Making the Case for Sustainable Funding for Community Health Worker Services

Talking to Payers and Providers

January 27, 2018

Families USA – Health Action 2018

Katharine London, MS, Principal
Center for Health Law and Economics, UMass Medical School

University of Massachusetts Medical School
umassmed.edu

Overview

Information you need about health reform:

- Delivery system reform: Accountable Care Organizations
- Payment system reform: Alternative payment methods

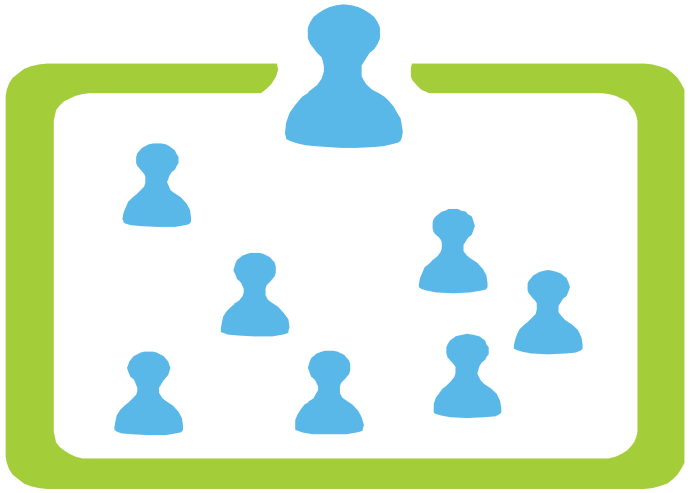
Information payers and providers need from you:

- Presenting evidence to support sustainable financing
- Sustainable financing models

Opportunity

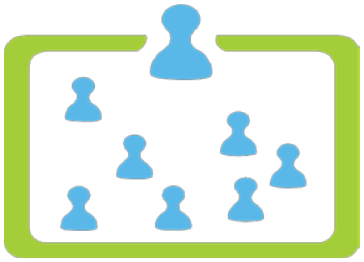
New payment methods give providers and payers flexibility to provide sustainable funding for community health worker services for high-risk patients if these services will result in:

- **Better health outcomes**
- **Positive Return on Investment** (ROI) = Reduction in Total Cost of Care



