Barriers to Pay for Success in Public Health

Coming to terms with Medicaid Payment Policy

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An overview of Medicaid payment policy and the required arrangements to ensure the viability of your Asthma Pay for Success project
The payment mechanism is a key issue that we are hopeful to resolve in a manner applicable to all states in the coming months.

Overview

Why you’re here
Each project needs to understand and create an arrangement that uses the value created by services to repay investors without negative consequences for our health partners.

Next steps
• Complete your questionnaire on health policy;
• Identify specific points of contact to leverage in your state and with CMS; and
• Set up time to discuss options with experts (optional).

How we’re going to do it
• Introduce yourself to our project partners.
• Provide an overview of Medicaid payment policy framework and system;
• Demonstrate key issues with the current arrangement; and
• Discuss possible and best courses of action going forward.

Note(s):
1. Pay for Success is a means to an end, it gets us something more important.
2. This presentation is most relevant for projects with managed care providers, we will set up separate discussions for projects that do not have a managed care provider.
Working with partners, we’ve investigated the possible options for Pay for Success payment mechanisms and determined...

### Summary table of models

<table>
<thead>
<tr>
<th>Rating</th>
<th>Payer</th>
<th>Pays for services from</th>
<th>Source of value created</th>
<th>Value created</th>
<th>Business conflict</th>
<th>Potential impact scale</th>
<th>Payment issues</th>
<th>Cost basis</th>
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<tr>
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<td>Plans</td>
<td>Converts acute care $ to prevention</td>
<td>Reducing payments to self</td>
<td>Process and political limits per unit</td>
<td>Double capitalization</td>
<td>Payment reduction</td>
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<td>Reduce plan overhead</td>
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<td>Plans</td>
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<td>Varies by arrangement*</td>
<td>Net charge reduction</td>
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<td>Reduce payments to hospitals</td>
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<td>All health plans</td>
<td>Varies by arrangement*</td>
<td>Net charge reduction</td>
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<td>Hospital</td>
<td>Reduce own operating costs</td>
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<td>All hospitals</td>
<td>Varies by arrangement*</td>
<td>Operating cost reduction</td>
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<tr>
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<td>Intervention provider</td>
<td>System</td>
<td>Reduce own operating costs</td>
<td>None</td>
<td>All systems</td>
<td>Varies by arrangement*</td>
<td>Operating cost reduction</td>
</tr>
</tbody>
</table>

**Note(s):** Accountable Care Entities function differently based on jurisdiction, for analysis please compare local functionality to table.

**Source(s):** GHHI analysis of publicly available information
Volume or Value?

An overview of current issues facing Pay for Success in the Medicaid payments system
The structure of the Medicaid payment system illustrates the process and isolates issues of reimbursement that are faced by project partners.

**Federal CMS**

Federal payment participation (FPP): CMS pays a percentage of State expenses if certain criteria are met. This is crucial funding for State Medicaid budgets.

**State Medicaid**

State reimbursements to care managers are based on the historical medical expenses covered by the CMS approved State Plan for serving a similar population.

**Managed care provider**

MCO payments for services rendered are fee-for-service based. Ideally, incentivizing reductions in cost, from providing fewer more impactful services.

**Service provider**

Key insight
The system effectively aggregates expected fee-for-service spending and pays in lump sums.

Note(s): We acknowledge each state is different and will happily work with individual partners to resolve their specific issues.

Source(s): GHHI analysis of publicly available information
So what? ... Well, there is really no long-term incentive to reduce costs if payments are still based on fee-for-service links in the system.

**Medicaid payments arrangement issue**

**Federal CMS**
- State spending determines federal matching potential.

**State Medicaid**
- Managed care expenditures determine future state reimbursements.

**Managed care provider**
- Service providers’ charges are still based on fees for services rendered.

**Service provider**
- **Key insight**
  With fee-for-service as the basis of value-based payments many of the core incentives and problems remain.

**Note(s):**
We acknowledge each State is different and will happily work with individual partners to resolve their specific issues.

**Source(s):**
GHHI analysis of publicly available information
Why redetermination matters?
How the process of re-racking or redetermination creates a barrier for investing in preventative care innovations
Determining rates aggregated everyone in categories and determined what the average payment should be.

Population and their average monthly expense

<table>
<thead>
<tr>
<th>Tier 3</th>
<th>Tier 2</th>
<th>Tier 1</th>
</tr>
</thead>
<tbody>
<tr>
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<td>$150</td>
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<tr>
<td>$8,000</td>
<td>$800</td>
<td>$80</td>
</tr>
</tbody>
</table>

Calculated rate

- Tier 3: $8,000 ÷ 4 = $2,000
- Tier 2: $800 ÷ 4 = $200
- Tier 1: $80 ÷ 4 = $20

Expense total: $4,440
Compensation total: $2,460

Key insight
Long-term investment value is captured by the State not Managed Care providers, so MCOs have little ability or incentive to invest in prevention.

