Aligning for Action

LAN SUMMIT

Health Care Payment Learning & Action Network

Use of Alternative Payment Models to Support Community-Wide Population Health

Use of Alternative Payment Models to Support Community-Wide Population Health

Health Care Payment Learning and Action Network
Fall Summit
October 25, 2016

Enrique Martinez-Vidal
Vice President, State Policy and Technical Assistance
AcademyHealth

VISION

AcademyHealth envisions a future where individuals and communities are made healthier by the use of evidence in decision-making.

MISSION

Together with its members, AcademyHealth works to improve health and the performance of the health system by supporting the production and use of evidence to inform policy and practice.

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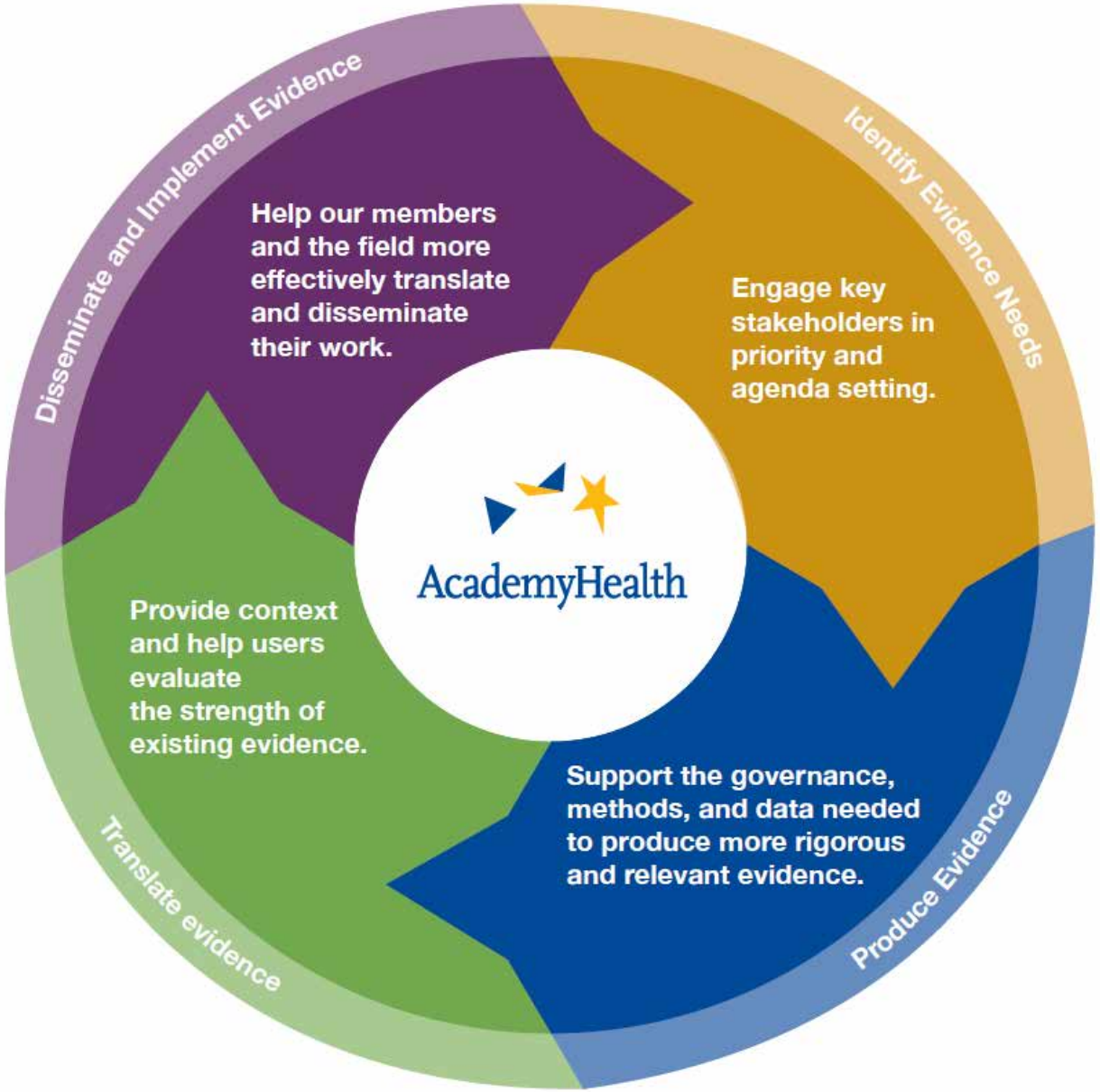

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Payment Reform for Population Health (P4PH) Overview

