The path to value: Early lessons learned

KPMG Government Institute

January 2017

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Introduction

Healthcare is a rapidly evolving space, where innovation, regulation, and best practices are constantly creating strong winds and pushing providers, regulators, and payers to evaluate their business models and adjust to the changing tides. While state healthcare reform has been focused on expanding access to care through Medicaid, and innovations in implementing delivery system transformation programs, the need to anchor required change through payment system reform represents the future. In addition to the underlying financial incentives as a part of delivery system transformation, the Centers for Medicare and Medicaid Services (CMS) has memorialized the goal of fundamental payment reform on a nation-wide scale in the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). Together, the combined Medicare and Medicaid focus on moving to value will undoubtedly have a far reaching effect on how healthcare will be delivered and paid for moving forward.

In this issue brief, we will discuss leading practices and early lessons learned for how states can embark on their payment reform journeys in collaboration with major stakeholders. Alternative payment models (APMs) describe a broad spectrum of reform implemented in various methods across multiple public and private programs. For purposes of this brief, we will focus on the value based payment (VBP) model that focuses on outcomes of care in addition to process or structural changes. Regardless of the specific approach to VBP, states who have started down this path have some important lessons to share in considering the move to value.

A collective vision

Collectively developing and communicating a vision for the future operating framework with stakeholders is a critical step in setting the stage for payment transformation. While distinct, these two steps should be related. Involving a broad group of stakeholders in the early development of your vision helps develop a collective effort to create change. This begins with early conversations and information gathering concerning best practices and anticipated challenges to incorporate the existing experience and expertise while building on previous work. This collaboratively developed vision positions policy makers for increased engagement and endorsement on significant policy shifts and leads to the early adoption of new frameworks. A successful engagement process will broadly identify stakeholders. They should represent all aspects of your Medicaid program, in particular, community based organizations and Medicaid member advocacy groups.

This longer-term vision, further developed into a roadmap, can then be clearly communicated, and will give all stakeholders a sense of the objectives, but also the "rules of the road" for the reform process. A meaningfully engaged stakeholder group can become a critical tool for communicating your vision and plan more broadly to their constituents. This clear understanding will allow providers and payers to feel confident making investments to achieve longer term goals and outcomes. This will likely only become more critical with MACRA's final rule. Providers will need a long term path to see how transformation and changes led by varied payers will ultimately align, giving them the opportunity to make the most important changes and investment to fulfill the longer-term vision of paying for value.

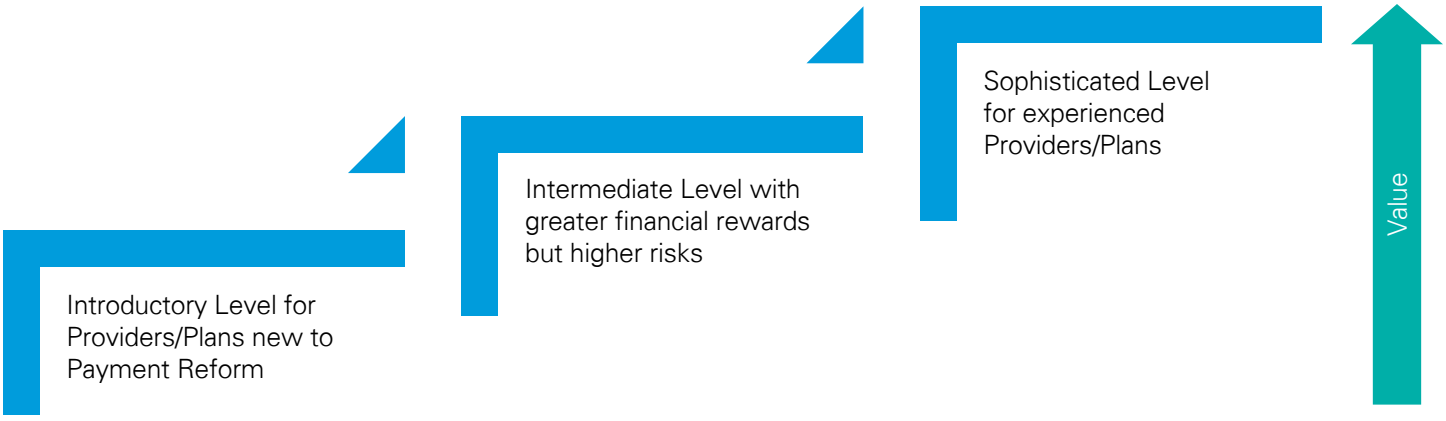
New York State

Since 2014, New York State has been engaged with various stakeholder groups in the policy development, design and implementation of value based payments as outlined in their VBP roadmap.