Source(s): GHHI analysis of publicly available information
With every redetermination, managed care providers reduce their compensation to by improving health outcomes.

Key insights
Managed care providers:

- Suffer financial losses for parties in the upper end of tiers
- Break even on parties that have average utilization for the tier
- Profit from those parties that have low utilization from their tier
With every redetermination, managed care providers reduce their compensation to by improving health outcomes.

The redetermination process

**Tier 3**
Payment rate: $2,000 per unit

- Year 1: $4,000
- Year 2: $2,000
- Year 3: $000

**Tier 2**
Payment rate: $200 per unit

- Year 1: $400
- Year 2: $400
- Year 3: $400

**Tier 1**
Payment rate: $20 per unit

- Year 1: $40
- Year 2: $60
- Year 3: $80

**Annual total**
- Year 1: $4,440
- Year 2: $2,460
- Year 3: $480

**Key insight**
Long-term investment value is captured by the State not Managed Care providers, so MCOs have little ability or incentive to invest in prevention.

Source(s): GHHI analysis of publicly available information
The redetermination process

The tier system creates strong incentives to prevent parties from changing tiers due to the potential for unexpected losses by MCOs.

<table>
<thead>
<tr>
<th>Tier 3</th>
<th>Payment rate: $2,000 per unit</th>
<th>Revenue</th>
<th>2,000</th>
<th>Expense</th>
<th>(1,500)</th>
<th>Gain (loss)</th>
<th>500</th>
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<td>$1,500</td>
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<table>
<thead>
<tr>
<th>Tier 2</th>
<th>Payment rate: $200 per unit</th>
<th>Revenue</th>
<th>200</th>
<th>Expense</th>
<th>(800)</th>
<th>Gain (loss)</th>
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<td>$800</td>
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</table>

**Key insights**

- Reducing costs within medical tiers is the most effective strategy for maximizing economic returns for managed care providers.
- Preventative care can actually result in a net loss and a substantial swing in profitability. Consider that 500 in gains became a loss of 600 for a full negative swing of negative 1,100.

Source(s): GHHI analysis of publicly available information
Issue #1:

Reimbursements and revenue losses
Demonstration assumptions

In the following demonstration we make a number of simplifying assumptions.

Assumptions

• The medical expense in a year determines revenue in the following year.

• Investments are not considered medical expenses.

• All parties are happy with a break-even scenario.¹

• We do not investigate administrative budgets or medical loss ratio yet.

• Investments in preventative care can either have a one year or lifetime impact.

Note(s): We understand that this is not always the case but it functions as a simplifying assumption that can be worked into negotiations.

Source(s): GHHI
Setting the steady-state

The baseline scenario is caring for a population will cost $4 million, care is provided, no investments are made, and everything stays steady.

Budgetary implications of investments

$ thousands

<table>
<thead>
<tr>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
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</thead>
<tbody>
<tr>
<td>Revenue</td>
<td>(4,000)</td>
<td>Expense</td>
<td>(4,000)</td>
<td>Gain (loss)</td>
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</table>

Baseline MCO scenario

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<tbody>
<tr>
<td>Revenue</td>
</tr>
<tr>
<td>Expense</td>
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<tr>
<td>Investments</td>
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</tbody>
</table>

Key insight

A steady state program neither costs nor benefits the managed care provider, but carries with it little risk.

Source(s): GHHI analysis of publicly available information
If an MCO invests in prevention that reduces the cost of care, it will be penalized in later revenue losses due to the redetermination process.

**Short term investment impact**

$ thousands

<table>
<thead>
<tr>
<th>Year</th>
<th>Revenue</th>
<th>Expense</th>
<th>Investment</th>
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<td>Year 3</td>
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<thead>
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<th>$ thousands</th>
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<th>Scenario</th>
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<td>Expense</td>
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<td>(18,000)</td>
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<tr>
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</tr>
<tr>
<td>Gain (loss)</td>
<td>0</td>
<td>(2,000)</td>
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</tbody>
</table>

**Key insight**

Even an investment that offsets its own value causes a net loss because it is not considered in the cost of care.

Source(s): GHHI analysis of publicly available information
If continuous investments in preventative care are required, it would result in losses for the MCO as investments are included in redetermination.

**Budgetary implications of investments**

$ thousands

<table>
<thead>
<tr>
<th>Year</th>
<th>Revenue</th>
<th>Expense</th>
<th>Investments</th>
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<td>Year 1</td>
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<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>Revenue</td>
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<tr>
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<td>(12,000)</td>
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**Gain (loss)**

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**Key insight**

One-time investments that reduce the cost-of-care by the amount of the investment have no benefit for a managed care provider. Being risk-averse, they have no incentive to proceed.