Delivery System Reform: Accountable Care Organizations

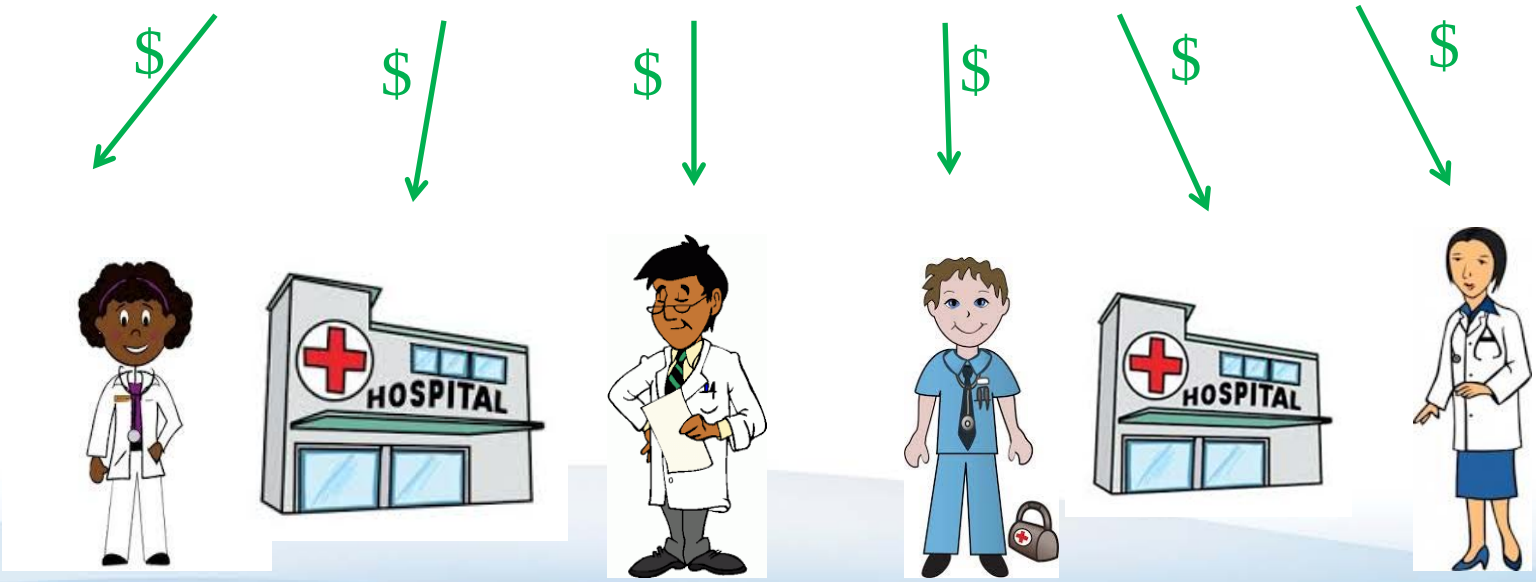
Delivery system discussion



- Traditional payment and delivery system
- Fee for service
- Paying for volume vs. paying for value
- Accountable care organizations

Traditional payment & delivery system

Payer (Medicare, Medicaid, BCBS, etc.)
pays each provider a fee for each service



Payment Method: Fee for Service

Definition: Health care providers receive a separate fee for each service they deliver

Payers often establish a fee for each service code, for example:

- Physician visit, new patient
- Physical therapy 15 minutes
- Hospital stay for asthma

- ➢ Providers only paid for covered services
- ➢ There are codes for CHW services, but most payers won't pay for them because they are afraid of incurring new costs
- ➢ MN & PA Medicaid pay FFS for CHW services

Pay for volume vs. pay for value

Pay for volume: Traditional payment and delivery system rewards providers for providing more services and more expensive services

- Health care costs rising
- Payers hesitate to cover new services because of cost

Pay for value: Reward providers for providing high quality care (evidence-based practices, healthier patients, better patient experience) and containing costs

- Hold provider organizations **accountable** for quality and cost
- *Can pay for new services that improve quality and contain cost*

Accountable care organizations (ACOs)

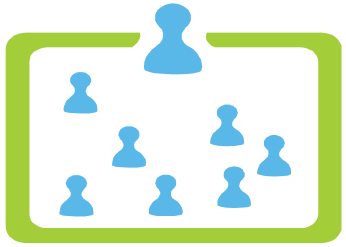
Payer (Medicare, Medicaid, BCBS, etc.) pays ACO an amount for all services

$

$

Providers join together into ACOs

Accountable Care Organizations (ACOs)



CMS/Medicare definition:

"**Accountable Care Organizations (ACOs)** are:

- groups of doctors, hospitals, and other health care providers,
- who come together voluntarily
- to give coordinated high quality care

"The goal of **coordinated care** is to ensure that

- patients, especially the chronically ill,
- get the right care at the right time,
- while avoiding unnecessary duplication of services and preventing medical errors."

Source: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/index.html?redirect=/aco/

Payment System Reform: Alternative Payment Methods

Alternative payment discussion

1. Pay for Performance (P4P)
2. Shared Savings
3. Bundled Payment
4. Global Payment
5. Quality Requirements

Payment method 1: Pay for Performance

Definition: Providers receive bonus payments for meeting specific quality improvement goals or targets

For example, a provider might receive a bonus for:

