CAQH CORE Webinar

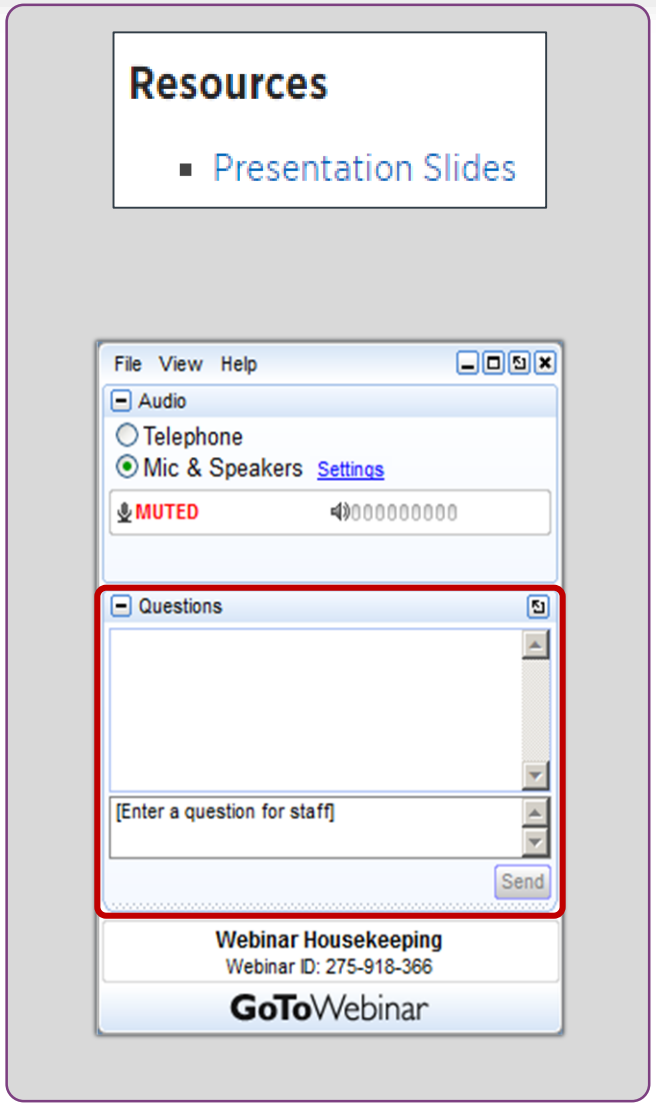
State Medicaid Experiences with Value-based Payments with Center for Health Care Strategies and Minnesota Medicaid

June 6, 2019

Logistics

Presentation Slides and How to Participate in Today's Session

- **You can download the presentation slides at www.caqh.org/core/events after the webinar.**
- Click on the listing for today's event, then scroll to the bottom to find the Resources section for a PDF version of the presentation slides.
- A copy of the slides and the webinar recording will be emailed to all attendees and registrants in the next 1-2 business days.
- Questions can be submitted ***at any time*** using the **Questions panel on the GoToWebinar dashboard.**



CAQH CORE

Session Outline

- Overview of CAQH CORE VBP Report
- Overview of State Medicaid Agency Trends in Value Based Payment
- Integrated Health Partnerships: A Collaboration between Payer and Provider
- Q & A

Thank You to Our Speakers

Tricia McGinnis

Senior Vice President

Center for Health Care Strategies

Mathew Spaan

Manager, Care Delivery & Payment Reform

Department of Human Services

Lina Gebremariam

Manager

CAQH CORE

CAQH CORE
Value-Based Payments Overview

Lina Gebremariam
CAQH CORE Manager

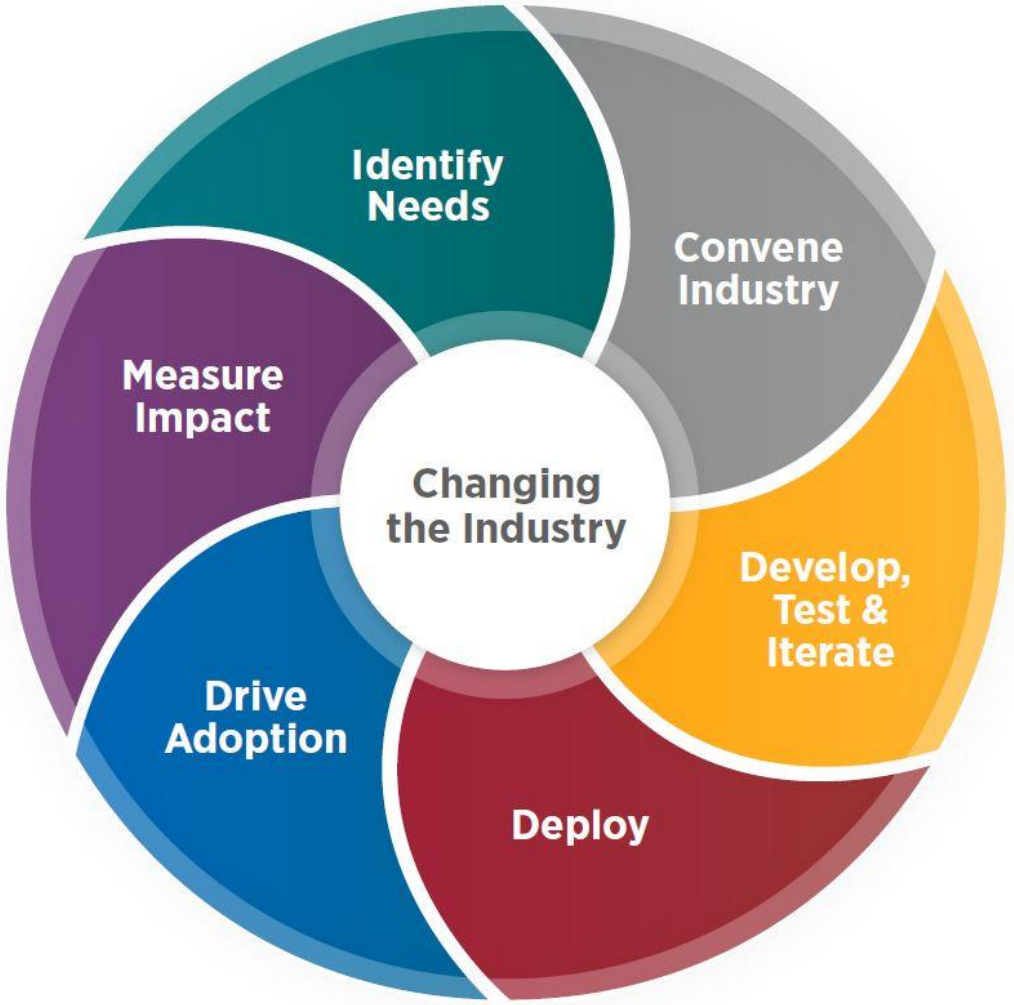
CAQH CORE Mission and Vision

MISSION Drive the creation and adoption of healthcare operating rules that **support standards**, **accelerate interoperability** and align administrative and clinical activities among providers, payers and consumers.

VISION An **industry-wide facilitator** of a trusted, simple and sustainable healthcare data exchange that evolves and aligns with market needs.

DESIGNATION **Named by Secretary of HHS to be national author for operating rules** mandated by Section 1104 of the Affordable Care Act.

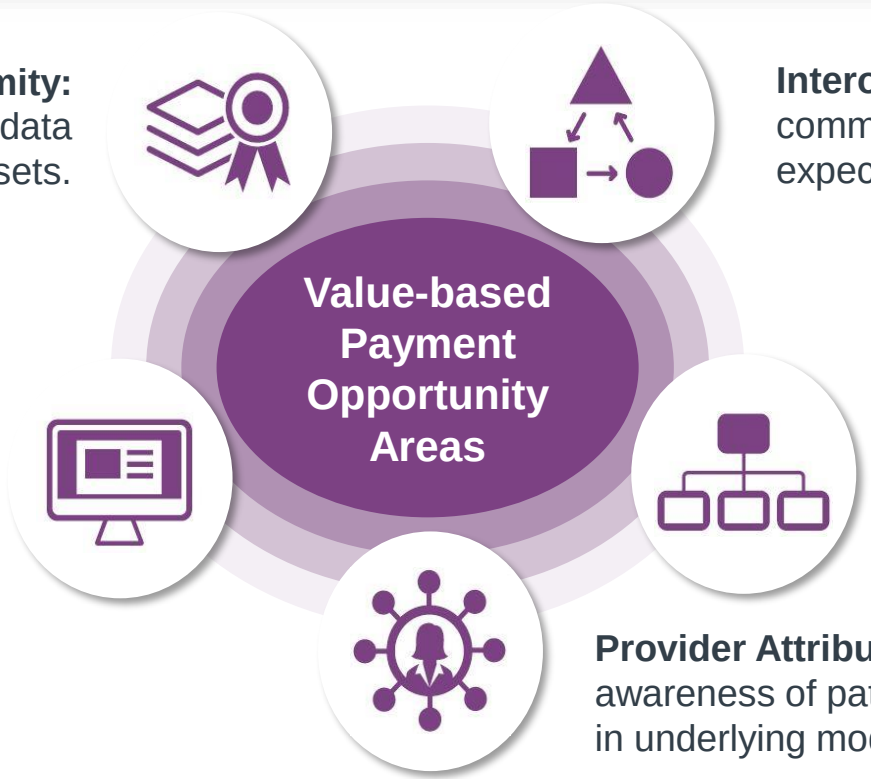
BOARD **Multi-stakeholder.** Members include health plans, providers (some of which are appointed by associations such as the AHA, AMA, MGMA), vendors, and government entities. Advisors to the Board include SDOs.



