

Medicaid Innovation Accelerator Program

Medicaid Value-Based Payment Approaches and Key Design Considerations National Learning Webinar

October 5, 2017

3:00 PM – 4:30 PM ET



Logistics for the Webinar

- All lines will be muted
- Please do not put your line on hold
- To participate in a polling question, exit out of “full screen” mode
- Use the chat box on your screen to ask a question or leave a comment

Learning Objectives

By the end of this webinar, participants will:

- Learn why state Medicaid agencies may wish to explore implementing a value-based payment (VBP) approach
- Gain an understanding of the general options and approaches available to state Medicaid agencies in implementing VBPs
- Gain an understanding of the considerations for states to select, design, and implement VBP approaches in Medicaid
- Understand various options and approaches states can use in working with managed care organizations (MCOs) in implementing VBP models

Agenda

- Welcome and Introductions
- What is Value-Based Payment (VBP)?
- Common VBP Approaches Used in Medicaid
- Key VBP Foundational Design Elements
- Other Considerations for States
- VBP within a Medicaid Managed Care Environment
- Questions

Presenters



- Scott Leitz, Senior Fellow, NORC at the University of Chicago and Project Director, Medicaid IAP VBP and Financial Simulations Project



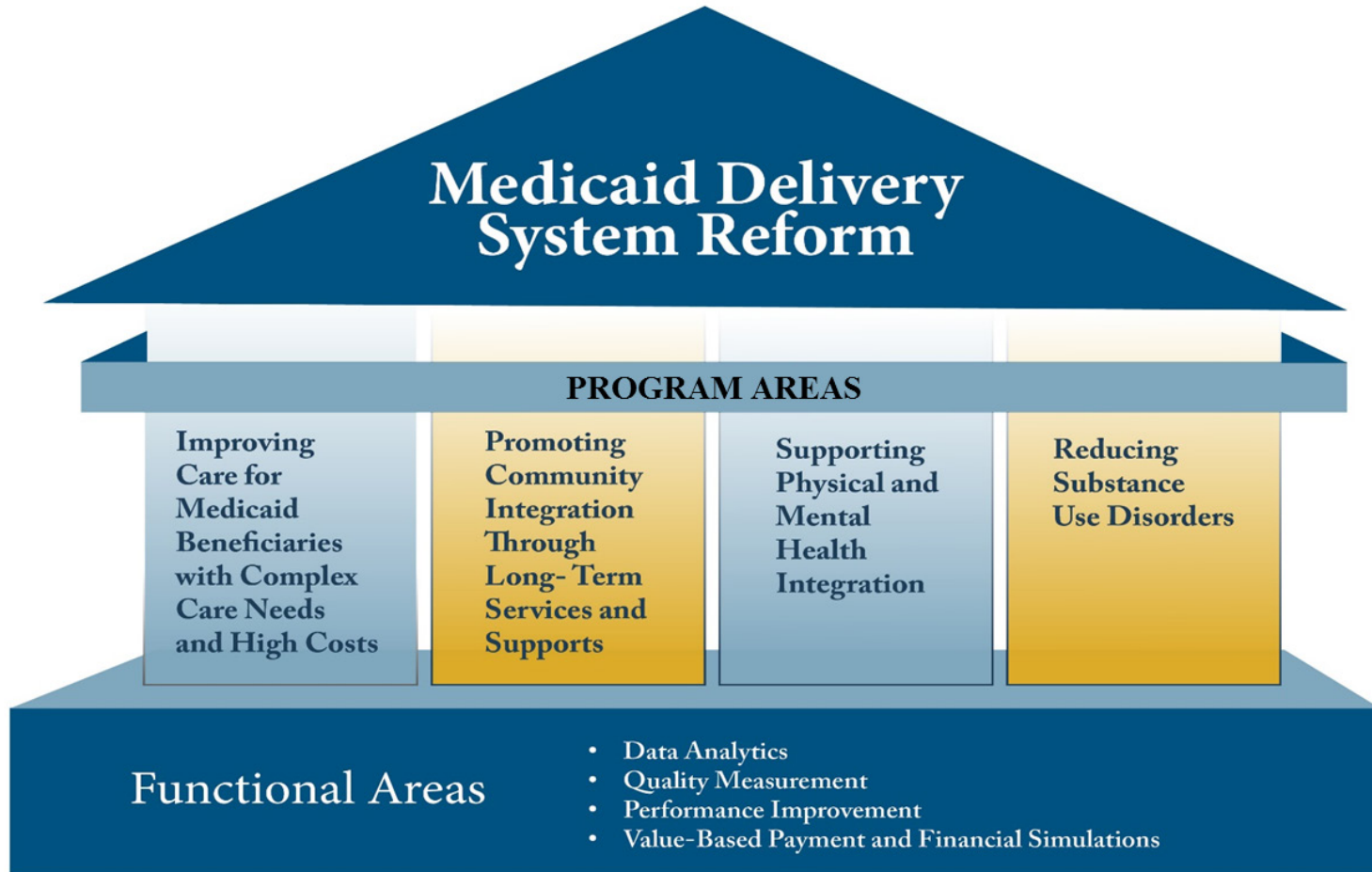
- Tricia McGinnis, Senior Vice President, Center for Health Care Strategies and Coach for the Medicaid IAP VBP and Financial Simulations Project