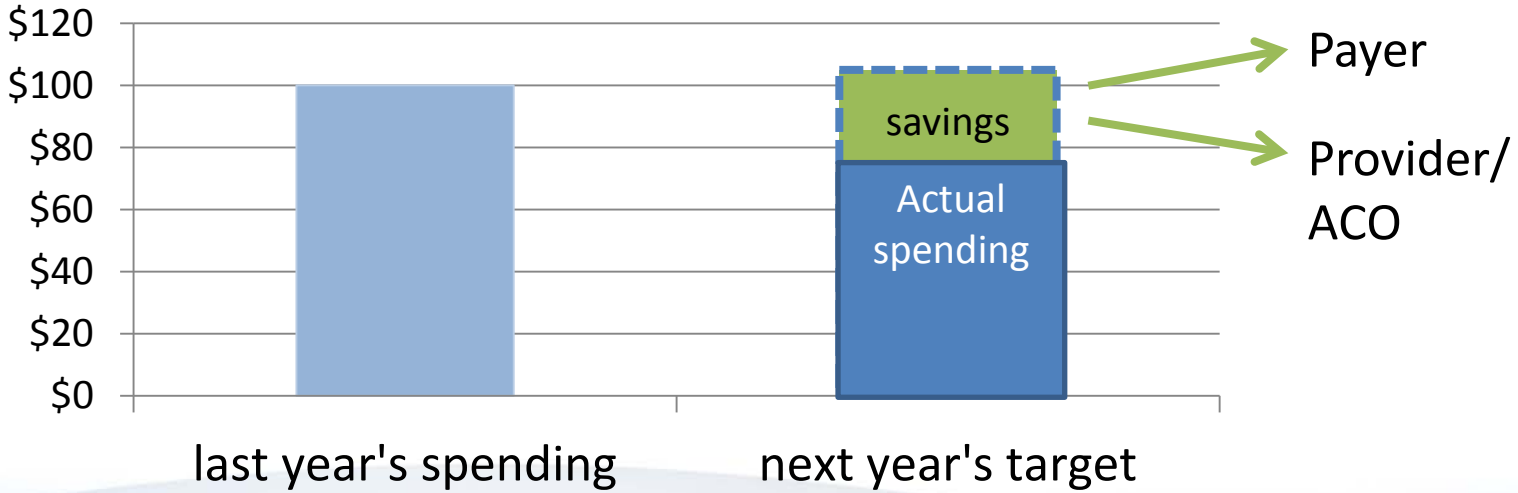
- Increasing by 10% the share of patients with diabetes who have good glycemic control (HbA1c < 7%)
- Ensuring 95% of patients with asthma have an Asthma Action Plan

- *Providers can invest in services that help achieve these outcomes and bonus payments can pay for those services*
- Providers receive bonus after end of year

Payment method 2: Shared Savings

Definition: Savings that accrue - when actual spending for a population is less than a target amount - are shared between the payer and the provider/ACO

Providers usually must meet quality goals to share savings



- *Providers can invest in services that produce savings*
- Providers receive savings after end of year

Payment method 3: Bundled Payment

Definition: A single payment to cover the cost of services to treat one episode of care (a knee replacement surgery, or a year's worth of asthma care), delivered by multiple providers. Usually paid as a per member per month (PMPM) or single case rate.

- *Provider has flexibility to spend payment on CHW and other services*
- Most episodes of care don't have clear boundaries like knee replacement: difficult to figure out what costs/services to include in the bundle
- Administratively very difficult to implement

Payment method 4: Global Payment

Definition: a fixed-dollar payment ("capitation") for **all** the care that a group of patients receive in a given time period, such as a month or year.

- Providers are at **financial risk** for both the occurrence of medical conditions (whether people get sick) as well as the management of those conditions (providing services)
- Contracts usually include quality goals
- Because of financial risk, usually paid to a large organization like an ACO
- *Flexibility to provide services that best meet patients' needs*

Quality requirements

ACOs & other providers often can only keep savings if they meet quality targets. Quality measures are usually included in contracts with payers.

For example, Massachusetts Medicaid uses a slate of ~20 measures to measure ACO quality, including:

- Controlling high blood pressure
- Medication management for people with asthma
- Comprehensive diabetes care: A1c poor control (>9%)
- Initiation and engagement of alcohol or other drug dependence treatment

➢ *Providers can invest in services that improve quality in these areas*

Opportunity

New payment methods give providers and payers flexibility to provide sustainable funding for community health worker services for high-risk patients if these services will result in:

- **Better health outcomes**
- **Positive Return on Investment** (ROI) = Reduction in Total Cost of Care

Presenting Evidence to Support Sustainable Financing

Evidence to demonstrate value

1. Use your own data
   - Pre-post data for intervention group
   - Pre-post data for control group (usual care)
2. Use published studies
   - Find studies that report quality and cost outcomes
   - Look for studies that had a similar target population and similar intervention protocol
3. Use the models UMass developed for Maine and Connecticut
   - Adjust to Massachusetts cost levels

