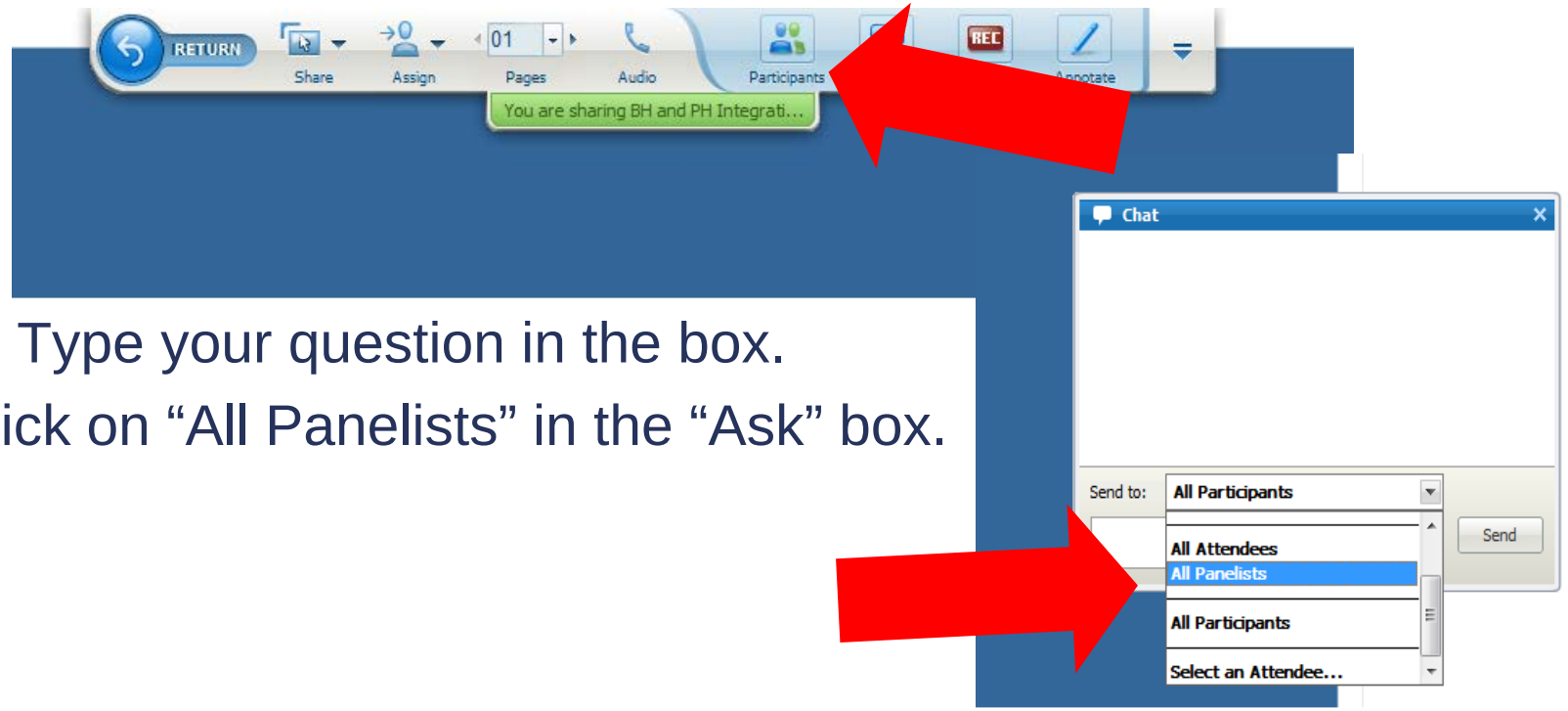
Asking Questions

- Roll over the green bar at the top of the page and left click on Q&A or Chat.



- Type your question in the box.

Click on “All Panelists” in the “Ask” box.