Medicaid Innovation Accelerator Program (IAP)

- Commitment by the Centers for Medicare & Medicaid Services (CMS) to build state capacity and support ongoing innovation in Medicaid through targeted technical support*
- A Center for Medicare and Medicaid Innovation (CMMI)-funded program that is led by and lives in CMCS
- Supports states' Medicaid delivery system reform efforts:
 - The IAP goal is to increase the number of states moving towards delivery system reform across program priorities
- Not a grant program; targeted technical support

*IAP refers to *technical support* as support, program support, or technical assistance.

Medicaid IAP



What is Value-Based Payment?

Poll Question

What do you know about value-based payment (select all that apply)?

1. I have heard of the term value-based payment (VBP) or alternative payment model (APM).
2. I can give an example of VBP involving a state Medicaid program.
3. I can describe the four categories of VBP in the HCP-LAN's Payment Framework.
4. I have helped design a Medicaid VBP approach.
5. I have been part of a team that has implemented a Medicaid VBP approach.
6. I have helped evaluate a Medicaid VBP approach.
7. Other [please specify and send your response via the chat box]

What is the purpose of value-based payment?





- ***Value-Based Payment (VBP)***
 - Payment models that range from rewarding for performance in fee-for-service (FFS) to capitation, including alternative payment models and comprehensive population-based payments.
 - Broad set of performance-based payment strategies that link financial incentives to providers' performance on a set of defined measures of quality and/or cost or resource use.*

*Source: Modified from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5161317>

Why Value-Based Payment?

