Design Payment Transformation

Updated November 1, 2024

AHE Advancing Health Equity
Leading care, payment, and systems transformation

Robert Wood Johnson Foundation

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Agenda

- Introductions
- Learning Objective 1: Understanding VBP basics
- Learning Objective 2: Applying a health equity lens
- Current Examples
- Wrap Up

Advancing Health Equity

Learning Objectives

- Understand the basics of value-based payment, including general payment approaches and the roles of each stakeholder
- Identify how Medicaid payers can use value-based payment to support care delivery transformations that promote health equity

Accountable Spaces Framework

At AHE, accountability is directly tied to care for others both in the work we do and the conversations we have. Being accountable means practicing good stewardship and ceding power to make space for others to shine. We will center this framework today to help us keep the tenets of accountability at the forefront of our conversations.

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Accountable Spaces Framework

- Do not interrupt others.
- Listen actively, instead of waiting to speak.
- Be mindful of your total talk time and resist the urge to add “sprinkles” to a perfectly good conversation sundae.
- Give everyone a chance to speak, without unnecessary pressure.
- Words and tone matter. Be mindful of the impact of your words, not just your intent.
- We are all learning, and we will make mistakes from time to time. If you said something offensive or problematic, apologize for your actions or words -- not for someone feeling insulted by them.

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Accountable Spaces Framework

- Recognize and embrace friction. Constructive conflict can often lead to substantive change.
- Give credit where credit is due. If you are echoing someone's previously stated idea, give them appropriate acknowledgment. If you notice others aren't receiving the credit they are due, speak up and highlight their work.
- Speak for yourself using "I" statements. Do not take ownership of others' lived experiences.
- Create meaningful opportunities for those belonging to communities that have historically been most impacted to share their experiences.
- Address racial inequities head on and call out racism when it happens.

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Accountable Spaces was first conceptualized by UCLA. The framework above is a modified version specifically tailored for the AHE community that was adapted from Elise Ahenkorah.

Learning Objective 1:

Understand the basics of value-based payment, including general payment approaches and the roles of each stakeholder

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Prescriptiveness vs. Flexibility

- Key decision to weigh when developing any policy or program:
  - →How prescriptive will the design be?
  - →Where and how much flexibility can we allow?
- **Power** and **relationships** play a key role in these choices
  - →Who holds the power in your contractual relationship?
  - →What does accountability look like?
    - In an ideal world, how can our definition of "accountability" include accountability towards community?
  - →How much trust is present in the relationship?
- **Discussion:**
  - →What are the pros to having very prescriptive VBP or other contract requirements to promote health equity? What are the cons?

How Flexible or Prescriptive Should a VBP Model Be?

More Flexible

Pros

- Encourages innovative approaches and supports community-specific interventions
- Allows variance for payer/provider capacity

Cons

- May encourage "least common denominator"
- Misalignment across payers
- Hard to evaluate

More Prescriptive

Pros

- Can ensure a specific VBP approach is implemented
- Leverages multi-payer alignment
- Easier to evaluate

Cons

- May stifle innovation or limit community-specific interventions
- May not allow for payer/provider capacity

What is Value-Based Payment?

- **Value-based payment (VBP)** = Broad set of performance-based payment strategies that link financial incentives to providers' performance on a set of defined measures of quality and/or cost or resource use
- **VBP Goals:**

- **Payment reform** is a broad term, referring to changes in how payment is made, typically to increase a focus on quality of care

