Funding Upstream Prevention via Global Budgets: Opportunities and Challenges

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Agenda

- **Upstream strategies**

- **Global budgets**
  - What are they?
  - Why are they interesting?

- **Case studies**

- **Issues**

- **Experience/Discussion**
Upstream Strategies

Individually-focused

Community-focused

AIR POLLUTION HAZARDS IN OAKLAND

Within 5 Miles of Docks
Downwind of Freeway or Heavy Industry
Within 2 Miles of Docks
Within 2 Miles of Docks & Downwind of Freeway or Industry
What’s Health Got to Do With It?
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“It is unreasonable to expect that people will change their behavior easily when so many forces in the social, cultural, and physical environment conspire against such change.”

Institute of Medicine
THRIVE
Community Determinants of Health

PLACE
◆ What’s sold & how it’s promoted
◆ Look, feel & safety
◆ Parks & open space
◆ Getting around
◆ Housing
◆ Air, water, soil
◆ Arts & culture

EQUITABLE OPPORTUNITY
◆ Racial & social justice
◆ Jobs & local ownership
◆ Education

PEOPLE
◆ Social networks & trust
◆ Participation & willingness to act for the common good
◆ Norms

Source: A Time of Opportunity: Local Solutions to Reduce Inequities in Health and Safety
Presented to the Institute of Medicine roundtable on health disparities, May 2009
Table 1. Community Factors Affecting health, safety, and mental health
Current Health Care Spending

Factors Influencing Health

- Behaviors & Environment: 70%
- Genetics: 20%
- Medical Care: 10%

Health Care Services: 97%
Prevention: 3%

$2.7 Trillion

Global Budget: What Is It?

- Defined population

- Scope
  - Services: defined scope of services
  - Infrastructure/capacity

- Global budget:
  - Annual cycle
  - Virtual vs. real

- Quality safeguards
Global Budget: Why Are We Interested in It?

- Incentive to deliver value, not volume
- Flexible: allows for reallocation of resources to improve efficiency and effectiveness
- Capture savings for reinvestment
Oregon Coordinated Care Organizations (CCOs)
Oregon CCOs

- Provide care to Oregon’s Medicaid population.
- Networks of payers, health care providers, mental health and addiction service providers, and sometimes dental care providers.
- 16 CCOs serving 16 distinct regions and 990,000 Medicaid beneficiaries in Oregon.
- Explicit goals to meet the Triple Aim: “Better health, better care, and lower costs.”
Oregon Coordinated Care Organizations

64% Federal Medicaid Contribution

97% CCO Global Budgets

36% State Medicaid Contribution

3% Quality Pool Incentives
Oregon CCOs Outcomes

- Emergency department visits
- Hospital admissions for chronic obstructive pulmonary disease and short-term complications from diabetes
- Enrollment in Patient-centered Primary Care Homes
Trillium CCO

Community-Informed Process

Physical, Mental & Dental Health Services
Prevention Fund
3 County Prevention Employees

Prevention Institute
Trillium and Lane County

- Trillium dedicates $1.33 per member per month for prevention efforts in Lane County
- Supports three prevention employees at Lane County Public Health, as well as an additional FTE to interface with schools
- Pays for implementation of prevention strategies
- Prevention strategies selected through community-informed process
What is Hennepin Health?

Minnesota Department of Human Services (DHS) &

Hennepin County Collaborative for Healthcare Innovation

Hennepin County Partners:
Hennepin County Medical Center (HCMC)
NorthPoint Health & Wellness
Human Services and Public Health Department (HSPHD)
Metropolitan Health Plan (MHP)
Population Served

• MA Expansion in Hennepin County
• 21 - 64 year-old Adults, without dependent children in the home
• At or below 75% federal poverty level ($677/month for one person)
• Targeting ~10,000 members/month
• Start date: January 2012 (two year demonstration project)
The Business Case

Problem:
• High need population
• Top 5% utilizing 64% of dollars
• Crisis driven care
• System fragmentation
• Safety net - cost shifting

Need:
• Address social disparities
• Improve patient outcomes
• Increase system efficiencies
• Increase preventive care
Goals: Years 1 and 2

Improve Residents Health Outcomes, Reduce Overall Costs

- Decrease admissions/readmits by >10%
- Reduce emergency department visits by >10%
- Increase primary care “touches” by >5%
- Reduce churn. Maintain coverage by >95%
Finance model

