



# **SIM Payment Reform Work Group**

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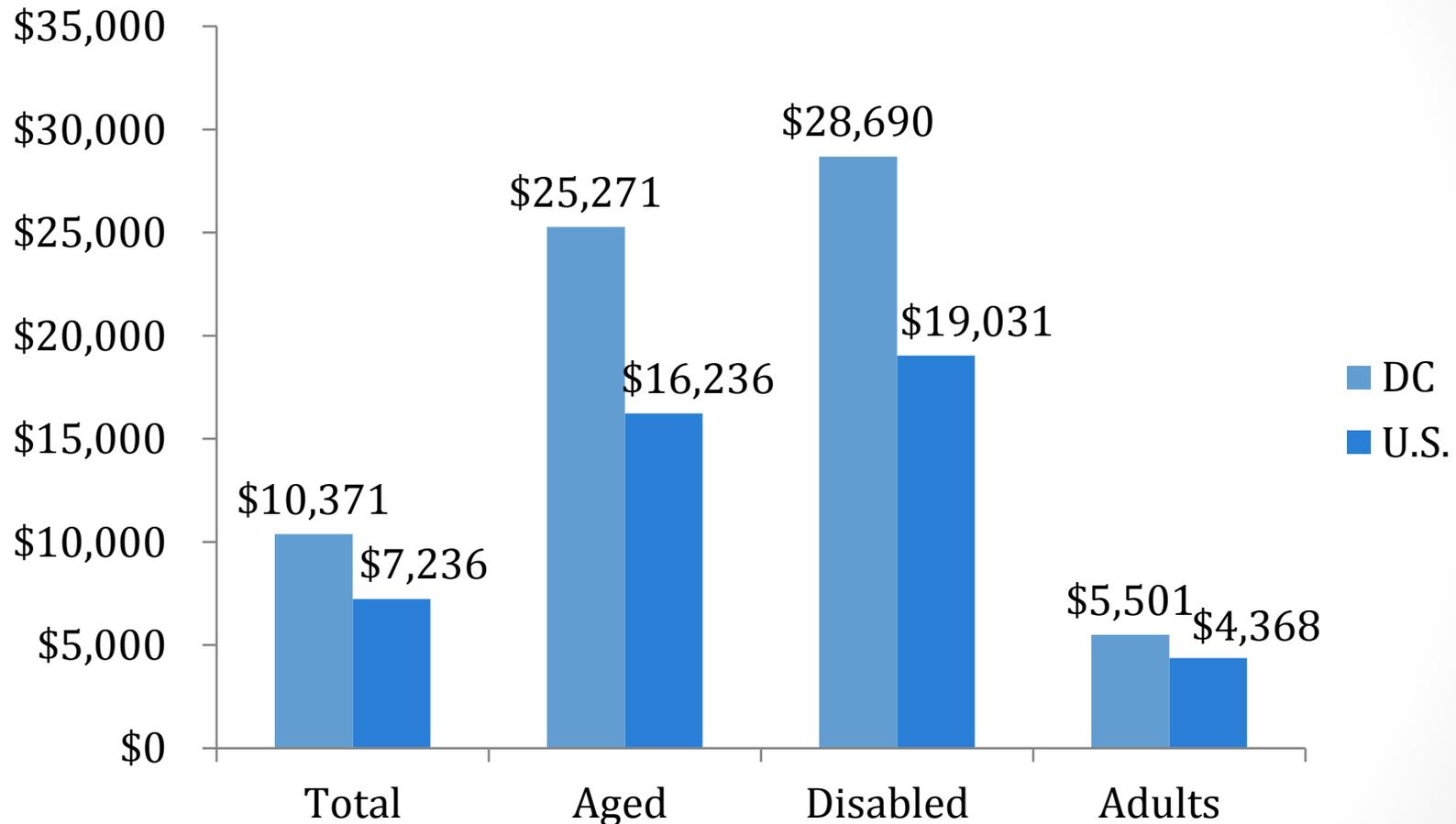
# Agenda

- District Health System Performance
- SIM Advisory Committee Aims
- National Value-Based Purchasing Agenda
- Payment Reform Models



# District Health System Performance

# DC Medicaid Per Person Spending, FY 2012



Source: Medicaid and CHIP Payment and Access Commission (MACPAC), "MACStats: Medicaid and CHIP Program Statistics," June 2014, based on Medicaid Statistical Information System (MSIS) data.

