Moving Past the Hype: Real World Payment Reform

Len M. Nichols, Ph.D.
Director, Center for Health Policy Research and Ethics
Professor of Health Policy
College of Health and Human Services

National Association of Medicaid Directors
Arlington, VA
November 8, 2011
Two Roads to Fiscal Balance

Where Innovation Is Tradition
Cost Containment Theory of PPACA

- End profitability of risk selection
  - Change insurance business model to value seeking
- Force transparency on private insurers
  - Channel competition into socially productive areas
  - Exchanges promote quality-price rankings
- Make FFS less attractive in Medicare
- Develop incentive structures that reward cost reduction, improve quality, and SPREAD**
Incentive Alignment Is Multi-Dimensional

- Decision Support
- Wellness & Cost Sharing
- Payment Reform

Provider <-> Employer/Payer

Patient
Payment Reform Models

- Pay for performance, value
  - Value = quality, cost, and patient experience
- Medical Home
- Bundling
- Accountable Care Organizations
- Private sector initiatives
  - Communities
  - AHIP’s showcase examples
Common themes of pay reform models

- Fewer, larger “units” of payment
  - Management/admin/infrastructure “fee”
  - 8000+ CPT codes, 450+ DRGs → tens of bundles/global caps with patient acuity adjustors
- Accountability for performance
- Data, data, data + shared incentives/risks
Is payment reform alchemy?
Payment Reform Sweet Spot

Old

New

Unfettered use

FFS payment levels

Process efficiencies

Bonuses for quality

Shared Savings

New > Old, or else!

Where Innovation Is Tradition

Make sure these matter
Multi-Payer Payment Reform

• Clinicians prefer one set of incentives, reporting requirements, etc.
• Medicaid shares focus on chronic diseases
• Medicaid payment levels problematic
• BUT: If cost-shift real, then decline in unnecessary Medicaid use saves private sector money => shared savings across payers legit
NASMD: Moving Past the Hype: Real World Payment Reforms in Virginia
November 8, 2011 (2:15-3:45 p.m. session)

Cindi B. Jones, Director
Virginia Department of Medical Assistance Services, Virginia Health Reform Initiative
DMAS’ mandatory managed care for Medicaid and CHIP with contracted Managed Care Organizations (MCO) marked a 15-year anniversary on 1/1/11:
– includes mostly children, families, and SSI (ABDs)
– excludes certain geographic areas, populations and services (such as southwestern Virginia; duals and foster care children; some behavioral and all long term care services)

**Enrollment - September 1, 2011:**
Medicaid/CHIP Fee For Service 295,883
Medicaid Primary Care Case Mgmt 53,231
Medicaid/CHIP MCO (Managed Care) 585,334
Why Managed Care?

Virginia has embraced Medicaid managed care for 6 major reasons:

1. **Financial Stability** – The MCO program is at full risk, thus it provides the State with a stable predictor of costs.

2. **Member Benefits** – Members receive health care benefits beyond FFS, such as health education, provider access, 24/7 call center, chronic care management, enhanced maternity and child program, enhanced provider network and improved health outcomes. 72% parents of children cited satisfaction with health plans (64% for FFS).
Why Managed Care?

3. **Provider Networks** – MCOs have specific business areas to manage, recruit, contract, monitor, and credential providers for network stability and quality outcomes. MCOs are uniquely positioned to develop variable payment mechanisms, including incentives for quality of care.

4. **Program flexibility** – MCOs are encouraged to be innovative and add new programs to meet the health care needs of members and administrative challenges of providers. CMS routinely excludes MCOs from burdensome policies and procedures that drive states’ FFS delivery systems. This allows MCOs to design and continuously improve their own programs—both effectively and efficiently.
5. **Utilization Review Management** – MCOs have strong clinical teams who develop protocols, review variances, and develop programs to control both over and under utilization of health care services. This allows for ease in forecasting utilization trends and identifying opportunities for both clinical and administrative improvements.

6. **Collaboratives** – The MCOs collaborate with each other and the Medicaid agency in operational, quality, and program integrity initiatives.
Virginia’s Medicaid MCOs in the Top 50 Nationally

- Virginia is one in a handful of states that require our contracted MCOs to obtain National Committee for Quality Assurance (NCQA) accreditation.