P4PH Guiding Committee Members

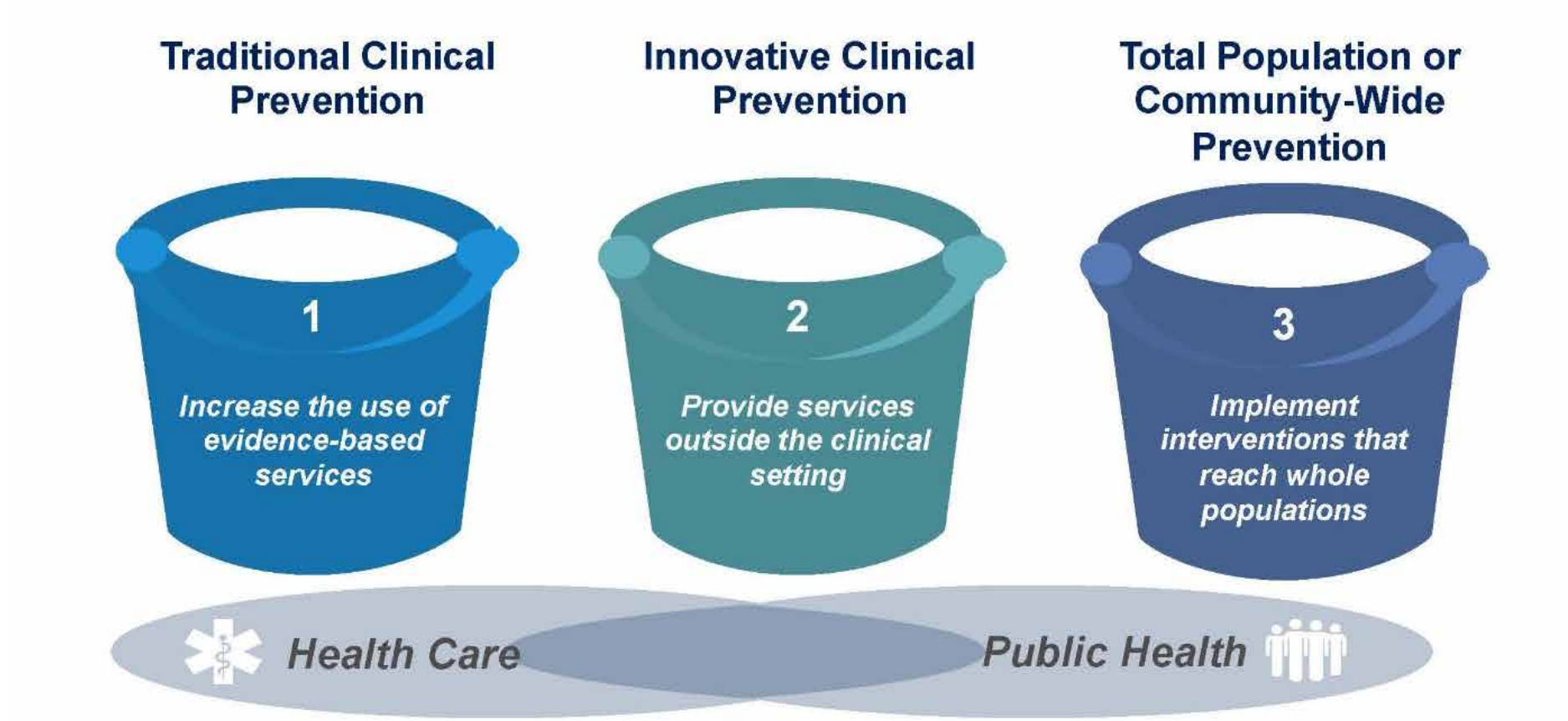
- **Stacy Becker**, ReThink Health
- **Anne Gauthier,** Health Care Payment Learning and Action Network (MITRE)
- **Richard Gundling,** Healthcare Financial Management Association
- **Karen Hacker,** Allegheny County Health Department
- **Dianne Hasselman,** Network for Regional Healthcare Improvement (NRHI)
- **Doug Jutte,** Build Healthy Places Network
- **Tricia McGinnis,** Center for Health Care Strategies (CHCS)
- **Jean McGuire**, Northeastern University
- **Marianne McPherson,** 100 Million Healthier Lives (Institute for Healthcare Improvement)
- **Chris Parker,** Bridging for Health (Georgia Health Policy Center)
- **Laura Seeff**, Centers for Disease Control and Prevention (CDC)
- **Matt Steifel**, Kaiser Permanente, Center for Population Health

Vision and Mission

- Defining *population health*:
  - "Health outcomes of a group of individuals, including the distribution of such outcomes within the group." (Kindig and Stoddart, 2003)
