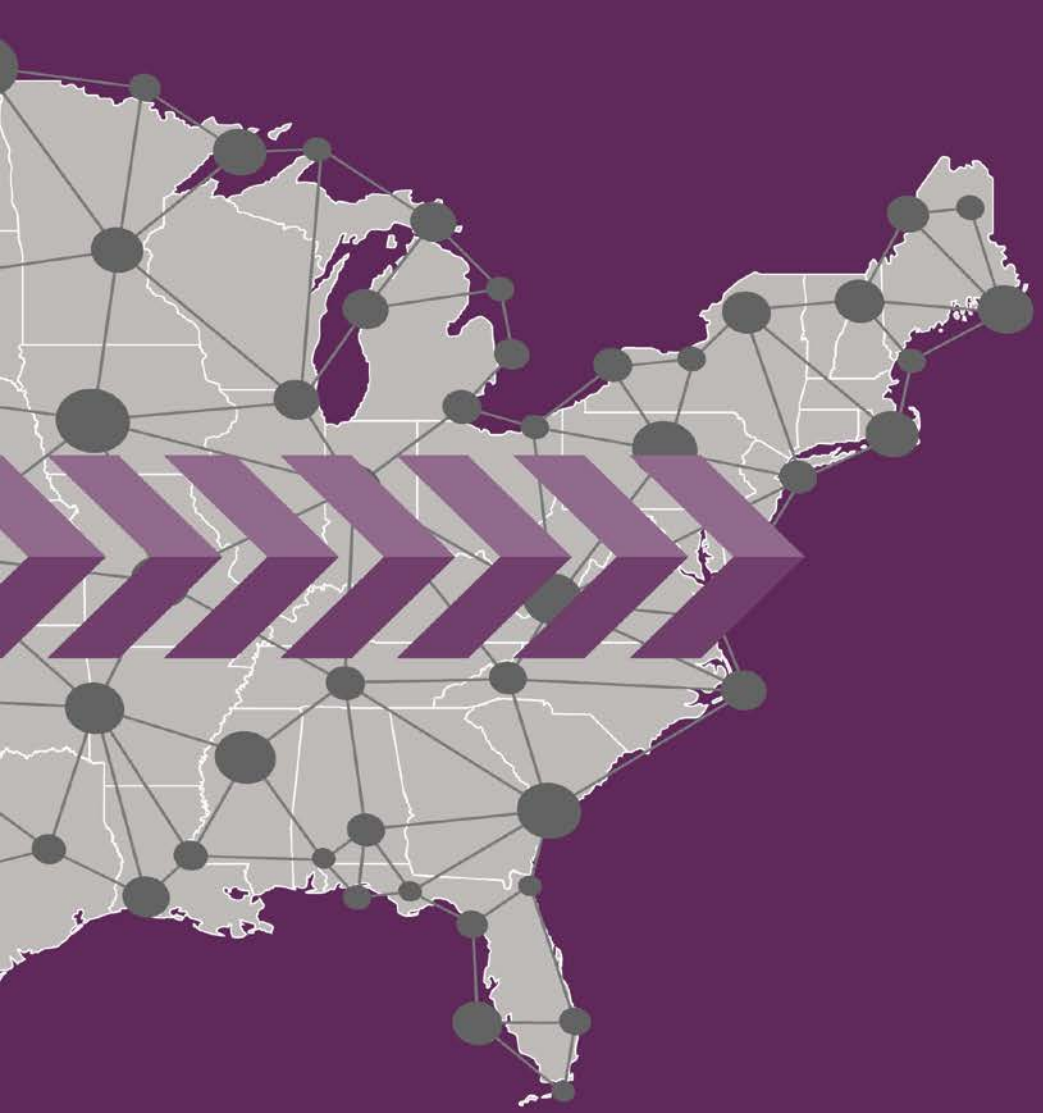

Categorizing Value-Based Payment Models According to the LAN

Megan Burns, MPP
Senior Consultant, Bailit Health

February 7, 2018

STATE Health & Value STRATEGIES

Driving Innovation Across States

A grantee of the Robert Wood Johnson Foundation

Webinar Presenter:
State Health and Value Strategies

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About State Health Value Strategies

State Health and Value Strategies (SHVS) assists states in their efforts to transform health and health care by providing targeted technical assistance to state officials and agencies. The program is a grantee of the Robert Wood Johnson Foundation, led by staff at Princeton University's Woodrow Wilson School of Public and International Affairs. The program connects states with experts and peers to undertake health care transformation initiatives. By engaging state officials, the program provides lessons learned, highlights successful strategies, and brings together states with experts in the field. Learn more at www.shvs.org.

