Medicaid Value-Based Purchasing

Review of Current Trends, Opportunities and Challenges
About Bailit Health

- Bailit Health is a consulting firm dedicated to working with public agencies and private purchasers to improve health care system performance.

- **Our Mission:** To support achievement of measurable improvements in health system quality and cost management.
  - We believe that delivery system transformation and payment reform are inextricably linked and form the foundation for system improvement.
1. Describe what is motivating Medicaid agencies to pursue value-based purchasing

2. Describe current trends in value-based purchasing activities

3. Describe opportunities and challenges facing Medicaid agencies as they pursue value-based purchasing
Value-Based Purchasing: Broadly Defined

- Any activity that a state Medicaid program is undertaking to hold a provider or a contracted managed care organization accountable for the costs and quality of the care they provide or pay for (in case of an MCO).
  - Value-based payment
  - Financial and technical assistance for delivery system transformation
What Motivates State Medicaid Reforms?

1. Pressure from CMS
2. Internal strategic initiatives
3. Desire to maintain (or cut) state health care budgets
4. Active legislators / governors
Centers for Medicare and Medicaid Innovation (CMMI) awarded nearly $1 billion dollars in State Innovation Model (SIM) grants to states
- Expanded use of value-based payment is a critical requirement of every state SIM grant

CMS is granting new Medicaid 1115 Waivers and Delivery System Reform Improvement Programs (DSRIPs), but requiring movement toward VBP to support sustainability
- DSRIP programs offer critical support to providers to focus on clinical outcomes and to prepare them for VBP

CMS is testing its own multi-payer models with Medicaid programs
CMS’ Framework for Payment Reform

**Category 1**
Fee for Service – No Link to Quality & Value

**Category 2**
Fee for Service – Link to Quality & Value

**Category 3**
APMs Built on Fee-for-Service Architecture

**Category 4**
Population-Based Payment

- **A** Foundational Payments for Infrastructure & Operations
- **B** Pay for Reporting
- **C** Rewards for Performance
- **D** Rewards and Penalties for Performance
Medicaid Programs are Significant Drivers of Payment Reform

- State Medicaid programs were early adopters of value-based payment models:
  - PACE, full risk capitation model started in the 1990s
  - Pay for Performance programs

Additional Payment in Support of Delivery System Reform

- **12**
  - Currently Implemented

We expect many more states to have implemented this model but did not report it in our survey

Episode-Based Payment

- **3**
  - Currently Implemented

4 more states are in the process of or considering implementation

Population-Based Payment

- **9**
  - Currently Implemented

2 states are making significant changes or expanding their population-based payment model

### Episodes Implemented by AR, OH, and TN

<table>
<thead>
<tr>
<th>Condition</th>
<th>ARKANSAS</th>
<th>OHIO</th>
<th>TENNESSEE</th>
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<tbody>
<tr>
<td>Appendectomy</td>
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<td></td>
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<tr>
<td>Asthma</td>
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<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Attention Deficit Hyperactivity Disorder*</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cholecystectomy</td>
<td>✓</td>
<td>Planned 2017</td>
<td>✓</td>
</tr>
<tr>
<td>Chronic Obstructive Pulmonary Disorder</td>
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<td>✓</td>
<td>✓</td>
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<tr>
<td>Colonoscopy</td>
<td>✓</td>
<td>Planned 2017</td>
<td>✓</td>
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<tr>
<td>Congestive Heart Failure</td>
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</tr>
<tr>
<td>Coronary Artery Bypass Graft</td>
<td>✓</td>
<td></td>
<td></td>
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<tr>
<td>Heart Failure</td>
<td>✓</td>
<td></td>
<td></td>
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<tr>
<td>Hysterectomy</td>
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<td></td>
<td></td>
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<tr>
<td>GI Hemorrhage</td>
<td></td>
<td>Planned 2017</td>
<td>✓</td>
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<tr>
<td>Oppositional Defiance Disorder</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percutaneous Coronary Intervention</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>Perinatal</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Pneumonia*</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Tonsillectomy</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Joint Replacement</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Upper Endoscopy</td>
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<td>Planned 2017</td>
<td>✓</td>
</tr>
<tr>
<td>Upper Respiratory Infection</td>
<td>✓</td>
<td>Planned 2017</td>
<td>✓</td>
</tr>
<tr>
<td>Urinary Tract Infection (IP &amp; OP)</td>
<td>✓</td>
<td>Planned 2017</td>
<td>✓</td>
</tr>
</tbody>
</table>