  - For our purposes, the population is geographically-based total community, not a patient panel or payer's covered lives.
- Vision
  - Community-wide population health will be improved through a more supportive health care payment system.
- Mission (i.e., P4PH Goals):
  - To better understand the systems, context and structures needed to create the conditions for a health care payment system to support community-wide population improvement; and
  - To identify and address barriers and promote promising opportunities.

Analytic Frameworks and Assumptions

Auerbach's Three Buckets of Prevention



Source: Auerbach, J. The 3 Buckets of Prevention. J Public Health Management Practice, 2016, 22(3), 215-218. http://journals.lww.com/jphmp/Fulltext/2016/05000/The_3_Buckets_of_Prevention.1.aspx.

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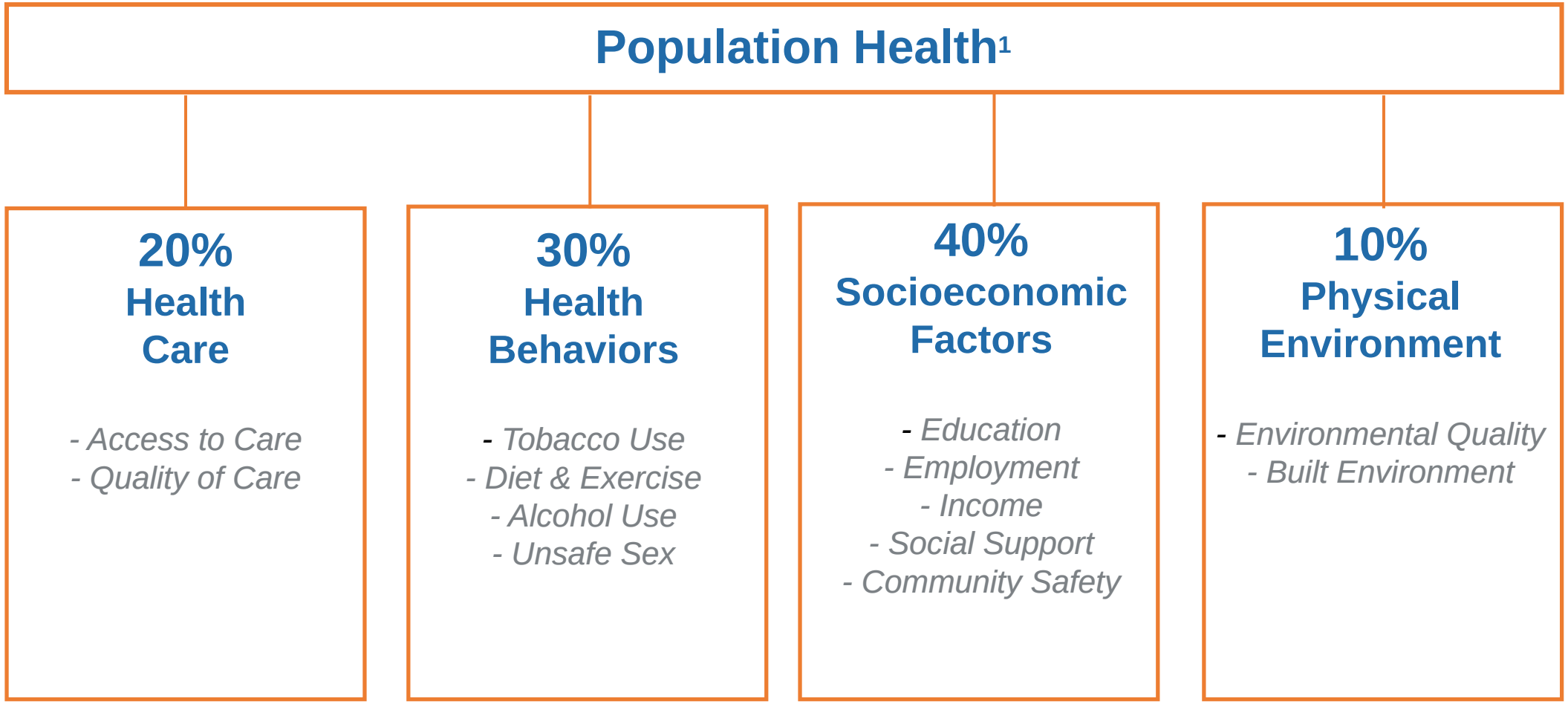
Determinants of Health

