Green & Healthy Homes Initiative®

Value-Based Payments within Medicaid and Medicare

How to Pay for What Works in Public Health

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The Green & Healthy Homes Initiative (GHHI), founded in 1986,
is a national 501(c)3 nonprofit, nonpartisan organization that provides evidence-based direct services and technical assistance to create healthy, safe and energy efficient homes to improve health, economic and social outcomes for low-income families
while reducing public and private healthcare costs.

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Executive Summary

Value-based payments can be a valuable tool in the transition from volume to value and can be incentivized under existing Medicaid and Medicare authorities with a basic technical framework.

As health care costs increase and health outcomes remain stagnant, the Centers for Medicaid and Medicare Services (CMS) and state Medicaid agencies have been working to implement strategies to shift from volume-based care (i.e., fee-for-service payments that incentivize more service provision) to value-based care (i.e., value-based payments that incentivize better care at lower cost).

However, current rate-setting practices serve as a key financial disincentive, preventing managed care organizations (MCOs, which serve more than two-thirds of Medicaid beneficiaries and more than one-third of Medicare beneficiaries) from implementing value-based payments. Under current rate-setting practices, when MCOs invest in improving the health outcomes of enrollees, state Medicaid agencies and CMS claim the entirety of subsequent savings through reduced rates ("rate slide"). This removes the incentive to invest in long-term prevention and address social determinants of health.

By establishing a mechanism to compensate MCOs for a reduction in need for medical care, CMS and state Medicaid agencies could catalyze MCO service delivery innovation, improving health outcomes and reducing costs across Medicaid and Medicare.

In this paper, we propose a value-based payment framework that leverages existing Medicaid and Medicare regulatory frameworks, integrates with actuarial processes, and establishes the necessary documentation and payment mechanisms to ensure appropriate compensation for MCOs. Under this framework, value-based payments for services that improve health and reduce costs are coded as medical spending, eliminating the potential issue of rate slide and allowing MCOs to sustain financing these services in the long-term.

This process would give MCOs a new tool in the transition from volume to value and allow them to invest in the long-term health of their specific populations in ways that meaningfully bend the cost curve for Medicaid and Medicare.

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The Move Towards Value-Based Payments

The ongoing shift from volume-based care (i.e., fee for service) to value-based care (i.e., incentivizing better care at lower cost) in the healthcare sector has the potential to improve health outcomes and patient experience while simultaneously lowering the cost of care,[1,2] especially for vulnerable and high-risk populations.

The fee for service system often provides no reimbursement for addressing upstream drivers of health (i.e., social determinants) such as healthy housing, for modalities of care such as telehealth, or for care models such as case management for high utilizers.[3]

In value-based payment models, payments are based on outcome measures – usually tied to total cost of care – and providers may share in the associated savings or risk.[4] This incentivizes service delivery innovation that supports the Triple Aim of improving population health outcomes, patient experience, and cost of care,[5] including more advanced and comprehensive care management strategies and expanding beyond the traditional continuum of care by targeting the social determinants of health and leveraging community or other supportive services.[6,7] Ultimately, paying for outcomes incentivizes the delivery of cost-effective preventive solutions, as opposed to simply providing more care.[8,9]

What is a value-based payment?