Over 500 stakeholders across the state participated in 16 subcommittees and clinical advisory groups held in 2015. Throughout the implementation process, a core group of stakeholders (including managed care organizations (MCOs), health plan associations, hospital associations, professional associations, legal firms specializing in healthcare contracting, New York State Health and Human Services agencies, community based providers, patient advocates, Performing Provider Systems and other industry experts) regularly meet to monitor the progress on VBP and ensure the objectives of the VBP roadmap are being achieved. The final VBP roadmap endorsed by all stakeholders in Medicaid.

A sliding scale of implementation

A payment framework that is inclusive of various types of arrangements with several levels of sophistication can help ensure that all providers can participate and won't stifle innovation. The approach to payment reform must recognize that providers and MCOs in a state are likely to be at different starting points when it comes to experience in contracting alternative payment arrangements. Sophistication is often indicated by how much financial risk the providers are capable of taking on as well as how much of their payments are linked to outcomes rather than the traditional service levels in addition to infrastructure and other tools likely required. In order to help all boats rise together, states must grapple with how to develop a framework that is broad and flexible to accommodate stakeholders at all levels of sophistication related to the move to value. Successful approaches include allowing those that have the least amount of experience are able to take their first steps towards more outcome based care cautiously while not restricting those that are already in value-based arrangements to enter into more far-reaching risk bearing arrangements. One approach is to create a glide path into VBP, or a sliding scale. In this approach providers are held to health outcomes and able to share in savings generated by the arrangement but do not assume the risks for poor financial performance. This method introduces providers to a value framework with only upside potential to start, but would encourage movement towards higher levels of risk-sharing with the potential to retain a greater share of financial savings, as well as potentially reduced reimbursement. Sophisticated providers with experience in assuming risk may move into the value-based full risk arrangements from the start where their remuneration is completely determined by performance on selected outcome measures (rather than just predetermined full capitation rates). Another approach could be to identify the types of arrangements including the level of risk sharing that would "count" towards APM goals, either by arrangement type, or level of shared risk the providers take on. In this approach, states will want to ensure there is range of options that give providers an opportunity to select the approach that is most likely to result in sustainable success.



A step approach to implementation allows providers/plans to adapt over time while gaining experience

Where consistency matters and where it does not

When developing a payment framework, states must decide where to require uniformity and where flexibility and freedom can best assist the long term vision. Flexibility in the type of arrangements, for example, total care versus a bundled payment, can allow providers to focus on areas where they are best suited to provide care and manage risk, without requiring that every provider accept fully capitated payments. By leveraging a scaled approach described above, states can allow flexibility in the amount of downside risk providers take on, allowing them to develop the capacity to manage risk over time. However, as the implementation of VBP affects plans and providers, some areas of consistency are key:

1. **Arrangement definitions** – Ensuring standard definitions of arrangements, coupled with close alignment to other major VBP initiatives, will help you measure the impact and compare providers, as well as simplify life for providers who otherwise would have to deal with competing definitions. For example, if considering using bundled payment models, all providers should be using a consistent definition of the bundle including trigger codes and inclusion and exclusion criteria.
2. **Outcome measures** – Consistent outcome measures are required for accurate comparisons across MCOs and providers as well as the primary mechanism to ensure value is the ultimate outcome. Further, tracking outcome measures monitors any unintended consequences or perverse incentives of policy changes such as decreased quality to achieve savings. A critical component of moving to paying for value is understanding how value will be measured. Consistency in the selected outcome measures for APM arrangements simplifies the implementation process for providers, allowing them to work towards improving a single set of measures across payers.
3. **Financial incentives** – Entities entering VBP should be assessed on a standard formula based off of financial and quality outcomes. If VBP arrangements are contracted through Medicaid Managed Care Plans, the adjustments to plan premiums based on VBP performance should be assessed consistently by the state. For example, if a state plans to increase or decrease MCO premiums based on participation in VBP, the mechanisms for adjustments should be transparent to all and consistent. This allows for entities to make investments and plan for success understanding how they will be evaluated.