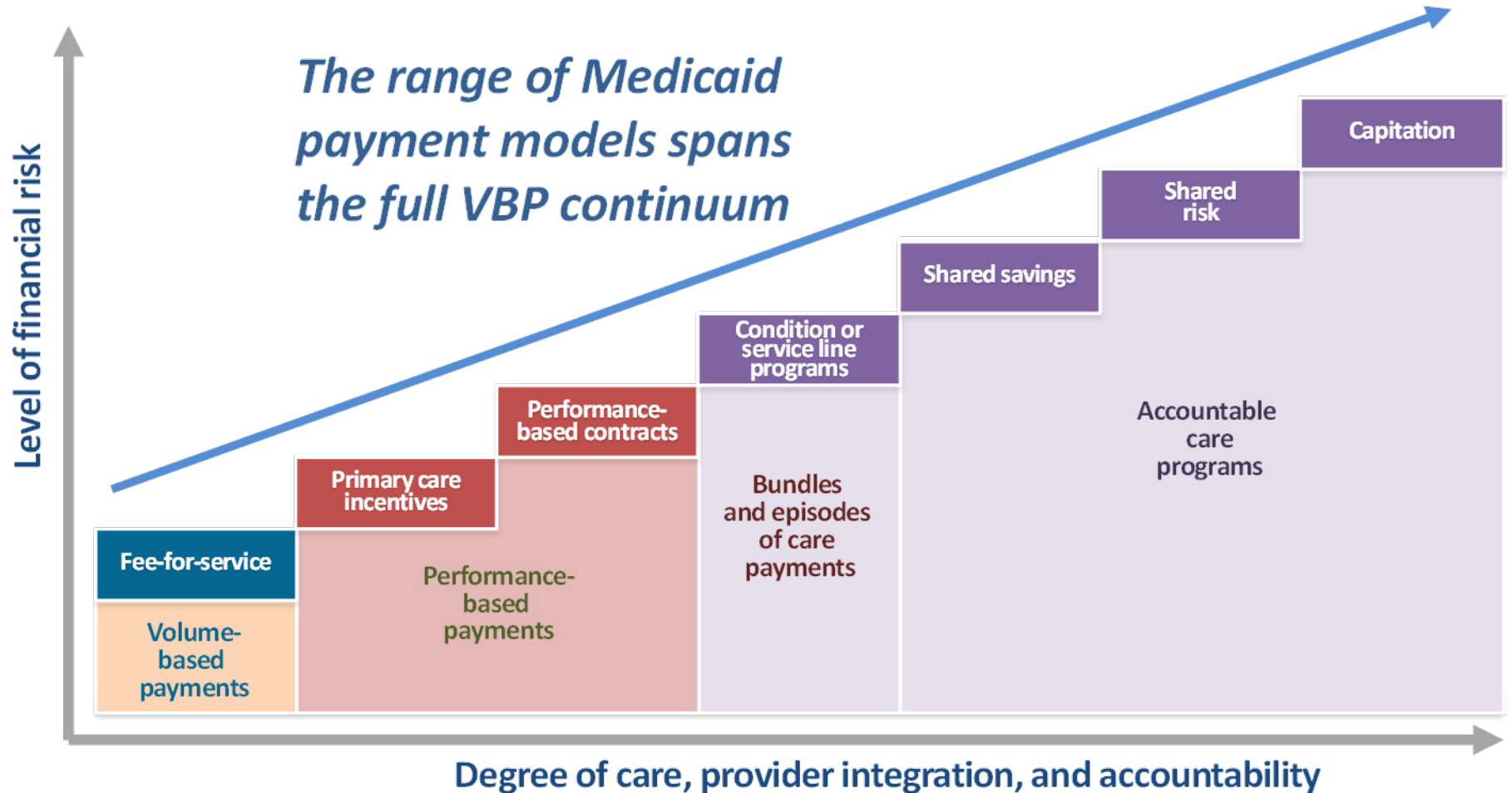
- Roots of current health care system in FFS payment → Providers are paid a certain amount for each service that is delivered
- FFS can create perverse incentives
 - Providers are paid more for doing more
 - Payment doesn't vary by quality of care, no incentives for high quality care
- Change the way providers are paid to deliver care → incentives to deliver high quality care and bend the cost curve, improve value
- VBP encompasses a range of approaches intended to better align incentives for providers to deliver high quality care and reward value in the health care system

Health Care Payment Learning and Action Network Alternative Payment Model Framework

			
<p>CATEGORY 1 FEE FOR SERVICE - NO LINK TO QUALITY & VALUE</p>	<p>CATEGORY 2 FEE FOR SERVICE - LINK TO QUALITY & VALUE</p> <p>A Foundational Payments for Infrastructure & Operations (e.g., care coordination fees and payments for HIT investments)</p> <p>B Pay for Reporting (e.g., bonuses for reporting data or penalties for not reporting data)</p> <p>C Pay-for-Performance (e.g., bonuses for quality performance)</p>	<p>CATEGORY 3 APMS BUILT ON FEE-FOR-SERVICE ARCHITECTURE</p> <p>A APMs with Shared Savings (e.g., shared savings with upside risk only)</p> <p>B APMs with Shared Savings and Downside Risk (e.g., episode-based payments for procedures and comprehensive payments with upside and downside risk)</p>	<p>CATEGORY 4 POPULATION - BASED PAYMENT</p> <p>A Condition-Specific Population-Based Payment (e.g., per member per month payments, payments for specialty services, such as oncology or mental health)</p> <p>B Comprehensive Population-Based Payment (e.g., global budgets or full/percent of premium payments)</p> <p>C Integrated Finance & Delivery Systems (e.g., global budgets or full/percent of premium payments in integrated systems)</p>
		<p>3N Risk Based Payments NOT Linked to Quality</p>	<p>4N Capitated Payments NOT Linked to Quality</p>

Source: Adapted from Alternative Payment Model Framework and Progress Tracking (APM FPT) Work Group. Alternative Payment Model Framework: Final White Paper. July 11, 2017; Figure 4. Accessed July 13, 2017.