Streamlining Adoption of Value-Based Payments

Data Quality & Uniformity: Standardize identifiers, data elements, transactions and code sets.

Interoperability: Define common process and technical expectations.



Quality Measurement: Educate on need for consistent and actionable quality data while considering physician burden.

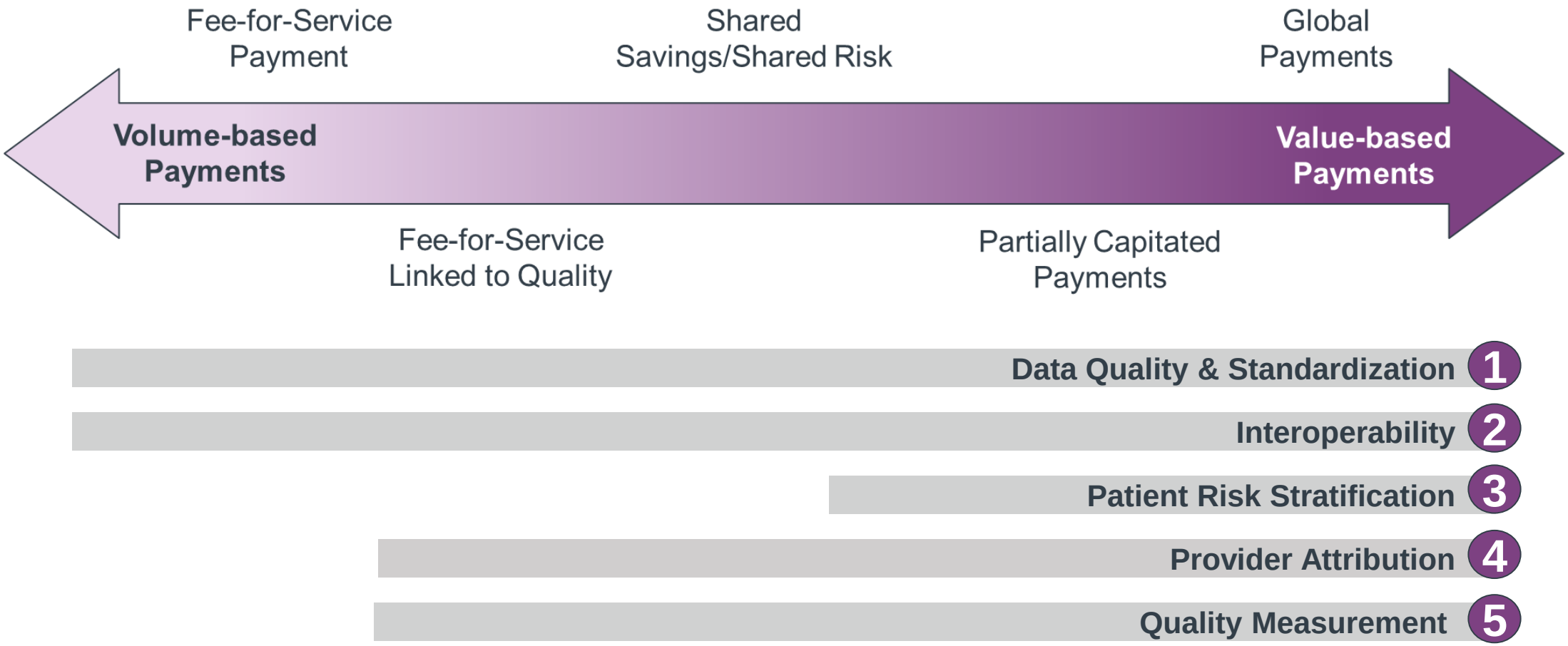
Patient Risk Stratification: Promote collaboration and transparency of risk stratification models.

Provider Attribution: Improve provider awareness of patient attribution and transparency in underlying models.

CAQH CORE Vision	CAQH CORE Report	Project Status
A common infrastructure that drives adoption of value-based payment models by reducing administrative burden, improving information exchange and enhancing transparency.	Identified five opportunity areas in the industry that could smooth the implementation of value-based payments and prevent variation across the industry.	CAQH CORE VBP Advisory Group identified five operating rule opportunity areas for the CAQH CORE Participants to pursue – rule development activity to begin in Q3 2019.

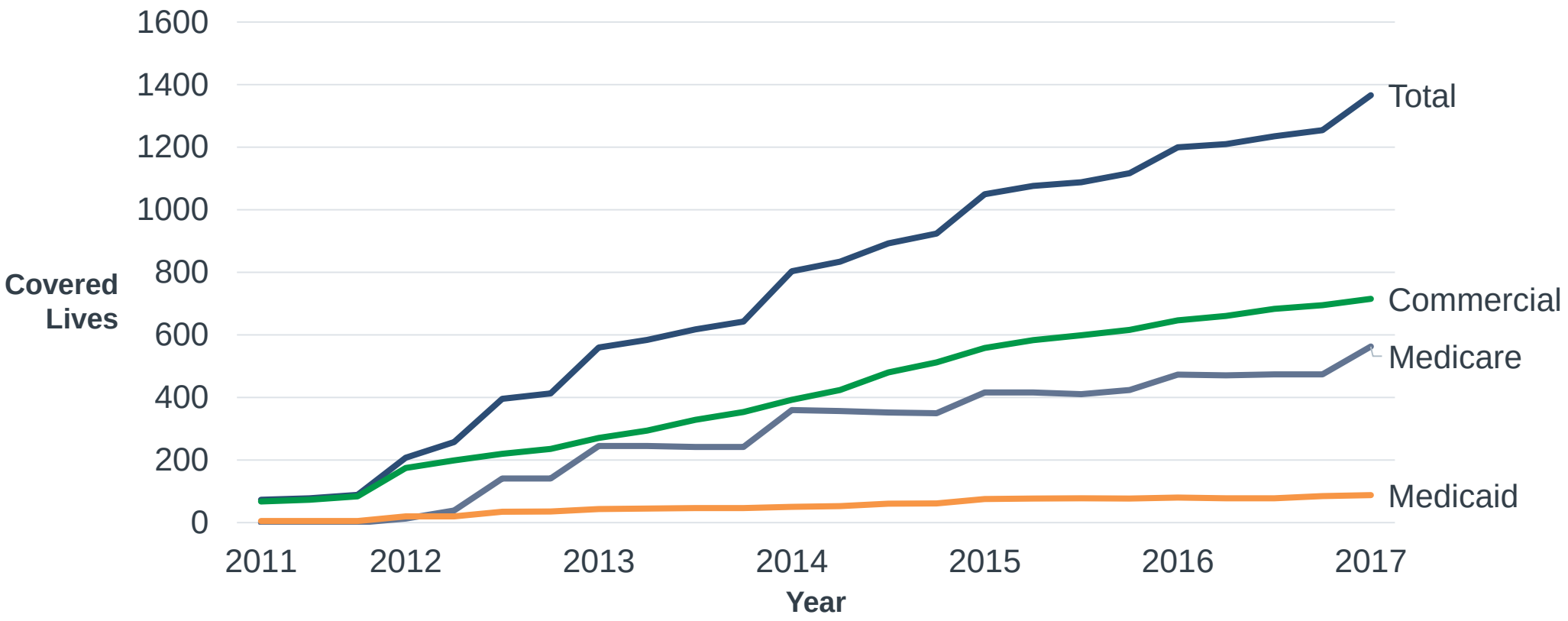
Continuum of Value-based Payment Models

CAQH CORE Opportunity Areas Have Direct Impact



CAQH CORE

Growth in ACOs Across Payers



Source: https://www.healthaffairs.org/do/10.1377/hblog20170628.060719/full/.

Not for public distribution.

CAQH CORE

CHCS Center for Health Care Strategies, Inc.