Questions? Email Heather Howard at heatherh@Princeton.edu.

Logistics

- This webinar is being recorded.
  - The recording and slides will be available following the webinar.
- Telephone lines will remain muted.
  - We want everyone to be able to hear our presenters!
- Questions can be submitted electronically at any time using the Q&A function.

Webinar Presenter: Bailit Health

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About Bailit Health

- Bailit Health is a consulting firm founded in 1997.
- We assist states, health plans, employer purchasers, and others with the design and implementation of strategies to improve health care quality and reduce cost growth.
- We offer many services, some of which include:
  - strategic program design for public and private health care purchasers,
  - design and implementation of value-based payment models,
  - design and management of procurement processes, and
  - design and facilitation of large-scale multi-stakeholder processes.
- Over the last 21 years, we have supported 35 states and the District of Columbia in this work.
- For more information, visit: http://www.bailit-health.com

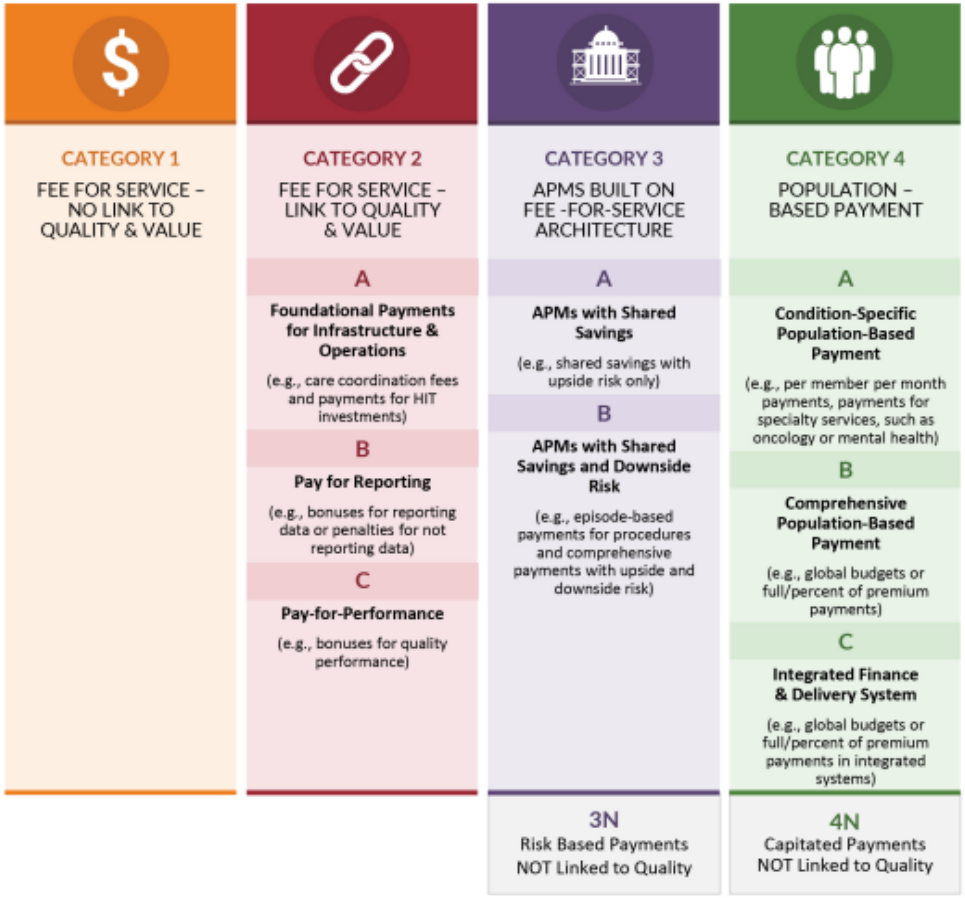
Overview

- Describe the APM LAN Framework
- Provide real-world examples of payment models
- Hear from the Community Health Plan of Washington (a Medicaid managed care organization) about how they categorize their payment models