- 100% at risk contract
- Partners share risk/gains
- Tiering approach
- Fee for Service “pmpm” with outcome contracts
System Investments Year 2

Project

- Sobering Center
- Transitional Housing
- Behavioral Health Continuum
- Psychiatric Consult model
- Intensive primary care - clinic expansion
- Vocational services

Return on Investment

- 80% cost reduction ED to sobering center
- One month of housing < 2 days of hospitalization
- 30 - 50% cost reduction expected
ACO Models-

Risks:

- Larger silos
- System fragmentation
- Competition vs. transparency/collaboration

ACO
- Single Payer
- Hospital(s)
- Provider System(s)

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Geographic-Community model

Risk:
- Standardization
- Complexity

Shared risk/gain partnership across systems
Profile: Vermont

600,000 total population

13 Hospital Service Areas: ‘community systems’

3 statewide ACO’s: 30% of population

Payers: 3 major commercial + 2 public

History of collaboration: bipartisan and multi-stakeholder
Delivery System Transformation

- Create single payment model for all payers
  - Primary care: Blueprint for Health Phase 2
  - 3 Statewide ACO’s: savings sharing, payment metrics,
  - Evolve to all payer population based budget: Medicare/Medicaid waiver, St J pilot

- Integrate Blueprint for Health and ACO’s
  - Regional unified community collaboratives
  - Unified reporting system

- Accountable Community for Health
  - Evolution: ACO to AHC to TACO
  - integrated medical, behavioral health, public health and community services
- A foundation of medical homes and community health teams that can support coordinated care and linkages with a broad range of services

- Multi-Insurer Payment Reform that supports this foundation of medical homes and community health teams

- A health information infrastructure that includes EMRs, hospital data sources, a health information exchange network, and a centralized registry

- An evaluation infrastructure that uses routinely collected data to support services, guide quality improvement, and determine program impact
Transition to a Community Health Focus

**Current**
- PCMHs & CHTs
- Community Networks
- BP workgroups
- ACO workgroups
- Increasing measurement
- Multiple priorities

**Transition**
- Unified Community Collaboratives
- Focus on core ACO quality metrics
- Common BP ACO dashboards
- Shared data sets
- Administrative Efficiencies
- Increase capacity
  - PCMHs, CHTs
  - Community Networks
  - Improve quality & outcomes

**Community Health Systems**
- Novel financing
- Novel payment system
- Regional Organization
- Advanced Primary Care
- More Complete Service Networks
- Population Health
Statewide Recommendations

A. Fostering an overarching statewide approach to support ACH effectiveness

B. Provide guidance to enable regions to effectively establish accountable Communities for Health

C. Build capacity and create an environment of ongoing learning

D. Explore Sustainable Financing Models for Accountable Communities for Health
Payment Model Options

- Global budget eg OR CCO, Hennepin
  - All payer waiver from CMS
    - More comprehensive scope than MD
  - St Johnsbury feasibility study: community global budget
  - Prior experience
    - 3 statewide ACO’s – 30% of population
    - Commercial global budget for 4 PHO’s

- Partnering with CDFI, eg Dignity Health, PHI
  - Hospital system investment portfolio

- Dedicated assessment for state wellness fund. Eg HIT Fund

- Social Impact bond backed by provider eg Johns Hopkins

- Employer: value based assessment per employee
Major Issues in Practice

- **How is population defined?**
  - Enroll
  - Attribution
  - Geography

- **Scope of covered services**
  - Rx
  - Mental health
  - Social services
Issues

- Setting target budget
  - Risk adjustment for population
    - Method
    - Accuracy of patient data for multiple Dx
  - Rebasing periodically

- Risk corridors

- Performance risk vs insurance risk
  - Individual stop loss
  - Aggregate stop loss
Issues

Developing Capacity to Manage

- Segmentation of population
- Tools for each segment

- Payer partner
  - Timely data
  - Oversight of delegation
  - Aligned interests
Sites’ Experience

- **Barriers to starting**
  - Internal
  - External

- **Challenges to success**

- Nationwide Children's Hospital

- Boston Children's Hospital
Discussion Prompts

- What are the key opportunities and challenges that a global budget would pose to your institution?
- What are the best metrics for evaluating quality in a global budget model?
- Who are the essential stakeholders in your community who should be involved in determining the way a dedicated prevention fund is invested?