Center for Health Care Strategies

HCP LAN APM Framework

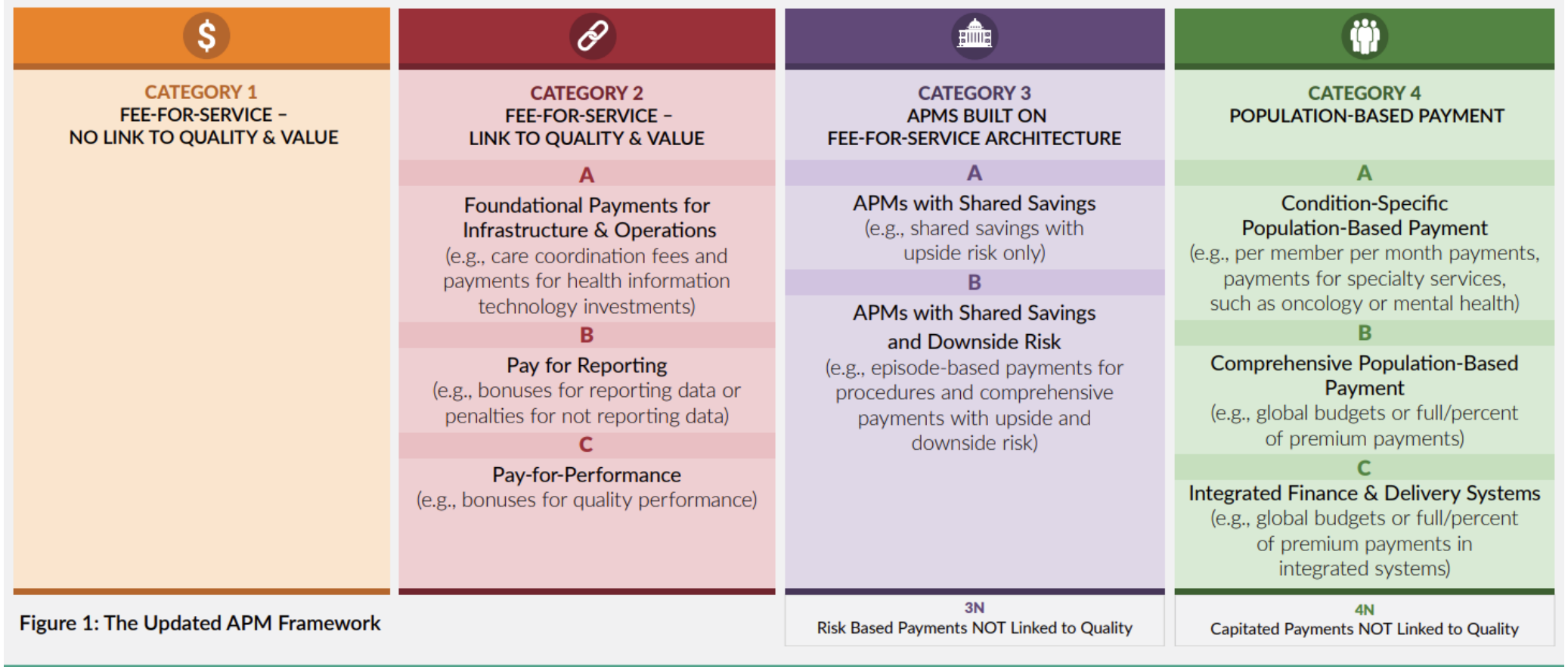
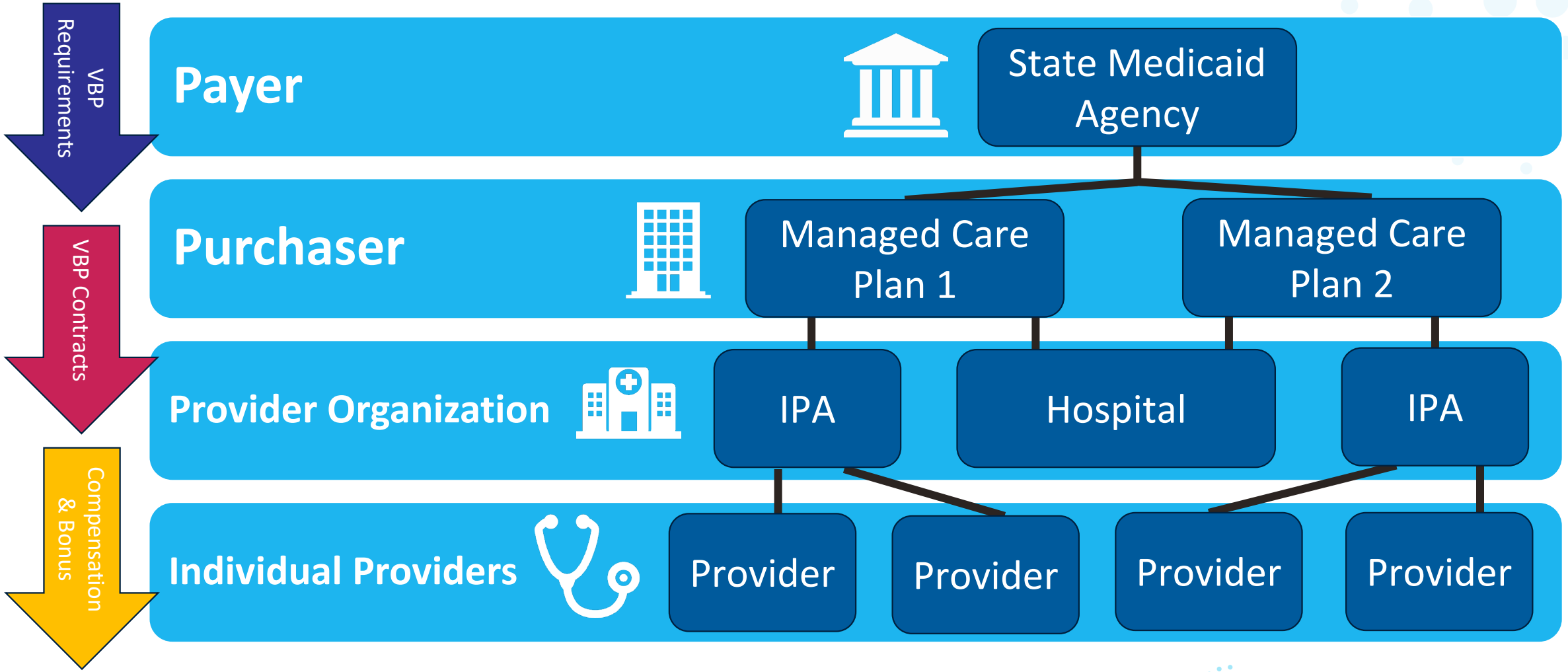


Figure 1: The Updated APM Framework

Source: https://hcp-lan.org/apm-framework/

Center for Health Care Strategies

Contractual Relationships and Flow of Funds
(AKA: Who does what?)



Center for Health Care Strategies

VBP in Managed Care vs. Non-Managed Care States

Managed care

State develops VBP adoption goals

Via managed care contract, state requires MCOs to develop VBP. (E.g., certain percentage of provider payments must flow through VBP.)

Via managed care contract, state requires MCOs to implement a specific VBP developed by the state.