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Robert Wood Johnson Foundation's State Health and Value Strategies Program

- Committed to providing technical assistance to support state efforts to enhance the quality and value of health care by improving population health and reforming the delivery of care services
- Connects states with their peers and experts to develop tools to undertake new quality improvement and cost management initiatives
- Places an emphasis on building systems capacity, engaging stakeholders, and promoting payment and other purchasing reforms

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Payment Reform Webinar Series

Three-part series on Tuesdays from 1:30-2:30 p.m. EDT:

- May 21: Payment Reform 101: Why Payment Reform? What is it?
- *Today: State-based Payment Reform Models*
- June 24: Special Topics in Payment Reform: State Levers, Multi-payer Approaches, and Measurement

- ***To register for future SHVS events go to:*** https://rwjfevents.webex.com/mw0401l/mywebex/default.do?siteurl=rwjfevents

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The Need for Payment Reform

"The health care payment system is the biggest barrier to better health care delivery."

Source: The Center for Health Care Quality and Payment Reform

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Reminders from May 27th Webinar

- FFS payment creates **strong economic incentives** for providers to deliver high volumes of high margin services – and **barriers** to delivering non-reimbursable services.
- Payment reform entails *moving away from FFS* and toward other ways of payment that create financial incentives for high quality, efficient care.
- **Payment reform is not an end in itself**, but rather a means to motivate improvement in the way that providers deliver health care.

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1. Supplemental Payment
Definition

- Generally a per member per month (PMPM) payment, supplementing another form of payment - often FFS.
- Purchasers or insurers pay qualifying providers
  - a pre-determined sum
  - for each qualifying patient every month
  - to support specified activity (e.g., in a PCMH, enhanced outreach, communication, coordination and care management)
- Payments sometimes vary based on patient characteristics and are based on enrollment or attribution.

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1. Supplemental Payment
Rationale

- Support practice infrastructure needed to support effective care delivery.
  - Patient registry management
  - Data analysis
  - Practice coaching
- Provide resources to support provision of traditionally non-reimbursable services.
  - Care management
  - Care coordination
  - E-visits

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1. Supplemental Payment
Pros and Cons

Pro

- Provides practices with the financial means to maintain infrastructure and provide services for which there would otherwise be no funding.
  - Especially important for small and independent practices

Cons

- Payments are typically of modest PMPM sums, limiting impact on practice operations.
- Payment is not tied to performance, so there is no accountability for the use of the funds, nor financial motivation to deliver better care.

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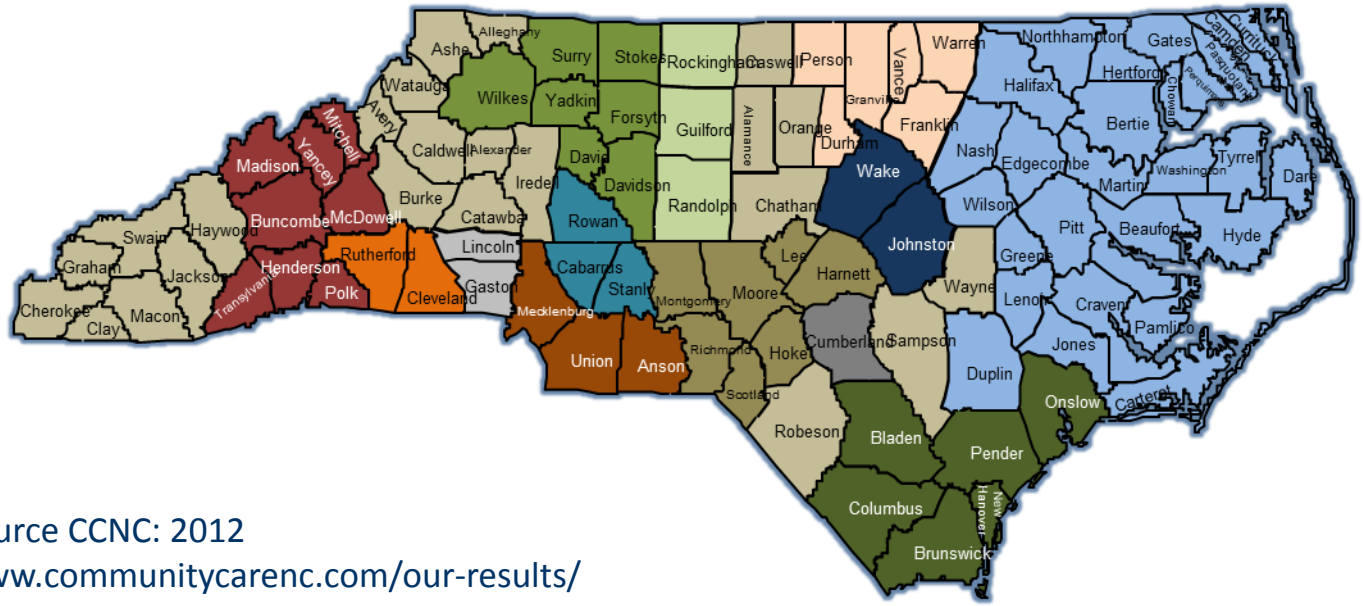
1. Supplemental Payment
State Example: North Carolina Medicaid