Advancing innovations in health care delivery for low-income Americans

Overview of State Medicaid Agency Trends in Value Based Payment

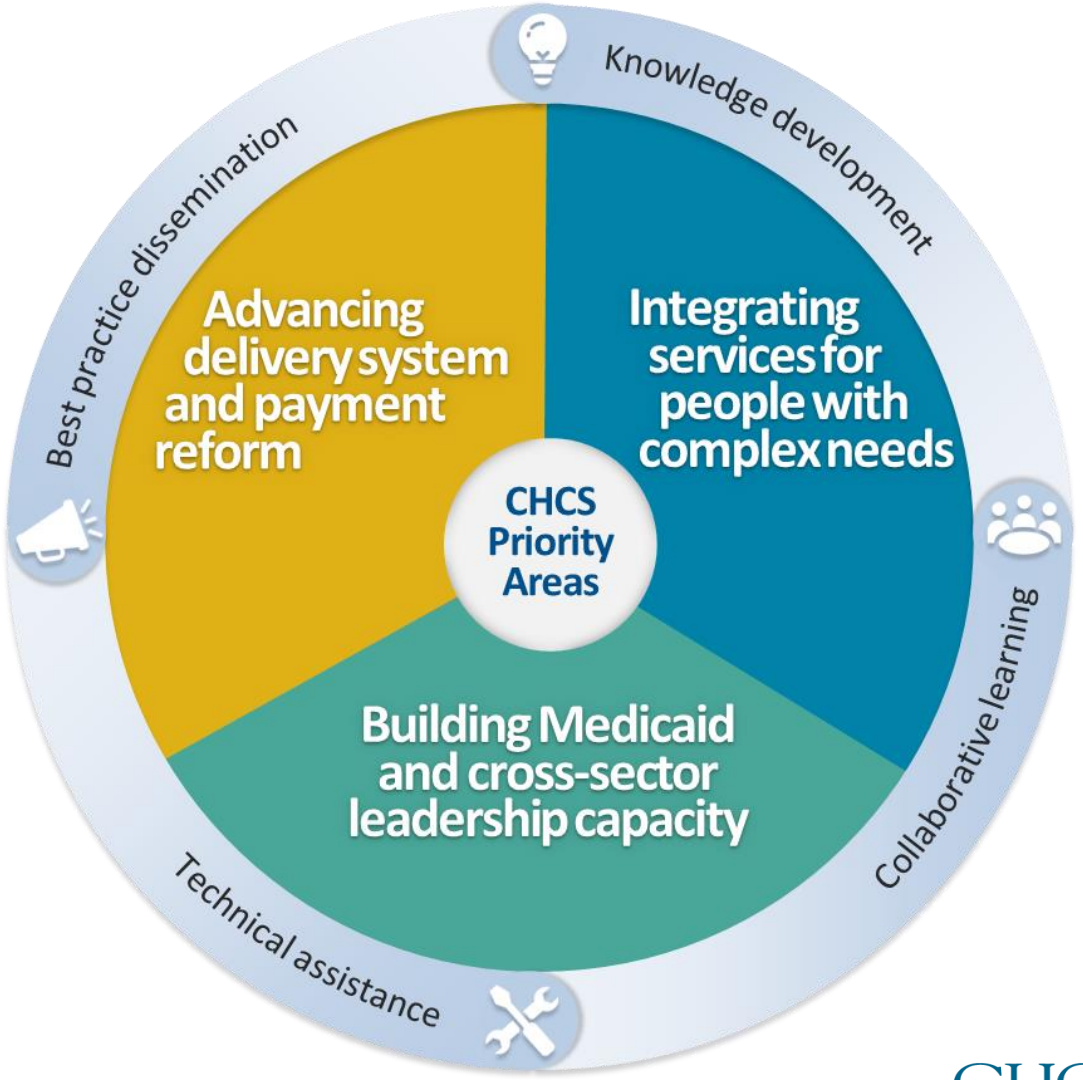
CAQH CORE National Webinar

June 6, 2019

Tricia McGinnis, Senior Vice President

About the Center for Health Care Strategies

A nonprofit
policy center dedicated
to improving
the health of
low-income Americans



Key Cost Drivers in Medicaid

- Poorly managed care for patients with complex care needs, including severe mental health issues, substance use disorders, and chronic conditions
- Facility costs for patients with long term support and services needs, including developmental disabilities and physical limitations
- Frequent and avoidable emergency room use
- Select high cost drugs (e.g., Sovaldi)

Key Levers for Addressing Medicaid Costs

- Value based payment and purchasing (VBP)
- Coverage and access to lower cost alternatives
  - Medication assisted therapy
  - Home and community based services
- Provider infrastructure and capacity building

What drives Medicaid VBP Approaches?

- State budget constraints
- Federal funding and regulations
- Health improvement priorities
- Provider uptake of Medicare models

The Four Most Common Medicaid VBP Approaches

Per member per month (40 states)

Bundled Payments (13 states)

ACO Shared Savings/Risk (12 states)

Capitation/ Global Payments (8 states)

Source: Change Healthcare, *Value Based Care in America*. Available at : https://www.changehealthcare.com/docs/default-source/press-release/change_healthcare_value-based_care_in_america_state-by-state_infographic.pdf?sfvrsn=9217b232_2

Medical Homes and Health Homes

- Patient-Centered Medical Homes (PCMH)
  - PCMH recognition from National Committee for Quality Assurance (NCQA or state-defined programs
  - Typically paid a per-member-per-month (PMPM) rate, sometimes tiered based on type of PCMH and its capabilities
  - Many states beginning to combine PCMH with shared savings models
- Medicaid Health Homes
  - Established for Medicaid under the Affordable Care Act
  - Focused on patients with multiple complex physical and mental health conditions
  - Six services, including care management and coordination and referral to community and social support services
  - Typically paid a PMPM rate substantially higher than PCMH

Bundled Payments: Arkansas

- **Retrospective Episodes of Care for 17 conditions:**
  - » Medicaid outcomes by episode bundle:
    - **Knee/hip replacement:** Average episode cost fell 4%
    - **Chronic obstructive pulmonary disease (COPD):** Average episode cost fell 8%
    - **Perinatal:** C-section rate reduced by 7 percentage points
    - **Asthma**: Number of providers in 'unacceptable' cost category reduced from 17 to 6
    - Increased follow-up visit rates, some quality improvements
  - » **Journal of Health Economics** 2018 study* on perinatal episode (across payers, not just Medicaid)
    - Spending per episode decreased 3.8%
    - 80% of savings due to changes in inpatient care price, rather than quantity
    - Reductions in C-section rates and inpatient stays not statistically significant

*Carroll, C. et al, "Effects of episode-based payment on health care spending and utilization: Evidence from perinatal care in Arkansas," *Journal of Health Economics*, Vol. 61 (2018): 47-62, https://doi.org/10.1016/j.jhealeco.2018.06.010.

Shared Savings/Risk: Massachusetts

- **MassHealth Accountable Care Organizations**
  - » Participate in one of three Medicaid Models
    - **Primary Care ACO** (FFS, with shared savings/losses)
    - **MCO-Administered ACO** (FFS, with shared savings/losses)
    - **Partnership Plan** (PMPM)
  - » Payment dependent on:
    - Cost performance: Risk-adjusted Total Cost of Care Benchmark
    - Quality performance: ACO Quality Measure Slate
  - » Collaborate with "Community Partners" (Behavioral Health & Long Term Services and Supports)
  - » Will provide "flexible services" to address social needs

Source: *What to Know About ACOs*, https://bluecrossmafoundation.org/sites/default/files/download/publication/ACO_Primer_July2018_Final.pdf

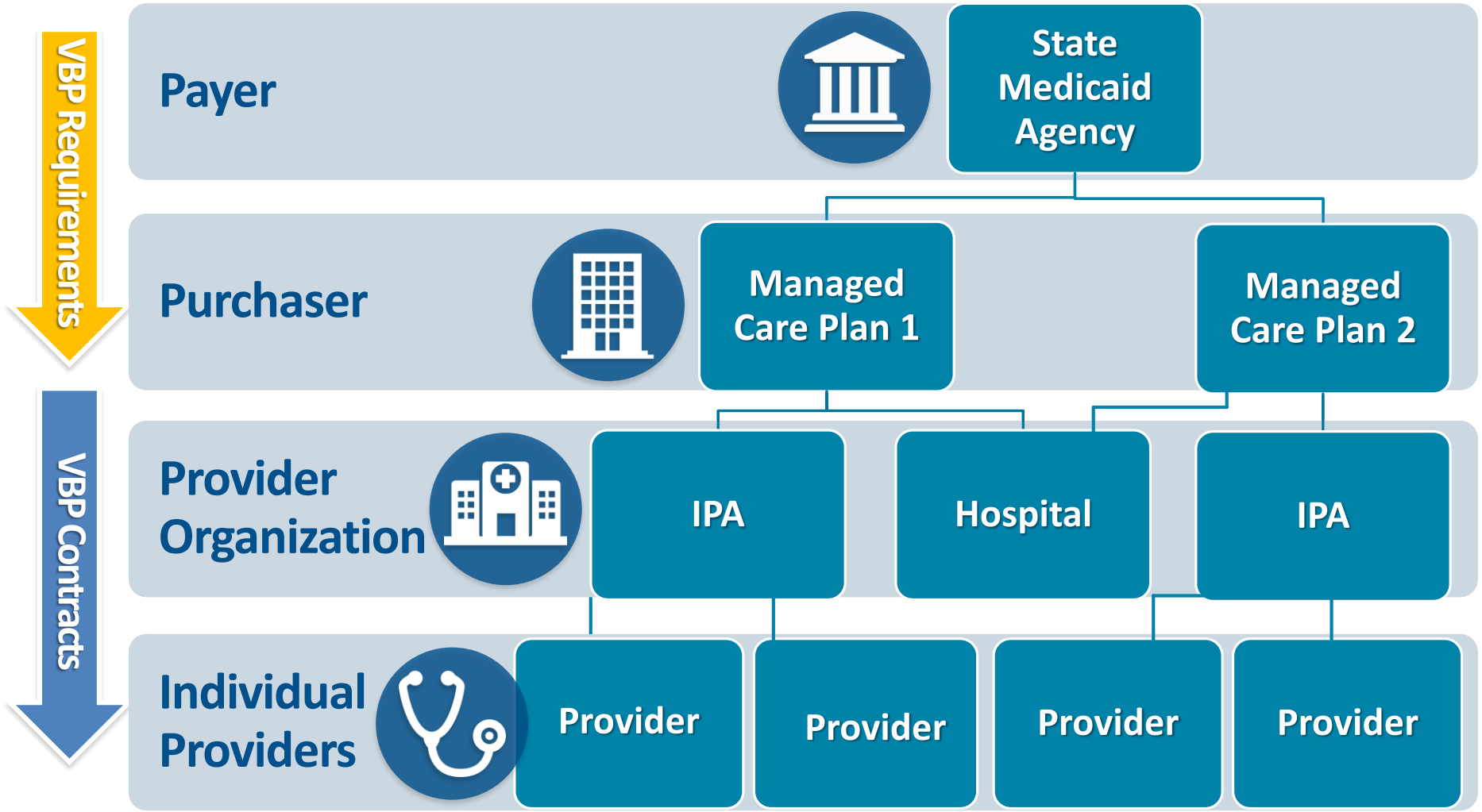
All Payer Global Budget for Hospitals: Maryland