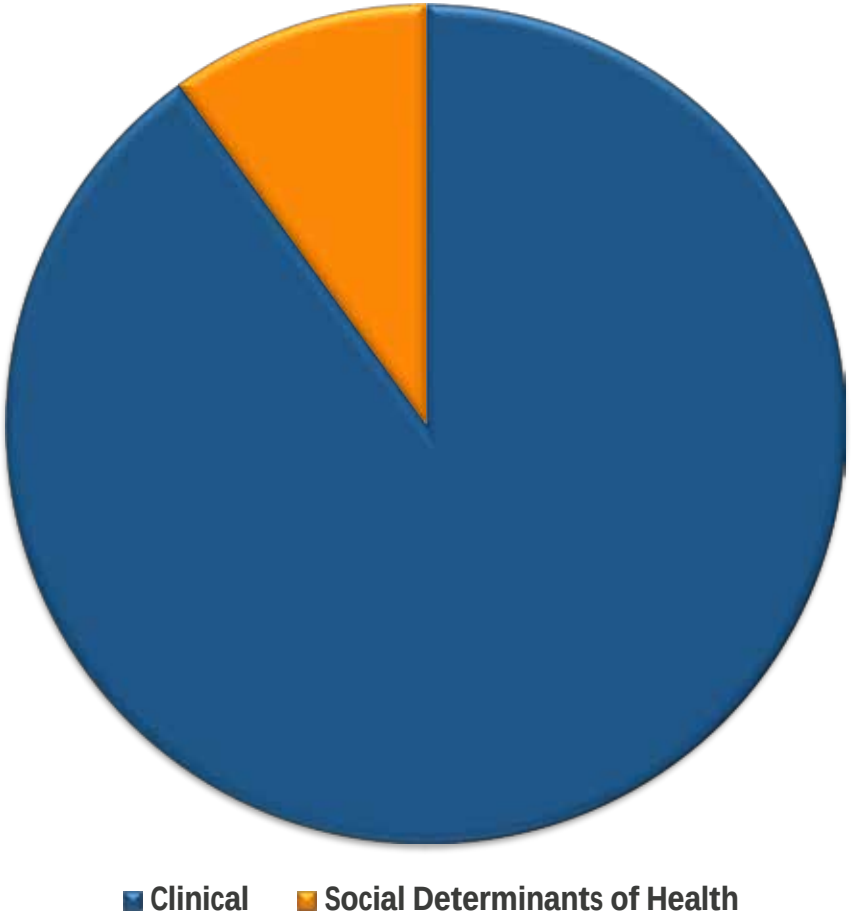


1. Defined as: “Health outcomes of a group of individuals, including the distribution of such outcomes within the group.” (Kindig and Stoddart, 2003). Not NOTE: “Genetics” as a determinant of health has not been included as we consider that facet much less amenable to being influenced by payment reform.

Source: County Health Rankings, Population Health Institute, University of Wisconsin-Madison; Magnan, Sanne. "Achieving Accountability for Health and Health Care." Minnesota Medicine (Nov. 2012).

Hypothetical Distribution of Health Care System Funds

For Clinical Services and Social Determinants of Health[1]