Episode-Based Payment Example
AR, OH and TN Medicaid Programs Asthma Episode

Episode definition:
- All related services during acute exacerbation and most services within 30 days post-trigger (e.g., including related inpatient and outpatient facility services, professional services, medications)
- Related post-trigger readmissions

Episode includes the following related services:
- Inpatient or outpatient / ED facility care
- Professional claims
- Labs, imaging, and diagnostic tests during treatment
- Medications
- 30-day post-trigger readmissions

- All relevant claims with a diagnosis code related to treating an acute exacerbation
- All relevant medications prescribed in outpatient setting related to preparation, recovery and complications
- Relevant inpatient readmissions within 30 days post-trigger as determined by BPCI exclusions list

Source: Arkansas Payment Improvement Initiative
First year 81 providers had savings to share ($400,000); 36 providers lost ($169,000)

Second year 248 providers had savings to share ($1.5 million); 34 providers lost ($79,000)

Nonfinancial results
- Improved compliance with perinatal screening measures
- Improved quality outcome tracking
- Increased transparency
  - Orthopedic surgeons are more selective in hospitals

Population-Based Payment Example
Minnesota’s Integrated Health Partnership

- IHPs (aka ACOs) enter into shared risk arrangements directly with State:
  - Shared savings or shared risk

- The IHP program utilizes an analytics program that gives providers comprehensive data reports to better manage care.

- Establishes a targeted IHP expenditure, based on TCOC for attributed beneficiaries.
  - TCOC includes primary care, behavioral health, inpatient medical care, pharmacy services, etc.
  - TCOC excludes dental, transportation, long term care and residential mental health.
  - Dual eligibles are excluded.
MN IHP Results To Date

• In 2013 providers saved $14.8 million compared to their trended targets.

• 2014 interim TCOC savings estimated at $61.5 million
  - For 2013, all beat their targets and met quality requirements; 5 received shared savings payments ($6 million total ranging from $570,000 to $2.4 million)
  - In 2014, all 9 providers received shared savings (interim) settlements ($22.7 million in total)

• Final 2014, interim 2015 results due June 2016

72% of Medicaid Beneficiaries are Enrolled in Managed Care

Number of MCOs by State

Source: Kaiser Family Foundation
A number of states require or encourage health plans to increase amount of value based purchasing without specifying models.

- Some states require from 20-50% of providers to be paid through a VBP model by the end of the current contract period.
- Some focus on increasing the percentage of medical expenses covered by VBP models.

A few states are providing more guidance (or mandates) to MCOs on how to build VBP programs.

- Ohio
- Tennessee
- New York
How VBP is Implemented Varies

- How alternative payments are being implemented varies by state Medicaid program.

- Given significant role of managed care, much is being implemented through MCOs.

- However, states are also contracting directly with providers (e.g., Arkansas, Oklahoma).

- Initial focus typically in acute care; some states beginning to focus on long term care.
While Medicaid Expansion Has Been Influenced in Large Part by Politics…

Adopted (32 States including DC)

Not Adopting At This Time (19 States)

“Red” states and “Blue” states are both pursuing value-based payment strategies.

Some examples include:

<table>
<thead>
<tr>
<th>Red States</th>
<th>Blue States</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oklahoma</td>
<td>Vermont</td>
</tr>
<tr>
<td>Tennessee</td>
<td>New York</td>
</tr>
<tr>
<td>Arkansas</td>
<td>Minnesota</td>
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<tr>
<td>Texas</td>
<td>Oregon</td>
</tr>
<tr>
<td>South Carolina</td>
<td>Massachusetts</td>
</tr>
<tr>
<td></td>
<td>Ohio (purple state)</td>
</tr>
</tbody>
</table>
Goals of Presentation

1. Describe what is motivating Medicaid agencies to pursue value-based purchasing

2. Describe current trends in value-based purchasing activities

3. Describe opportunities and challenges facing Medicaid agencies as they pursue value-based purchasing
Challenges (1 of 6)

- Approval of changes required at multiple levels
  - Hamper efforts
  - Slow momentum

- Leadership changes can change strategies
  - Medicaid directors’ average tenure is 18 months
  - Federal elections in November

"It is not the strongest of the species that survives, nor the most intelligent that survives. It is the one that is most adaptable to change".

