Payment Reform in Idaho:
Placing Value on Health Outcomes

Idaho Behavioral Health Alliance
System Transformation through Consumer Advocacy

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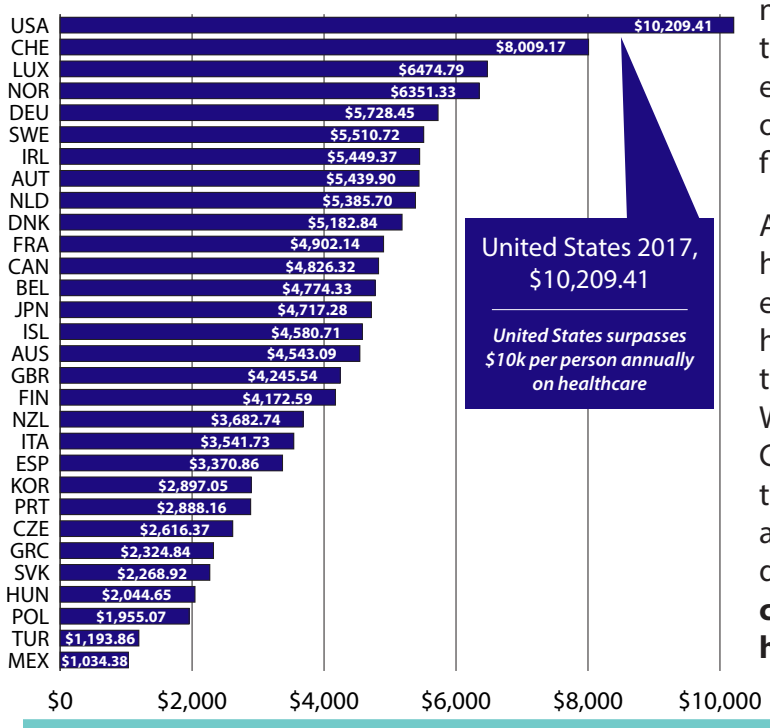
A fully-integrated behavioral healthcare system is dependent on many things, such as a strong and stable workforce, home and community-based services, and accountability measures. Placing a value on quality, however, is a primary lever to efficiently delivering those services, but reliable and accurate data is elusive. Current payment structures focus on volume and not value, and this doesn't make us healthier. Without a model to structure payments to support such a system, behavioral health in Idaho will remain fragmented, treatment will continue to occur primarily in crisis and in silos, and overall health outcomes will continue to decline while expenditures go up.

Why Payment Reform in Idaho is Necessary

Modern American healthcare infrastructure was crafted over generations and rooted in private industry, creating a system of isolated functions that are tied to payment rather than a person. Access to and affordability of healthcare was seemingly simpler back when it truly was between a doctor and a patient. Private health insurance changed that relationship for many Americans, shifting most dramatically during WWII when wage and price controls were put in place to prevent inflation. During this period of unprecedented national sacrifice, U.S. tax policy was crafted to allow employers to offer health insurance to their employees, and neither party paid a tax on that benefit. While other first-world countries established public options for their citizens, American policy favored private options. By the early 1960s, access to healthcare for most Americans was tied to a job.

Figure 1

United States Surpasses $10k Annually on Healthcare



Advancements in technology and science increased the complexity of healthcare as well. As people began living longer and healthier lives, demand for improvements and health equality increased. The private market tended to serve best those who were healthy and/or financially secure, while public safety nets—Medicaid and Medicare—were established to protect the most vulnerable. Healthcare expenditures began a steady ascent, and by the end of the 20th century the system began to show its flaws.

As people were consistently priced out of affordable healthcare, either on their own or through an employer, medical-related bankruptcies rose, healthcare outcomes declined, and costs continued to climb exponentially beyond the cost of living. While the 2010 Patient Protection and Affordable Care Act (ACA) stemmed the financial hemorrhage to an extent, the system itself remains tied to a payment model, fee-for-service (FFS), which depends on volume, rather than value. **The financial consequence of this is the United States has the highest health expenditures in the world (fig. 1),**

Why Payment Reform in Idaho is Necessary cont...

yet ranks last in health outcomes for wealthy and developed nations (fig. 2).