Health Care Payment and Learning Action Network (LAN)

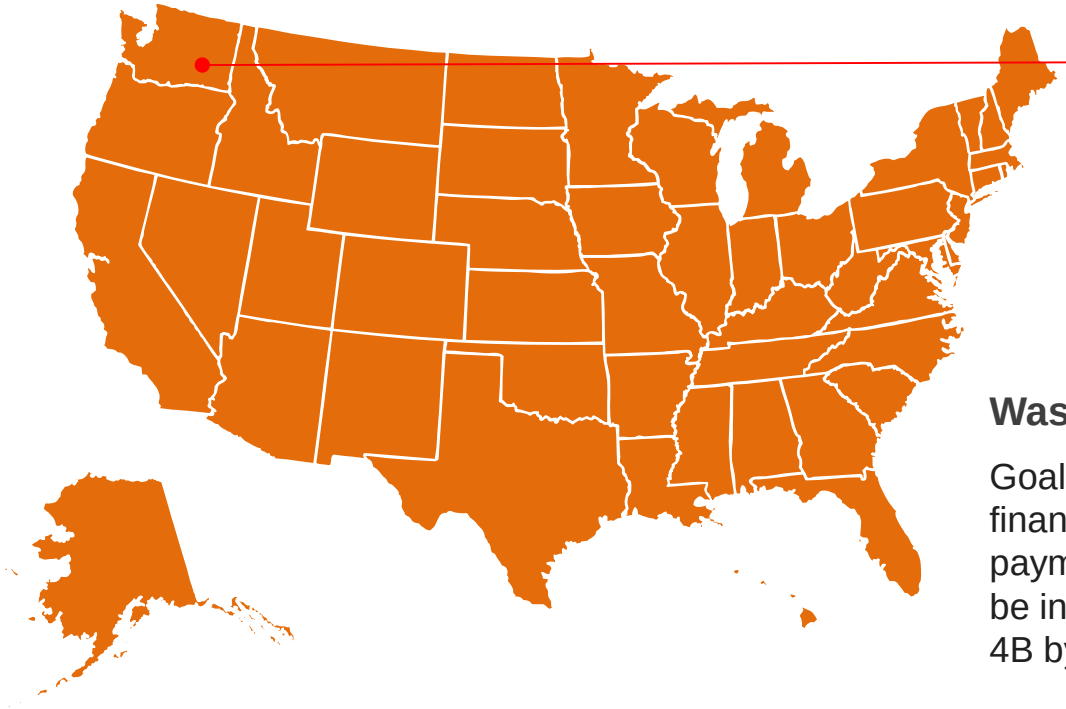
- As the movement from volume to value payment progresses, more state purchasers are requiring their contracted health plans to implement alternative payment models (APMs).
- The LAN is a national effort funded by the Centers for Medicare & Medicaid Services (CMS) to accelerate APM adoption by states and in the commercial insurance market.
- The LAN provides guidance, education, and measurement of APMs. Its website is full of resources applicable to state purchasers: https://hcp-lan.org/

LAN APM Framework



- The LAN APM Framework was created by public and private stakeholders as a way of establishing a standardized and nationally accepted method to measure progress toward greater penetration of APMs.