- NCQA is the gold standard in evaluating health plan quality by employers, consumers, regulators and health plans.

- All current MCOs not only meet this requirement, they have all been ranked nationally by NCQA in the top 50 for 2011.
Quality Improvement Examples with MCOs

- **Amerigroup’s** HEDIS 2010 rate for one comprehensive well-child visit per year for ages 3-6 years improved from 72% to 77% based on increased monthly data analysis, member outreach, and updates to primary care physicians on their patients who were overdue.

- **Anthem’s** HEDIS 2010 rate for six comprehensive well-child visits between birth and 15 months improved from 56% to 66% based on public transportation campaign in English and Spanish; additional member education strategies, and a physician pay for performance program.

- **CareNet’s** HEDIS 2010 scores for pharmacotherapy management of COPD-E improved from 54% to 74% for systemic corticosteroids and 62% to 84% for bronchodilators based on increases to its case management program, which matches interventions with member risk for complications.
Quality Improvement Examples with MCOs

- **Optima Health Plan** – HEDIS 2010 rate for follow-up after hospitalization for mental illness increased for both 7 and 30 days, from 54% to 62% and 73% to 78% respectively based on licensed behavioral health clinician visits during the inpatient stay and on discharge.

- **Virginia Premier Health Plan** – HEDIS 2010 rate for antidepressant medication management increased for the acute phase (49% to 65%) and continuation phase (35% to 51%) based on increased analysis of pharmacy data and outreach to members.
Future Service Delivery and Payment Reform within MCOs: Patient Centered Medical Homes

Virginia Medicaid has language in its MCO contracts to promote the development of patient centered medical homes to improve the timeliness of, access to, and quality of care received by members.

Through medical homes, *all* components of health care are “de-fragmented” and the primary care provider serves as the hub for the patient’s to make informed decisions regarding their care.

Virginia Medicaid envisions working with its MCOS to integrate these features into the way care is delivered efficiently and effectively:

1. Behavioral Health
2. Care Coordination
3. Dental
4. Telemedicine
5. Urgent care rather than emergency care
What’s Next for 2012

- **Geographic Expansion**
  - Complete expansion of MCOs to Southwestern Virginia

- **Populations**
  - Add Foster Care Children to MCOs; start with a small pilot first and then move statewide
  - Add Home and Community Based Care Clients to MCOs; keeping HCBC waiver services carved out

- **Care Coordination**
  - Shift to a single vendor for all *non-traditional* Behavioral Health Services (begin with ASO and transition to a full risk in year 3); must engage key stakeholders and the MCOs throughout the entire process to ensure care is *not* fragmented
  - Dual Eligibles: fully integrate acute, primary, behavioral, and long term care services and Medicare and Medicaid payment; pilot planned with MCOs
Arizona Payment Reforms
Arizona Overview

- Arizona Health Care Cost Containment System (AHCCCS) was established in 1982 when Arizona became the last state to participate in Medicaid – Established with mandatory managed care
- Provides coverage to 1.3 m Arizonans – 2.0 m over year unduplicated
- American Indians and FES services are FFS
- 95% of expenses are through Managed Care Organizations
- Provides coverage up to 100% FPL including Childless Adults
AHCCCS Population as of July 1, 2011

1985 – 2011

200,000 400,000 600,000 800,000 1,000,000 1,200,000 1,400,000

144,450 318,383 456,385 508,917 1,047,982 1,369,637
## Arizona MCO Plans by Region

<table>
<thead>
<tr>
<th>Region</th>
<th>Acute</th>
<th>Behavioral Health</th>
<th>Long Term Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phoenix</td>
<td>6 Plans</td>
<td>1 Plan</td>
<td>3 Plans</td>
</tr>
<tr>
<td>Tucson</td>
<td>5 Plans</td>
<td>1 Plan</td>
<td>2 Plans</td>
</tr>
<tr>
<td>Greater AZ</td>
<td>2 Plans (per region)</td>
<td>1 Plan (per region)</td>
<td>1 Plan (per region)</td>
</tr>
<tr>
<td>Total Unique Plans</td>
<td>9 Plans (all are SNP)</td>
<td>4 Plans (1 SNP)</td>
<td>4 Plans (all are SNP)</td>
</tr>
</tbody>
</table>
Power of Alignment – Long Term Care