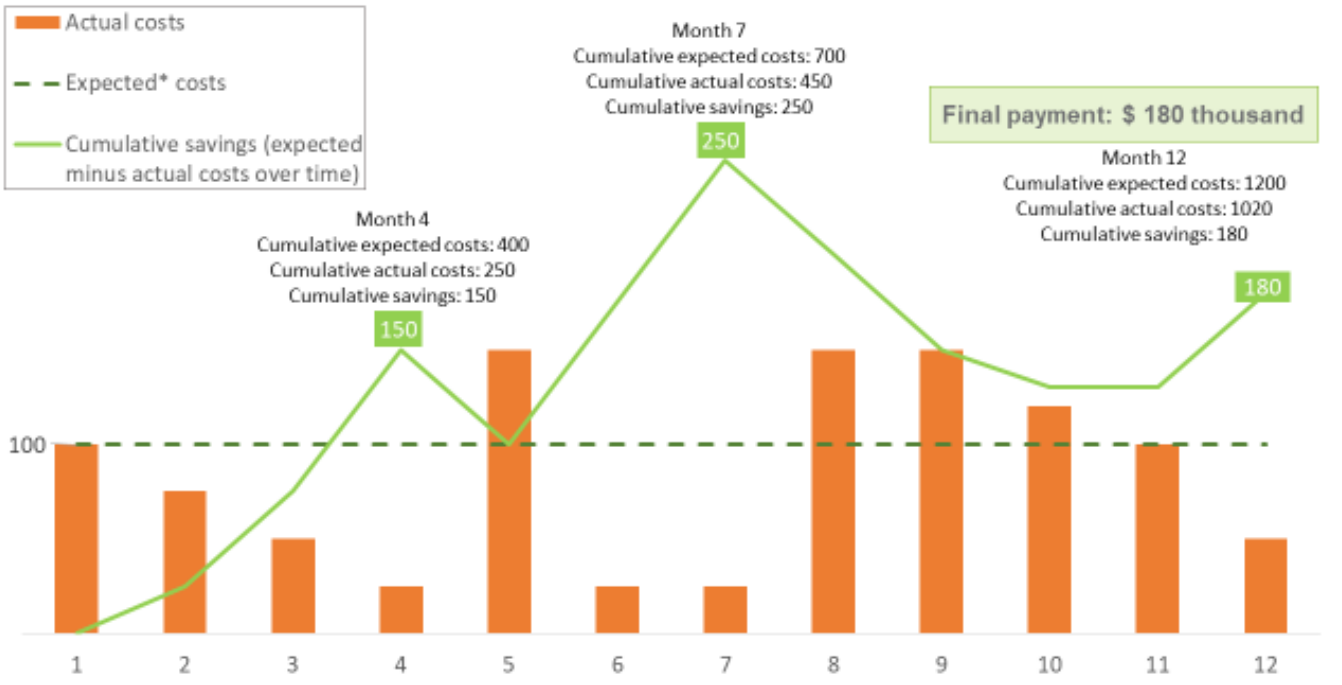
Any compensation arrangement where payment is based on a measured effect rather than performing a duty or delivering a service

As opposed to traditional fee-for-service payment, where providers are paid for duties performed/services provided – e.g., number of visits to the doctor's office, medications, emergency care, hospitalizations – value-based payments, which can take many forms, are based on one or more of the following:

- Costs (e.g., service providers are paid for reductions in the amount of care needed or the associated cost)
- Value-created (e.g., service providers are paid for improvements on key health measures)
- Other (e.g., service providers are paid for improvements on quality of care metrics)

Standard value-based payment models in which providers share savings or risks generally compensate providers in accordance with costs saved over the life of the project, as illustrated below. Payments can be determined over multiple years, as long as the investment is still impacting outcomes, making it useful for long-term investments – such as those in social determinants of health – that can take multiple years to demonstrate a financial return.

Value-Based Payments Mechanism – Costs and Savings ($, Thousands) over 12-month Period



KEY INSIGHTS
Value-based payments ensure that projects are effective at reducing costs and can use new savings or change in financial risk to determine payments. Value-based payments reward cost-savings over the life of the project (irrespective of month-to-month variability in costs), with a final payment equivalent to the cumulative cost-savings value.

* Expectations could be based on historical projections or comparisons against a selected target population.

Greater use of value-based payments – and the service delivery innovation that enables them – within Medicaid and Medicare has immense potential to improve national health outcomes and reduce national healthcare costs. Over a third of Americans are served by Medicaid or Medicare,[10] and these Americans represent among the most vulnerable and high-risk populations, including low-income populations, children/youth, the elderly, and disabled and institutionalized individuals.[11,12] These two insurance programs account for 37 percent of national health expenditures.[13]

Key Barrier: Rate-Setting Practices

Rate-setting practices are a key barrier to including value-based payments in Medicaid and Medicare managed care contracts.

While the Centers for Medicaid and Medicare Services (CMS) and state Medicaid agencies are aiming to move toward value over volume, a lack of precedent has led to hesitancy in adopting such strategies. Moreover, current rate-setting practices serve as a key financial disincentive to implementing value-based payments.