- As part of Community Care of North Carolina (CCNC), the state provides a PMPM payment to ***PCPs*** and a separate PMPM payment to regional ***community networks***.
- The state provides the networks access to claims data.



Source CCNC: 2012
www.communitycarenc.com/our-results/

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1. Supplemental Payment
Impact: North Carolina Medicaid

- The CCNC program includes payment reforms and delivery system reforms beyond supplemental payments – the impact of each component cannot be separated.
- Milliman estimated that North Carolina's CCNC program saved nearly a ***billion*** dollars over 4 years.

State Fiscal Year	Total Annual Savings
2007	$103,000,000
2008	$204,000,000
2009	$295,000,000
2010	$382,000,000
	$984,000,000

Source CCNC: 2012
www.communitycarenc.com/our-results/

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1. Supplemental Payment
State Example: Maryland PCMH

- In 2011, Maryland began a legislatively-directed multi-payer initiative involving the Patient-centered Medical Home (PCMH) model of care.
  - includes 53 primary and multi-specialty practices and about 200,000 patients statewide
  - PCP practices are comprised of private and all FQHCs across the state
  - Maryland Learning Collaborative provides education, technical assistance, and customized coaching to help practices transform
- Maryland law requires the five major private insurers to participate:
  - Aetna, CareFirst, CIGNA, Coventry, and UnitedHealthcare
- FEHBP, Maryland State Employees Health Benefit Plan, TRICARE, and some plans provided by private employers have also voluntarily elected to participate.

Source: http://mhcc.maryland.gov/pcmh/

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1. Supplemental Payment
State Example: Maryland PCMH

- The Fixed Transformation Payment (FTP) offers a set per-patient per-month fee *paid semi-annually* to practices achieving National Committee for Quality Assurance (NCQA) PCMH recognition.
  - The fixed fee is adjusted for NCQA recognition level and practice size and Medicaid vs. commercial insurance status.
  - Practices must spend some of their PMPM payments for a care coordinator.
- Practices annually report on approximately 20 performance measures, most focused on prevention and chronic care management.
- Maryland also offers the potential for shared savings.

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1. Supplemental Payment
Impact: Maryland PCMH

Findings from December 2013 analysis of first year results

- Participating PCMH practices' patients experienced:
  - Larger decrease in the proportion of young adults with a hospital admission due to asthma
  - A relative increase in the annual rates of well-care visits among adolescents
  - An increase in the proportion of patients with one or more office visits to the attributed primary care physician
  - A decrease in the mean number of specialist office visits among patients with such visits
  - A relative decrease in total outpatient payments
  - A relative decrease in total other payments (excluding inpatient, outpatient, emergency department, office visits, home health, nursing home, hospice, radiology, and lab).