Via provider contract, MCOs requires or offers opportunities to providers to participate in VBP

Non-managed care

State develops VBP adoption goals

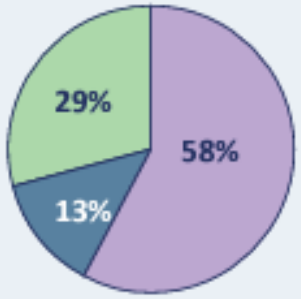
State develops VBP model(s)

Via provider contract, state requires or offers opportunities to providers to participate in VBP

2023 Health Plan Survey Respondents

In its sixth year, the 2023 survey findings represent health plan data from almost every state with Medicaid managed care. The annual survey collected information at the parent company/corporate levels and is intended to equip Medicaid stakeholders with the information needed to accurately articulate the national narrative about Medicaid managed care. The survey respondents are representative of the national demographics of all Medicaid health plans.

Health Plan Tax Status

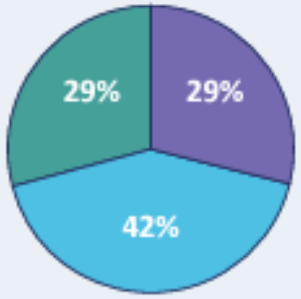


- Private Nonprofit
- Private For-Profit
- Government or Other

Health Plan Markets

- Single State
- Multistate

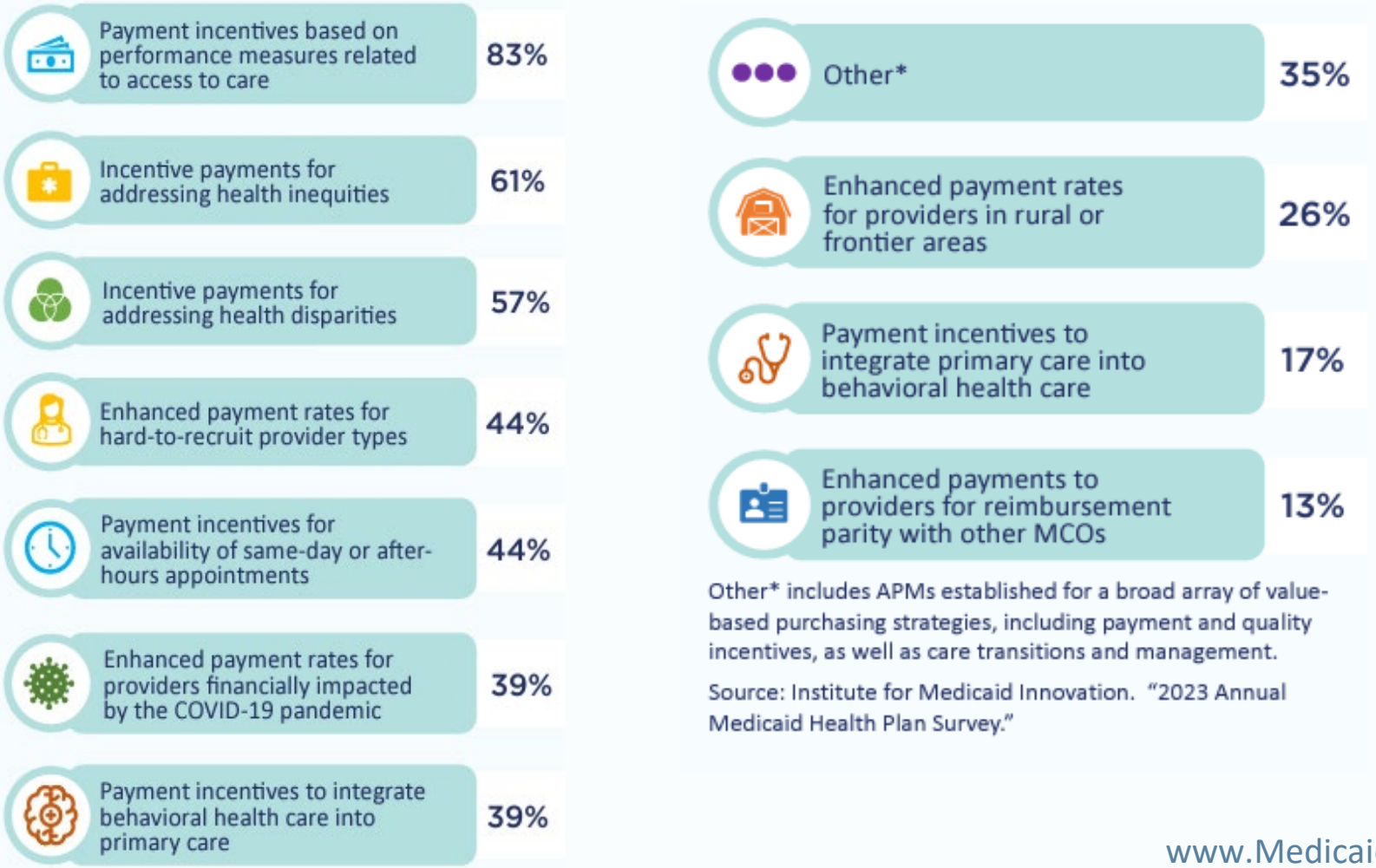
Health Plan Size



- Small Health Plan (<250K Covered)
- Medium Health Plan (250K–1 Million Covered)
- Large Health Plan (>1 Million Covered)

Source: Institute for Medicaid Innovation. "2023 Annual Medicaid Health Plan Survey."