In general, states provide Medicaid benefits through either fee-for-service (where states reimburse health care providers for services delivered to Medicaid beneficiaries) or managed care (where states pay a set per capita fee to private health insurance plans or provider groups (MCOs) that provide comprehensive Medicaid services to enrollees).[14,15] Similarly, Medicare beneficiaries can receive their benefits through the federally administered traditional Medicare program or via Medicare Advantage plans, private health plans that receive per capita payments to provide comprehensive Medicare services to beneficiaries.[16]

Notably, more than two-thirds of Medicaid beneficiaries receive most or all their care from MCOs, and more than a third of Medicare beneficiaries are enrolled in Medicare Advantage.[17]

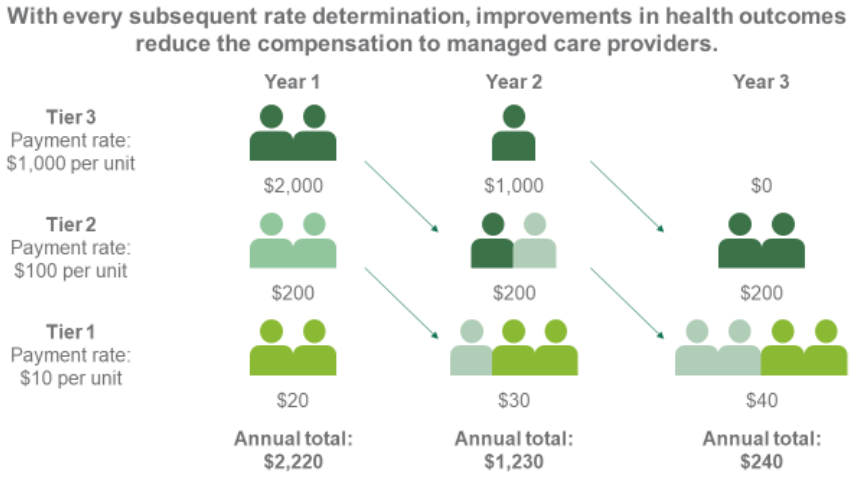
However, despite federal and state efforts to transition partnering MCOs to utilizing value-based payments with their providers (via a range of requirements, incentives, and other policy levers), current Medicaid and Medicare rate-setting practices serve as a strong deterrent to MCOs adopting such an approach.

How Do Current Rate-Setting Practices Disincentivize Value-based Payments?

Under current rate-setting practices, when MCOs invest in improving the long-term health outcomes of enrollees and these investments result in reduced costs, MCOs do not realize the gains of that investment; rather, state Medicaid agencies and CMS retain the value through reduced rates in subsequent years.

CMS and state Medicaid agencies set managed care rates as a function of the number of persons being cared for and each person's expected risk. Payments from MCOs to subcontracted medical providers form the basis for the compensation the MCO receives the following year.

Thus, as illustrated below, if a MCO's efforts to improve medical outcomes are successful for a certain person, that person transitions to a new lower risk tier, which means the MCO will receive less compensation in the next cycle of rate determination. Over time, improving health and reducing risk leads to much lower revenue for the MCO.



Unless value-based payments factor into future rates the way that traditional fee-for-service Medicaid and Medicare payments do, MCOs have no financial incentive to make value-based payment arrangements.

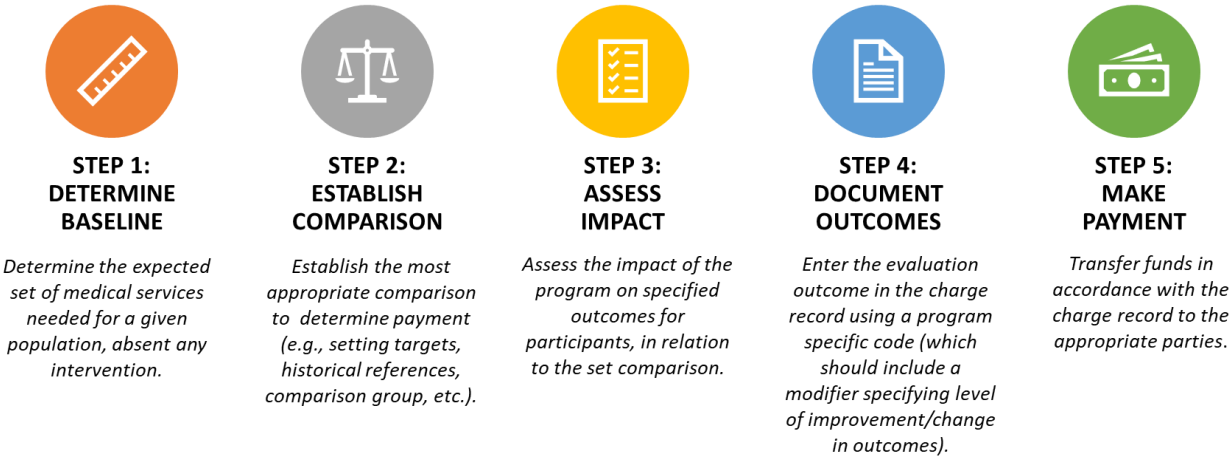
Proposed Solution: A Mechanism to Incentivize Use of Value-based Payments

The proposed solution, a mechanism to incentivize use of value-based payments by MCOs, can simultaneously improve health and reduce costs.

