Value Lessons from PFS for Medicaid's VBP

Introduction

Increased pressure on public sector budgets has prompted government to focus on improving value for money in social service contracts. In response, Pay for Success (PFS) has been trialed across a range of sectors, from supportive housing to juvenile recidivism, to improve the measurement and delivery of quality outcomes. Since 2015, Value Based Payment (VBP) models have emerged in the healthcare field as a shift away from paying for volume of services. These two innovative contracting models both aim to improve public sector value, and Medicaid entities can use both to more effectively manage population health.

However, the models differ in their approaches and development. PFS focuses on improved service quality and government accountability for expenditure through outcomes-based repayment. By contrast, VBP shifts cost fluctuations to providers, while standardizing quality through performance thresholds. PFS models are more likely to be developed through a feasibility process that involves services providers and their data, whereas co-development is not necessarily a fundamental part of the VBP model. PFS also offers flexible funding to providers for infrastructure and other improvements, whereas this level of flexibility is not available in VBP models until the most sophisticated manifestations, such as population-based payment.

This paper offers a brief overview of both VBP and PFS models, discusses differences between them and how each can offer improved value for money, and lessons to apply to the future development of VBP.

Pay for Success Models

PFS models address service providers' need for flexible capital to deliver services and invest in data measurement and evaluation when contracted under an outcomes-based contract.

In a PFS transaction, the payor (usually government, but with growing interest from healthcare entities) develops a contract that pays for services only when agreed upon outcomes are achieved. In the field of supportive housing, this usually means that payments are made on the basis of housing stability. This component is referred to as an outcomes-based contract.

The second element of a PFS transaction is private financing. PFS stakeholders acknowledge that shifting to payments on the basis of outcomes can require the service provider to expend significant resources to deliver the services prior to being repaid; it can often take up to 18 months to measure and validate the first year of outcomes achieved in a PFS contract.

Furthermore, the providers may need to invest in their data or performance management systems to be able to track outcomes and understand if they are successfully delivering the pre-agreed measures. In order to support the provider financially and enable them to deliver a high quality service, private, socially-motivated investment is used to pay for services and support. These private investors are repaid only when the outcomes are achieved. For more information on this structure, see the CSH Pay for Success resources.

Value Based Payment Models

Value Based Payment models describe a shift in the traditional reimbursement of healthcare activities from the basis of volume or services (fee for service) to alternative payment structures. Payments within the traditional fee for service system reward greater volumes of activity. For example, hospitals are paid by admission or by Emergency Room visit. A longstanding criticism of this payment model is that it incentivizes volume over quality of services. In response, CMS has paved the way for VBP models in healthcare by targeting 50% of all payments delivered through alternative payment models by the end of 2018.

VBP include a wide range of reimbursement structures. In 2017, the Health Care Payment Learning and Action Network (HCP LAN) refreshed CMS's original four categories of payment into a range from fee for service to population-based payment approaches. These are summarized below.[1]

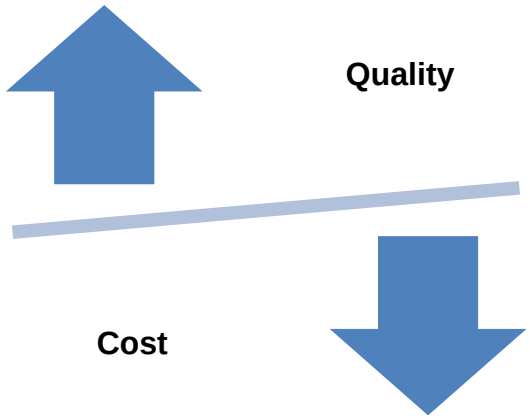
- *Fee for Service – No Link to Quality & Value:* Payments based on service volume
- *Fee for Service – Link to Quality & Value:* A proportion of payment is based on reporting or outcomes data, e.g. bonuses for quality
- *Alternative Payment Models Built on Fee for Service Architecture:* Cost expectations for particular services, populations, or episodes of care are denoted. In a shared savings model, any spend below this amount can result in a payment to the provider that was responsible for reducing the costs. In a shared risk model, the provider is accountable for any expenditure above the specified payment. This has been trialed with pregnancy episodes and knee or hip replacements, as well as particular priority populations.
- *Population Based Payment:* Similar to the alternative payment model, a payment is denoted up front for the cost of all specified healthcare services for a defined population and no adjustments to this rate are made. For example, in global capitation, a group of organizations including primary, acute, and specialist providers may come together to cover the entire cost of healthcare services for a particular population through one negotiated payment. Alternatively, partial capitation models may set a monthly fee for a subset of services per patient.

[1] "APM Framework," HCP-LAN, 2017. Available at < http://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf>.