Payment Strategies Used By Medicaid Health Plans



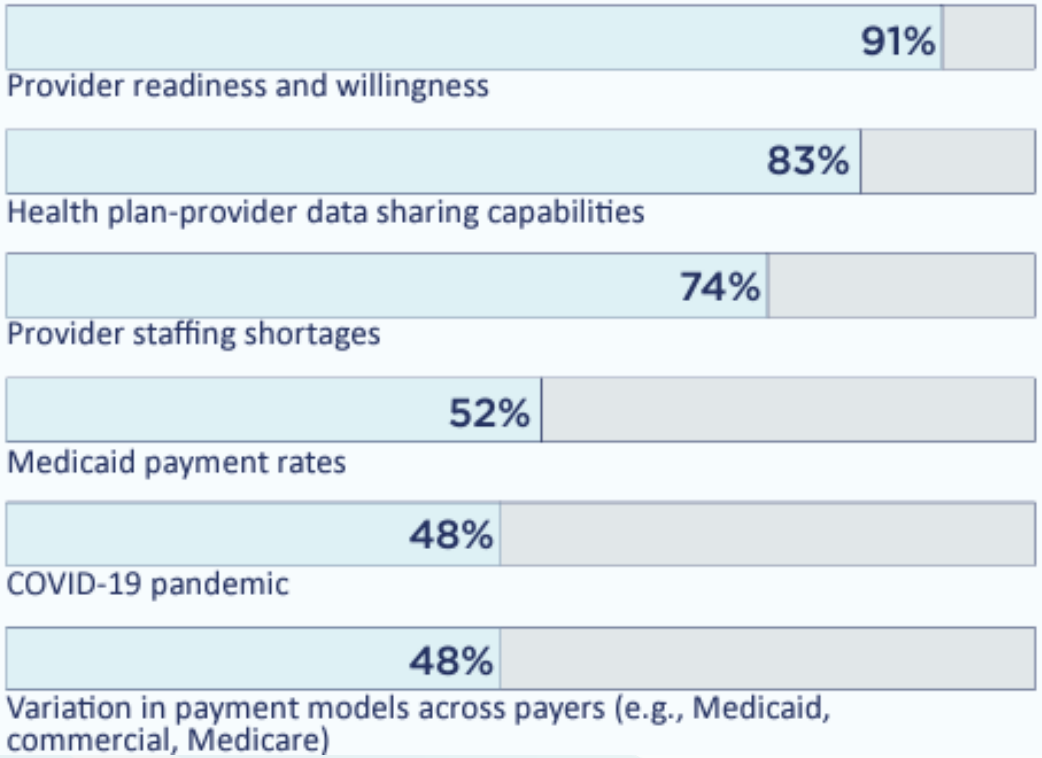
Other* includes APMs established for a broad array of value-based purchasing strategies, including payment and quality incentives, as well as care transitions and management.

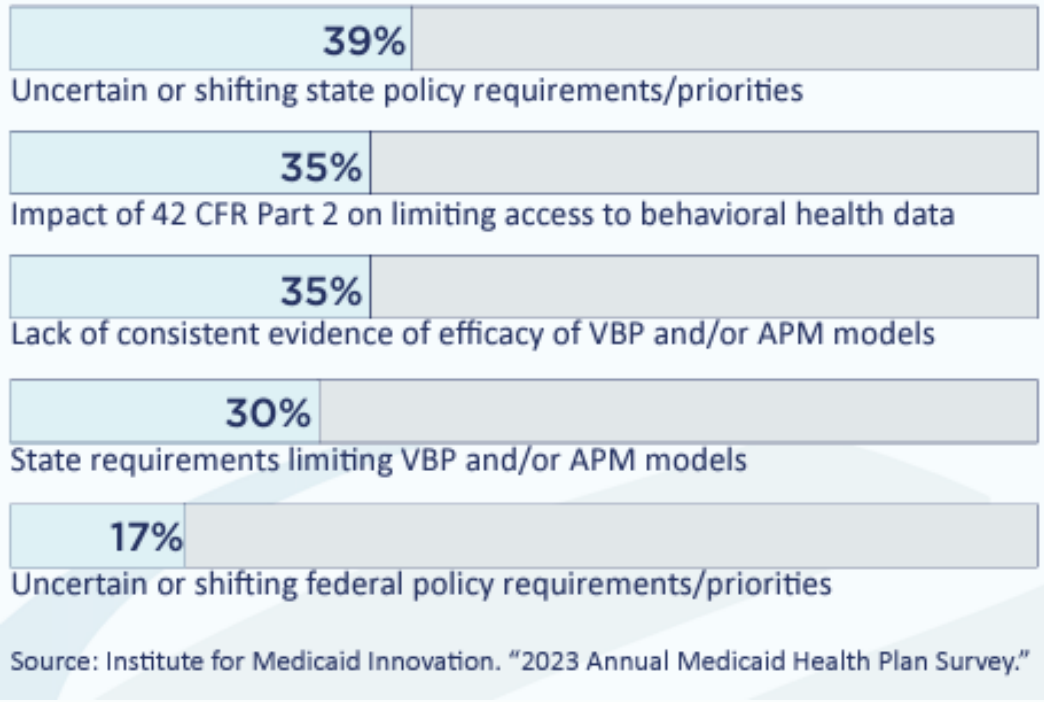
Source: Institute for Medicaid Innovation. "2023 Annual Medicaid Health Plan Survey."