➢ *Evaluate the effect of an intervention on **cost** the same way you would evaluate the effect on any other outcome variable*

University of Massachusetts Medical School
UMASS
umassmed.edu

Key Terms

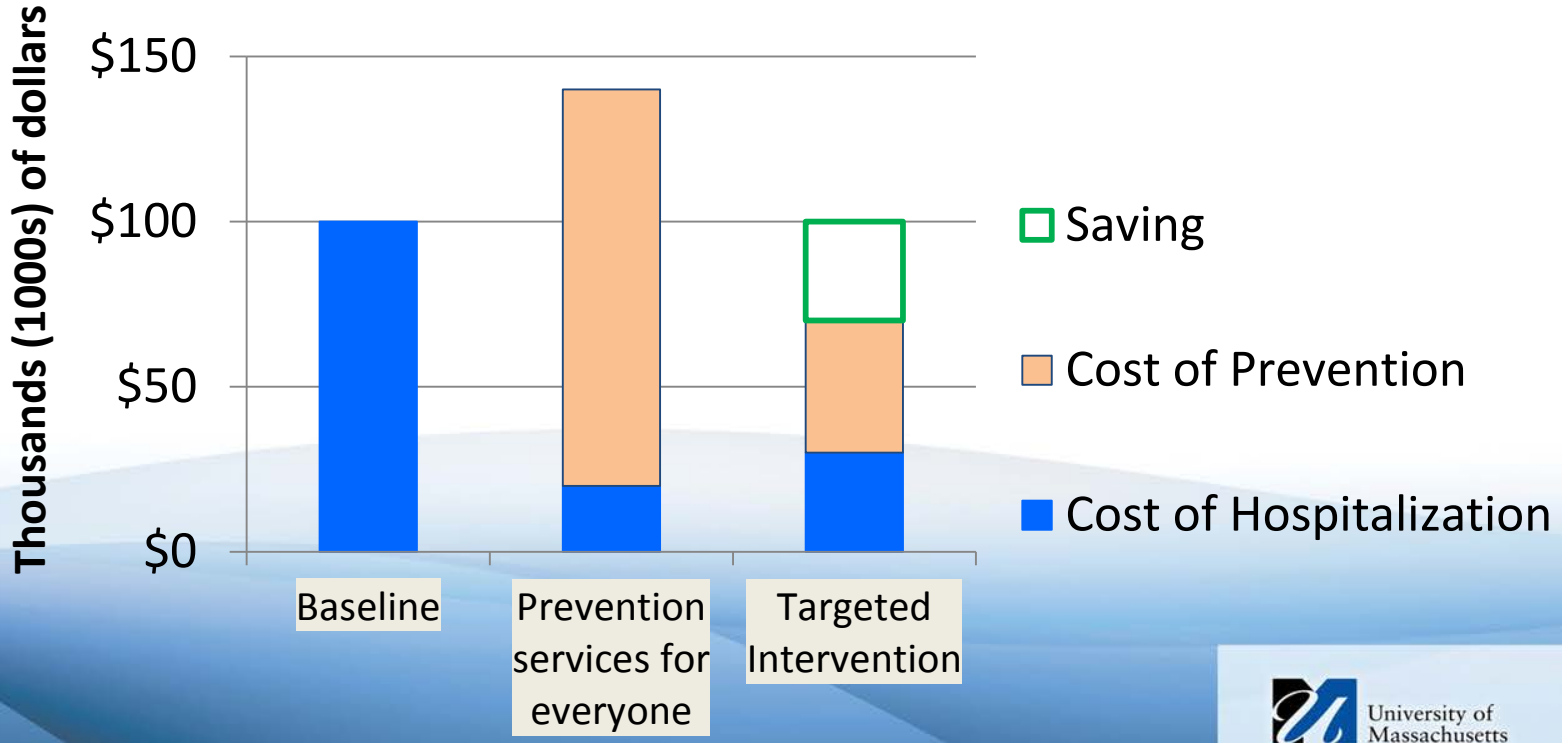
- **Target population:** People we most want to reach
- **Financial Return on Investment (ROI):** For every $1 invested in the intervention, how much is returned in savings
  - Calculated as: $\frac{\text{Savings}}{\text{Program cost}}$
  - Positive ROI: For $1 invested, return is greater than $1
  - Negative ROI: For $1 invested, return is less than $1
- **Social return:** Benefit to society: Healthy days and wages recovered