1. Social Determinants of Health are the 80% outside of the health care system that impacts population health.

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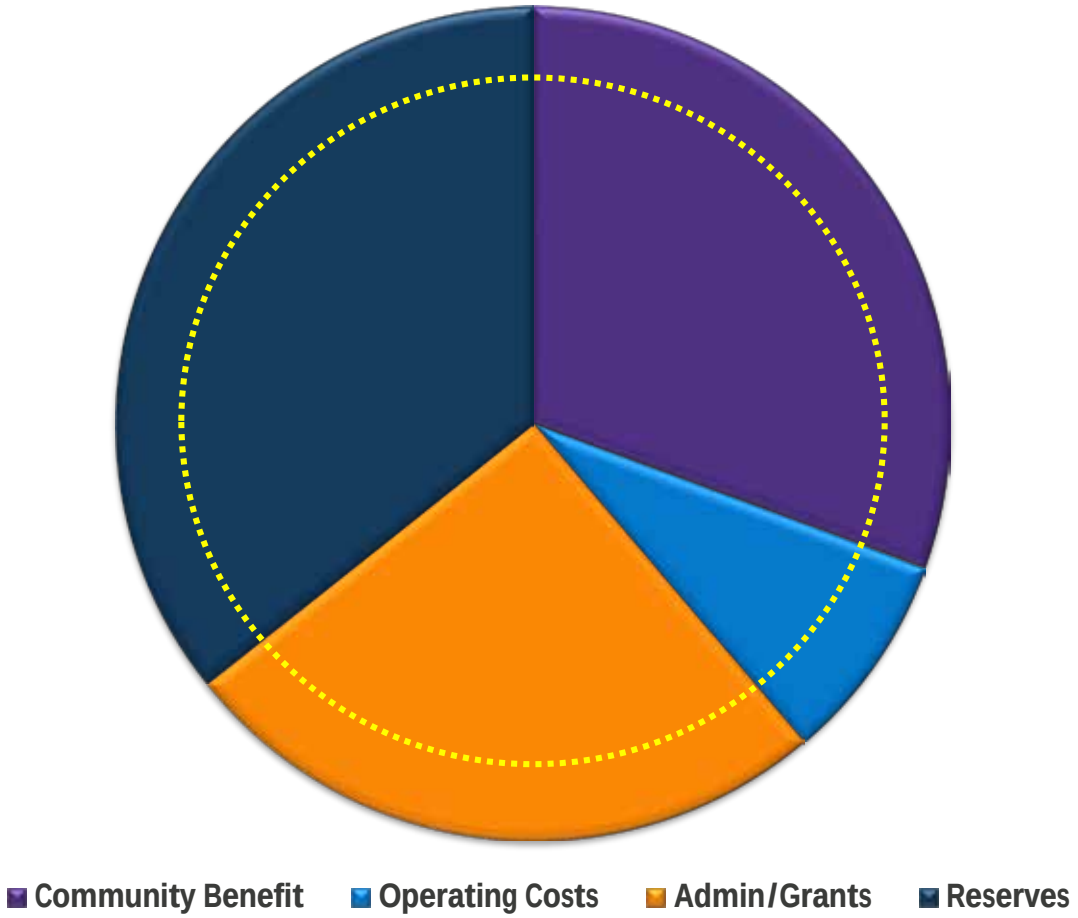
Hypothetical Distribution of Health Care System Funds

For Social Determinants of Health[1] by Funding Source



1. SDH funding may apply to Health Care System's own population (inside dotted line) or community-wide population (outside dotted line).

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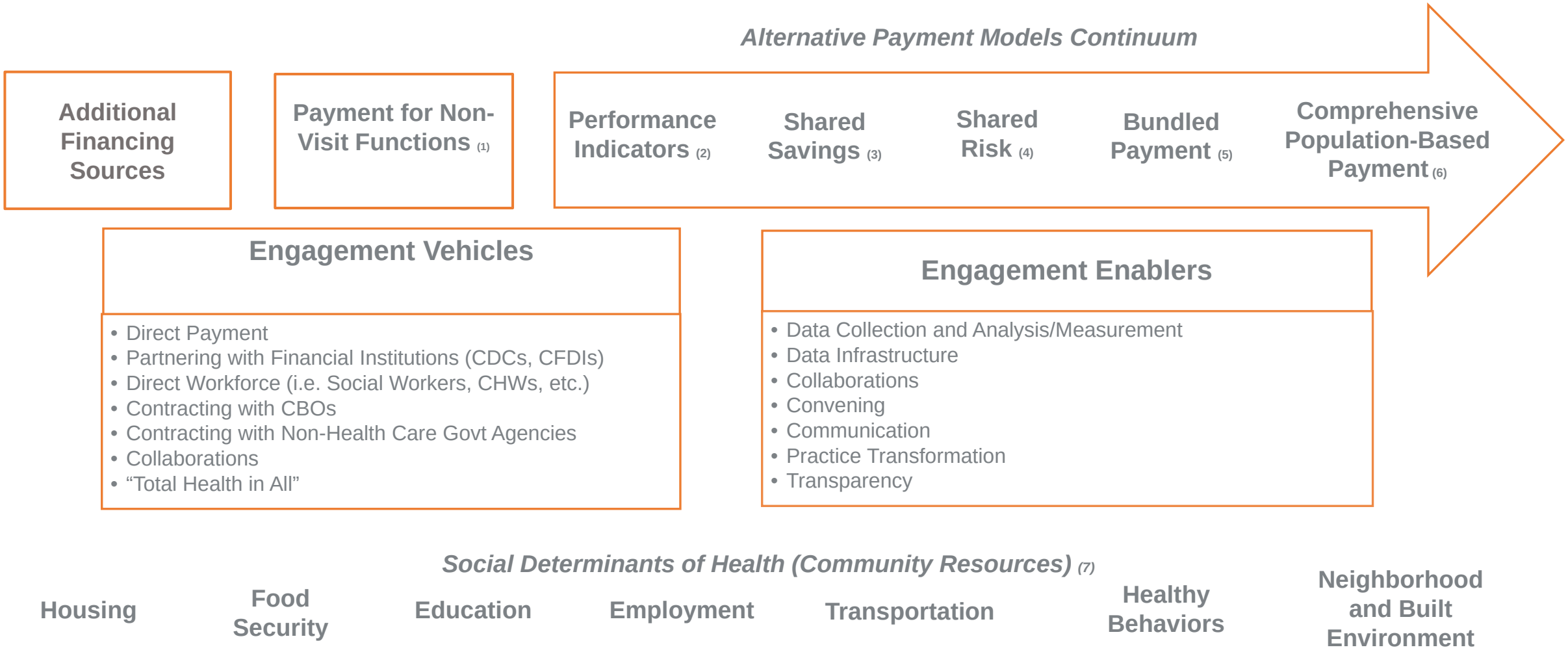
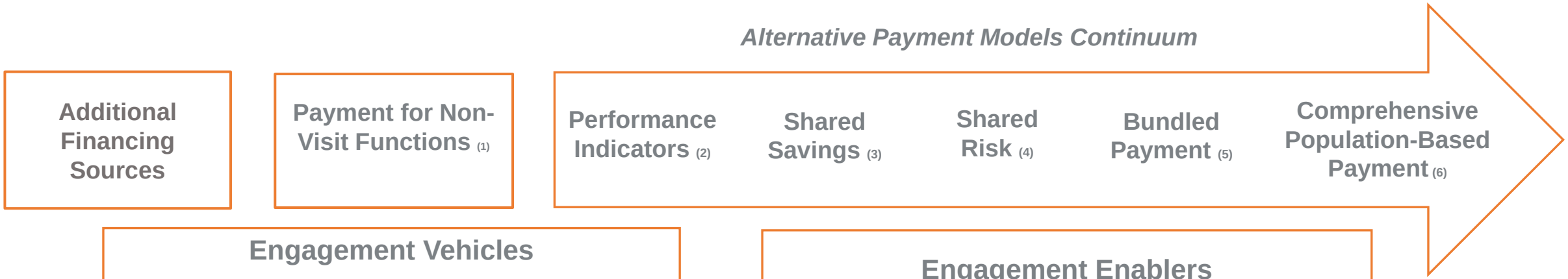
Role of Health Care Financing in Addressing SDH Services