Charles Darwin
1. Medicaid Agency Readiness
   - Staff Resources: size and skill set to sustain current initiatives and drive new payment reform efforts
     - Particular need for additional data analytic capabilities
     - Competing with payers, plans, ACOs for same skill sets
   - Data: collect, analyze, report data is key to implementing payment reform and to hold providers accountable
     - Data systems must be able to process data by new accountability structures (e.g., ACOs, PCMHs, bundles)
     - Need information on clinical outcomes
     - Timely reports to providers
Challenges (3 of 6)

- **State Medicaid Budgets**
  - Under pressure because of state budget shortfalls
  - Providers’ concern that reimbursement already low, so don’t want to take on risk of payment reform
  - Not conducive to long-term investments in payment reform
2. Provider Readiness

- Different points of readiness
- Not all are sufficiently well resourced to shift delivery system processes
- Requires leadership, data analytics, care coordination/care management resources, dedicated time, technical assistance
- States providing varying levels of technical assistance around provider skill development and infrastructure development
3. **Unintended Impact on Provider Landscape**
   - Provider consolidation can lead to higher prices for services and challenge the viability of small independent practices
     - Hospital acquisition of practices
     - Need for minimum number of attributed lives to participate in some types of payment reform

4. **Quality**
   - Challenge to align quality measures across payers to maximize focus and impact
   - Gap in meaningful quality measures for Medicaid populations
   - Gap in outcome measures that account for social determinants of health
   - Challenges to get outcomes through claims
5. Prospective Payment System (PPS) and APM
   - FQHCs are paid under the PPS
   - Federal requirements do not permit states to pay below the encounter rate in the PPS for FQHCs
   - Prohibits state from designing models that hold FQHCs accountable for poor outcomes and high costs through use of shared risk
   - Increases difficulty for Medicaid programs to align innovation efforts across provider types
1. **Multi-payer Alignment**
   - Increases impact of delivery system redesign/payment reform
   - Areas of opportunity include core quality and performance measures, attribution methodology, payment model framework, key definitions (e.g., PCMH)
   - RI: Medicaid and OHIC have aligned payment reform adoption targets and definition of PCMH
   - MA, MN, OR have established multi-payer forums
2. Technical Assistance and Support
   
   - Federal: SIM, DSRIP and Medicaid Innovation Accelerator Program programs have enabled states to accelerate delivery system reform by providing infrastructure funds for state and TA for providers
     
     - NH has a significant initiative to help providers create regional Integrated Delivery Networks through its DSRIP program
   
   - Non-profit
     
     - NESCO – organized by 6 NE Health and Human Services Agencies
     
     - RWJF’s State Health and Value Strategies initiative provides customized support for states selected to receive assistance
     
     - NASHP
3. **Stakeholder Engagement**
   - Essential to begin early in the change process, including during planning phase
   - Helps to build consensus and creates a shared commitment
4. Behavioral Health Integration

- Medicaid is largest payer for BH services in US
- Increasing appreciation of interconnection between BH and physical health and importance of integrated treatment
- States are developing integrated payment models. Examples:
  - MA: PCP cap incentives integrated PCMH models
  - MN: Integrated Health Partnership model holds participating providers for TCOC including limited set of MH/CD services
  - AR/NY: developing BH episodes (e.g., ODD, ADD, schizophrenia, bipolar, substance use, major depression)
  - OR: CCO exploring bundle for pregnant women with SUD issues
- Opportunity to change state and federal laws that inhibit data sharing, build common data sharing tools and processes
CMS Support for BH Integration

- Innovation Accelerator Program – helping states advance new payment/service delivery reform, including BH integration
- MH Parity and Addiction Equity Act
- Certified Community Behavioral Health Centers includes requirement for delivering integrated care
- Current regulatory reform efforts aim to facilitate information sharing governed by 42 CFR Part 2 within new health care models
5. Long-term Services and Supports
   - Next frontier for APMs
   - Huge opportunity as population ages (number 65+ will double by 2050)
   - Increased opportunity as states participate in duals demonstrations and with increased Medicaid/Medicare initiative alignment by CMS
   - Recognized need to develop relevant quality measures for LTSS
6. Social Determinants of Health (SDOH)
   - Population-based models require providers to think more broadly about how to keep patients healthy
   - Increasingly important to address SDOH within APM model
     • Some states are providing funding to enable providers to provide traditionally non-reimbursable services that help address SDOH (i.e., PCMH payments for CM/CC services)
     • Other states are requiring PCMHs to demonstrate how they are addressing unmet non-medical needs, such as housing, food insecurity, transportation, employment.
   - Increasing interest in promoting regional entities responsible for improving population’s health status, including addressing SDOH
     • OR: CCOs
Questions
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