- In 2014, implemented per member per month global budgets for hospitals across Medicaid, Medicare, and commercial payers

CMMI agreement requirements:	Results:
• Hospital spending growth below 3.58% per year	• Average annual hospital spending growth 1.53% per year
• $330M Medicare savings over 5 years	• $586M in Medicare savings in first 3 years
• Reduce Medicare 30-day readmission rate to at or below national average over 5 years	• No statistically significant change in readmission rate in first 3 years, vs. comparison group
• Reduce rate of hospital-acquired conditions by 30%	• Hospital-acquired conditions reduced by 44% through 2016

MD Dept. of Health All-Payer Hospital Model Results Performance Year 3, March 2018: http://www.hscrc.state.md.us/Documents/Modernization/Maryland%20APM%20Performance%20Report%20-CY2016_3_9_18.pdf

VBP in Medicaid Managed Care



VBP Benchmarks in MCO Contracts

- States often require MCOs to tie a percentage of provider payments to a value-based payment arrangement.
  - » Definition of qualifying VBP may differ by state (e.g., HCP LAN Framework Categories)
  - » The benchmark usually increases over time (e.g., OR requires 35% in '21 and 70% in '24).

State	% of Contracts under VBP by 2021
Arizona	70%
Delaware	50%
Hawaii	80%
Massachusetts	70%
New Mexico	33%
Oregon	35%
Rhode Island	65%
Texas	50%
Washington	90%

Value Based Purchasing for Pharmaceuticals in Medicaid

- Creates skin in the game for pharmaceutical companies to ensure that drugs are delivering better patient outcomes
- Emerging Medicaid VBP models include:
  - A results based arrangement
  - A drug adherence model
  - A capped financing model

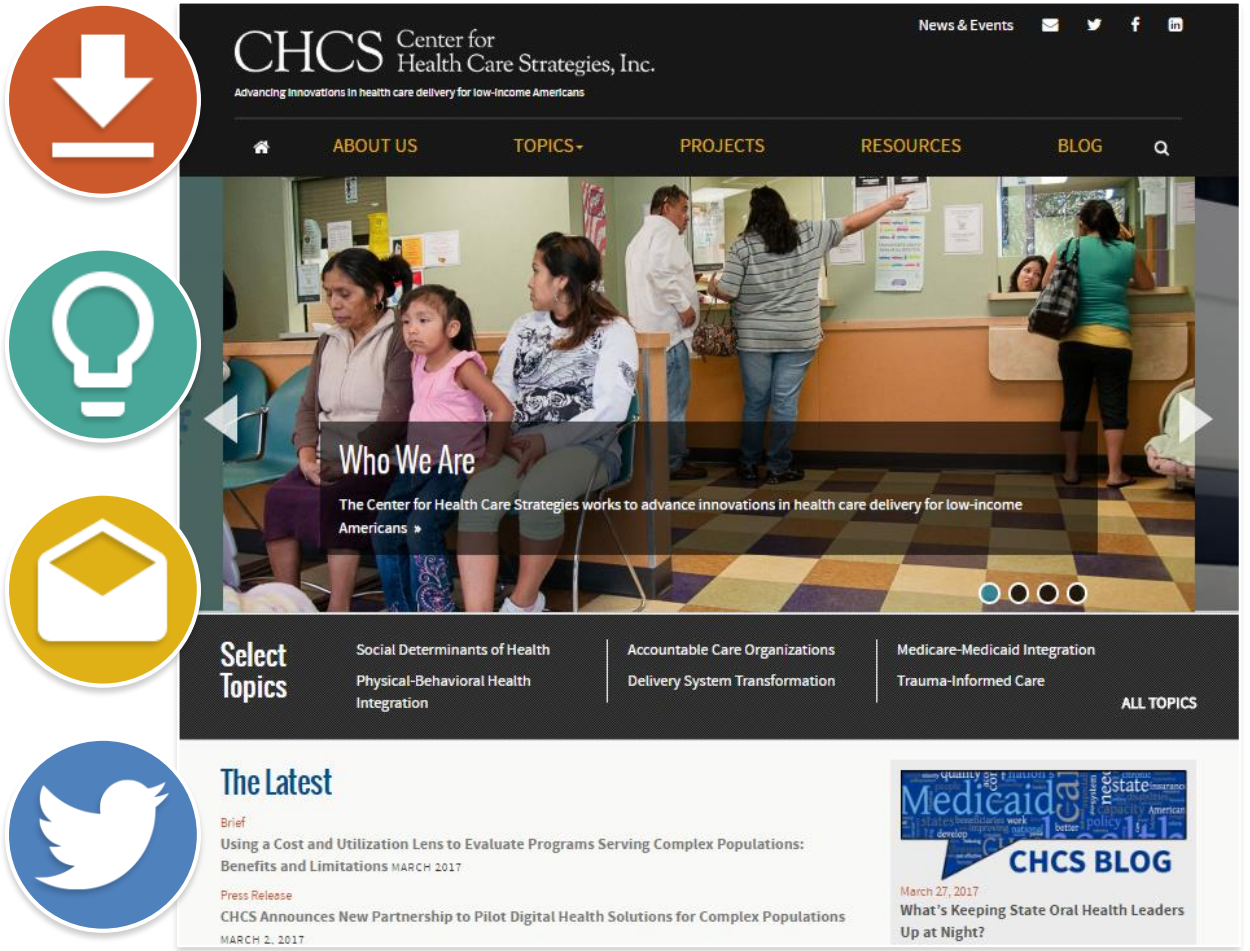
Dworkowitz et. Al, "Extending VBP Models into Medicaid Drug Purchasing: Challenges and Opportunities," Health Affairs Blog, May 22, 2019

Implementation of VBP in Medicaid Is Challenging

- New demands on a fragile provider network, particularly for community-based providers
- Limitations of data sharing and analytics
- Limited evidence on which VBP approaches are most effective
- Significant upfront investments for providers
- Misalignment of payers
- Health plan rate-setting barriers

Visit CHCS.org to…

- **Download** practical resources to improve the quality and cost-effectiveness of Medicaid services
- **Learn** about cutting-edge efforts to improve care for Medicaid's highest-need, highest-cost beneficiaries
- **Subscribe** to CHCS e-mail, blog and social media updates to learn about new programs and resources
- **Follow** us on Twitter @CHCShealth



Polling Question #1

Is your organization actively working on value-based payment models/strategies?

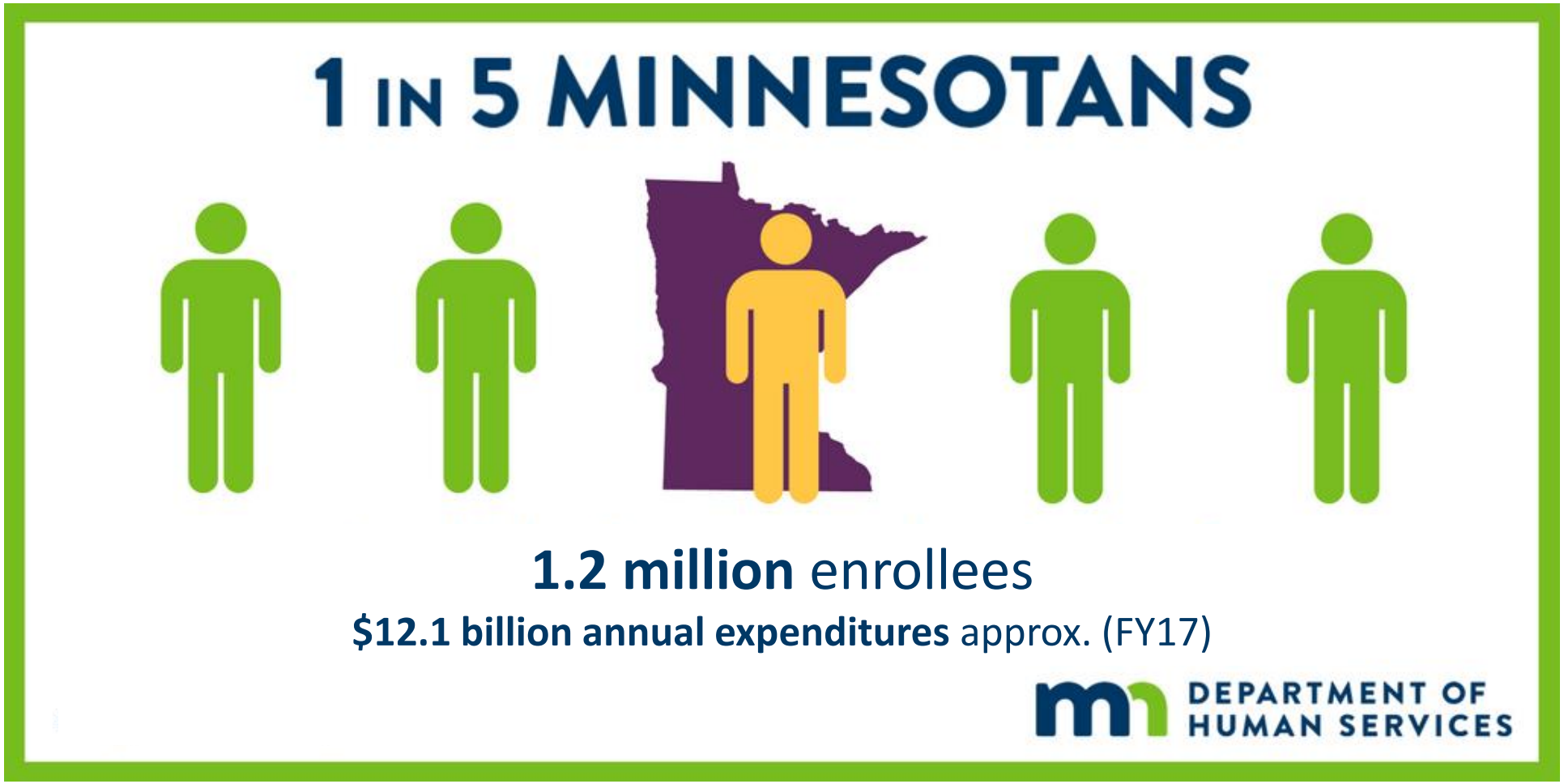
- Yes – We are actively implementing value-based models.
- Yes – We are actively designing models for implementation.
- No
- Unsure