Source: http://mhcc.maryland.gov/pcmh/documents/PCMH_EvaluationYear1_Report%20FINAL.pdf

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2. Pay-for-Performance (P4P) Definition

- CMS has defined P4P as: “the use of payment methods *and other incentives* to encourage quality improvement and patient-focused high value care”

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

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2. Pay-for-Performance (P4P) Definition (continued)

- There are different types of P4P, but *generally* it:
  - offers providers a **financial bonus** for meeting pre-established targets of excellence or improvement on specific performance measures (e.g., access, quality, efficiency)
  - **may include financial disincentives** (such as eliminating payments for negative consequences of care or reducing payments for poor performance on specific measures)
  - **continues to use FFS** as the underlying mechanism of payment

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2. Pay-for-Performance (P4P) Rationale

- Counter the volume incentive of FFS payment by creating rewards for provider quality and efficiency
  - In addition to direct financial incentives, rewards can include increased patient volume, public recognition and exemption from administrative requirements.

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2. Pay-for-Performance (P4P)
Pros and Cons

Pro

- Counters the exclusive emphasis of FFS payment on volume to address performance

Cons

- Rewards much be large to counter the FFS volume incentive
- Often focus on quality with very little, if any, consideration of cost and efficiency
- Hard to measure if patient counts are low – problem for small market share payers and with specialists

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2. Pay-for-Performance (P4P)
State 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.

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2. Pay-for-Performance (P4P)
State Example: Massachusetts Medicaid

- 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 acute hospital contract includes terms for incentive payments related to 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)

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2. Pay-for-Performance (P4P)
Impact: Massachusetts Medicaid

- One study of the MassHealth hospital incentive in the early years found small but not statistically significant hospital improvement in pneumonia or surgical care infection rate performance in 2008/2009.
  - Andrew M Ryan and Jan Blustein, "The Effect of the MassHealth Hospital Pay-for-Performance Program on Quality" *Health Serv Res*. Jun 2011; 46(3): 712–728.
- The state has made significant changes to the incentive program over time, adding funds and more performance metrics.

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2. Pay-for-Performance (P4P)
State Example: Iowa Medicaid

- For years, Iowa has applied financial incentives and disincentives to an array of performance measures in its managed behavioral health (BH) contract for Medicaid.
- For each BH performance indicator the state sets a specific acceptable threshold.
- The performance indicators cover consumer involvement, involuntary hospitalization, access, scope of services, and other quality process and outcome measures.

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2. Pay-for-Performance (P4P)
State Example: Iowa Medicaid

- Historically, Iowa has tied **financial incentives** for its managed BH contractor to about nine or ten performance measures and **financial penalties** to about the same number of measures.
- In a few cases, the state ties both a financial incentive and a penalty to the same performance indicator, depending on the contractor's level of performance.
- For each contract year, the managed BH contractor can receive up to $1 million in bonus payments based on its performance.
- Performance penalties increase for each successive failure by the managed BH contractor.

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2. Pay-for-Performance (P4P)
Impact: Iowa Medicaid

- Iowa Medicaid's behavioral health contract incentive and penalty strategy is generally considered to be successful at improving desired performance.
- The BH contractor has met the vast majority or all of the performance indicators for bonuses each year.
- Iowa's BH contractor's performance has continued to improve on almost all indicators with financial incentives.
- In several instances, the performance improvement has been quite dramatic.

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2. Pay-for-Performance (P4P)
Impact

- There have been many studies on the effects of P4P. They have found mixed results.
- Generally, P4P models have shown modest improvements in specific outcomes and increased efficiency, but in some cases, the results were not upheld over time.
  - Critics have found small incentives and focus on benchmarks and not improvement to be limiting factors.
- There are less conclusive or consistent findings on cost savings of P4P models, in part because cost has been less of a focus in P4P.

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Moving to Budget-Based Models

- "Remember, it's not about putting lipstick on a pig – it's about the pig."
  Aidan Petrie, March 2011
- Recent payment reform efforts have tried to apply stronger counter weights to FFS volume incentives by creating "budgets" of different models and intensity to serve as volume (and cost) growth constraints.