The Value-Based Payment Continuum



Source: Adapted from UnitedHealth Group

Questions



Common Value-Based Payment Approaches Used in Medicaid

The Four Most Common VBP Approaches

**Pay-for-
Performance
(P4P)**



**Clinical
Episode
Payment**



**Shared
Savings/Risk**



**Capitation/
Global Payments**



Pay-for-Performance (P4P)



- Ties provider payment directly to specific indicators of quality or efficiency
- Can be built off:
 - **Rewards**
 - Providers receive a bonus payment for measurable performance in quality, patient satisfaction, resource use, and/or cost (e.g., hospital readmissions from nursing homes)
 - **Penalties**
 - Providers may have a penalty imposed if they fail to meet performance requirements

Clinical Episode Payment



- Clinical Episode Payment: A bundled payment for a set of services that occur over time and across settings*
- This payment model can be focused on:
 - a setting (such as a hospital or hospital stay);
 - a procedure (such as knee/hip replacement); or
 - a condition (such as diabetes)
- Incentivizes efficiency and coordination of care across providers to offer care at or below the payment level
 - Payment is contingent on quality performance
- Payment can be made retrospectively or prospectively

* Source: Definition from HCP-LAN: <https://hcp-lan.org/resources/glossary/>

Shared Savings/Risk



- Providers that succeed in keeping costs below a total cost of care benchmark and achieve quality of care results at or above a benchmark keep a percentage of the savings
 - Incentivizes activities, such as coordination and effective care management across all services, to lower the total cost of care
 - Payment received retrospectively, contingent upon cost and quality performance
 - Utilized primarily in Accountable Care Organizations (ACOs)
 - But increasingly being explored in Primary Care Medical Homes, health homes, and super-utilizer initiatives

Global or Capitated Payments



- Providers receive an upfront per member per month (PMPM) payment to cover a wide range of services
 - Providers bear full financial risk by receiving fixed payment for contracted service
 - Access to upfront funding to invest in care coordination, quality improvement, and efficiency across the full continuum of care
 - While traditionally used as the method of payment for MCOs, a global or capitated payment is sometimes also utilized between Medicaid and advanced ACOs, hospitals, and multi-specialty provider groups
 - MCOs sometimes employ a sub-capitation with providers as well

Questions



Key Value-Based Payment Foundational Design Elements

Key VBP Foundational Design Elements

The design elements that go into an VBP approach tend to get more complex as they move from the left to right on the HCP-LAN framework. Some key elements are:

- Patient population of focus
- Services included in the VBP approach
- Financial performance measurement and benchmarking
- Quality performance measurement and alignment
- Attribution of patients
- Risk adjustment

Patient Population of Focus

- Medicaid VBP approaches have initially focused on populations whose expenses were most “medically traditional”
 - Upstream focus and investment to lower downstream cost
 - Acute care, adult populations
 - Chronically ill populations
- Some approaches have focused on pediatric populations
- As approaches have evolved, states have begun to expand their focus to enrollees with a more long term services and supports focus
 - Disabled, elderly
- Different populations, and the providers who serve them, may require different approaches to VBP

Services Included in the VBP Approach for Cost Calculation

- Create accountability around cost and quality within the control of the participating provider(s) to coordinate and deliver
- The costs associated with services that fall within the reasonable control of providers in the VBP approach are often the target services and should be appropriate to the population or treatment
- In general, services include the spectrum of medical benefits
- For episodes, services included for calculation typically include the range for a given typical course of treatment for a condition
- Defining services is an emerging field in long term supports and services and Home and Community Based Services, as these approaches develop