DEPARTMENT OF HUMAN SERVICES

Integrated Health Partnerships: A Collaboration Between Payer and Provider

Mathew Spaan | Manager, Care Delivery & Payment Reform at DHS

Minnesota health care programs serve …



How Minnesota has purchased health care for enrollees

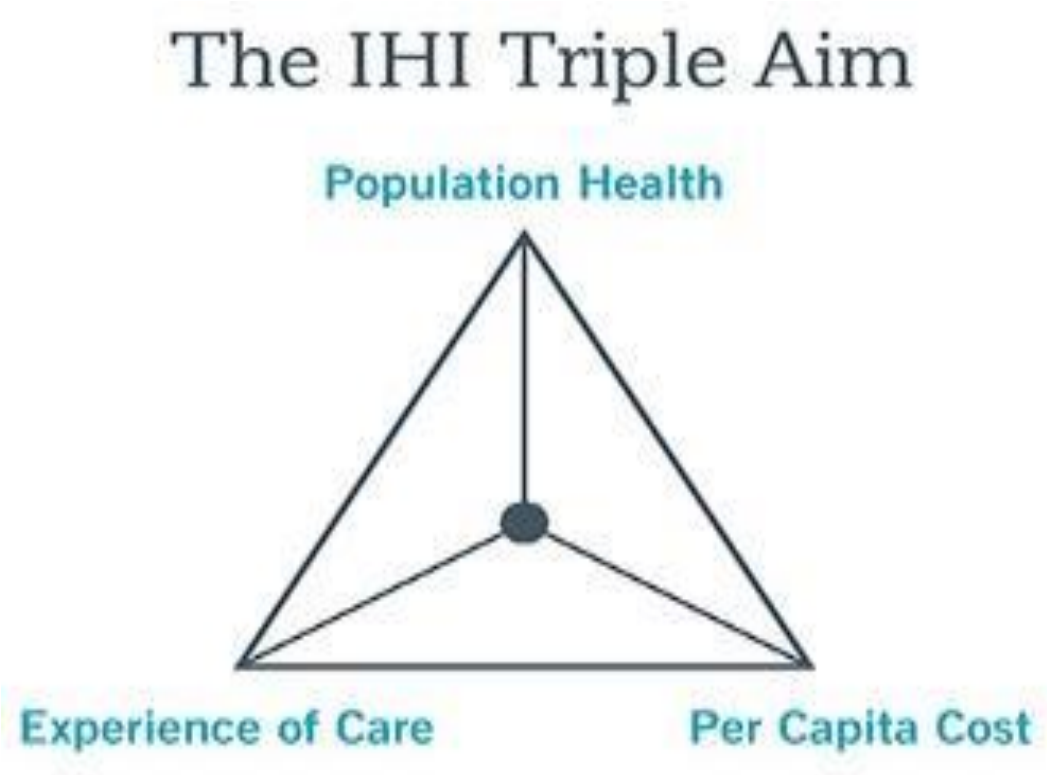
Fee for service (25%)

- DHS processes claims and pays providers directly

Managed care organizations (75%)

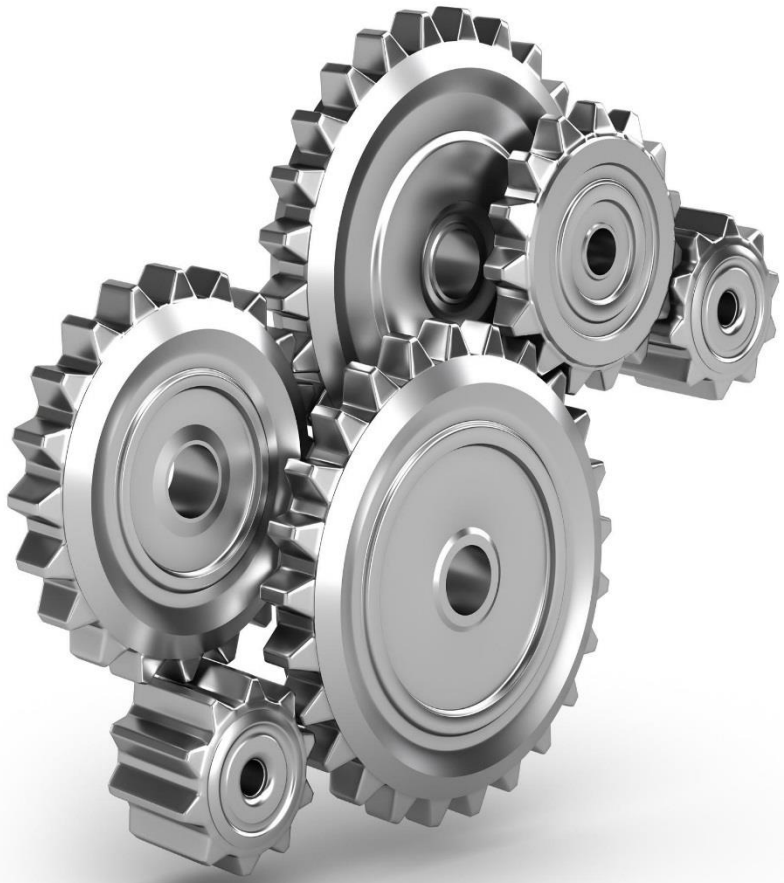
- DHS pays managed care organizations (MCOs) to provide benefits to enrollees. MCOs process claims and pay providers.

Where the IHP program comes in…



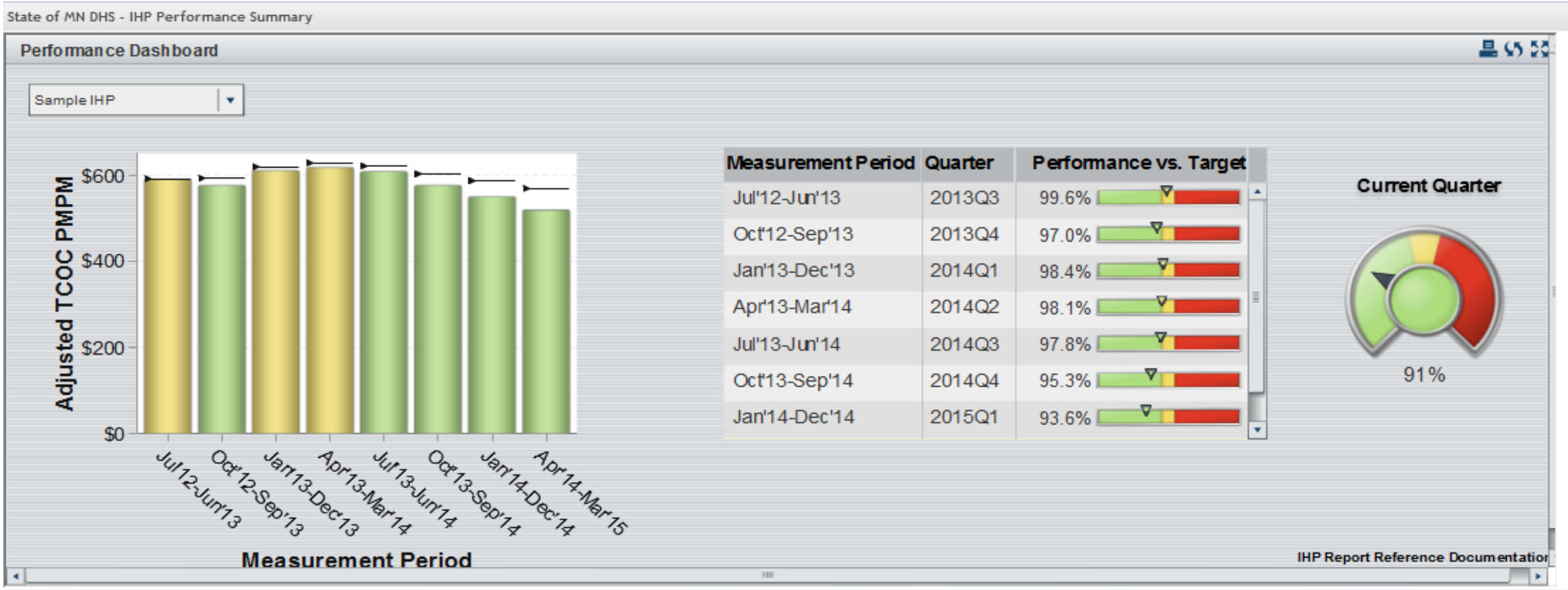
- MN's Medicaid Accountable Care Organization (**ACO**) model
- **Enhance accountability** for patients' care, **create incentives for innovative care models** that meet IHI triple aim
- First **six (6) IHPs started in 2013**, covering ~100,000 Medicaid beneficiaries
- We now have **25 IHPs, covering about 460,000** beneficiaries, with wide diversity and spread
- In 2018, we launched our "**IHP 2.0**" model