1. Payments for infrastructure and operations
2. Financial Bonus for meeting quality / cost targets
3. Upside risk only
4. Upside and downside risk
5. Episodic or condition-specific billing
6. Capitation
7. Components from Healthy People 2020

Role of Health Care Financing in Addressing Housing Services



Engagement Vehicles

- Direct Payment
- Partnering with Financial Institutions (CDCs, CFDIs)
- Direct Workforce (i.e. Social Workers, CHWs, etc.)
- Contracting with CBOs
- Contracting with Non-Health Care Govt Agencies
- Collaborations
- "Total Health in All"

Engagement Enablers

- Data Collection and Analysis/Measurement
- Data Infrastructure
- Collaborations
- Convening
- Communication
- Practice Transformation
- Transparency

Social Determinants of Health (Community Resources) *(7)*

Referral to Public Housing | **Transitional Housing Services** | **Critical Repairs** | **Lead Abatement** | **Rental Deposits** | **Utilities**

1. Payments for infrastructure and operations
2. Financial Bonus for meeting quality / cost targets
3. Upside risk only
4. Upside and downside risk
5. Episodic or condition-specific billing
6. Capitation
7. Components from Healthy People 2020

The Value Imperative: Improving payment models to support value

Richard Gundling
Vice President, Healthcare Financial Practices, HFMA

Health Care Payment Learning & Action Network
October 25, 2016

hfma
healthcare financial management association

HFMA's Value Project

A Fundamental Shift in Focus

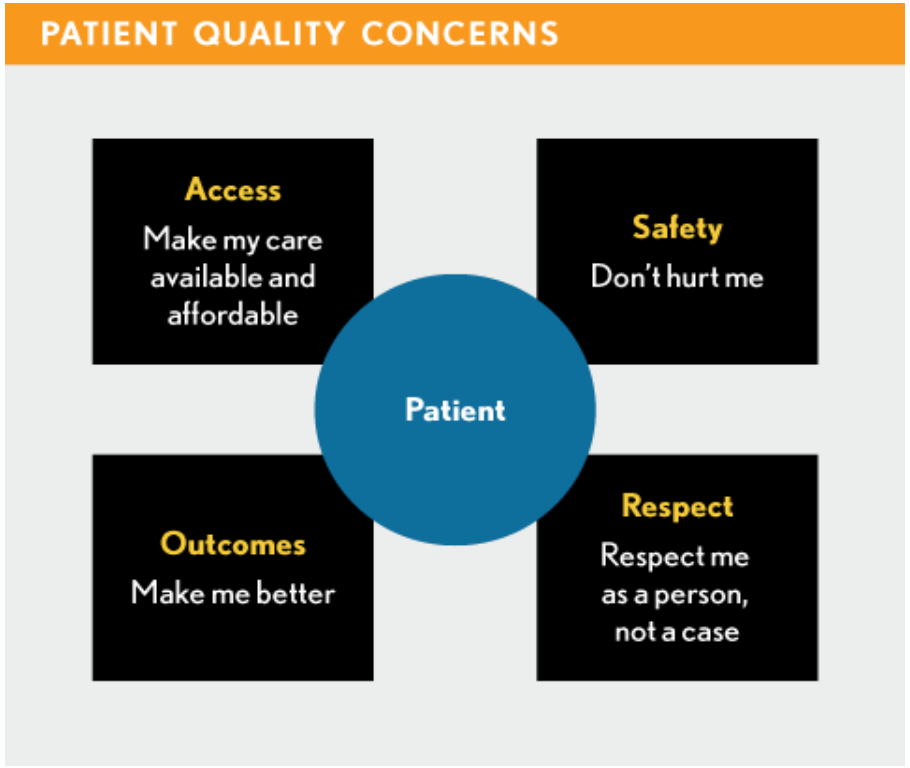
The Value Equation

$$\text{VALUE} = \frac{\text{Quality}^{\{1\}}}{\text{Payment}^{\{2\}}}$$

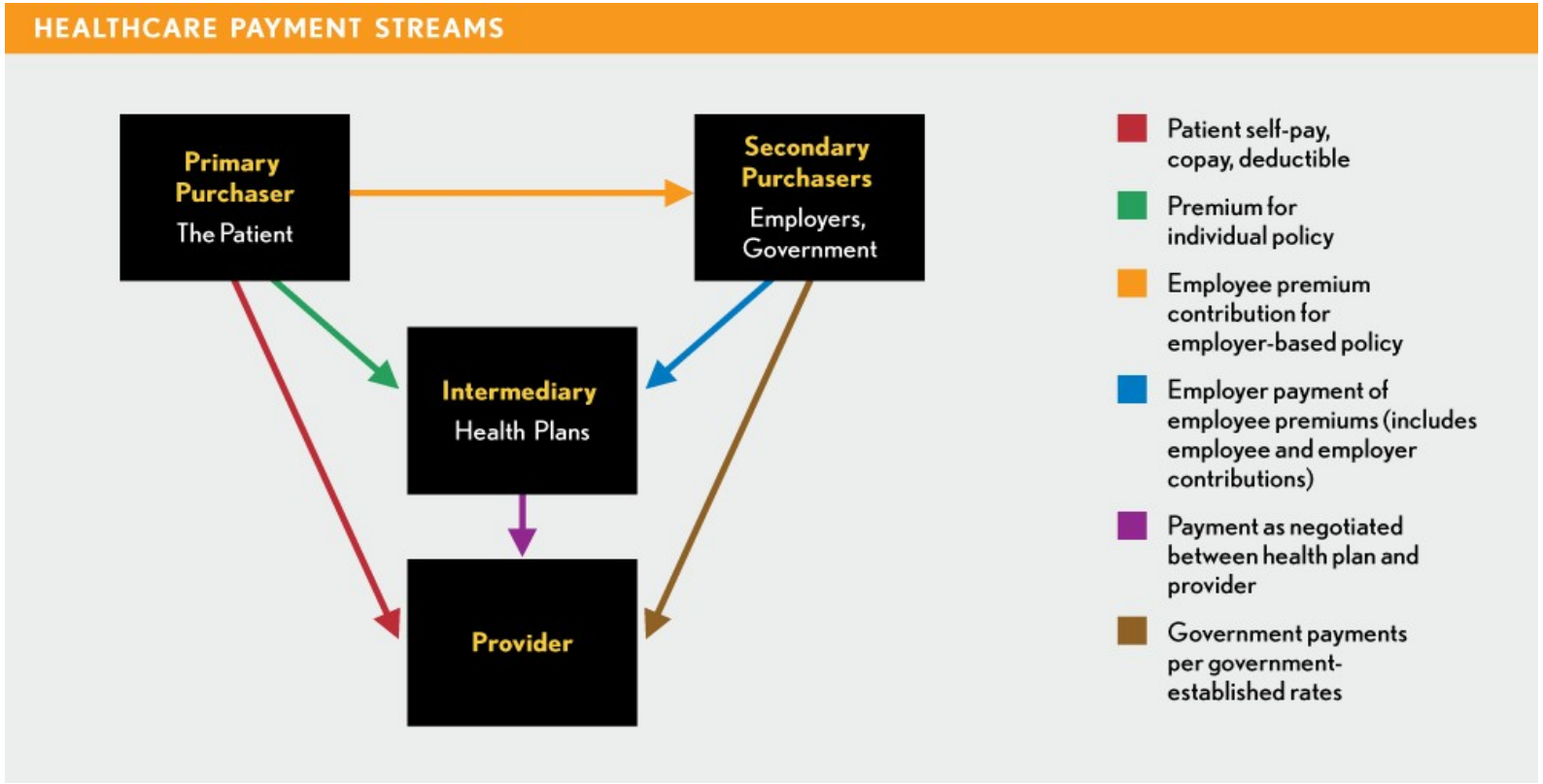
{1} Composite of patient outcomes, safety, and experiences