Medicaid Health Plans' Use of VBP and APMs with Providers	All Health Plans
Incentive/bonus payments tied to specific performance measures (e.g., pay for performance)	96%
Arrangements with upside risk	83%
Shared savings arrangements	70%
PMPM (per member per month) for care management services	65%
Global or capitated payments to primary care providers or integrated provider entities	61%
Bundled or episode-based payments	57%
Arrangements with downside risk	48%
Payment withholds tied to performance	39%
Upfront payments to encourage faster movement to more advanced APMs	22%
Nonpayment or reduced payment for patient safety issues (e.g., never events)	17%
Nonpayment or reduced payment for elective deliveries before 39 weeks	9%

Source: Institute for Medicaid Innovation. "2023 Annual Medicaid Health Plan Survey."

External Barriers That Influence the Adoption and Innovation in VBP by Health Plans





Source: Institute for Medicaid Innovation. "2023 Annual Medicaid Health Plan Survey."

Changes to State Requirements and Guidance That Would Assist Medicaid Health Plans to Effectively Implement VBP and/or APMs	All Health Plans
Provision of additional policy and/or fiscal levers for MCOs to ensure provider engagement in VBP models	65%
Better education for providers on state and health plan expectations	65%
Reporting of consistent metrics	65%
Policies to facilitate data sharing between payers and providers	61%
Streamlined VBP design across payers, including aligned performance measures	61%
Better education for health plans on state expectations for VBP	57%
More flexibility in the design of VBP components (e.g., member attribution, benchmarking)	48%
Development of a multiyear VBP strategy to allow for longer-term contracts with Medicaid	48%
Removal of data sharing restrictions	48%
Multipayer alignment in VBP strategies	35%
Removal of requirements that limit VBP model and APM development	26%

Source: Institute for Medicaid Innovation. "2023 Annual Medicaid Health Plan Survey."

Learning Objective 2:

Identify how Medicaid payers can use value-based payment to support care delivery transformations that promote health equity

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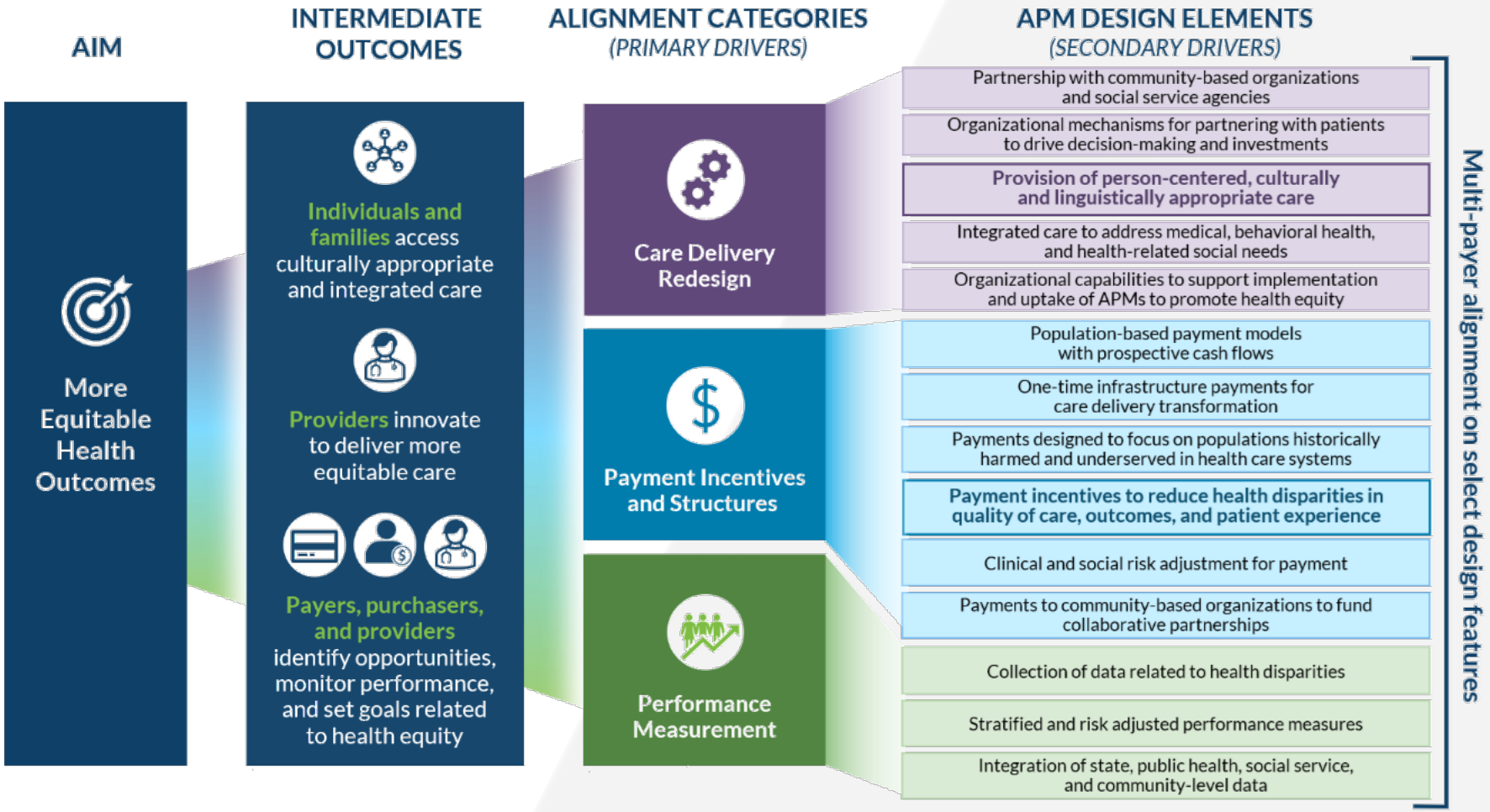
VBP with a Health Equity Lens