Core concepts and accountability

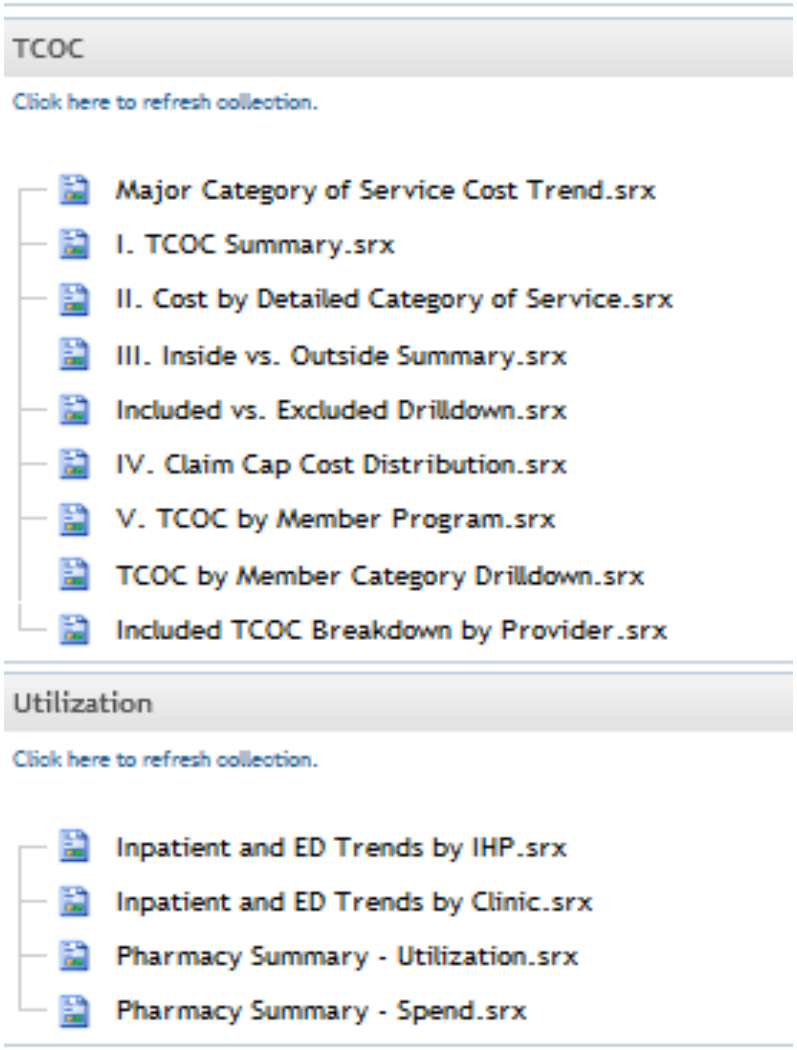


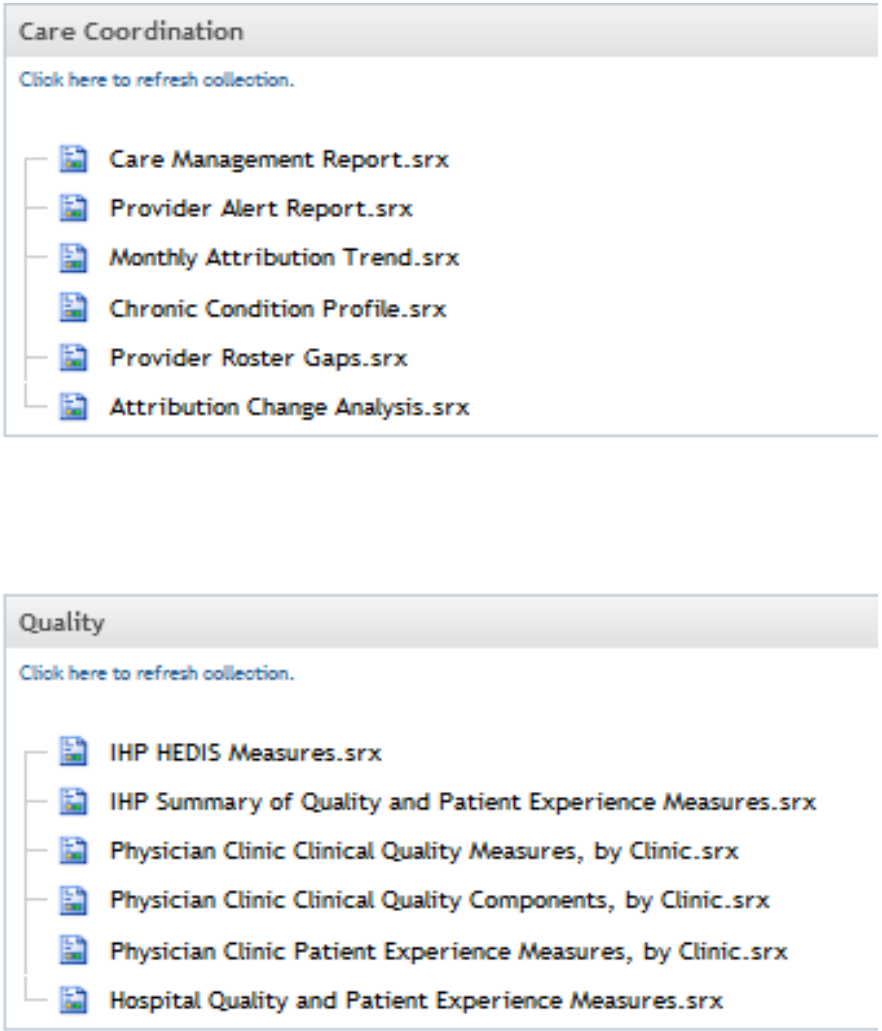
- **Medical Assistance** and **MinnesotaCare; fee for service** and **managed care**
- **Primary care** centric, but with built-in **flexibility**
- IHP system is responsible for:
  - Defined **core set of health care services** for an **identified population** (retrospective)
  - Potential **total cost of care shared risk** (savings and losses)
  - **Robust quality metrics:** clinical, utilization and health equity
- DHS acts as **facilitative partner**, providing detailed data analytics, reports, ad hoc support