CMS and state Medicaid agencies can rapidly accelerate the transition from volume to value and catalyze innovations that improve health and reduce costs across Medicare and Medicaid programs by establishing a mechanism to compensate MCOs for a reduction in need for medical care or for an improvement in health outcomes. This would allow MCOs to move from paying for the cost of delivering services to paying their service-providing subcontractors based on the additive impact the services have on health outcomes and medical utilization costs.

Notably, this can be done under the existing authorities, regulations, and standards of Medicare and Medicaid. We propose the following framework for MCOs to determine and make value-based payments.

Framework for managed care organizations to determine and make value-based payments



To contractually approve MCO-led service delivery innovations that utilize value-based payments, CMS or the appropriate state Medicaid agency would issue an informational bulletin that states that:

> *"Under existing authorities, value-based purchases that share savings or risk utilizing value-based payments that are included or referenced in the contracts of managed care*

organizations should be included in the determination of appropriate rates under the rules and guidelines of actuarial soundness as if they were traditional state plan services."

The documentation and payment mechanism within this framework, detailed below, integrates value-based payments within the regular fee-for-service structure and incentivizes greater use of such payments by MCOs.

Documenting Outcomes

To ensure appropriate documentation and accountability, value-based payments should be integrated into the existing medical claims and encounter record system.

Specifically, MCOs could make a value-based payment for cost-savings under existing value-based purchasing authorities and include that payment in each patient's encounter record as a program code. The code would be treated as a standard encounter and include all the relevant program information such as the service provider, patient, a program code, place of service, and other details. The program code should include a modifier specifying level of improvement or change in outcomes. The program code and modifier system would enable multiple types of value-based payment programs to be administered simultaneously, while maintaining data-clarity. As each value-based payment will be different, there is no need to create a national standard for the payment code so long as all parties to the agreement use a common unique identifier – though standards may emerge as effective programs scale beyond any one MCO.

These program codes can be calculated by the MCO using an automated process and submitted with charge or encounter records on a regular basis to State Medicaid-responsible agencies or other parties as needed for approvals and other purposes – ensuring the burden on state resources is minimal.

The charge record would then be used in actuarial calculation in accordance with regulation and CMS guidance. It would include a record of the payment, its type, a reference to the program, and a factor that could be used in the adjustment of risk for the party in any subsequent analysis.

Making Payments

By making a payment – and thus adjusting risk – in accordance with the improvement or change in outcomes noted in the charge record, the financial interests of MCOs are aligned with improving health outcomes and reducing avoidable healthcare utilization – and thus costs – among the public. This payment mechanism will incentivize MCOs to work with local community-based providers to achieve these goals (i.e., improve health outcomes, service quality, and patient experience, while lowering long-term costs).

The volume of these MCO-led experiments in service delivery, through inherent variations, will advance service delivery innovation faster than any centrally led program could alone, by allowing state and federal partners to scale proven programs while verifying the results.

Ultimately, this mechanism would give MCOs a new tool in the transition from volume to value and allow them to invest in the long-term health of their populations in ways that meaningfully bend the cost curve for Medicaid and Medicare.

Example: An Asthma Value-Based Payment Arrangement

The proposed framework, documentation, and payment mechanism enable MCOs to address social determinants of health that negatively impact vulnerable communities, such as poor housing conditions that contribute to asthma.

To illustrate the use of the proposed mechanism, this section details how an MCO would calculate, record, and report value-based payments made to a subcontracted health-related social-service provider and how those payments would be used in future rate setting. This example assumes that the state contract with MCOs allows the MCOs to develop value-based purchasing arrangements with their subcontractors.

In this example, the MCO enters into a value-based purchasing arrangement with a provider that offers a comprehensive home-based asthma program to a high-risk asthma

population. Value-based payments are based on reductions in the total cost of caring for the specific population enrolled in the program.

About the Asthma Program

The program involves three components:

1. Close integration with clinical providers,
2. Home-visiting with asthma self-management education, and
3. Remediation of home-based environmental triggers of asthma.