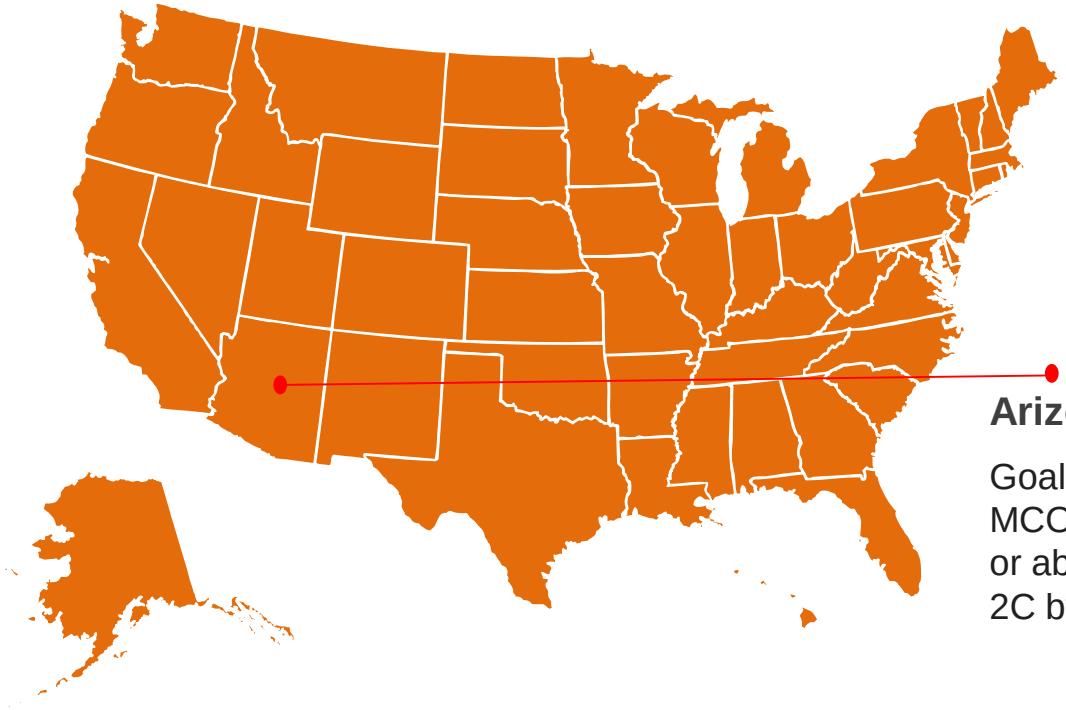
States are Using the LAN Framework to set APM Goals in Different Ways



Washington

Goal: 90% of state-financed health care payment to providers will be in LAN Categories 2C-4B by 2021

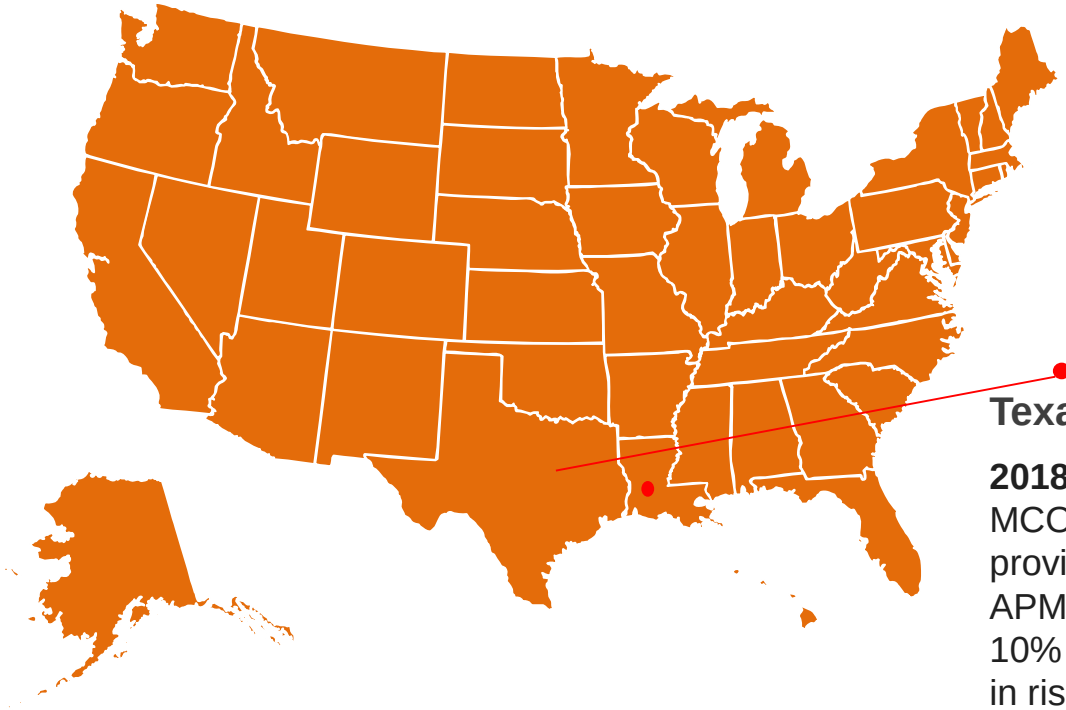
States are Using the LAN Framework to set APM Goals in Different Ways



