Payment Models, Value Based Purchasing Design Elements and Overview of Vermont Models

VHCIP

DLTSS Work Group Discussion

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Goals

- Presentation Goals
  - Review Base Payment Models
  - Review Design Elements related to Value Based Purchasing
  - Snapshots of Vermont Models
  - Discussion
- Ultimate goal to provide recommendations for payment models that:
  - Support DLTSS specific outcomes
  - Promote integration of medical (traditional) and disability and long term services and supports

Base Payment Models

A base payment model is the underlying method that defines how a provider gets paid for services. Value Based Purchasing designs can be used with any base payment model. There are three base payment models:

- Fee-for service (FFS) payments
- Bundled payments
- Population-Based payments

Fee For Service (FFS)

Operational Definition	Potential Impact	Financial Risk/Rates
Providers are paid for each service they render (e.g., an office visit, test, procedure or service). Payments are issued retrospectively, after the services are provided.	Pays providers for doing things to sick people, rather than getting and keeping people well. May be a barrier to coordinated and/or integrated care because it rewards individual clinicians for performing separate treatments. Over –utilization or up coding (coding the service to a category that pays a higher rate)	Payer is at risk for paying for all services Payers set rates based on the costs of providing the service, based on a percentage of what other payers reimburse for equivalent services, and/or based on negotiations with providers.

Bundled Payment

Operational Definition	Potential Impact	Financial Risk/Rates
Providers are paid a fixed dollar amount based on the expected costs for defined episode or bundle of related health care services. Bundles can be defined in different ways, cover varying periods of time and include single or multiple health care providers of different types. *Different types include:* • *Case rate* • *Episode-of-Care Payment* • *Global Bundled Payment* • *Prospective Payment System*	Providers have flexibility to decide on necessary services. Reduces the incentive to overuse or provide unnecessary services. May create incentive to provide the lowest level of care possible, not diagnose complications of a treatment before the end date of the bundled payment, or delay care until after the end date of the bundled payment. May not provide incentive to control the number of episodes that the person experiences.	Providers assume financial risk for the cost of services as well as costs associated with any preventable complications. Historical expenditures typically used to determine rates. Rates can be set to increase, decrease, or maintain historical levels. Rate determined by: • Services included • Time window (e.g., week, month, year, episode) • Target group • Provider type

Population Based Payment

Operational Definition	Potential Impact	Financial Risk
Providers are prospectively paid a set amount for all of the healthcare services needed by a specified group of people for a fixed period of time, <u>whether or not that person seeks care.</u> *Different types include:* • *Full Capitation* • *Risk Adjusted Capitation* • *Partial Capitation*	Removes incentive for volume. Providers have flexibility to decide what services should be delivered and when; and provides upfront resources to support services. Creates incentive to ensure quality care is delivered because providers receive no added payment for potentially avoided complications. May encourage a focus on preventive care. Unintended consequences may include: • Over stating caseload numbers • Creating incentives for enrollments • Underutilization of appropriate care • Avoidance of high-risk (potentially more expensive) individuals • Cumbersome appeal processes; ineffective grievance process; • Inadequate or unreasonable prior authorization requirements.	Provider is accountable for managing the total cost and quality of care. Historical expenditures are typically used to determine the initial bundled payment rates. The rate can be set to increase, decrease, or maintain historical levels. The amount of the payment may be adjusted based on the characteristics of the services expected and/or the target population. Special provisions may include outlier payments or other mechanisms to address unforeseen circumstances.

Value Based Purchasing (VBP)

- http://healthcareinnovation.vermont.gov/node/863

- Literature and research is still emerging

- No single definition or 'one size fits all' approach

- Value Based Purchasing can be used with any type of base payment model

Value Based Purchasing Definition

*A broad set of performance-based payment strategies that **link <u>financial incentives </u>to providers' performance** on a set of defined measures of quality and/or cost or resource use. The goal is to achieve better value by driving improvements in quality and slowing the growth in health care spending by encouraging care delivery patterns that are not only high quality, but also cost-efficient.*

- Definition derived from (1) the CMS Roadmap for Implementing Value Driven healthcare and (2) comprehensive 2013 research reports developed by the RAND Corporation on behalf of the Office of the Assistant Secretary for Planning and Evaluation (ASPE) in the U.S. Department of Health and Human Services (HHS) to inform HHS about future policy-making related to VBP.