Source(s): GHHI analysis of publicly available information
Continuous investments in preventative care result in net-losses for MCOs due to revenue losses because investments are not considered.

Short term investment impact

<table>
<thead>
<tr>
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<th>Baseline</th>
<th>Scenario</th>
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<tbody>
<tr>
<td>Revenue</td>
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<tr>
<td>Expense</td>
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<td>(12,000)</td>
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<tr>
<td>Investments</td>
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<td>(10,000)</td>
</tr>
<tr>
<td>Gain (loss)</td>
<td>0</td>
<td>(8,000)</td>
</tr>
</tbody>
</table>

Key insight
Because preventative care investments are not considered medical expenses, any program that requires regular upkeep will cause a managed care provider losses on a continuous basis.

Source(s): GHHI analysis of publicly available information
So even highly-beneficial investments cause losses when investments are not considered in reimbursement because of the rate of revenue adjustment.

**Demonstration of a major but lasting investment**

Long-term investment impact

<table>
<thead>
<tr>
<th>Year</th>
<th>Revenue</th>
<th>Expense</th>
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**$ thousands**

<table>
<thead>
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<td>Investments</td>
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<td>(5,000)</td>
</tr>
<tr>
<td>Gain (loss)</td>
<td>0</td>
<td>(2,000)</td>
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**Key question**

How does $9 million in savings cause $2 million in losses?
Demonstration of a major but lasting investment

Ideally the system would reimburse parties for investments that reduce future costs, generating a win-win situation where savings are shared.

Long-term investment impact
$ thousands

<table>
<thead>
<tr>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
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<tbody>
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<td>($1,000)</td>
<td>($1,000)</td>
</tr>
<tr>
<td>Investments</td>
<td>($5,000)</td>
<td>($1,000)</td>
<td>($1,000)</td>
<td>($1,000)</td>
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</tbody>
</table>

$ thousands | Baseline | Scenario
--- | --- | ---
Revenue | 20,000 | 16,000
Expense | ($20,000) | ($8,000)
Investments | ($0,000) | ($5,000)
Gain (loss) | 0 | 3,000

Key insight
A substantial one-time long-term investment of $5 million in preventative care can result in:
• $4 million in CMS and state savings; and
• $3 million in MCO net gains; but
• $5 million in initial investment required.

Source(s): GHHI analysis of publicly available information
A Pay for Success project can offset the initial need for investment instead using outcomes-based payments to limit risk for MCOs and public payers.

Long-term investment impact

<table>
<thead>
<tr>
<th>Year</th>
<th>Baseline Revenue</th>
<th>Baseline Expense</th>
<th>Baseline Outcomes payments</th>
<th>Scenario Revenue</th>
<th>Scenario Expense</th>
<th>Scenario Outcomes payments</th>
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Key insight
By using savings to return capital to investors, the project can generate savings for all:1
- $4 million in CMS and state savings,
- $3 million in MCO net gains, and
- $5 million in outcomes-based payments.

Note(s): Some component of savings would be needed to provide investors a return to compensate them for the risk taken funding the program.

Source(s): GHHI analysis of publicly available information
Issue #2: Spending classification

How investing in prevention of medical expenses reduces revenue, forces budget cuts, and penalizes managed care providers.
The problem with calculating compensation

Current policy does not treat preventative care measures not listed on the state plan as medical expenses.

Organizational spending classification

<table>
<thead>
<tr>
<th>$ millions</th>
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<tbody>
<tr>
<td>Before (80-20)</td>
</tr>
<tr>
<td>Total cost-savings</td>
</tr>
<tr>
<td>After (70-30)</td>
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<tr>
<td>Medical loss ratio</td>
</tr>
</tbody>
</table>

Scenario
An MCO with a $100 million budget and existing 80-20 medical loss ratio undertakes a Pay for Success project that:
- Reduces cost of care by $10 million per annum, and
- Repays investors $5 million per annum.

Result
- Subsequent compensation will be based on 7/8ths the real cost of care due to investor funding and repayment.
- Penalties for dropping below the MLR set at 80:20.

Note(s):
Investor repayments for investments would be amortized initial investments, which can be aligned to outcomes-based payments.

Source(s):
GHHI analysis of publicly available information
The problem with calculating compensation

The compensation policies result in unintended consequences for innovative programs, including decreased compensation and forced budget cuts.