State of Texas

Texas Medicaid-CHIP utilizes various payment methodologies across the 19 Medicaid-CHIP MCOs involved in value based contracts. Generally, the payment structures in these contracts are represented by one of the following methods or a combination of these methods[1]:

1. **Fee-for service with bonus payments** – Additional payments are made for achievement of administrative activities (such as the use of electronic health records), quality outcomes, and access to care.
2. **Partial capitation** – Providers receive prospective payments and may also receive bonuses for quality improvement.
3. **Shared savings** – Providers share in savings generated by lowering total cost of care, reducing emergency department admissions or readmissions, and pharmaceutical spending.

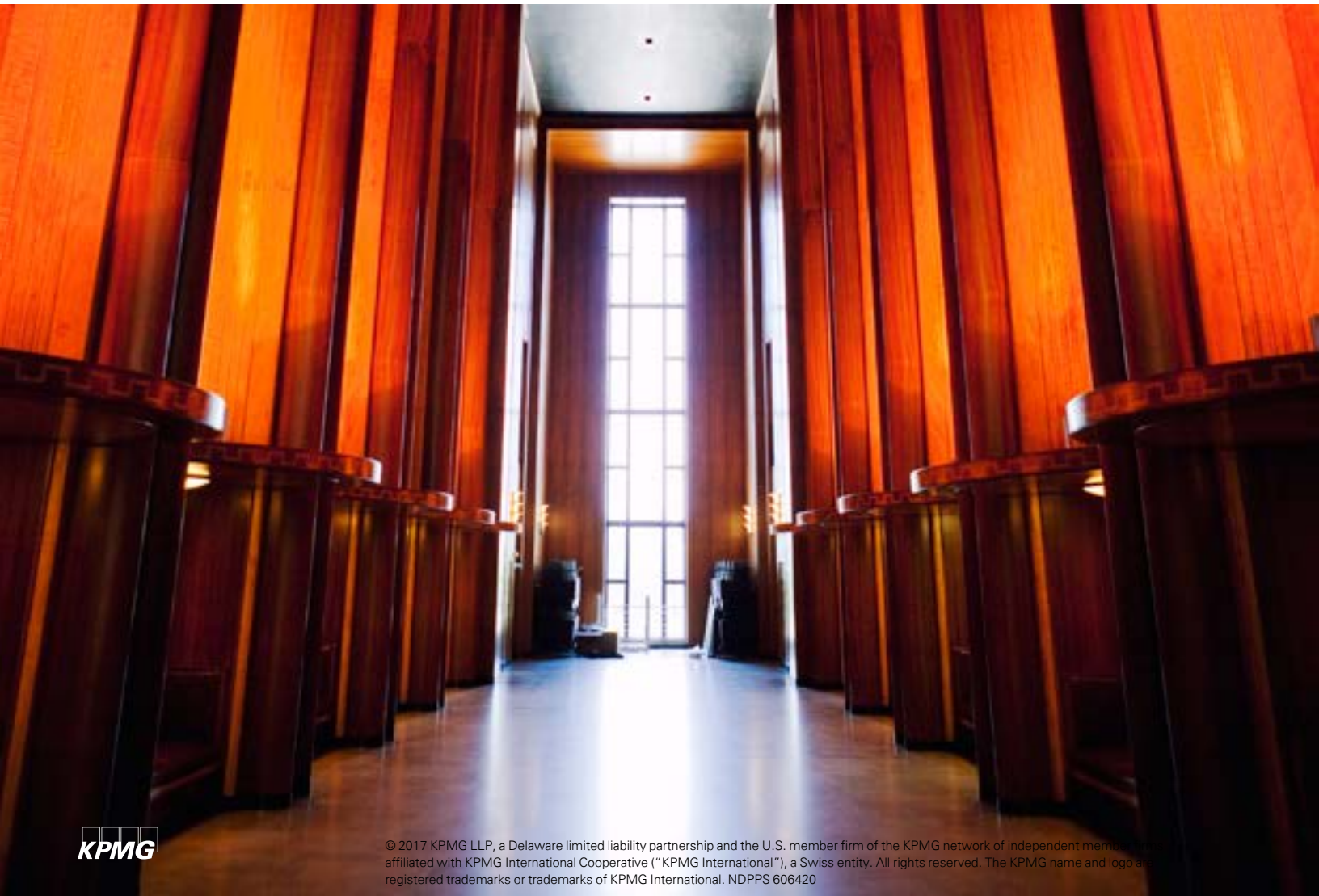
These approaches differ to accommodate provider and plan experience in value based contracting, plan size, geographic diversity, characteristics of the network, and member needs. By allowing for various payment structures, Texas has ensured a greater number of Medicaid providers are able to participate in value based contracts.