- State has historically established blended capitation for Long Term Care – mix for HCBS and Nursing Facility costs
- Incentivized gradual use of HCBS placement
- Maintained quality oversight to ensure proper placements and services
- Properly Aligned Incentives can help move large systems
Effective Use of Home and Community Based Care

ALTCS Trend in HCBS Utilization

Percentage %

Nursing Facility

Home and Community
Payment Reform Opportunities

- Align Incentives at Payer Level
  - Align at MCO level – eliminate historical carve out structures – single point of accountability
  - Pursue Dual Eligible Alignment
  - Continue to align incentives for better quality

- Support Alignment of Incentives between Plan and Provider
<table>
<thead>
<tr>
<th>Services</th>
<th>SMI Dual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid Acute</td>
<td>AHCCCS Acute Contractor</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>Part D or MA Plan or RBHA</td>
</tr>
<tr>
<td>Behavioral Health</td>
<td>Medicare FFS, MA, MA SNP, RBHA</td>
</tr>
<tr>
<td>Medicare Services</td>
<td>Medicare FFS, MA, MA/SNP</td>
</tr>
<tr>
<td>ALTCS - DD LTC Services</td>
<td>DES/DD</td>
</tr>
<tr>
<td>Total Different Entities</td>
<td>5</td>
</tr>
</tbody>
</table>
AHCCCS/Medicare Alignment

AHCCCS 1,382,524

Acute 1,331,109
Including Prop. 204 and waiver groups (396,566)

ALTCS 51,415

EPD 25,332
83% Medicare

DD 26,083
22% Medicare

AHCCCS Medicare 115,213
8% Total pop.

Enrolled in SNP 62,630
54% Duals
7/2011 CMS SNP Enrollment Numbers

Aligned 35,351
30% Medicare pop.

Numbers based on 8/1/11 enrollment data provided by AHCCCS Division of Business and Finance
MCO Payer Alignment

- October 1, 2013 – Triple Crown – Address Historical Structures
  - Maricopa Behavioral Health - $5 billion plus – 5 year contract - integrating SMI acute services – requiring to be SNP
  - Children’s Specials Needs Program - $700 m – 5 years - eliminate carve out – make MCO responsible for all acute and behavioral health services
  - Acute - $35b plus – 5 years –
MCO Alignment – Duals Strategy

- Currently have high percentage of duals in aligned SNPs
- Requested participation in Dual Eligible 3 way contract Demonstration to try and increase alignment
Alignment for MCO Quality Incentives

- Risk adjusters for acuity diagnosis – important alignment
- Portion of Auto assignment algorithm based on quality performance scores
- Planning on incorporating adjustment of Health Plan capitation rates based on Potentially Preventable Readmissions
Payer (MCO) – Provider Alignment

- Currently AHCCCS actuaries set rates based fully on encounter data –
- Decreases in utilization or cost would be accounted for in future rates
- Limited incentive for gain-sharing structure
- Demonstration Request for plans and providers
- Requesting plans to identify types of services to be contracted and details of contracting structure
- Actuaries will build costs of incentives into future rates
- ED Diversion Example
Questions
Utah’s 1115 Waiver: Payment & Service Delivery Reform

NAMD Conference
Presented by Michael Hales
November 8, 2011
Utah Medicaid Snapshot

- 75% of Medicaid population live in 4 urban counties surrounding Salt Lake City
- All 75% are enrolled in a managed care plan
- All 3 health plans have a separate contracting arrangement (MCO, PAHP, PCCM)
- Of 3 contracted health plans, 2 are integrated systems (health plan, hospital, physician groups)
- Fee For Service Rates are payment benchmarks
- Payment disparity between hospitals and physicians (100% and 75% of Medicare, respectively)
Utah’s Payment & Service Delivery Reform
Goals of the Reform

- Target areas of highest rates of growth
- Restructure reimbursement to pay for quality rather than billable events.
- Provide incentives for providers to collaborate in the delivery of care.
- Pay providers under a risk-based methodology
- Restructure cost sharing and provide new incentives to reward clients for personal efforts to maintain or improve their health.
- Keep the same funding amount in the system
Result: Utah Medicaid ACO Model

- Does **NOT** Follow the Medicare ACO model
- Defines flexible qualifications of an ACO
- Establishes mandatory quality targets
- Makes payments on a risk-adjusted, per member per month (PMPM) amount
- Provides new incentives for clients to better manage their health
ACO Qualifications — Must be able to…

