Population-Based Payments in Medicaid: Strengthening Provider Incentives to Transform Care

December 6, 2022
2:00 - 3:00 PM ET

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Questions?

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Agenda

• Welcome and Introductions
• Introductory Comments from Arnold Ventures
• What Is Population-Based Payment?
• Medicaid Population-Based Payment Models: Early Insights and Considerations for Policymakers
• Panel Discussion: Exploring PBP Models in Colorado, Massachusetts, and Pennsylvania
• Audience Q&A
Center for Health Care Strategies

Dedicated to strengthening the U.S. health care system to ensure better, more equitable outcomes, particularly for people served by Medicaid.

Together with our partners, our work advances:

- **Effective models for prevention and care delivery** that harness the field’s best thinking and practices to meet critical needs.

- **Efficient solutions for policies and programs** that extend the finite resources available to improve the delivery of vital services and ensure that payment is tied to value.

- **Equitable outcomes for people** that improve the overall wellbeing of populations facing the greatest needs and health disparities.
Today’s Presenters

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Introductory Comments from Arnold Ventures

Amber Burkhart
Health Care Manager
What Is Population-Based Payment?
NEW REPORT: Medicaid Population-Based Payment: The Current Landscape, Early Insights, and Considerations for Policymakers

- What is a PBP Model?
- Current Medicaid PBP Landscape
- Analysis of Current Medicaid PBP Approaches
- State Profiles
  - Colorado, Maryland, Massachusetts, New York, Pennsylvania, Washington State
- Table Comparing State Models
What is a Population-Based Payment Model?

• **Population-based payment (PBP):** An upfront, prospective value-based payment (VBP) model that includes provider accountability for both quality and cost of care and is based on the number of patients a provider serves—as opposed to the number of services a provider performs.

• **Hybrid PBP:** A VBP model where providers are reimbursed through a mixture of fee-for-service (FFS) payment and PBP. In this model, FFS rates are decreased in response to the addition of the capitated payment.

• Our research focused on three types of models: primary care PBPs, hospital PBPs, and total cost of care PBPs.
Why are Population-Based Payments Important?

- PBPs are the “end state” of value-based payment reform
  - Maximizes incentives to move away from volume-based fee-for-service architecture
  - Offers the greatest opportunity to achieve elusive health care goals
## Benefits and Challenges of PBPs

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<th>Benefits</th>
<th>Challenges</th>
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<tr>
<td>• Aligned financial incentives</td>
<td>• Barriers to entry</td>
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<td>• Flexibility for providers</td>
<td>• Financial risk mitigation</td>
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<td>• Budget predictability</td>
<td>• Limited participation</td>
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<td>• Financial stability</td>
<td>• Potential for perverse incentives</td>
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<td>• Straightforward design</td>
<td>• Short-term administrative burden</td>
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Medicaid Population-Based Payment Models: Early Insights and Considerations for Policymakers
## Factors Influencing Medicaid PBP Design

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<th>STATE ENVIRONMENTAL FACTORS</th>
<th>PAYMENT MODEL DESIGN ELEMENTS</th>
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<tr>
<td>Engaging stakeholders and getting buy-in</td>
<td>Defining PBP model goals and scope</td>
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<td>Implementing PBPs in Medicaid managed care</td>
<td>Transitioning to a PBP model</td>
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<td>Navigating federal and state regulatory barriers</td>
<td>Determining voluntary or mandatory participation</td>
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<td>Determining provider readiness</td>
<td>Setting PBP rates</td>
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<td>Considering a multi-payer approach to increase alignment</td>
<td>Evaluating the PBP model</td>
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Getting Approval: Navigating Regulatory Issues

Key Findings

• More challenging in FFS delivery system states compared to Medicaid managed care states – the regulatory path is less clear

Considerations for Policymakers

• CMS can encourage development of new PBP models by:
  → Releasing additional guidance particularly for FFS delivery systems;
  → Designing new CMS Innovation Center models; and
  → Creating new waivers or waiver flexibilities.
Preparing for Change: Provider Readiness

Key Findings
• PBP models require provider organizations to take on a range of new tasks:
  → Care delivery transformation
  → Administrative responsibilities
  → Financial risk management

Considerations for Policymakers
• Design PBP models for the appropriate level of readiness
  → Assess provider readiness – multiple ways to do so
  → Support increased readiness over time with a health equity approach
Getting Going: Transitioning to a PBP Model

Key Findings

• It takes time to see results
  → All stakeholders are learning

• Multi-year timelines to full implementation are common

Considerations for Policymakers

• Develop an on-ramp:
  → Start with a measurement-only year;
  → Include upfront funds to build capacity;
  or
  → Support group learning opportunities.

• Consider a hybrid model – which can be a transition phase or the final design
Doing the Math: Setting the Right Rates

Key Findings
• Multiple options for setting rates – and each has equity implications
  → Historical utilization
  → Optimal utilization
  → Average or benchmark costs

Considerations for Policymakers
• Good risk adjustment (clinical and social) is a way to mitigate risk of adverse selection
• There are tradeoffs in breaking free from FFS payment reconciliation
  → Safeguards around stinting on care
  → Adds administrative burden
  → Limits flexibility
Getting it Right: Evaluation

Key Findings

- Evaluations are limited
  → Most models are new, and COVID-19 impacted ongoing evaluations
- Results vary among states
  → Some models have shown promising results on cost control, quality improvement, and patient experience but not all

Considerations for Policymakers

- PBP is a dramatic change – need to support evaluations to see what works
  → Prioritize evaluation in the design phase
  → Federal funding to support evaluation
- Include health equity in evaluation efforts
Panel Discussion: Exploring PBP Models in Colorado, Massachusetts, and Pennsylvania
Colorado’s APM 2 Model

- Primary Care model in a fee-for-service (FFS) delivery system
- New model implemented in January 2022
- Voluntary model includes participating providers serving 20% of the state’s Medicaid enrollees
- Providers can choose a hybrid or full PBP by selecting the percentage of upfront PBP they would like to receive vs FFS payment
- PBP is paired with a total cost of care gainsharing incentive for patients with a qualifying chronic condition
  - PBP rate and gainsharing payments can be enhanced by quality performance
- Colorado has requested legislature to increase PBP by 16% to match Medicare rates
- Model is new! – no results yet
Massachusetts’ Accountable Care Partnership Plans

- Total Cost of Care model implemented in an MCO delivery system
- Began in 2018, authorized by an 1115 waiver
- Voluntary model in which MCOs and providers partnered to create 13 ACOs that serve over 640,000 MassHealth members
- PBP, adjusted for social risk, covers all care provided by the ACO
  → Recently approved waiver will add a complementary primary care PBP model in 2023
- In 2018 and 2019, there was evidence of shifts in utilization toward outpatient settings. Clinical outcomes, self-reported health and hospitalization rates generally improved or remained stable.
Pennsylvania Rural Health Model

• Hospital PBP model in an MCO delivery system

• All-Payer model implemented in 2019 in partnership with the CMS Innovation Center

• Voluntary model – 18 participating hospitals serving 1.3 million Pennsylvanians
  → All major payers in the state participate in the model

• Hospitals are paid a PBP by MCOs, which covers all hospital-based services

• Evaluations of the program found that the PBPs helped stabilize the finances of participating hospitals, especially during the early portion of the COVID-19 pandemic
Questions?
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