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

- Disseminate and Implement Evidence
  Help our members and the field more effectively translate and disseminate their work.

- Identify Evidence Needs
  Engage key stakeholders in priority and agenda setting.

- Transcribe evidence
  Provide context and help users evaluate the strength of existing evidence.

- Produce Evidence
  Support the governance, methods, and data needed to produce more rigorous and relevant evidence.
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

1. Traditional Clinical Prevention
   - Increase the use of evidence-based services

2. Innovative Clinical Prevention
   - Provide services outside the clinical setting

3. Total Population or Community-Wide Prevention
   - Implement interventions that reach whole populations

Determinants of Health

**Population Health**

- **20% Health Care**
  - Access to Care
  - Quality of Care

- **30% Health Behaviors**
  - Tobacco Use
  - Diet & Exercise
  - Alcohol Use
  - Unsafe Sex

- **40% Socioeconomic Factors**
  - Education
  - Employment
  - Income
  - Social Support
  - Community Safety

- **10% Physical Environment**
  - Environmental Quality
  - Built Environment

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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.

Hypothetical Distribution of Health Care System Funds
For Clinical Services and Social Determinants of Health

1. Social Determinants of Health are the 80% outside of the health care system that impacts population health.
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).
Role of Health Care Financing in Addressing SDH Services

Alternative Payment Models Continuum

Additional Financing Sources
Payment for Non-Visit Functions (1)
Performance Indicators (2)
Shared Savings (3)
Shared Risk (4)
Bundled Payment (5)
Comprehensive Population-Based Payment (6)

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)

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

Housing
Food Security
Education
Employment
Transportation
Healthy Behaviors
Neighborhood and Built Environment
Role of Health Care Financing in Addressing Housing Services

**Additional Financing Sources**

**Payment for Non-Visit Functions**

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

**Performance Indicators**

1. Population-Based
2. Indicators

**Shared Savings**

3. Savings

**Shared Risk**

4. Risk

**Bundled Payment**

5. Payment

**Comprehensive Population-Based Payment**

6. Comprehensive Payment

**Engagement Vehicles**

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- Collaborations
- "Total Health in All"

**Engagement Enablers**

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- Collaborations
- Convening
- Communication
- Practice Transformation
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7. Components from Healthy People 2020

**Referral to Public Housing**

1. Lead Abatement
2. Rental Deposits
3. Utilities
4. Transitional Housing Services
5. Critical Repairs
6. Repairs
7. Abatement
8. Deposits
9. Utilities
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’s Value Project
A Fundamental Shift in Focus

View value ...

... through the purchaser’s lens
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

PATIENT QUALITY CONCERNS

- Access
  - Make my care available and affordable

- Safety
  - Don't hurt me

- Outcomes
  - Make me better

- Respect
  - Respect me as a person, not a case

Patient
The Payment Component

HEALTHCARE PAYMENT STREAMS

Primary Purchaser
The Patient

Secondary Purchasers
Employers, Government

Intermediary
Health Plans

Provider

- Patient self-pay, copay, deductible
- Premium for individual policy
- Employee premium contribution for employer-based policy
- Employer payment of employee premiums (includes employee and employer contributions)
- Payment as negotiated between health plan and provider
- Government payments per government-established rates
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

- People and Culture
- Business Intelligence
- Performance Improvement
- Contract and Risk Management

Value

Collaboration, accountability, and communication

Data and metrics

Elimination of variation, unsafe practices, and waste

Measurement, assessment, and mitigation of risk
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.)
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

¹By 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.
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.
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
<table>
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<tr>
<th>CCO</th>
<th>Contracts Direct/Indirect</th>
<th>Claims Payment</th>
<th>APMs</th>
<th>Examples of Upstream Services</th>
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| Columbia-Gorge CCO  | 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 CCO    | 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 CCO         | 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
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