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3. Episode-based Payment
Definition

- A fixed dollar amount that covers a set of services, for a defined time period.
- There are two types of episode-based payment
  1. **Acute care episodes,** which include services related to a condition or procedure (e.g., joint replacement, URI, colonoscopy, pregnancy & delivery)
  2. **Chronic condition episodes**, which include services for a fixed amount of time related to a chronic condition (e.g., one year's worth of care for a diabetic)

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3. Episode-based Payment
Definition (continued)

- Payment is typically administered on a FFS basis with retrospective reconciliation.
  - There are, however, some payers and providers using prospective payment.
- There are examples of both shared-savings and shared-risk approaches.
- Quality is typically a component of payment.
  - Sometimes it is used as a “gate” to obtain savings.
  - Other times it is used as a qualification to continue receiving episode-based payment.

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3. Episode-based Payment
Rationale

- Motivate providers to find efficiencies in care delivery and reduce unit costs:
  - standardize care processes for the episode of care by developing comprehensive systems of care
  - reduce potentially avoidable complications
  - find suppliers with high quality and lower unit costs (e.g., device manufacturers, hospitals)
- Episode-based payments create incentives for the delivery of coordinated, evidenced-based care and increase the focus on high-quality outcomes.

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3. Episode-based Payment
Key Elements for Success

- Episode-based payment works best:
  - with conditions or procedures that have **wide variation** in costs, unrelated to price, suggesting an opportunity for improvement
  - when there are a **sufficient volume** of episodes (to reduce random variation)
  - when **analytics are available** from the payer and to the provider to make data-informed decisions
  - with strong and **engaged state/health plan, and provider leadership**

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3. Episode-based Payment
Pros

- Episode-based payment **rewards efficiency**. Providers are motivated to save money by reducing cost variation.
- Motivates substantive **change in health care delivery** – the goal of payment reform
- States can borrow from **existing episode-based payment definitions** in Medicare, some Medicaid programs (e.g., Arkansas, Tennessee) and the private sector (Prometheus Payment).

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3. Episode-based Payment
Cons

- A **lot of work** for a narrow set of conditions or procedures – it takes time and up-to-date data!
- Can be **complex** to implement.
- Increased price/utilization outside the bundle could limit overall savings
- Many parameters of episode-based payments are **up for negotiation** and can erode the savings potential. Such parameters include:
  - Definition of the bundle (time frame, inclusions, exclusions)
  - Quality performance requirements

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3. Episode-based Payment
State Example: Arkansas

- 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
- Adding new episode bundles in waves
- Overlapping models in Arkansas approach:
  - Episode-based payment and supplemental payment to medical homes/health homes

Arkansas Medicaid

QualChoice HEALTH INSURANCE

Arkansas BlueCross BlueShield
An Independent Licensee of the Blue Cross and Blue Shield Association

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3. Episode-based Payment
State Example: Arkansas

- 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.