- Payment can be a lever for:
  - Reimbursing for activities that promote health equity
  - Rewarding providers and organizations that produce more equitable outcomes
- VBP must be intentionally designed to produce equity
  - Stratified performance metrics
  - Equity-enhanced payments
  - Risk adjusted payments
- Payment is just one lever to support your health equity interventions – other activities from the AHE Roadmap should inform and work with your VBP model or other payment reform efforts

HCP LAN's Health Equity Advisory Team's Theory of Change



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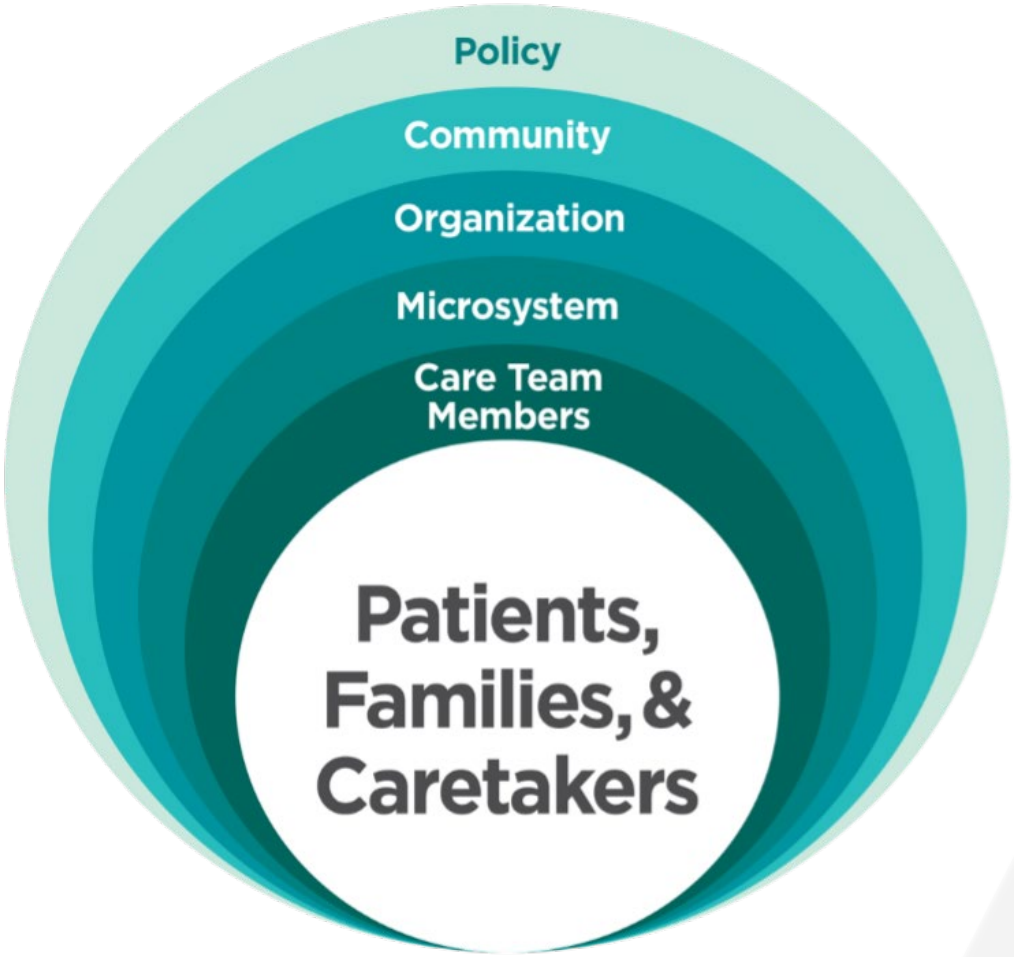
Source: https://hcp-lan.org/health-equity-advisory-team/

Designing Payment Approaches for Health Equity



- To address the multiple causes of inequities, care delivery transformation will address multiple levels (who is being impacted); using multiple strategies (what tactics are being used); and modes (how strategies are implemented)
- Payment transformation should aim to support the strategies by reducing barriers such as capacity, resources, time, and misaligned incentives
- True partnership with patients and communities impacted by health disparities is key to designing care transformation models, and supportive payment models, that can succeed at promoting health equity

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Checklist for Designing Payment Approaches for Health Equity

- ❑ Articulate the health equity goals with stakeholders
- ❑ Assess the current payment environment
- ❑ Design payment approaches that support care delivery transformation strategies
- ❑ Select performance and quality measures that reflect health equity goals
- ❑ Address operational issues in partnership with stakeholders (CBOs, providers and provider organizations, and MCOs)

1. Articulate the Health Equity Goals of Payment Transformation

- Work with key partners to identify your goals, including provider organization staff and frontline workers; and patients and community members
- Explore how progress on your health equity goals can be measured
  - →**Increasing delivery of services that promote equity** (e.g., increase screening of Black birthing people for postpartum depression)
  - →**Improving quality of care** (e.g., improved scores on 'trust' measure in experience of care surveys)
  - →**Improving health outcomes** (e.g., decreased opioid overdose deaths of Medicaid members returning to the community after incarceration)
- Consider measures that can identify short-, medium-, and long-term changes that point towards your goals