Data analytics support to help IHP's succeed



Example - IHP portal drilldown reports



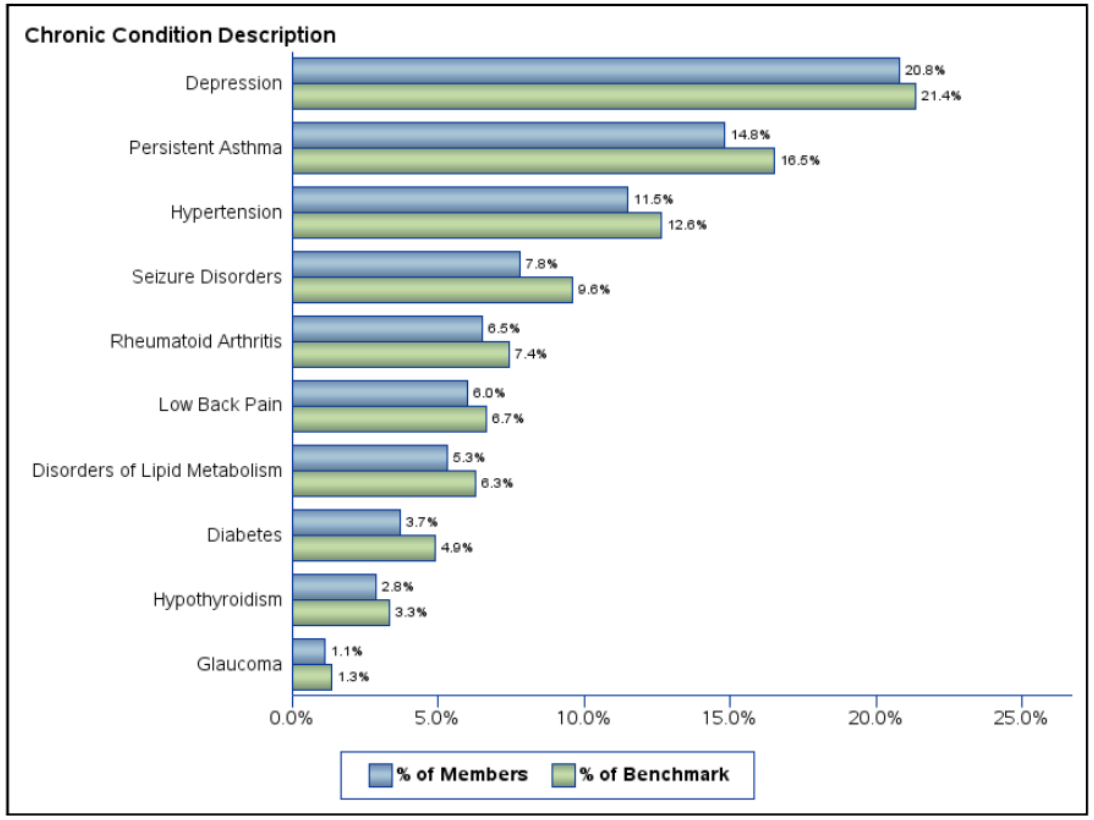


Example – Chronic condition profile

State of Minnesota DHS – IHP Demonstration Project

Chronic Condition Profile

IHP Organization: Sample IHP
Age Group: All Ages
Run Month: JUN2017



Click text to view ALL attributed members with conditi

Chronic Condition Rank ▲	Chronic Condition Description	Members	Member Risk	% of TCOC
1	Depression	6,790	2.08	18.6%
2	Persistent Asthma	4,832	1.77	11.9%
3	Hypertension	3,740	2.33	13.2%
4	Seizure Disorders	2,539	3.05	12.2%
5	Rheumatoid Arthritis	2,115	2.62	9.2%
6	Low Back Pain	1,958	2.76	6.6%
7	Disorders of Lipid Metabolism	1,730	2.62	6.8%
8	Diabetes	1,203	2.83	5.5%
9	Hypothyroidism	926	2.28	3.1%
10	Glaucoma	362	2.43	1.1%

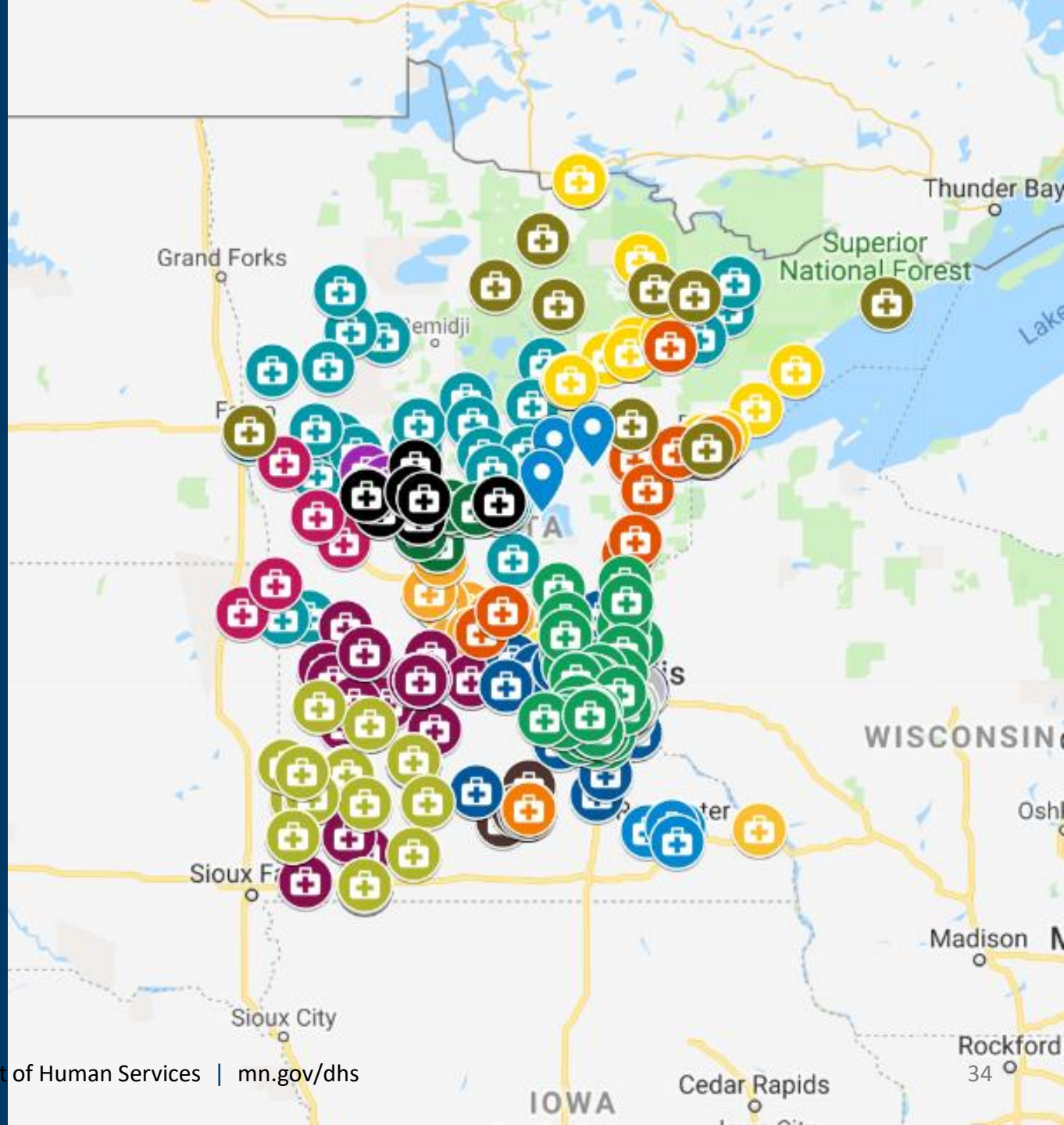
Rows 1 - 10

IHPs across Minnesota

- 47% of enrollees in Greater Minnesota

- More than 500 different provider locations

- More than 10,000 individual practitioners



The current impact of IHPs

Cost savings

~~$277 million~~

$401 million
(2013 – 2018)

People served

460,000+

Emergency room visits

Down 7%

Hospital stays

Down 14%

Unfortunately, we still have unmet needs - Health disparities across Minnesota

Differences in Health Outcome Measures Among Counties and for Racial/Ethnic Groups in Minnesota

	Healthiest MN County	Least Healthy MN County	AI/AN	Asian/PI	Black	Hispanic	White
Premature Death (years lost/100,000)	3,500	12,900	16,800	4,000	8,400	3,700	4,800
Poor or Fair Health (%)	10%	21%	29%	10%	16%	27%	11%
Poor Physical Health Days (avg)	2.5	4.6	5.5	2.0	4.1	3.5	2.9
Poor Mental Health Days (avg)	2.6	4.3	6.0	2.1	3.6	3.1	3.2
Low Birthweight (%)	6%	7%	8%	8%	10%	6%	6%

American Indian/Alaskan Native (AI/AN), Asian/Pacific Islander (Asian/PI)

Source: *2018 Minnesota State Report*. County Health Rankings & Roadmaps.
http://www.countyhealthrankings.org/explore-health-rankings/reports/state-reports/2018/minnesota
Accessed February 28, 2019.