Additional information about VBP models can be found on the CMS website and in publications such as "Value Based Payments in Medicaid Managed Care: An Overview of State Approaches" by Center for Health Care Strategies.

Increasing Value for Money

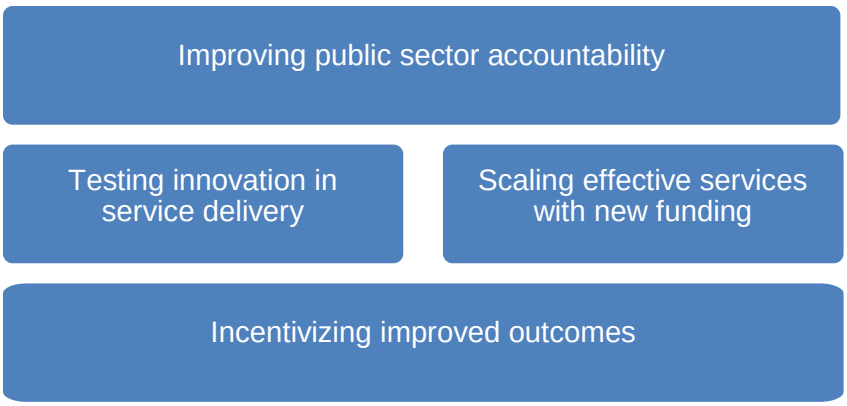
The impetus for structuring contracts in innovative ways is to deliver improved value for money for the public sector. Greater value can be achieved through improving service quality, reducing service cost, or both improving quality and reducing cost.



Pay for Success models measure, evaluate, and improve quality through a focus on outcomes. There are many reasons for governments to contract on the basis of outcomes, including:

- Public sector accountability: Government knows what it gets for its money.
- Testing innovation in services: Government and providers can build a business case for new or enhanced interventions based on the outcomes they achieve, particularly when implemented alongside a robust evaluation.
- Scaling effective services: Government can unlock different sources of funding (e.g. general fund dollars or reinvestment dollars) by paying on the basis of outcomes.
- Incentivizing improved outcomes: Provider's financial incentives are aligned with government's focus on outcomes.

Benefits of Outcomes-Based Contracts



To date, the majority of outcomes that trigger payments in PFS contracts have focused on measures linked to quality, e.g. days spent in supportive housing for a homeless population, number of re-arrests for a forensic population, educational attendance and attainment for youth populations. However, there has been growing interest in using service cost figures as an outcome. If realized, this would shift the emphasis of the PFS transaction to cost stabilization or reduction. The PFS sector should employ this approach with care, as it may lead to perverse incentives if quality metrics are not similarly incentivized.

PFS includes an implicit stabilization of cost by defining and paying a cost per outcome for a particular target population. Additionally, the majority of PFS contracts provide an upper cap on total potential payments for outcomes, which further regulates cost. However, it seems prudent to say that as long as the outcome triggering a payment is not a cost figure, PFS most effectively improves the quality component of value for money.

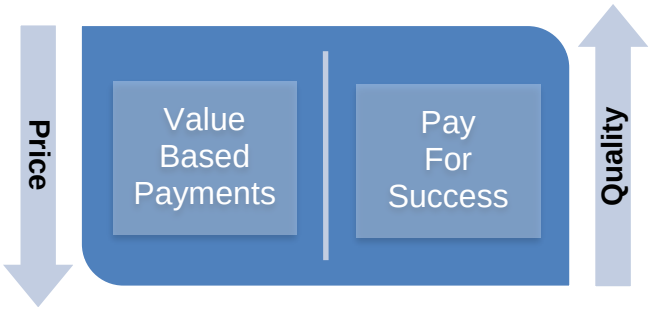
The alternative and population payment based models of Value Based Payments focus on managing, stabilizing, and sometimes reducing the price of services, alongside quality thresholds. By introducing an expected price for either a service, bundle of services, episode of care, or population, these models controls expenditure for government, which enables better forecasting of budgets.

VBP models can improve care quality in a number of ways:

- There is an expectation in the healthcare sector that expenditure negatively correlates with quality of care, as in the case where multiple readmissions to hospital are likely to indicate a patient is not recovering from an episode of ill health.
- The second category of VBP structures (fee for service – link to quality) introduces bonus payments based on reporting or outcome metrics. It might be argued that the 'pay for performance' model in this category most closely resembles Pay for Success, though Pay for Success usually reimburses a much larger proportion of a contract on the basis of outcomes. There are explicit intentions to shift the bulk of contracts to the final two categories of VBP and away from this outcomes-focused payment structure.
- Most significantly, VBP contracts can and should include a minimum threshold for quality standards as a pre-requisite for shared savings or similar financial incentives. The 2017 HCP LAN framework emphasizes the importance of "safeguards that go beyond the standard types of quality measures" used in the first and second categories of VBP.[2] The emphasis on quality perhaps responds to studies that have found a lack of robust quality measures in implemented VBP models. This is especially important for less well-researched and potentially vulnerable sub-populations. For example, a survey of VBP in twelve children's hospitals in 2015 found that quality metrics were underdeveloped compared to cost metrics.[3]

[2] "APM Framework," HCP-LAN, 2017. Available at < http://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf>.
[3] "You Get What You Pay For." United Hospital Fund. 2016. Available at <http://partnersforkids.org/wp-content/uploads/2017/09/You_Get_What_You_Pay_For_Special_Report.pdf>.