Developing a sustainable model (1 of 2)

1. Document **unmet health needs** in your community
2. Identify your **target population**
   - Characteristics
   - Geography
   - Number of individuals

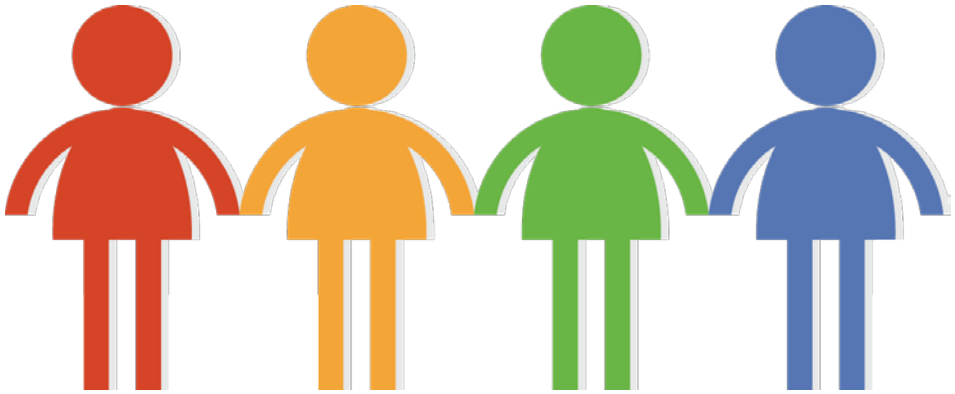
Target population is key to ROI

- If goal is to produce a positive ROI, intervention must target people who otherwise would use more services or more expensive services. Hypothetical example:



Developing a sustainable model (2 of 2)

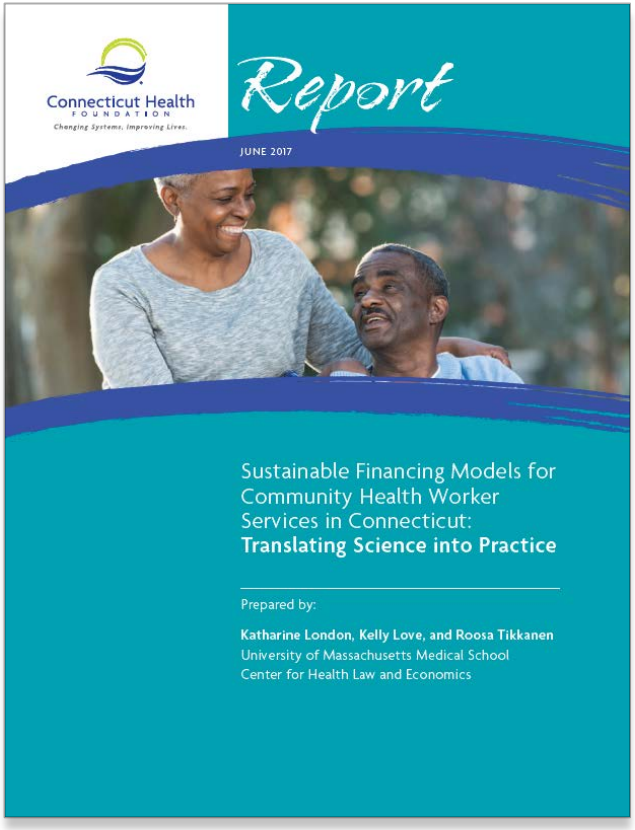
3. Identify **cost-effective CHW interventions** in other states from published literature
4. Estimate **caseload** and develop **budget**
5. Use published results to project (estimate) **outcomes** in your community
   - Health outcomes
   - Social outcomes (e.g. working days gained)
   - Health care utilization and cost
   - Return on investment