Value Based Purchasing Design Elements

Design considerations identified in literature
- Financial incentive and performance measurement
  - Type of incentive (e.g., bonus, holdback, performance, shared savings)
  - Type and breadth of measures
    - Process, structure and outcomes
    - Cost, quality, and patient experience

- Characteristics of the providers
  - Size, scope (e.g., type, specialty, infrastructure, percentage of clients for whom the incentive is relevant)
  - Single or multiple providers or provider types
  - Other regulatory requirements

- External factors that can enable or hinder provider response to the incentive.
  - Other payment policies or quality initiatives
  - Regulatory structure
  - Resources available to support the Value Based Purchasing Design (e.g., data analytics, IT, staff, incentive payments, provider transformation and technical assistance)

Vermont Model Snapshots

Project	Base Payment Model	Value Based Financial Incentive	Status
Accountable Care Organization	FFS	Shared savings	Pilot Statewide
Blueprint Patient Centered Medical Homes (PCMH) (supported by Community Health Teams)	Physicians: FFS CHT: Population Based	Quality bonus paid to practices based on National Committee for Quality Assurance (NCQA) recognition as a PCMH.	Implemented Statewide
Medication Assisted Treatment: (Hub and Spoke)	Bundled	None at this time	Implemented Statewide
Integrating Family Services	Bundled	None at this time	Pilot Two Regions
Community Rehabilitation and Treatment (CRT)	Bundled	None at this time	Implemented Statewide
Accountable Communities (St. Johnsbury)	Under Discussion	Under Discussion	Design Stage

Discussion

Objectives

- Promote person-centered/directed care
- Promote quality care
- Improve care coordination and integration
- Ensure access to care
- Ensure appropriate allocation of resources/manage costs

Principles

VBP should support DLTSS objectives through incentives that are:

- Specifically tailored to members and systems of care within each DLTSS program
- Designed to promote integration and coordination across the full array of healthcare services
- Designed to offer financial incentives that reward change but do not compromise other DLTSS objectives (e.g., access to care)

Discussion

Structural Considerations

- DLTSS are a relatively small part of Vermont's overall healthcare system but a large part of Vermont's Medicaid program
- Many DLTSS providers receive a majority of their funding from Medicaid
  - Medicaid is in a strong position to influence behavior
  - Reductions in Medicaid funding can have significant and immediate consequences; absent demonstrated savings, it is challenging to implement incentives that could create "winners and losers" (e.g., penalties, incentive pools)
- Parts of the DLTSS delivery system are subject to extensive regulatory requirements that define performance expectations
- Coordination and alignment of providers varies by program and region

Discussion Question
  - How does the DLTSS delivery system present unique opportunities and challenges related to linking payment to performance?

Discussion

Design Considerations

- Entity receiving payment incentive (specific provider, risk-bearing entity, provider coalition)
- Payment type (risk-based, savings sharing, withhold)

Discussion Questions: Evaluation of VBP Model

- Does the model recognize the unique needs of members receiving DLTSS?
- Does the model recognize the unique nature of Vermont's DLTSS systems of care?
- Does the model create appropriate incentives for both medical and DLTSS providers?
- If incentive payments are based on demonstrated savings, how does the additional funding support system improvement? Who determines how additional funding is distributed and invested?

Discussion

Development of Performance Measures Specific to DLTSS

- Types of Measures
  - Structural (e.g., access to health information across providers)
  - Process (e.g., timeframe for completion of care plan, physician involvement in care planning)
  - Performance/Outcomes (e.g., beneficiary satisfaction, stable housing, employment, independence)
- Some Measures Specific to Each Program

Discussion Questions

- What measures are best achieved through VBP (rather than regulatory framework)?
- Are the values and outcomes measureable?
- Is there an existing Vermont framework for reliable and valid measurement?

Discussion

Next Steps: VBP Recommendations

❑ Identify specific measures by program
❑ Review and evaluate VBP Model and opportunities for the model to support DLTSS objectives

Discussion Question

❑ What is the process and timeline for informing the VBP model?