Work with Community Members to Articulate Health Equity Goals

- Seek perspectives from community members, MCO plan members, providers of healthcare services, and other stakeholders to set relevant and actionable goals
- **All stakeholders** can start with community focus groups or individual interviews while developing/designing ongoing committees
  - →Connecticut's Medicaid agency hosted member focus groups to set goals for ongoing primary care payment reform activities
- Organizations should seek to move from one-off conversations and towards ongoing relationships with community members
  - →**Medicaid agencies** can leverage Medicaid Advisory Committees and Beneficiary Advisory Councils
  - →**MCOs** can incorporate members in health equity advisory councils and committees to inform decision-making
- Ideally, organizations will push themselves to move from a "feedback" or "consultation" mindset to a structure that cedes decision-making power to community members whenever possible

2. Assess the Current Payment Environment

- Are payment reforms currently underway that can be leveraged?
  - →E.g., A maternity bundle in place that could incorporate additional equity measures?
  - →E.g., VBP models in other contracts that could be implemented more widely?
- Are payment reforms currently underway that might conflict with this new model?
- Is there a source of start-up funding that can be leveraged to make administrative changes required for model success?
  - →Identify options for one-time start up costs (e.g., updating your data systems)
  - →Think about the potential to start with a pilot to collect more data on how to succeed under a new model
- What is the level of buy-in from involved parties?
  - →How can you work with and learn from partners, stakeholders, and other impacted parties to meet their needs?
  - →How can you understand if this model is meeting community needs?

3. Design Payment Approaches that Support a Care Transformation Addressing Root Causes

- Upfront or prospective funding
  - Cover infrastructure and workforce for interventions such as community health workers or changes to IT systems to track equity
  - Support efforts to strengthen partnership with community members, focusing on a move towards ongoing relationships and sharing power
  - CMS's Making Care Primary Model includes prospective payments to enhance care management and screening for health-related social needs.
- Retrospective payment
  - Reward and incentivize reducing disparities and advancing health equity
  - Minnesota's Integrated Health Partnerships program incentivizes overall quality results and reducing specific disparities in VBP contracts

Design Payment Approaches: Additional Functional Questions

- What is the magnitude of incentive needed to reduce barriers and support care delivery transformation ?
  - → What barriers need to be overcome? What activities should change?
- How can incentives at the provider organization level flow down to individual providers?
- Can non-financial incentives increase individual provider engagement and improve performance?
- Who are we responsible for, and how can we track our population's health?
  - → Is population attribution by insurance? Geographic? By another method?
  - → How can data be shared across organizations?

Design Payment Approaches: Additional Functional Questions (cont.)

- What level of financial risk or reward is appropriate?
  - →May depend on who is involved with the care transformation, e.g., an individual provider, a provider organization's clinical staff, an entire organization?
- How much flexibility is needed?
- Consider how and when to assess value and success of the model
  - →Is there potential financial return on investment (ROI)?
    - If so, how may the model be designed to take advance of this financial return over time?
  - →Are there other forms of "value" being delivered?
    - E.g., social ROI, value of investment (VOI)
  - →Can changes to the design process or care delivery process reflect "value?"
    - E.g., more equitable payment model design processes that include true partnership with community members
    - E.g., delivery of more equitable health care

Ensure Payment Approaches Support Care Transformation: Value-based Payment

Care Transformation Goals	Potential VBP Approach
Increase visits to providers	Link participation in a specific VBP model to increased payment rates
Adding team members such as doulas or CHWs	Develop a flexible VBP strategy (e.g., upfront PMPM, shift to population-based payment) that allows hiring of new staff members
Enhance service responsiveness • Offer additional services • Increase flexibility	Add incentive payments linked to delivery of specific types of care (e.g., incentive payment linked to depression screening) Increase flexibility in process measures that lead towards achievement of outcome measures
Health care worker training or supports	Provide time-limited upfront payments for capacity-building
Improve diabetes care for patients of color	Link incentive payments to reduced racial disparities in HbA1c control
Strengthen community partnerships	Provide upfront payments to support changes in community partnership activities; move towards financial accountability for working with community members and incorporating their perspectives into decision-making

4. Select Performance and Quality Measures

- What are the appropriate achievement criteria to advance health equity?
  - **Improvement** - assess performance relative to a baseline
  - **Absolute attainment** - a specific outcome or score must be achieved
  - **Relative attainment** - achieve a score relative to a benchmark
- In many VBP models, providers are rewarded based on **attainment**, such as 90% achievement or the 75th percentile
  - Evidence is beginning to suggest that this might exacerbate disparities, because within group comparisons can lead to a zero-sum outcome – where there must be winners and losers
  - It can also be difficult, especially initially, to identify realistic **attainment** goals
  - Making payment contingent upon **improvement** may be optimal to support equity and encourage collaboration

Select Performance and Quality Measures (cont.)

What measures can tell us if there is change that is moving us towards our goals?