Source: 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

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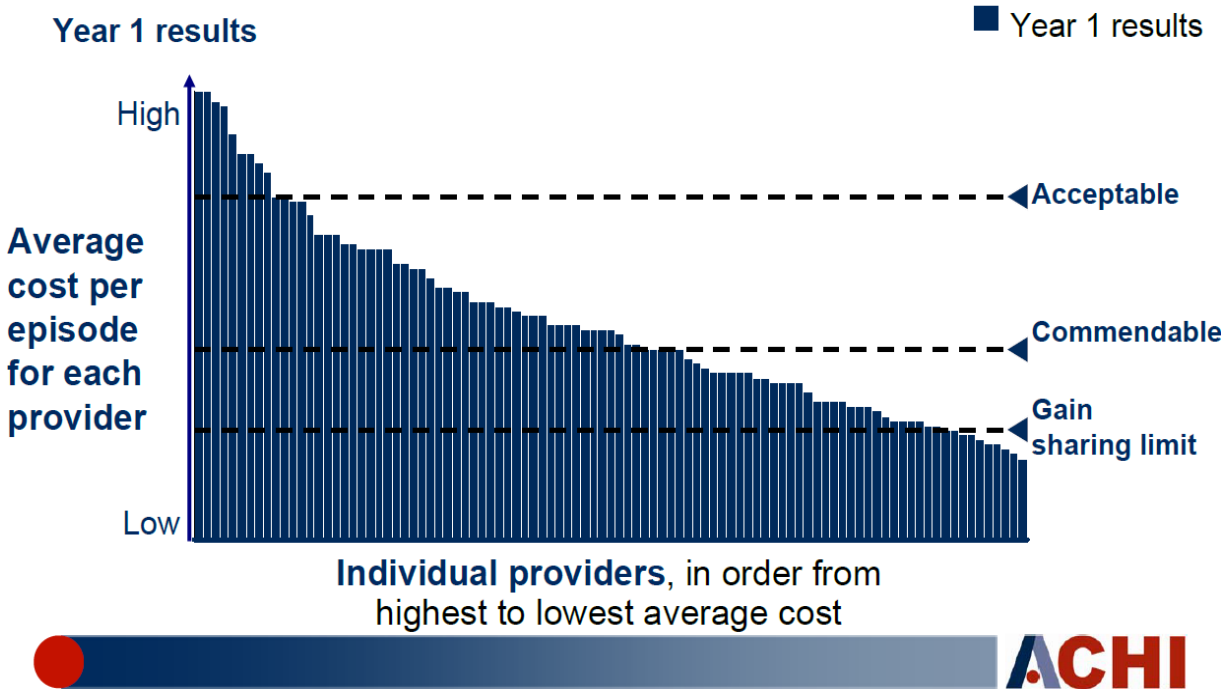
3. Episode-based Payment
State Example: Arkansas

How the Episode Payment Model Works

- **Thresholds are selected to promote high-quality and cost-effective care**



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3. Episode-based Payment
State Example: Arkansas

- 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.

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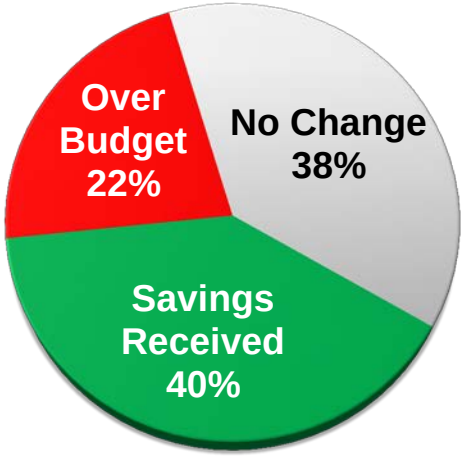
3. Episode-based Payment
State Example: Arkansas

Initial results for URI:

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



- Anecdotal reports also suggest quality improvements

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4. Population-based Payment
Definition

- Population-based payment also defines a spending budget, but on a *per capita basis* for a broad population of patients for whom the provider assumes clinical and financial responsibility.
- Retrospective reconciliation to the target defines a population based on enrollment or attribution, and frequently includes risk adjustment.
- Providers can assume just “upside risk” (reward for savings), or also “downside risk” (responsibility for loss).
- Financial reconciliations typically adjust for performance on assessments of quality.

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4. Population-based Payment
Rationale

- Providers need a financial incentive to be responsible for the quality and total cost of care for their patients. Cost growth will not slow without a meaningful incentive to do so.

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4. Population-based Payment
Pros and Cons

Pros

- Brings attention to management of patient populations and not just individual patients
- Enhances the role of primary care

Cons

- Requires large patient populations and significant provider infrastructure - unclear how many providers could manage under such a payment system
- Potentially financially threatening hospitals and high-margin specialty care service providers

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4. Population-based Payment
State Example: CalPERS

- In 2010, after 3 years of planning, the California Public Employees Retirement System (**CalPERS**) and Blue Shield of California launched a population-based pilot program in Sacramento with providers **Catholic Healthcare West** (now Dignity Health – a hospital group) and **Hill Physicians** Medical Group (HPMG).
- CalPERS paid the ACO a pre-determined amount to provide care to 41,500 employees and dependents.
- Blue Shield **guaranteed CalPERS** that they would not raise their premiums in 2010 for members in the pilot.
- Blue Shield, Dignity Health and HPMG shared risk for all services and executives from the partner organizations serve on the ACO Board Committee.