Arizona

Goal: 70% of acute care MCO spending will be at or above LAN Category 2C by 2021.

States are Using the LAN Framework to set APM Goals in Different Ways

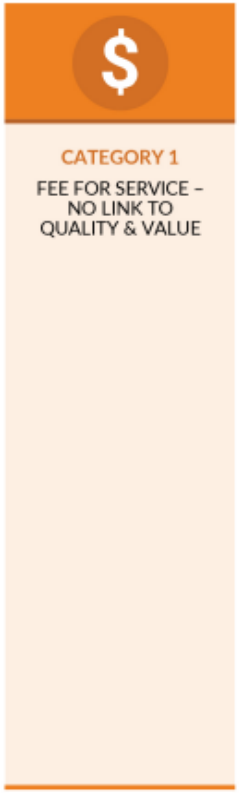


Texas

2018 Requirements
MCOs must have 25% of provider payments in APMs (Category 2 and up)
10% of which need to be in risk-based APMs (Category 3B and up)

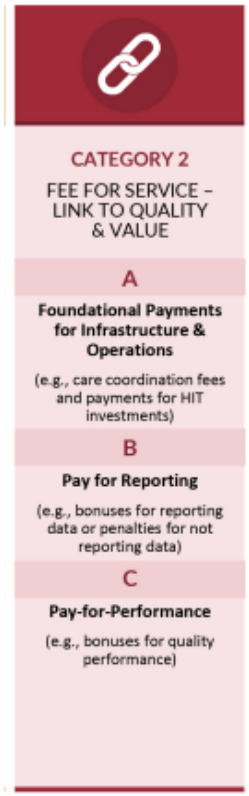
Details on how states are defining and tracking MCO implementation of APMs will be discussed in the SHVS webinar on February 14, 2018 (from 2-3pm EST).

Category 1: Fee-For-Service – No Link to Quality & Value



- Traditional fee-for-service, including:
  - hospital DRGs
  - % of charge payment models
  - per diem
  - outpatient CPT codes
- **No financial link to quality or value.**
- Often the “chassis” for other APMs

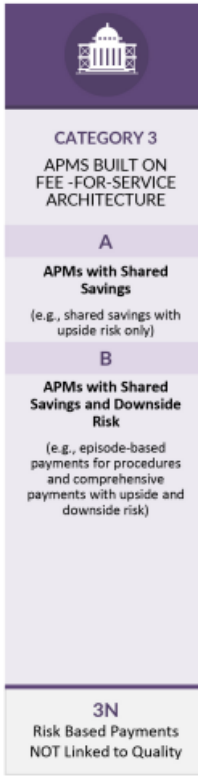
Category 2: Fee-for-Service with Link to Quality & Value



- Fee-for-service is the primary payment method, but incentives or reductions in payment are applied for certain activities.