{2} Cost to all purchasers of purchasing care

The Quality Component



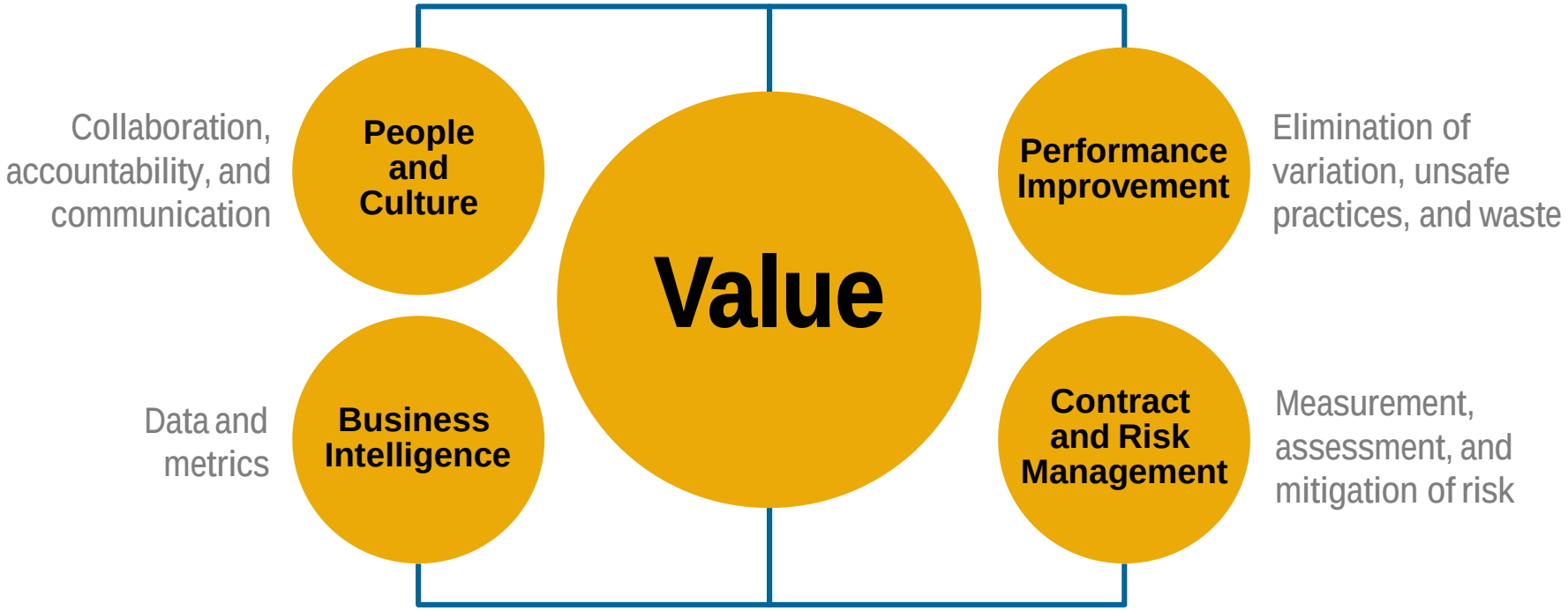
The Payment Component



Common Issues Related to Reform Across Healthcare Organizations

- Expectations of diminished future revenues
- Uncertainty about future payment models
- Inflexible cultures and organizational structures
- Difficulty aligning physicians and hospitals/health systems around common organizational goals
- Lack of accountability
- A vague value proposition

Build Four Key Organizational Capabilities



Payment systems to support the Nation's health goals

- Wellness
- High-quality care
- Access to care and other societal benefits
- Sustainable health system

Principles of a payment system

- **Principle 1 Quality**
  - Reward high-quality care
  - Discourage medical errors and ineffective care
  - Wherever possible, reward positive outcomes rather than adherence to processes
- **Principle 2 Alignment**
  - Align incentives among stakeholders
  - Maximize efficiency and coordination
  - Stimulate and reward healthful behavior choices and value-based services

Principles of a payment system

- **Principle 3 Fairness**
  - Sufficiently balance the needs and concerns of all stakeholders
  - Recognize appropriate total costs of care that is necessary and consistent with evidence
  - Financial incentives for consumers to select high-quality, efficient care
- **Principle 4 Simplification**
  - Process should be simple, standard, and transparent
  - Reduce complexities of payment models and financial communications to healthcare consumers

Principles of a payment system

- **Principle 5 Societal Benefit**
  - Resources to support broad societal benefits
  - Reward innovators who develop technologies, services, processes, that enhance safe, high-quality care

Types of Societal Benefit

- Provision of charity care
- Provision of essential healthcare services
- Medical research
- Public education
- Serving other unmet human needs

Questions?

- To access Value Project reports and resources, visit www.hfma.org/ValueProject
- Is your organization doing innovative work to prepare for reform and create value? Let us know at
  - rgundling@hfma.org

Lessons from Washington and Oregon

P4PH Site Visits: Northwest Region

Washington

- Center for Community Health and Evaluation (Interview)
- King County Accountable Community of Health (ACH) Leadership Council Meeting (Observed)
- Cascade Pacific Action Alliance (CPAA) ACH (Interview)
- WA Health Care Authority (HCA) (Individual Interviews and *Healthier WA* Core Team Meeting)

Oregon

- PacificSource Columbia Gorge Coordinated Care Organization (CCO), The Dalles, OR (Interview)
  - Met with Health Council Leadership and community service providers in housing, transportation, food insecurity
- PacificSource Columbia Gorge Health Council Meeting (Observed)
- PacificSource Health Plan, Portland, OR (Interview)
- Health Share of Oregon CCO, Portland, OR (Interview)
- Yamhill Community Care CCO, McMinnville, OR (Interview)

Washington Accountable Communities for Health (ACHs)

State Environment:

- ACHs are simply one component of a state-led health transformation effort, *Healthier Washington,* that includes Value-Based Payments, a Population Health Improvement Plan, a Practice Transformation Support Hub, a Common Measurement Set, and their Medicaid Transformation Waiver.
- Guided by the WA Health Care Authority (HCA).

ACH Characteristics:

- Comprised of multi-sector stakeholders including health systems, local government agencies and CBOs.
- "Voluntarily organizing to coordinate activities, jointly implement health-related projects, and advise state agencies on how to best address health needs within their area." (ACH FAQs)
- Medicaid MCOs are very involved, but commercial payers are seemingly not yet very engaged in the efforts.
- Initial funding by SIM Grant, but project funding appears to require additional resources.
  - Expected to use anticipated Medicaid Transformation waiver dollars to continue funding.
- ACHs differ in governance and decision-making structures, as well as geographic size and level of collaboration.
- Have developed collaborative health improvement projects, largely clinical to meet desired need to measure success. (Five of the nine ACHs have selected care coordination projects as a primary focus.

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Washington Accountable Communities for Health (ACHs)

Observations:

- ACHs have many questions regarding HCA's transition to value-based payments.[1]
  - How to calculate and capture the actual dollars to reinvest?
  - How will these be attributed/distributed to stakeholders across each ACH?
  - What is the incentive for the CBOs to stay at the table for true sustainable community health transformation?

Barriers:

- Stakeholder Competition vs. Collaboration
- Consistent and Sustainable Funding
- Competing Priorities/Initiatives ("many tables")
- Current data metrics are primarily clinically-focused
- Lack of data collection/analysis capacity

[1]By 2019, HCA has pledged that 80% of HCA provider payments to Apple Health (WA Medicaid) and the Public Employees Benefits Board (PEBB) program will be attached to quality and value.

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ACH: Cascade Pacific Action Alliance (CPAA)

Strengths

- Strong backbone integrator (CHOICE) with history as trusted convener in a five-county region
- Little competition, strong collaboration
- Collective Impact framework with consensus-based decision-making structure
- Emphasis on shared learning

Barriers

- ROI: Ability to make the longer-term business case to their health system partners.
- Metrics/Data: Lack of metrics to measure SDH/population health efforts; no internal workforce capacity for data analytics, need to understand what is actionable, and how to disseminate/translate the information.
- Overall Capacity: Lack of resources, staffing, etc.
- *Virtuous Cycle*: Need to create a self-perpetuating financial mechanism to identify savings, capture it and reinvest.