- Ensure measures reflect health equity goals & are related to your root cause analysis
  - →Community and patient partnership is key
- Consider feasibility of collecting timely, accurate data
- Plan for the time-span for implementation and effects
- Think about who can influence the measures
- Prioritize a limited, but meaningful, measure set
- Choose a mix of process, outcome, and experience measures. Think through a balance that indicates overall impact on goals
  - →Process measures can include not only process of care, but also other processes – e.g., a VBP model might provide incentive payments related to design processes and commitment to community partnership

5. Address Operational Issues in Partnership with Stakeholders

- In what ways can MCOs, state Medicaid agencies, health care providers, social service organizations, and community-based organizations partner to implement care transformation and receive payment supports?
  - → Data collection, sharing and analysis
  - → Training and skill-building around payment reform
- What is the plan for assessment and evaluation?
  - → Consider ways to tailor the evaluation to assess the impact and fit of the payment approaches

Current Examples

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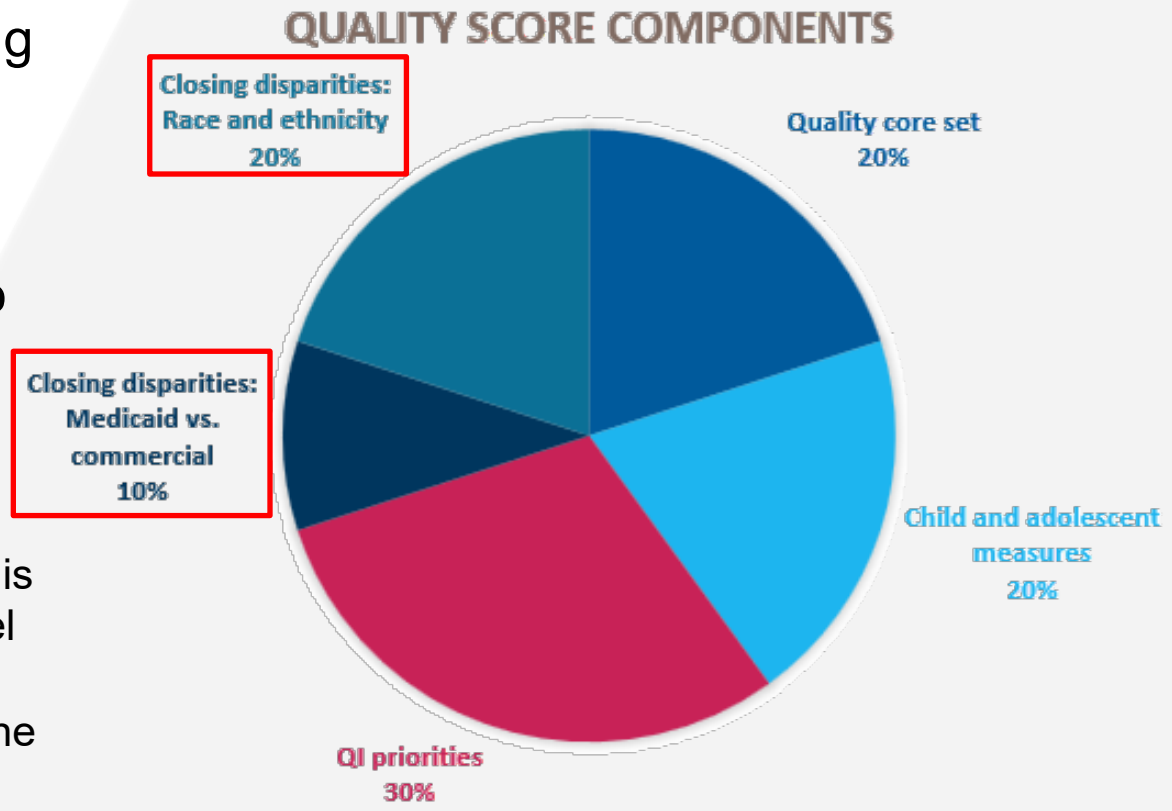
Minnesota Medicaid's ACO Program

- Minnesota's Medicaid agency has undertaken many health equity activities in the last few years, including community engagement, MCO procurement and accountability focused on antiracism, and public reporting on health disparities
- The agency has also incorporated health equity into its VBP approach:
  - 30% of the total quality score used to determine provider organization shared savings is based on health equity performance
  - Provider organizations receive flexible, upfront funding that is adjusted based on the social risk factors of the patient panel
  - Provider organizations must design a health equity/SDOH intervention, along with a metric that can assess how well the intervention is working



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Advancing Health Equity: Delaware and Washington teams

Delaware

Context: state accountable care organization (ACO) contract with shared savings/risk and total cost of care accountability

Model:

- P4P add-on based on ability to close disparities within the pediatric population
- Measures performance on 4 preventive care measures

Washington State

Context: shared savings model with total cost of care accountability for FQHCs, developed by FQHC-owned plan

Model:

- Years 1-3: upfront payment of anticipated shared savings (framed as a grant) to support health equity learning and culture change
- Years 4-5: continued support for learning and culture change, along with:
    - Year 4: process measures linked to quality payment
    - Year 5: development of equity initiative linked to quality payment
- Year 6: reduction of disparities linked to quality payment

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Connecticut Medicaid's Maternity Bundle

Maternity bundled payment model design process incorporated a 3-part Health Equity Framework

- **Design Readiness Checklist:** developed a set of questions at the beginning of the design process to drive equity-focused work
  - Questions included: goals of the program, populations for impact, strategies for community engagement, and necessary data
- **"Equity Yardstick" for Design & Implementation:** completed for each design element
  - Answered questions developed as part of the readiness checklist for each design element of the model
- **Post-Implementation Evaluation of Overall Program:** evaluate whether program goals are being met and identify needed changes
  - Will be used to identify relevant statewide measures to assess if program goals – as defined through parts 1 and 2 of this framework – have been met
  - Will incorporate community feedback along with data analysis

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Source: https://portal.ct.gov/-/media/departments-and-agencies/dss/health-and-home-care/husky-maternity-bundle/32222-ct-maternity-bundle-stakeholder-deck.pdf