# Commonwealth Scorecard Utilization Metrics

Measure	DC State Rank (1-51)
Hospital admissions among Medicare beneficiaries for ambulatory care–sensitive conditions, ages 65–74	43
Potentially avoidable emergency department visits among Medicare beneficiaries	51
Medicare 30-day hospital readmissions	51

# Commonwealth Scorecard Healthy Lives Metrics

Measure	DC State Rank (1-51)
Mortality amenable to health care, deaths per 100,000 population	49
Breast cancer deaths per 100,000 female population	51
Colorectal cancer deaths per 100,000 population	49
Infant mortality	51
Adults ages 18–64 who report fair/poor health or activity limitations because of physical, mental, or emotional problems	13
Adults who smoke	22
Adults ages 18–64 who are obese (BMI $\geq$ 30)	2
Children ages 10–17 who are overweight or obese (BMI $\geq$ 85th percentile)	42

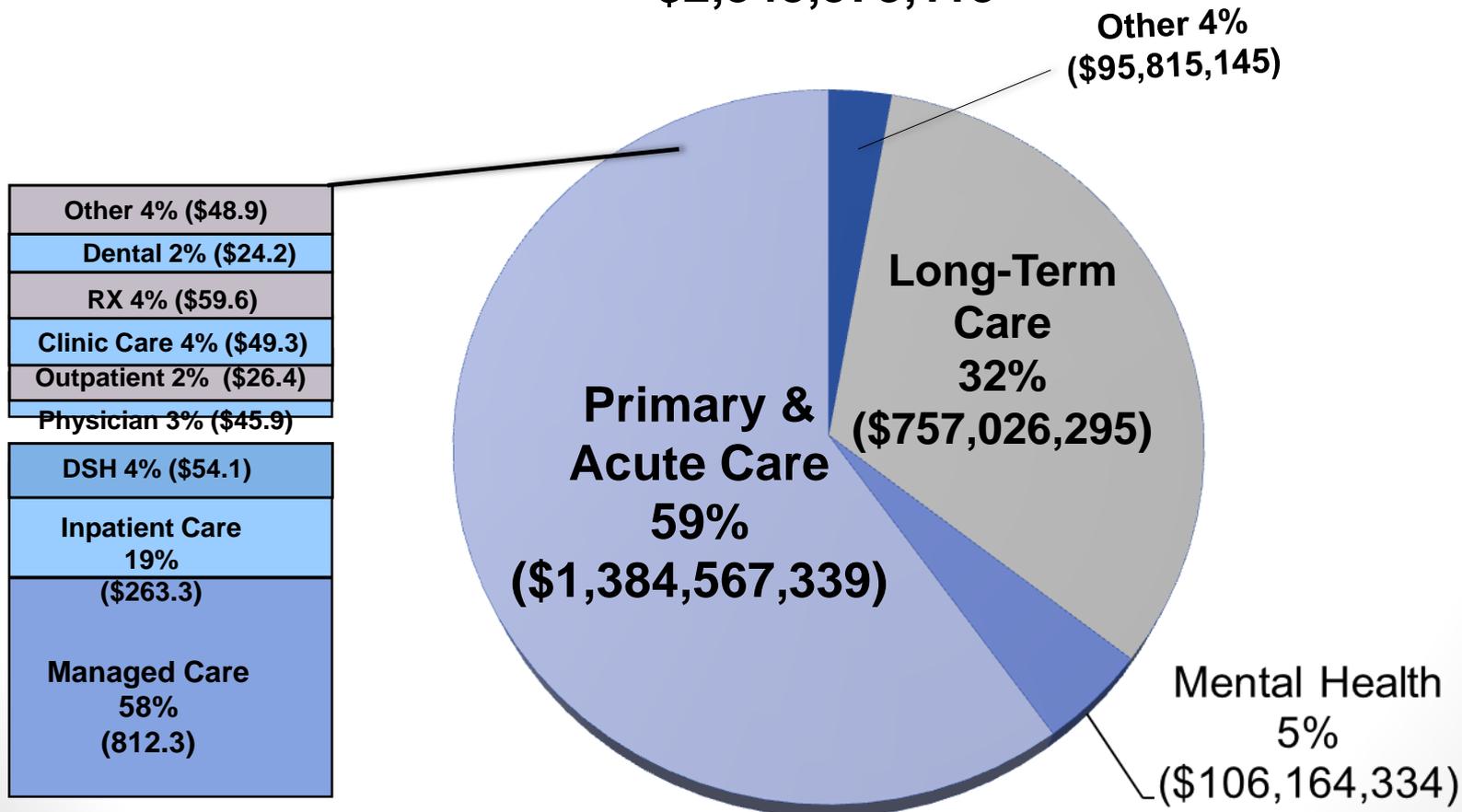
# Health Disparities Within the District