Organizational spending classification

$ millions

<table>
<thead>
<tr>
<th>Before (80-20)</th>
<th>Total cost-savings</th>
<th>After (80-20)</th>
</tr>
</thead>
<tbody>
<tr>
<td>80</td>
<td>10</td>
<td>70</td>
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<table>
<thead>
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<th>Investor repayment (restricted cash-flow)</th>
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<td>10</td>
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<table>
<thead>
<tr>
<th>Medical loss (Cost of care)</th>
</tr>
</thead>
<tbody>
<tr>
<td>70</td>
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<table>
<thead>
<tr>
<th>Net cost savings</th>
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<td>5</td>
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<table>
<thead>
<tr>
<th>Admin budget</th>
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<tr>
<td>7.5</td>
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</table>

Required budget cut to maintain 80-20 12.5%

Results of $10 million project

- 12.5 percent (100 to 87.5) reduction in total budget; and
- 37.5 percent* (20 to 12.5) reduction in non-medical budget (excluding investor repayment as a restricted cash-flow).

Key insight

Each dollar of Pay for Success savings will result in:

- $1.25 reduction in overall budget; and
- Between $0.25 and $1.25 reduction in admin budget ($0.75 shown).*

Note(s):

* If all savings are repaid to an investor in a given year, the unrestricted admin budget would be just $7.5 million or 62.5 percent less.

Source(s): GHHI analysis of publicly available information
Solution

An Equitable Value-Sharing Arrangement

How incentivizing innovation through cost-savings distribution bends the long-term cost-curve for CMS, states, and managed care providers
Recommendations for equitable value sharing

The right rate-setting framework enables private investment in public health, incentivizes innovation, and ensures long-term public benefits.

Recommendations

1. Hold the initial compensation rates (A) constant for the duration of the project (D) to allow investor repayment.

2. Determine the new cost of care (B) from the data provided. Negotiate a new rate (C) that allows the MCOs to retain a portion of cost savings (C-B) continuously.

3. Negotiate a rate adjustment period (E-D) after completion to incentivize future projects.

Key takeaway
The long-run public benefit of a successful initiative will substantially outweigh the short and medium-run price concessions.

Source(s): GHHI analysis of publicly available data.
In consultation with Jack Meyer of Health Management Associates
The Pay for Success project will lower the cost of providing care to the target population.

Value-sharing framework explained

Rate adjustment mechanism concept

\[
\begin{array}{c}
\text{Current cost of care} \\
\text{New cost of care}
\end{array}
\]

Source(s): GHHI analysis of publicly available information
Value-sharing framework explained

Negotiating a new rate that lets the MCO retain a portion of the cost savings will incentivize future projects or cover unforeseen costs.

Rate adjustment mechanism concept

Note(s): In our discussions with many health plans, they expressed hesitation to fully absorb the risk that there will be no unforeseen additional costs, such as increases in regular medication use et cetera, and that there are no relapses in cost of care.

Source(s): GHHI analysis of publicly available information
Value-sharing framework explained

Holding the compensation rate constant for the duration (D) of the project will enable the MCO to provide investor returns and scale their efforts.

Rate adjustment mechanism concept

$\text{Current cost of care}$

$\text{Negotiated rate}$

$\text{New cost of care}$

Source(s): GHHI analysis of publicly available information
Value-sharing framework explained

Negotiating a transitional period will allow for the MCO to adjust to new rates and provide them capital incentives to undertake new projects.

Rate adjustment mechanism concept

Source(s): GHHI analysis of publicly available information
A successful project will reduce the cost of care over time and ushers in a new standard of care for all providers, creating across the board savings.

Rate adjustment mechanism concept

Current cost of care

Negotiated rate

New cost of care

Cost of care

Source(s): GHHI analysis of publicly available information
Value-sharing framework explained

The cost-savings captured by the MCO during the project will be used to provide investor returns.

Rate adjustment mechanism concept

Current cost of care

Negotiated rate

New cost of care

Cost of care

MCO retained value

MCO captured value repaid to investors

Source(s): GHHI analysis of publicly available information
Value-sharing framework explained

The subsequent cost savings will serve to provide capital to sustain or scale the program and incentivize undertaking new projects.

Rate adjustment mechanism concept

$\Delta$

![Diagram]

- Current cost of care
- Negotiated rate
- New cost of care
- Cost of care
- MCO retained value
- MCO captured value repaid to investors

Source(s): GHHI analysis of publicly available information
Value-sharing framework explained

CMS and the states will begin to capture value as the new rates transition in after the project’s completion and can change broad cost care policy.

Rate adjustment mechanism concept

Source(s): GHHI analysis of publicly available information
Over time, the public benefits most from cost savings, improved quality of care, and providing incentives for private sector innovation or investment.

Rate adjustment mechanism concept

Cost of care

MCO retained value

MCO captured value repaid to investors

Medicaid retained value split between Federal CMS and the State

Long term State and CMS Savings

Health entity retained value

Investor returns

| A: Current cost of care |
| B: New cost of care |
| C: Negotiated cost of care |
| D: Project end |
| E: End transition period |

Source(s): GHHI analysis of publicly available information
Contact information

We’re always here to help.

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Thank you for your time.