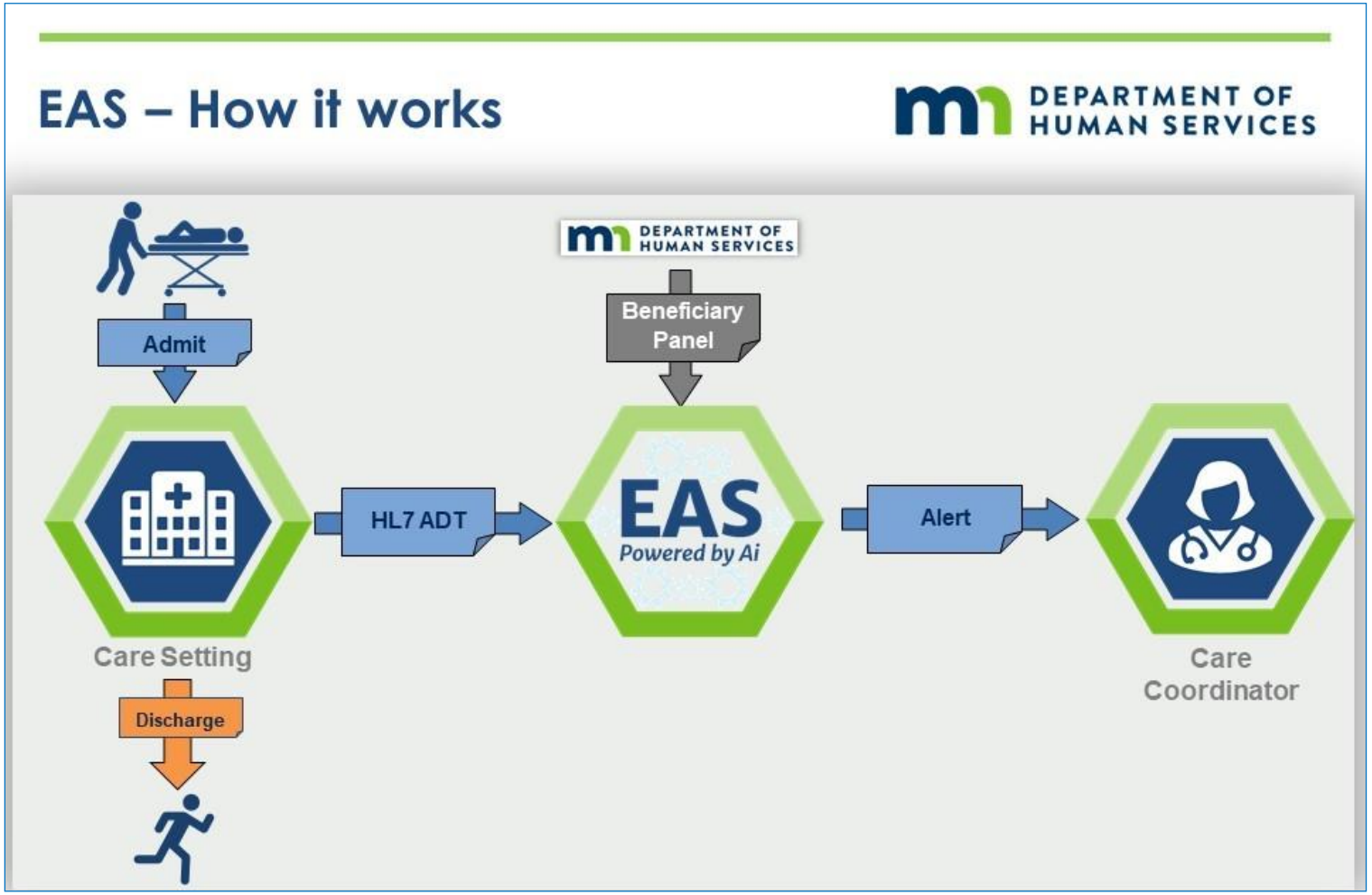
IHP recent enhancements

Source: www.healthypeople.gov

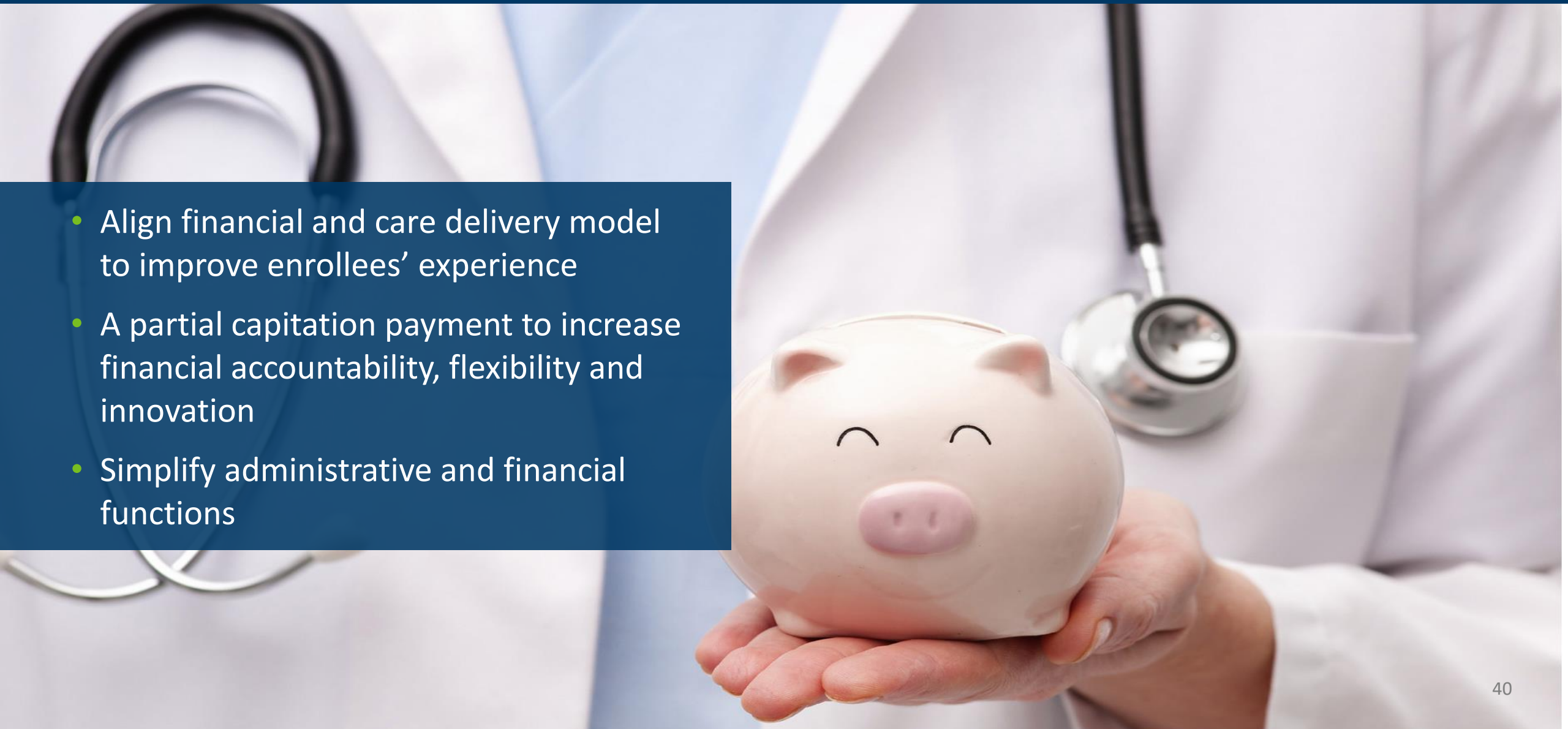
- **Population-based** payment to support innovate care delivery, care coordination and infrastructure
- Multiple opportunities for a **wide variety of provider participants**
- Enhanced focus on **social determinants of health** and **meaningful partnerships**
- Updates to **quality metrics**
- **Accountable Care Partnerships** for enhanced risk arrangements
- Enhanced data availability and timeliness

Evolution and enhancements?

Encounter Alert Service - more timely information



Development of the “Next Generation” of IHP



- Align financial and care delivery model to improve enrollees’ experience
- A partial capitation payment to increase financial accountability, flexibility and innovation
- Simplify administrative and financial functions

Thank you!

Mathew Spaan

Manager, Care Delivery & Payment Reform

mathew.spaan@state.mn.us

Polling Question #2

Which challenge related to VBP is of most concern to your organization? (Select all the apply.)

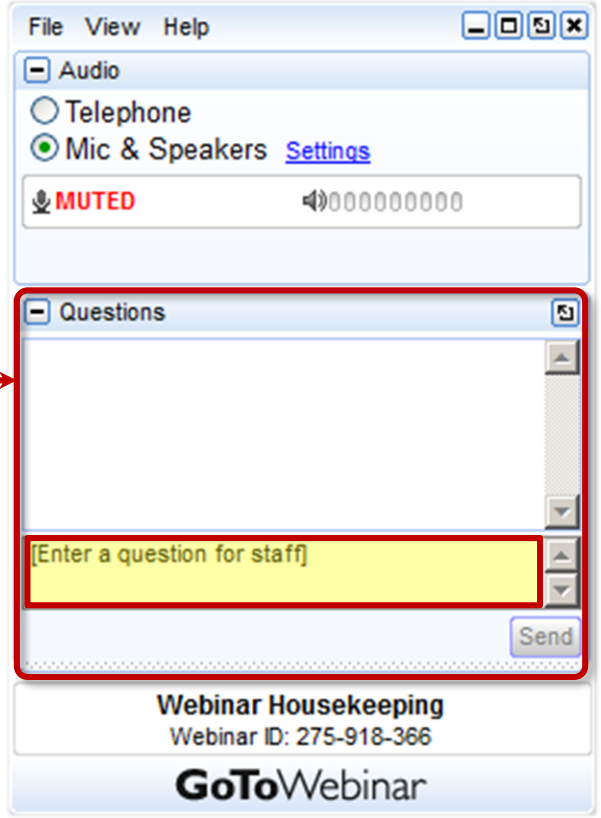
- Data quality and uniformity
- Interoperability
- Quality measurement
- Provider attribution
- Patient risk stratification

Audience Q&A

Please submit your questions

Enter your question into the “Questions” pane in the lower right hand corner of your screen.

You can also submit questions at any time to CORE@caqh.org



- The slides and webinar recording will be emailed to attendees and registrants in the next 1-2 business days.

CAQH CORE

Upcoming CAQH CORE Education Sessions

CORE Certification Webinar Series: Security Health Plan Demonstrates Commitment to Administrative Efficiency
THURSDAY, JUNE 20, 2:00 – 3:00 PM

CMS, WEDI and CAQH CORE Webinar Series: Part 1 - CMS Complaint Management Reports
WEDNESDAY, JUNE 26, 2019 | 2:00 - 3:00 PM ET

CORE Attachments Webinar Series: Defining a Path to Electronic Exchange of Medical Documentation
WEDNESDAY, JULY 10, 2:00 – 3:00 PM

CMS, WEDI and CAQH CORE Webinar Series: Part 2- CMS Compliance Reviews
THURSDAY, JULY 18, 2019 | 2:00 - 3:00 PM ET

CONFERENCES

HFMA 2019 Annual Conference
JUNE 23-26, 2019

Thank you for joining us!

 @CAQH

Website: www.CAQH.org/CORE

Email: CORE@CAQH.org

The CAQH CORE Mission

Drive the creation and adoption of healthcare operating rules that support standards, accelerate interoperability and align administrative and clinical activities among providers, payers and consumers.