The program is evidence-based, drawing from the National Institutes of Health (NIH), [18] Centers for Disease Control (CDC), [19] and others,[20,21,22,23] to reduce the medical utilization needs of high-risk asthma patients.[a] These evidence-based programs have been shown to reduce the medical utilization of high-risk asthma patients through both behavioral means (i.e., by improving self-management) and mechanical means (i.e., by removing causes and triggers of asthma attacks in the patient's environment).

Asthma is expensive, and primary research by Green & Healthy Homes Initiative (GHHI)[b] has shown that health plans are spending anywhere from $7,500 to over $40,000 for an asthma patient with a history of hospitalization in a given year, with outliers being substantially higher. Preventing even a small percentage of these utilization costs can effectively fund comprehensive interventions. Offering the program more broadly has the potential to not only reduce the medical needs of other members of the household, but also deliver secondary benefits to communities including more stable housing and improved school and work attendance.

[a] High-risk patients are considered those with a previous diagnosis of asthma, who subsequently are hospitalized or receive emergency care for an asthma related respiratory condition.

[b] GHHI has worked with health-plans and states to conduct 15 actuarial analysis covering nearly 500 thousand member-months in markets throughout the United States, with more pending completion. Publication of the results is forthcoming.

In this example, a feasibility study confirmed that the project was appropriate for a specific high-risk population, in sufficient numbers, with an actuarial analysis determining there was enough economic potential to warrant the program.

Calculating Program Impact

The program impact should be determined in accordance with the MCO's contract, which establishes the program's enrollment terms and justification. The justification may be a summary of services provided or a theory of change that describes how the program goes beyond traditional service delivery to improve outcomes. In this example, the asthma program aims to change behaviors (by providing advanced education that improves self-management) as well as remove asthma triggers from the home.

The subcontracted service provider needs to provide verification that the party is enrolled as of a set date, as well as verification of when services are completed. Established in the services subcontract will be the duration of service (if applicable) as well as a maximum term of evaluation for the outcomes payment.

In this example, eligible members are enrolled through a process that establishes an overview of the program, expectations of all parties, and appropriate disclosures before securing a signed program enrollment form. Once a member is enrolled, the comprehensive services are initiated as soon as possible and continue over a period of months as home-based assessments establish the individual's needs in terms of education, environmental remediation, and medical management. The effects of the intervention are assessed for the duration of the program including a period of years after services have been completed.

The MCO or actuarial partner then uses a comparison[c] dataset to establish the intervention's marginal impact on the specified metrics. In this example, the MCO arranges to have a statewide medical claims and encounter database provide statewide records to an

[c] Ideally, a state or national body would provide the medical claims or encounter record of a comparable population over the same time as the program operates for an appropriate and broad matched-comparison group analysis of comparative claims cost, medical utilization, or other appropriate metrics.

actuarial partner to conduct a matched comparison analysis of the program enrollments, controlling for prior risk-adjustment factor, socioeconomic status, gender, and other factors. The analysis determines that the average cost of the non-enrolled population was $1,000 per-member per-month, while the average cost of the enrolled population was $500 per-member per-month – a savings of 50 percent for the year.

Using the Existing Claims or Encounter Reporting System

The MCO then includes the savings or risk value in their claims or encounter record for each person, which is provided to the state at the close of the period. They do so by recording an encounter for each patient enrolled in the project totaling $500 of medical savings attributed or for an appropriate risk value for care-volume reductions.

In this example, each encounter code includes start and end dates of service, with the financial value determined by the actuarial analysis and the service provider recorded as the name of the organization's comprehensive asthma program. In lieu of a Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPS) code, the program could include an identifier for the program that indicates it was a value-based payment as well as a program identifier, such as "VBP.CAHV.01" for **V**alue-**B**ased **P**ayment for **C**omprehensive **A**sthma **H**ome **V**isiting program number **01**. There is no need to create national standards for these program codes, because they will vary as new programs are formed or developed. It would be beneficial to create a registry of such programs so that duplicate codes are avoided and each program can be tracked over time.

Future Rate-Setting

The value-based payments made by MCOs are then included in the actuarial rate-setting process. Since the contracts with MCOs include such value-based payments, these are treated no differently than any other encounters under the state plan.

By incorporating value-based payments into future rate-setting the same way fee-for-service payments are currently included, the mechanism proposed in this paper incentivizes MCOs to advance value-based payment models. The resulting service delivery innovation

can simultaneously improve population health outcomes and patient experience while reducing cost of care.

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