Youth Behavioral Health Coordination Project

- To identify children with behavioral health challenges as early as possible in both education and health care settings, and connect at-risk children with appropriate community-based interventions and treatment services. Project uses school-related and clinical measures.
- Initial pilot findings successful: Behavioral incidents and truancy dropped by significantly.
- Funding: 70% by BH Organizations (managed care) for Medicaid qualifying students and those that meet *access to care* standards; 30% by schools for staff salary, non-Medicaid qualifying students and those that do no meet *access to care* standards.

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Oregon Coordinated Care Organizations (CCOs)

State Environment:

- In 2011, in response to the Triple Aim and a broad health system transformation effort, Oregon created CCOs to serve as local health plans and provide Medicaid services for the Oregon Health Plan.
- CCOs were established to provide integrated, patient-centered care, focusing on primary and preventative care.

CCO Characteristics: *"When you have seen one CCO, you've seen ONE CCO."*

- Guided and funded by the Oregon Health Authority (OHA).
- Provide physical, behavioral and dental health care, as well as non-emergency transportation benefits.
- Solely serve Medicaid Managed Care enrollees.
- CCOs funded through global budgets.
- Similar in governance and decision-making structures with each having a *Health Leadership Council or Board of Directors*, a *Community Action Council* (with required 51% community members) and a *Clinical Advisory Council*.
- CCOs closely aligned with county lines, with many comprised of two or more counties.

Oregon Coordinated Care Organizations (CCOs)

Observations:

- Strong culture of collaboration.
- Strong commitment to population health and SDH.
- CCOs global budget pay provider claims primarily on a FFS basis.
- Little funded through Alternative Payment Models.
- Upstream SDH services largely identified through CHNAs.

Barriers:

- Adequate Metrics
- Alignment
- Business Case
- Costs
- Incentives for Investments in Flexible Services
- Sustainable funding

CCO Snapshots

CCO	Contracts Direct/Indirect	Claims Payment	APMs	Examples of Upstream Services
Columbia-Gorge CCO (The Dalles)	Contracts indirectly thru PacificSource	FFS; some Capitation	- Shared Savings	Reliant largely on grants to fund: - Implementing Pathways Hub to track services for those needing healthcare and housing. (Leadership Council paying for outcomes funding.) - MARC (Provides Trauma-Informed care workshops) - Veggie Rx Program (screens for food needs and provides vouchers for whole fruits/veggies); large collaboration - CHWs
Health Share (Portland)	Contracts directly with MMCOs	FFS; Capitation	- P4P - Global Withhold - Capacity Payments	- Advanced PC Medical Home Model for Foster Care - Community-based CHWs (collaborating with larger CHW hub for training/education) - Early Learning Hub (Kindergarten Readiness) - Under Project ECHO-like program, OHSU provides professional assistance (psychiatric medication mgmt. and developmental pediatric support) to providers - Project Nurture provides funding gap for non-clinical services (i.e., doulas, addiction services). (Consulting with Bailit to create APM.) - Regionalized BH Services
Yamhill (Yamhill County)	Contracts directly with MMCOs	Capitation; some FFS	- Add-on PMPM for clinicians engaged in PCMH Model. - P4P - Specialized Case rates for Maternal MHM	- CHW Hub (Child focus targeting BH needs, avoidable ER visits, engaging PC physicians) - Community EMS Program (Avoidable ER Readmissions) - Early Learning Hub (Kindergarten readiness) - SNAP (childhood obesity) - Wellness Center (persistent pain mgmt; considering expanding to chronic disease mgmt.)

Achieving Health Equity in Baltimore

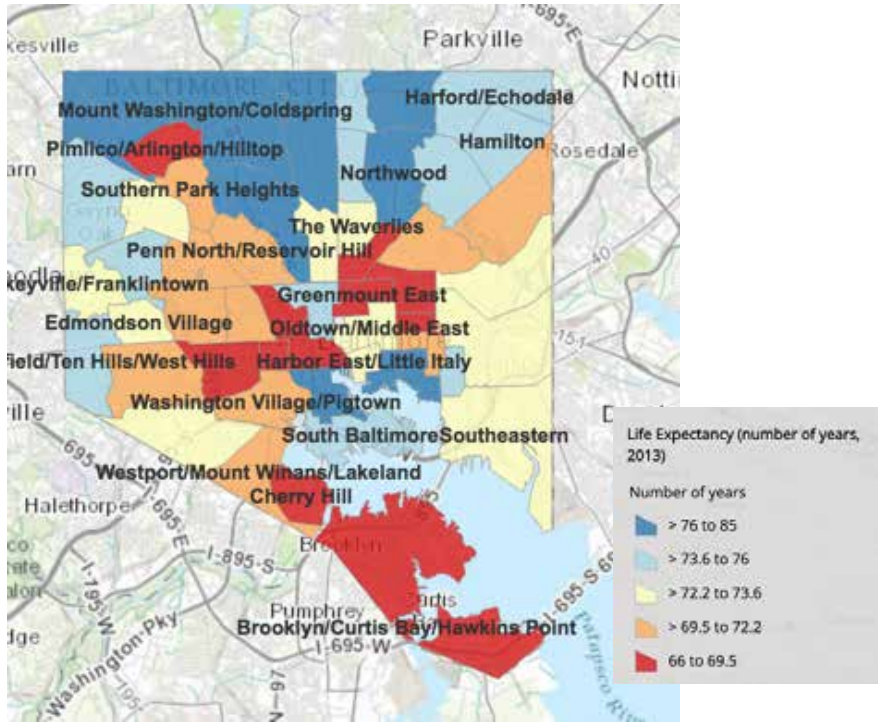
Sonia Sarkar
Chief Policy and Engagement Officer
Baltimore City Health Department

Dr. Leana Wen
Health Commissioner

Stephanie Rawlings-Blake
Mayor

Baltimore City Health Department

- City agency that functions like a start-up
  - History
  - Funding & structure
- Health tied to all issues
  - Education
  - Crime
  - Jobs
  - Health is not healthcare



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