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4. Population-based Payment
State Example: CalPERS

- The ACO partners set a global three-way budget, but did not change the existing payment mechanisms or contracts.
- The hospital was still paid fee-for-service and the physician group was paid capitation.
- The ACO partners negotiated a formula for how savings would be distributed among the partners.

Sources:

http://healthaffairs.org/blog/2012/05/15/early-lessons-from-a-shared-risk-integrated-care-organization-serving-a-commercial-population/

http://content.healthaffairs.org/content/31/9/1969.abstract

http://healthaffairs.org/blog/2014/04/17/four-years-into-a-commercial-aco-for-calpers-substantial-savings-and-lessons-learned/

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4. Population-based Payment
Impact: CalPERS

- According to a recent *Health Affairs* blog post, from 2010 to 2013 this California ACO generated over $105 million in gross savings.
  - Providers earned $10.36 million in incentive payments during this time
  - Net savings to CalPERS just shy of $95 million for the first 4 years.
  - This translates into just under 3% increase in costs, as compared to a non-ACO annualized trend of 7.6%.
- Over the four years, the ACO reportedly has achieved and sustained reductions in LOS and in inpatient days.
  - After adjusting for rising case mix, total days per thousand have fallen 25%.
- Overall inpatient admission rate unchanged.
- ED visits/1000 increased by 17% since 2010.

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4. Population-based Payment
Impact

- Early managed care experience with capitation showed positive cost impact and generally positive quality findings.
- Aside from recent CalPERS experience, some positive evaluation findings from BCBSMA AQC program.
- Medicare Pioneer and MSSP results decidedly mixed.
- BCBSMA and Medicare results still for early implementation.

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5. Global Budget
Definition

- Under a global budget a hospital agrees to accept clinical and financial responsibility for the health care for individuals living in a specified geographic region.
- Global budgets are often adjusted to reflect changes in the health status of the population, as well as changes in population size.
- Global budgets have been used with hospitals, but could perhaps be applied more broadly.

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5. Global Budget
Rationale

- Foster a community health orientation by creating a financial incentive for a provider(s) to see an entire community or county population as its responsibility.
- Create a guaranteed revenue stream for providers (especially hospitals) to help them cover fixed costs as volume declines.

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5. Global Budget
Pros and Cons

Pros

- Creates a strong financial management incentive.
- Allows hospitals to transition with **some assurance of financial sustainability**.
- Affords the opportunity for integration with public health programs.

Cons

- Challenging to implement in a region with multiple hospitals with **overlapping service areas** and patients crossing county boundaries.
- Payer concern about building in historical inequities and inefficiencies.

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5. Global Budget
State Example: Maryland

- In January 2014, CMS a significant waiver modification to Maryland's unique all-payer rate-setting system for hospital services.
- Over five years, Maryland will shift virtually all hospital revenue into global budget models.
- The state seeks to incentivize hospitals to partner with other providers to prevent unnecessary hospitalizations and readmissions, improve patient health and reduce costs.
- This CMS waiver requires Maryland to limit its annual all-payer per capita total hospital cost growth to 3.58%.

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5. Global Budget
Impact: Maryland

- Completing the design details for implementation of global budgets and quality targets for hospitals in suburban or urban regions of the state – too early to comment on impact.
- Previously implemented global budgets for 10 rural hospitals with good results in the initial three years.
- Has 10 rural “Total Patient Revenue” or “TPR” hospitals that have been operating under fixed Global Budgets since 2010.

Source: http://www.hscrc.state.md.us/init_tpr.cfm

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5. Global Budget
Impact: Maryland

2010-2013 TPR Results:

- 10 TPR global budget hospitals achieved significantly better performance controlling inpatient utilization (including admissions, length of stay, readmissions, ambulatory care-sensitive conditions and one-day-stay cases) than the 36 non-TPR hospitals.
- Outpatient utilization at TPR hospitals increased more rapidly than for non-TPR facilities.
- TPR hospitals outperformed non-TPR hospitals on the state's quality-of-care metrics.