[1] Texas Health and Human Services Commission, "Quality-Based Payment and Delivery Reforms in Medicaid and the Children's Health Insurance Program," published February 2016.

Policy levers and added incentives

State policy makers should be prepared to use all policy levers at their disposal to help usher in the transformation of value based payments. Once your vision and a flexible framework is identified, you can begin to underpin it with policy incentives in a gradual and responsible manner. This motivate change while not threatening the foundation of the delivery system. A number of states reward early adopters of payment reform with incentives that include bonus payments, investment assistance, and increased reimbursements. On the other hand, states can also make use of penalties or decreased reimbursements to further incentivize providers. For negative incentives, it is important to clearly articulate policy changes well in advance of implementation to give payers and providers a chance to prepare themselves for the transition and understand the financial implications of reform.

In addition to incentives, states may utilize policy tools and collaboration comes to align disparate payment models. Alignment of payment initiatives across a state along with federal reform creates cohesion and a single level of understanding of payment reform. A single approach to reform across programs aids understanding, lessens the burden of implementation, and leverages a greater population to achieve goals. This should include states exploring allowable APMs under MACRA. It will be in states' best interest to align their VBP policy and definitions to those APMs which will be counted under MACRA. As part of the proposed rule, MACRA allows providers to use APMs across payers to meet the required threshold for participation in the APM, and benefit from the associated increases in reimbursement.



Going all in

For VBP to truly become the prevailing payment mechanism for U.S. healthcare, states need to engage with a critical mass of providers who are changing their business models to achieve patient-centered and cost-effective care. States with significant Medicaid programs can help drive this effort, but alone they cannot achieve nation-wide success. Smaller pilots and demonstrations have benefits, but they do not create enough momentum for meaningful change. Ultimately, if the majority of provider and payer incentives are not aligned and pointed towards value, there will not be sufficient motivation for providers to make the foundational changes to their business models that will move the system away from volume. The more states can align incentives across payers, the more successful reform efforts are likely to be. MACRA creates an obvious opportunity, allowing providers to use a combination of payers, including Medicaid to reach the APM threshold, thereby becoming eligible for the higher reimbursement rates within the APM program. In addition, states can and are exploring collaboration that can be achieved with commercial payers.

Conclusion

As healthcare transformation becomes more pervasive, it is also becoming increasingly clear that long term success and sustainability is reliant on payment reform as the anchor that will ensure delivery changes are maintained. State led efforts, along with the impact of MACRA, will continue to push the healthcare delivery system toward one that pays for value. Early lessons learned can help inform what works, what does not, and serve as a model as other states begin to undertake the process of designing and implementing a new payment model that focuses on value.

State of Ohio

Following a State Innovation Model award from CMS in 2014, Ohio implemented episode-based payments across all payers in the state that provide public and private insurance. In conjunction with stakeholders, Ohio created a five year goal for payment innovation to have 80 percent of patients enrolled in a value-based payment model and 50+ episodes designed and launched.[2] Six episodes[3] launched in 2015 under a 'reporting only' structure as 'Wave 1' of implementation. As part of 'Wave 2' in 2016, the initial six episodes begin their first performance period with asthma, chronic obstructive pulmonary disease, and perinatal episodic performance linked to payments and the introduction of seven additional episodes[4] under a 'reporting only' structure. 30+ episodes are currently under development and scheduled to be launched in 2017.

[2] Governor's Office of Health Transformation, Ohio SIM: Episode-based payments update, Webinar, June 7, 2016.

[3] Perinatal, asthma exacerbation, COPD exacerbation, Acute PCI, Non-acute PCI, and total joint replacement.

[4] URI, UTI, cholecystectomy, appendectomy, upper GI endoscopy, colonoscopy, and GI haemorrhage.

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