- Diabetes:
  - Diabetes is highest among African Americans with 13.4% of the population having been told that they have diabetes:
    - 2.5% of Caucasians
    - 5.5% of Hispanics
    - 7.3% of other race groups
- Cancer:
  - African Americans had a mortality rate of 250.4 per 100,000, which was more than double the rate among Whites (111.9)
- HIV/AIDS:
  - Hispanics newly diagnosed with HIV were more likely to be younger than other groups
  - 18.8% of people living with HIV in DC are in Ward 8; 2.4% in ward 3 (2014)
  - 75% of people living with HIV in DC are black (2014)

# Managed Care And Fee-For Service Hospital Spending Are The Major Cost Drivers For Medicaid Acute Care

## Total Medicaid Program Expenditures, FY2014

**\$2,343,573,113**



# SIM Advisory Committee Aims

**Improve health outcomes, experience of care, and value in health care spending for high-cost, high-need patients in D.C.**

By 2020:

- 1) Significantly improve performance on selected health and wellness outcome quality measures and **reduce disparities**;
- 2) Reduce inappropriate utilization of **inpatient and emergency departments by 10%**;
- 3) Reduce preventable **readmission rates by 10%**;
- 4) Better align overall health spending and re-invest savings towards prevention and addressing housing and other **social determinants of health**;
- 5) Develop a **continuous learning health system** that supports more timely, efficient, and higher-value health care throughout the care continuum.

How can we improve  
the health care  
system and what is  
being done nationally?

# The National Strategy for Quality Improvement In Healthcare

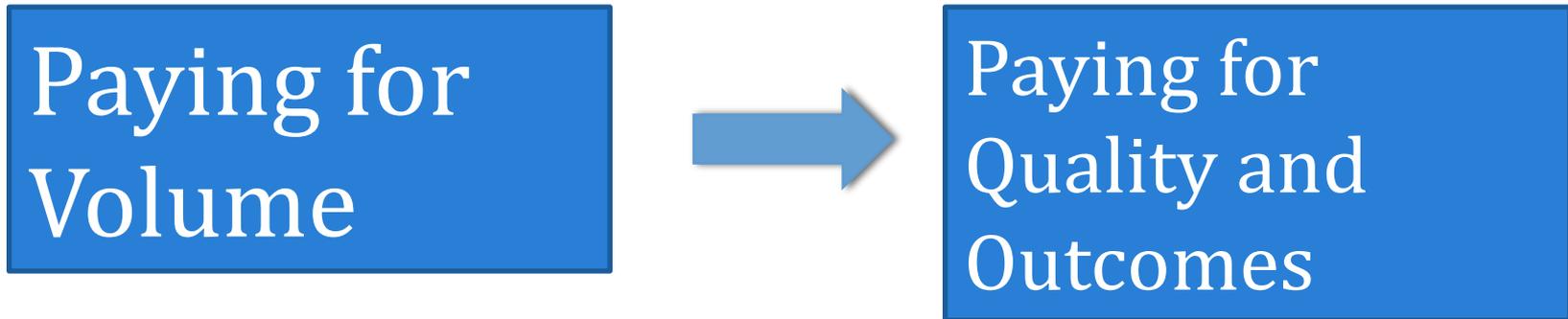
The Strategy outlines the Triple Aim to improve quality in healthcare:

1. Better Care and Lower Costs
2. Healthy People/Healthy Communities
3. Affordable Care

Payment Reform can be a component of working towards the Triple Aim

# Value-Based Purchasing

**Demand side strategy** to measure, report, and reward excellence in health care delivery



# Value-Based Purchasing Aligns Payment with Mission

- Aligns goals of financial department with care team
- Promotes innovation
- Enables providers to address social determinants of health
- Allows full use of care team (plus care extenders like community health workers)
- Encourages use of technology (texts, emails, apps) to stay in contact with patients

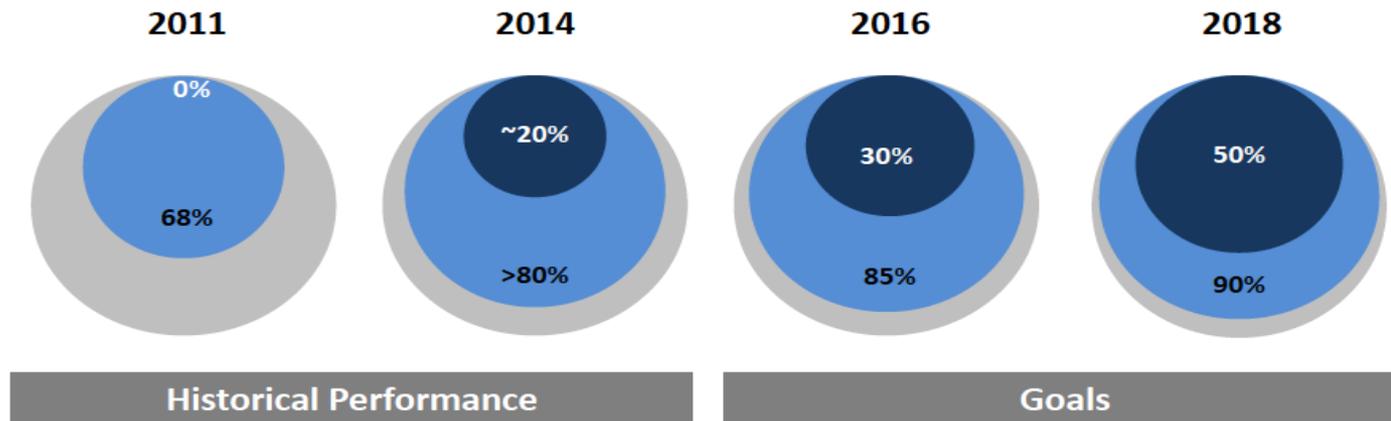
# What is the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)?

- The **Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)** is a bipartisan legislation signed into law on April 2015.
- What does Title I of MACRA do?
  - **Repeals** the Sustainable Growth Rate (SGR) Formula
  - **Changes the way that Medicare** rewards clinicians for **value** over volume
  - **Streamlines** multiple quality programs under the new **Merit-Based Incentive Payments System (MIPS)**
  - Provides **bonus payments** for participation in **eligible alternative payment models (APMs)**

# CMS Payment Reform Goals

Target percentage of payments in 'FFS linked to quality' and 'alternative payment models' by 2016 and 2018

- Alternative payment models (Categories 3-4)
- FFS linked to quality (Categories 2-4)
- All Medicare FFS (Categories 1-4)



# CMS Components of Value-Based Purchasing

*“Improving the way providers are incentivized, the way care is delivered, and the way information is distributed will help provide better care at lower cost across the health care system...”*

## Pay Providers

- Promote value-based payment systems
  - Test new alternative payment models
  - Increase linkage of Medicaid, Medicare FFS, and other payments to value
- Bring proven payment models to scale

## Deliver Care

- Encourage the integration and coordination of clinical care services
- Improve population health
- Promote patient engagement through shared decision making

## Distribute Information

- Create transparency on cost and quality information
- Bring electronic health information to the point of care for meaningful use

# Payment Model Approaches

# 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
  - for all, or nearly all

# 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

- 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.