Source: Communications with Robert Murray, MA, MBA, President, Global Health Payment LLC former Executive Director, Health Services Cost Review Commission

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Conclusion

- ***Remember: Payment reform is the first domino.***
- Payment influences provider behavior.
- It's not the only influence – but it is a significant one.
- If we want to improve care delivery, we have to improve payment.
- The more popular and promising models today are among the most complex and furthest from FFS.

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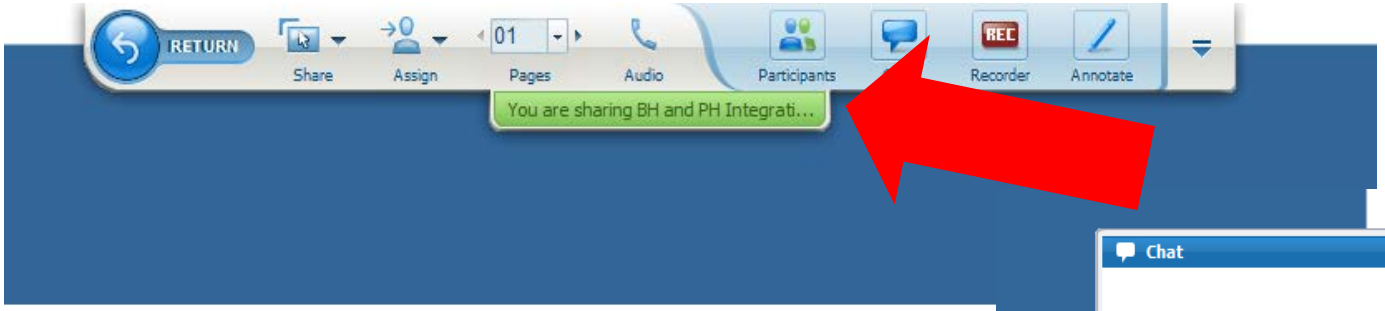
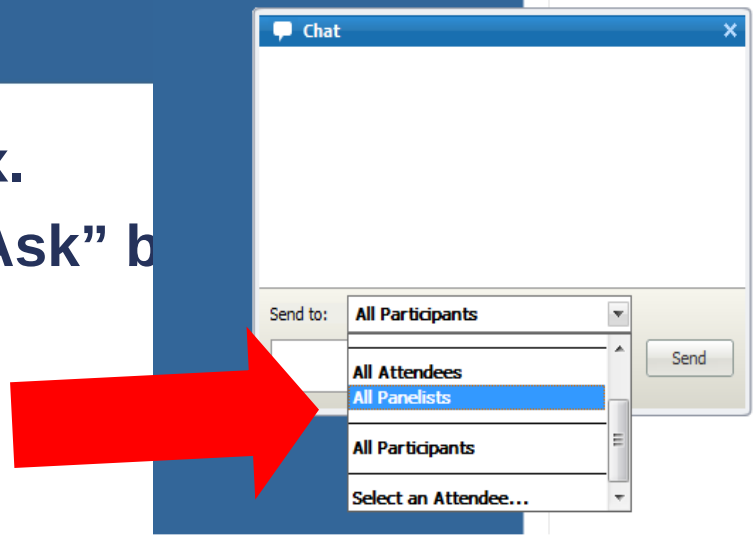
Questions and Discussion

- **Roll over the green bar at the top of the page and left click on Q&A.**



- **Type your question in the box.**

Click on “All Panelists” in the “Ask” b



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Payment Reform Webinar Series

- The recording and slides will be available following the webinar.
- www.rwjf.org/en/grants/grantees/state-health-and-value-strategies--shvs.html
- An email with this information will also be sent to all webinar participants in the next few days.

Final Payment Reform Webinar:

June 24, 2014: 1:30-2:30 p.m. EDT

- Special Topics in Payment Reform: State Levers, Multi-payer Approaches, and Measurement
- To register for future SHVS events go to: https://rwjfevents.webex.com/mw0401l/mywebex/default.do?siteurl=rwjfevents

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