Therefore, while VBP should incentivize quality performance when implemented well, it has not aligned quality and financial reimbursement as closely as PFS. We suggest that PFS is best suited to improving quality and VBP most effectively stabilizes cost, unless each is constructed carefully to do both.



If reduced expenditure is a priority for PFS end payors, an evaluation should be carried out alongside PFS projects to better understand the impact of the intervention on cost. This cost data should then be used to more appropriately forecast end payor budgets. Conversely, VBP healthcare payors should ensure that quality is measured in all VBP contracts so that shared savings or shared risk incentives do not endanger patients, particularly for vulnerable, high cost populations.

Lessons for Future Development of VBP Models

The PFS design process draws on community partnerships to determine whether PFS is feasible and how it should be implemented. This approach has made PFS accessible to service providers, which has in turn empowered providers to take central roles in convening and developing these contracts alongside government. In the experience of CSH, providers are often the most numerous applicants for PFS Technical Assistance competitions. By contrast, there is a perception among some providers that VBP contracts are imposed by government entities without significant stakeholder input on the metrics, targets, and contract terms. VBP payors can address these concerns in the following ways:

- **Include financial support for providers to upgrade data systems or improve their monitoring and reporting on outcomes and expenditure.** PFS transactions include flexible, upfront funding that can be used for capacity building for providers. Additionally, an investor or intermediary is likely to work alongside the provider to build reporting capacity. For example, in the Los Angeles Just in Reach Pay for Success transaction, CSH as the intermediary works closely with the County to verify data on supportive housing placements and housing outcomes. The resulting analysis of housing stability rates and days spent in housing is fed back to providers during meetings to empower them to continue or improve high quality service delivery.

- **Involve service providers in contract design**. PFS transactions often develop over a year or more of feasibility and transaction structuring. This extensive development period brings together government, providers, evaluators, and other stakeholders to discuss all aspects of a PFS contract, including the payment trigger and targets. In the ongoing development of a supportive housing PFS project in Philadelphia, for example, the leadership committee that makes decisions on likely contract terms includes the local behavioral health MCO, the city, service providers, program staff from potential referring services, an evaluation design organization, and CSH as transaction coordinator. In this case, the behavioral health MCO saw value in partnership working as a way to set the stage for further outcomes-based contracts in VBP models. Although some states have used State Innovation Model (SIM) test grants to support providers in the transition, this engagement is not a core part of VBP contracts, and communities risk developing inaccurate targets for expenditure if provider data is not used and providers are not empowered to discuss data and other challenges.

- **Validate key contract terms with an external party.** While partnership working is key for buy-in and accurate understanding of system outcomes and costs, having a third party validator of the agreed contract targets or baselines is invaluable. PFS builds in this validation role through the inclusion of private investors whose incentives are aligned with the providers; during their due diligence process, investors ensure that an appropriate level of risk is posed by the contract targets. For example, in most PFS transactions, the government and investors review both national and local data and results to determine the most appropriate success metrics and their thresholds for success. For VBP contracts, it may be helpful to bring in a separate consultant or other evaluator in order to provide a final check of the contract terms.

Improving Value through PFS and VBP Models

In conclusion, PFS and VBP both aim to improve quality of services and accountability of public sector financing. VBP payors should adopt some of the learnings from PFS design to better support service providers transitioning to a new form of contracting. Similarly, PFS could learn from VBP's efforts to create standard performance thresholds across providers. However, even for the best designed PFS or VBP model, there are circumstances in which provider accountability for outcomes or financial risk is inadvisable. Most notably, a lack of high quality data on which to base forecasts for achievable outcomes or realistic expenditure baselines can place undue risk on the service providers. Defining costs for highly vulnerable and small populations is problematic and challenges many assumptions of VBP design. The PFS 'feasibility study' phase can be instructive in its deliberate determination of whether or not PFS is a valuable tool for a particular population or in a particular community.

Innovative contracting can bring together partnerships that add value beyond a single document or service delivery model. Deeper understanding between government and providers of the challenges faced by each will better position communities to make positive change through procurement and implementation processes. Although the development of good contracts requires an upfront investment of time and resource by all parties, the potential to demonstrate improved value is itself a high value proposition.