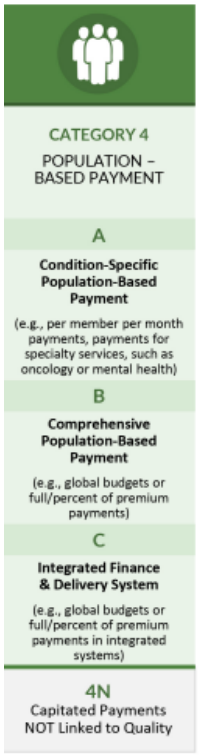
- Some examples of models in this category include:
  - PCMH incentive payments: providers receive a small PMPM for working toward, or achieving NCQA PCMH certification
    - Or for having certain qualities (e.g., a care manager)
  - Penalty for not reporting quality measures: providers receive a downward adjustment in future payment update for not reporting certain quality data
    - This could also be pay-for-reporting
  - Pay for performance: providers receiving additional dollars for:
    - Achieving superior performance on quality, patient satisfaction and/or efficiency measures

Category 3: Shared Savings and Shared Risk



- Fee-for-service is the primary payment method, but post-performance period reconciliation of the model determines total payment.
- Some examples of models in this category include:
  - Shared savings: providers share in savings with the payer if the cost of services is below a pre-determined budget.
  - Shared risk: providers share in savings with the payer if the cost of services is below the pre-determined budget, but share in losses if above.
    - Many *retrospectively reconciled* ACO payment arrangements fit in this category.
  - Episode-based payment: payments for a patient receiving a defined set of services for a specific condition across a continuum of care by multiple providers or care for a specific condition – both for a specified time period. (Episodes must be *retrospectively* reconciled to fit within this Category).

Category 4: Prospective Population-Based Payment



- Prospectively paid models – where the provider receives up-front payments (in a single lump sum, or periodically).
- Models in this category include:
  - Condition-based episodes: prospectively paid dollar amounts for all services related to a condition over a specified time period
  - Primary care capitation: prospectively paid dollar amounts for all services expected to be performed by a single provider (e.g., primary care).
  - Some ACO models: prospectively paid dollar amounts that cover the total cost of care for a population of patients over a specified time period.
  - Integrated finance and delivery systems: payments that cover services delivered by systems that have both an insurance plan and health care providers (even if the health plan is paying its providers FFS).

Seems Easy, Right?

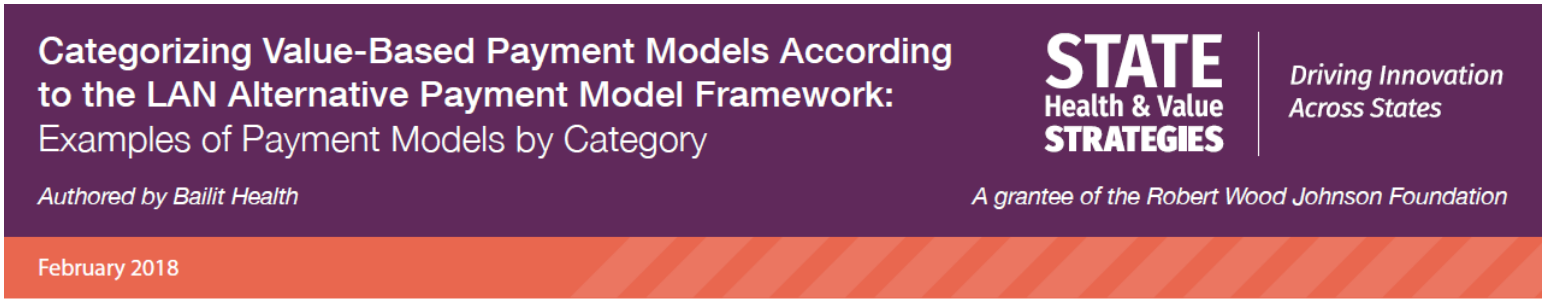
APM Categorization: Not as Straightforward as it May Seem

- Many provider payment arrangements are multifaceted, leaving states with the challenge of trying to identify into which LAN category any one given APM will fit.

- The LAN instructs users to categorize provider payment arrangements by the "dominant APM" – defined as the most advanced payment model employed within the design – regardless of the amount of incentive dollars (or risk) attached to it.

Questions?