Quality Performance Measurement

- Inclusion of quality and measures are important to ensure that focus isn't *only* on financial/cost outcomes
- Payments for VBPs are affected wholly or in part by quality performance, both for meeting benchmarks or for improvement:
 - Bonus payments
 - Withholds or penalties for failing to meet quality benchmarks
 - A lower/higher percentage of shared savings/losses being paid for meeting/exceeding/failing to meet quality benchmarks
 - No shared savings being paid for failing to meet quality benchmarks
- Alignment of measures chosen for VBP approaches with other state/federal initiatives

Financial Performance Measurement and Benchmarking

- In general, total cost of care is calculated across the included set of services, for the attributed population, for a chosen time period (typically a year)
- Outlier claims typically excluded, sometimes based on the size of the attributed population
- Trend rates are oftentimes in line with expected managed care rate trends, and can be directed or negotiated between the state and provider
- Oftentimes, a minimum savings threshold is applied before shared savings is achieved
 - Helps ensure savings are not based on random fluctuations

Attribution of Patients

- Method for “assigning” patients for total cost of care calculations without requiring them to “enroll” with a particular providers
- There are various ways to do this “assignment” but generally
 - Patients are assigned to the primary care provider with which the patient has the most established care pattern;
 - If the state is using a medical home model, patients are generally assigned to that home for cost calculations

Risk Adjustment

- Risk adjustment is a way to adjust for differences in patient complexity
 - Key to ensuring that year to year, or patient population comparisons, are consistent
 - Key to ensuring providers are not penalized for serving complex patients
 - Can be used to adjust both cost and quality
- Risk adjustment is utilized across the various VBP approaches
 - Risk adjusting total cost of care for shared savings models so year to year comparisons are apples-to-apples
 - Risk adjusting episodes of care to reflect patient complexity
- States increasingly interested in examining how to include non-medical, social determinants in their risk adjustment models

Questions



Other Considerations for States

Some Other Factors for States to Consider in Moving to VBP



- What is the current degree of VBP in your state?
 - Stakeholder engagement
- Alignment with federal and private payer initiatives
- Medicaid managed care or fee-for-service?
- How robust are your data systems and ability to share key information with health providers?
- What is the state of provider readiness for VBP in your state?
 - Provider training
- What are the upfront state investment and internal resources needed?

Value-Based Payment within a Medicaid Managed Care Environment

State Levers for VBP Implementation via Managed Care

Encourage

- Request for Proposal (RFP) questions
- Contractual supports
- Quality/efficiency transparency

Incent

- Contractual incentives or penalties for adoption
- Rate-setting incentives
- Patient assignment rules

Require

- Contractual requirements
- Legislation
- Regulatory requirements

General Approaches to VBP in Managed Care Contracts



MCO Requirement to:	State
Adopt a standardized VBP model	MN, TN
Make a specific percentage of provider payments through approved VBP arrangements	AZ, NY, PA, WA
Move toward implementation of more sophisticated VBP approaches over the life of the contract	NY
Actively participate in a multi-payer VBP alignment initiative	TN
Launch VBP pilot projects subject to state approval	NM, MN

Managed Care Considerations



- How flexible or prescriptive should a managed care VBP requirement be?
- What levers should the state use?
- What counts?
 - States can use HCP-LAN categories to decide what counts
 - What counts can “evolve” over time and vary among categories
 - What counts may vary among health plans

Questions



Key Takeaways on Value-Based Payment

- Value-based payment is increasingly being examined and used by states to provide better delivery system incentives for higher quality, lower costs, and improve patient outcomes
- The HPC-LAN framework provides a very useful model for examining approaches available for VBP
- States should consider where they are on the HPC-LAN framework, and where they would like to be
- While there are key foundational design elements for VBP, each state will have a different starting place, should consider their unique situations, and apply VBP design in a way that works for the state.

Thank You for Joining Today's Webinar!

We hope to see you for the following Medicaid IAP VBP Webinars that will build off this one:

- Medicaid Value-Based Payments for Children's Oral Health-
October 19th from 2:00-3:00 pm ET
- Medicaid Value-Based Payments for Substance Use Disorders-
October 26th, 2:00-3:30 pm ET
- Medicaid Value-Based Payments for Maternal and Infant Health-
November 2nd, 2:00-3:00 pm ET

Please take a moment to complete a short feedback survey.