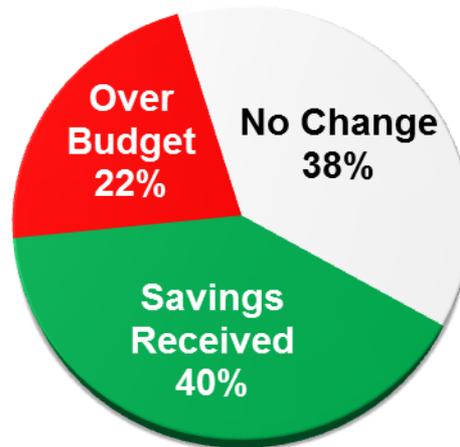
# Arkansas (cont'd)

- 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

# Provider Performance Incentives

Provide examples of Medicaid and multi-payer provider performance incentive programs:

- Medicaid Hospital Performance Incentives
- Medicaid Nursing Facility Performance Incentives
- Health Home agencies
- Specialists

# Examples of P4P Measures

- 30-day hospital readmission
- Mental health follow-up visit within 30 days of discharge for mental health inpatient care
- Asthma care for children (Home Management Plan)
- Surgical Care Improvement Index
- Initial antibiotic: % of immunocompetent patients with community-acquired pneumonia who receive initial antibiotic regimen during first 24 hours consistent with guidelines

# Examples (continued)

- Health Care Personnel (HCP) influenza vaccination – as reported to the National Healthcare Safety Network (NHSN)
- Early Elective Induced Delivery: % of patients with elective vaginal deliveries or elective cesarean sections at  $\geq 37$  and  $< 39$  weeks of gestation completed
- CAUTI – Catheter-Associated Urinary Tract Infections
- Perinatal Measures
  - Birth Trauma-Injury to Neonate (AHRQ PSI-17)
  - Obstetric Trauma –Vaginal Delivery With Instrument (AHRQ PSI-18)
  - Obstetric Trauma –Vaginal Delivery Without Instrument (AHRQ PSI-19)
- CLABSI – Central Line Blood Stream Infections
  - This measure is reported to CheckPoint and represents a standardized infection ratio. Checkpoint reports an individual hospital's ratio and the Wisconsin standard.

# P4P: Medicare Programs

## Hospital Acquired Condition Program

- Penalty only
- Reduces payments to hospitals that rank in the worst performing quartile of hospital-acquired conditions, based on risk-adjusted performance
- 1% penalty for top quartile of hospital-acquired conditions (FY15)
- Saves the Medicare program ~\$30M annually

## Hospital Readmissions Reduction Program

- Penalty only
- Rate based on national average from retrospective three year period
- CMS assesses performance on heart attack, heart failure, pneumonia, hip/knee replacement, and COPD (coronary artery bypass graft to start in FY17)
- 1% penalty cap (FY13); 2% cap (FY14); 3% cap (FY 15 and onward)
- Readmission rates began to fall in 2012, suggesting hospitals quickly initiated new strategies

## Hospital Value Based Purchasing Program

- Bonus or penalty
- Assesses performance based on: 1) clinical process; 2) patient experience; 3) outcomes; and 4) efficiency measures; compares to national benchmarks & improvement
- Hospitals base DRG payment withheld by 1% (FY13), 1.25% (FY14), 1.5% (FY15), 1.75% (FY16), and 2% (FY17)
- Budget neutral: roughly half of hospitals earn back more than withhold, others earn back less