Issue Brief



- The new SHVS issue brief describes the LAN Framework in more detail
- Over a dozen examples of payment models and their methodologies, categorized according to the LAN
- Released February 6th and available here: www.shvs.org

Health Plan Participant

Kat Latet

Manager, Health System Innovation

Community Health Plan of Washington

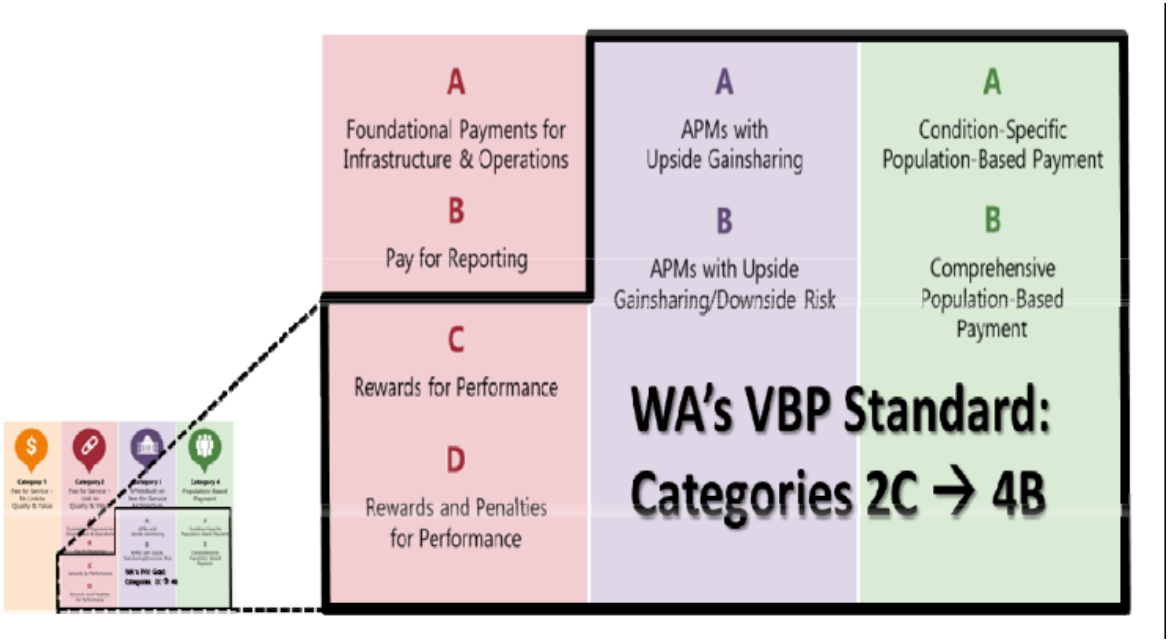
Example: Community Health Plan of Washington

- Founded in 1992 by Washington's community health centers.
- They formed a non-profit health insurance plan to help coordinate care and advocate for people who were not being served by traditional insurance companies.
- The network consists of 19 health centers, 130 clinics, 2500 primary care providers, 14,000 specialists and over 100 hospitals.
- 300,000 members

Washington State Health Care Authority's Value-Based Payment Goals and Framework

- **WA HCA set a goal that 90% of state-financed health care payments to providers will be in CMS Categories 2c-4b by 2021.**

  - 2017: 30%
  - 2018: 50%
  - 2019: 80%
  - 2020: 85%
  - 2021: 90%



CHPW's VBP Payment Model for Medicaid

- CHPW has several VBP models within Medicaid.
- CHPW makes a prospective payment to the Community Health Network of Washington.
  - A portion is withheld, to be paid out based on quality performance.
- CHPW shares risk with the Community Health Network of Washington on the total cost of care, which includes all primary care, specialty, hospital and pharmacy services.
- The Network pays its primary care providers (community health centers) using prospective primary care capitation.
- The Network's CHCs share risk with all Network CHCs on the financial and quality performance of the specialty providers, hospitals and pharmacy services for certain Medicaid populations.

Questions?

Resources:

Upcoming Webinar:

- How State Programs are Defining and Tracking MCO Implementation of APMs
  - Wednesday, February 14, 2018 2:00-3:00PM ET

Two New Issue Briefs:

- Categorizing Value-Based Payment Models According to the LAN Alternative Payment Model Framework
- State Approaches for Defining and Tracking MCO Implementation of APMs

www.shvs.org

Thank You

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