SUSTAINABLE FINANCING MODELS

Connecticut models

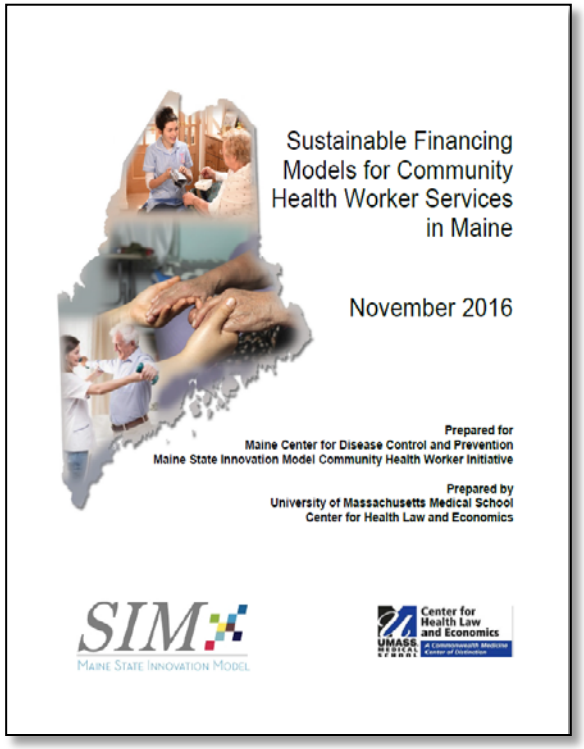
1. Diabetes
2. Pediatric asthma
3. Multi-visit patients with chronic conditions
4. Cardiovascular disease



London, K., K. Love, and R. Tikkanen, *Sustainable Financing Models for Community Health Worker Services in Connecticut: Translating Science into Practice*. Connecticut Health Foundation. June 2017. https://www.cthealth.org/wp-content/uploads/2017/06/CHF-CHW-Report-June-2017.pdf

Maine models

1. Diabetes
2. Pediatric asthma
3. Multi-visit patients with chronic conditions
4. Underserved individuals



London, K., K. Love, and R. Tikkanen, *Sustainable Financing Models for Community Health Worker Services in Maine*. Maine Center for Disease Control and Prevention. November 2016. https://commed.umassmed.edu/sites/default/files/publications/Sustainable%20Financing%20ME%20CHWs%20-%20UMass%20Report%20Nov%202016%20Final.pdf

Using published data in your analysis (1 of 2)

Example: Study provides data on Minnesota in 2005. You want to use it in Massachusetts in 2019. Here's how to convert it in 3 steps.

	(A) From	(B) To	(C) Conversion Factor = (B)/(A)	(D) Source
(1)	**Minnesota** personal health care cost per capita, 2005	**Massachusetts** personal health care cost per capita, 2005	1.18	State Health Expenditure Accounts, Table 11 https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsStateHealthAccountsResidence.html
(2)	Massachusetts personal health care cost per capita, **2005**	Massachusetts personal health care cost per capita, **2014**	1.41	State Health Expenditure Accounts, Table 11 https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsStateHealthAccountsResidence.html
(3)	US national health expenditures per capita, **2014**	US national health expenditures per capita, **2019**	1.25	National Health Expenditure Projections, Table 1 https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected.html
(4)	**Minnesota** personal health care cost per capita, **2005**	**Massachusetts** personal health care cost per capita, **2019**	**2.09**	Factor (1) * (2) * (3)

University of Massachusetts Medical School
UMASS
umassmed.edu

Using published data in your analysis (2 of 2)

Here are the dollar values found in the tables so you can try to reproduce the result later at home.

	(A) From	(B) To	(C) Conversion Factor = (B)/(A)	(D) Source
(1)	$6332	$7484	1.18	State Health Expenditure Accounts, Table 11 https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsStateHealthAccountsResidence.html
(2)	$7484	$10,559	1.41	State Health Expenditure Accounts, Table 11 https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsStateHealthAccountsResidence.html
(3)	$9515	$11,912	1.25	National Health Expenditure Projections, Table 1 https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected.html
(4)	$6332	$13,219	**2.09**	Factor (1) * (2) * (3)

University of Massachusetts Medical School
UMASS
umassmed.edu

DISCUSSION