While there is intense debate about what kind of system is the "best," the American model overwhelmingly underperforms, as indicated by the health outcomes ranking in Figure 2. **Over many decades, American healthcare policy has been defined by what serves the private sector, rather than the end user—American consumers.** There is no expectation that the United States will soon adopt policy models used in other countries, but there is a recognition within the industry that how we pay for healthcare creates incentives that have nothing to do with health outcomes, leading to crushing costs for Americans without better health.

Figure 2

	UK	AUS	NETH	NZ	NOR	SWE	SWIZ	GER	CAN	FRA	US
OVERALL RANKING	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**
Care Process	1	2	4	3	10	11	7	8	6	9	5
Access	3	4	1	7	5	6	8	2	10	9	11
Administrative Efficiency	3	1	9	2	4	5	8	6	6	11	10
Equity	1	7	2	8	5	3	4	6	9	10	11
Healthcare Outcomes	10	1	6	7	3	2	4	8	9	5	11

What's the Solution?

Value-based payment models provide the opportunity to focus on health outcomes of the patient—such as what happened after the person received care? Did their health improve? Medical professionals know it is the health of the patient that should be the ultimate deciding factor for how effective treatment is and not something that should be determined by how much money is available for treatment.

This shift toward value-based contracts in the United States has been a long process. Initiatives to attribute value to care go back to the development of Medicare and Medicaid in 1965 and continued over the decades in public and private insurance plans. Lack of valid and reliable data, performance methods, and reporting mechanisms have historically presented formidable barriers, so little traction was gained. However, with the passage of the ACA, the challenge to find the quality in healthcare, while improving access and reducing costs, was written into law. Starting in 2012, the Medicare Value-Based Purchasing program began, in addition to other provisions to create more accountability for providers.

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Efforts in Idaho

Idaho has lagged behind the rest of the nation when it comes to incorporating value-based models into healthcare contracts. In 2013, the State of Idaho was awarded a $40 million, 4-year federal grant by The Center for Medicare and Medicaid Innovation (CMMI), which was created through the ACA to help states with healthcare innovation. In 2014, Governor C.L. "Butch" Otter (R) established the Idaho Healthcare Coalition (IHC) to oversee the development of the State Healthcare Innovation Plan (SHIP), and in 2015 Idaho began testing their model to transform Idaho's healthcare system and ultimately align payment with value.

When Idaho's SHIP funding ended in January 2019, it was evident that more time was needed to advance payment reform and healthcare system transformation in Idaho. To further those goals, the IHC developed the mission of the Healthcare Transformation Council of Idaho (HTCI) to convene Idaho stakeholders to work together. Representative providers from primary care, behavioral health, and sub-specialties began meeting in February 2019 with hospital representatives and the hospital, medical, primary care, and nursing associations. This group also includes a public health district representative, a consumer, and an Idaho Department of Health and Welfare (IDHW) representative.

The HTCI determined that increasing value-based contracting (shifting the volume of care to the value of care) by beneficiary would be their first initiative, and they unanimously coalesced around the goal of 50 percent by 2023, from the current state of 29 percent.

Additionally, the State of Idaho began a pilot project July 2019 in Idaho's Treasure Valley to test value-based contracts with Medicaid providers. There are a variety of value-based contracts, but they are based on the understanding that the providers take on more responsibility for health outcomes of patients, rather than billing an insurance company for more services. The goal is to work with primary care centers and clinics to create a path for assuming risk without stepping too quickly into a fully-integrated model. Outcomes of this pilot project will help inform the state how to serve Idaho's other distinct regions so that contracts can be flexible depending on the needs of the communities.

Many private organizations across the state have undertaken their own initiatives to test payment models focused on the patient, health outcomes, and provider accountability. The major health systems, like St. Luke's and Saint Alphonsus, have created their own networks, and private insurers like Blue Cross of Idaho, Select Health, Regence, and PacificSource have been developing these models for the last few years.

Looking Ahead

Transitioning to value-based contracts is critical for meeting the needs of consumers and stabilizing expenditures. As Idaho follows evidence-based models that focus on the patient, the view will need to broaden to incorporate all payers, practices, and most importantly, the consumer voice. This will be especially important to prioritize in the state Medicaid contracts, as Medicaid expansion as passed in 2018 will allow up to 91,000 adults access to healthcare. Nothing less than a comprehensive approach will change the system so that it's designed for patients and not private industry.