✓ Meet established quality standards
✓ Distribute payments across the spectrum of covered benefit providers
✓ Bear risk and accept an all-inclusive, capitated rate
Quality Targets

- Healthcare Effectiveness & Data Information Set (HEDIS)
- Consumer Assessment of Healthcare Providers and Systems (CAHPS)
- Additional, Utah Medicaid-specific quality targets
Rate-Setting Process

- Initial year’s rates will be based on historical costs
- Risk-adjusting will occur every 6 months for the first 2 years
- Will recognize savings sharing payments within ACO network
- Future rates tied to general fund growth
New Client Incentives

- ACOs may waive or charge differential cost sharing based on service
- ACOs may provide incentives to clients based on managing health or following medical directives
Opportunities to Innovate

- Restructuring reimbursement to provider groups
  - Sub-capitation
  - Saving sharing
- Realigning where healthcare is delivered
- Changing what care is delivered
Opportunities to Innovate (continued)

- Enhancing the medical home concept
- Improving care coordination
- Increasing client participation in care
- Improving access to appropriate care
Implementation Time Line

- Submitted Waiver request to CMS on June 30, 2011
- Began content discussions with CMS on August 25, 2011
- Continue working through CMS process
- Anticipate implementation between July to October 2012
Future Reform Phases

- Integrate *mental health* benefit to ACO model
- Integrate *long-term care benefit* to ACO model
- Integrate *dental benefit* to ACO model
- Expand ACO model into *rural* counties
Transforming the Oregon Health Plan

Moving Past the Hype:
Real-world Payment Reforms
National Association of Medicaid Directors

Judy Mohr Peterson
Medical Assistance Programs
Oregon Health Authority

November 2011
Why transform?

- Health care costs are increasingly unaffordable to individuals, businesses, the state and local governments
- Inefficient health care systems bring unnecessary costs to taxpayers
- Dollars from education, children’s services, public safety
- Even for all we spend, health outcomes are not what they should be – estimated 80% of health care dollars go to 20% of patients, mostly for chronic care
- Lack of coordination between physical, mental, dental and other care and public health means worse outcomes and higher costs
Why now?

- High costs are unsustainable
- A better way to deal with budget shortfall than cutting people from OHP or cutting rates
- Cost shifts to Oregon businesses and families
- The budget reality calls for real system change for the long term.
- Emphasizes better health – recognizes if we deal with budgets alone, we won’t succeed
Projected costs / state revenue

Revenues (11/2010)

Expenditures

Best 4 Biennia

Worst 4 Biennia

State health expenditures vs. revenues

![Graph showing the comparison of state health expenditures to revenues from 2001 to 2019, with projected data for 2011 to 2019. The graph displays the percent change (index=100) for Medicaid (TF), PEBB (TF), and Statewide General Fund Revenue.]
The cost-shifting cycle

Public

Employers and/or employees drop coverage

Private

ER (uncompensated, expensive care)

Pressure on state/federal budgets

Those who do not fit into a category (uninsured)

Change eligibility
Wrong focus = wrong results

Focus:
Medical Care 10%

Human Biology 30%
Environmental 5%
Social 15%
Lifestyle & Behavior 40%

Shroeder, James; “We Can Do Better – Improving the Health of the American People,” NEJM, 2007: 357:1221-1228
GOAL: Triple Aim
A new vision for a healthy Oregon

2. Better care.
3. Lower costs.
Vision of HB 3650

Integration and coordination of benefits and services

Local accountability for health and resource allocation

Standards for safe and effective care

Global budget indexed to sustainable growth

Redesigned delivery system

Improved outcomes
Reduced costs
Healthier population
Better health, better care, lower costs
<table>
<thead>
<tr>
<th></th>
<th>Not working</th>
<th>Better</th>
<th>Even better</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Payment</strong></td>
<td>Fee for service</td>
<td>Episode-based reimbursement</td>
<td>Quality Global budgeting</td>
</tr>
<tr>
<td><strong>Incentives</strong></td>
<td>Conduct procedures</td>
<td>Evidenced-based care</td>
<td>Address root causes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pay for performance</td>
<td>Reduce obstacles to behavior change</td>
</tr>
<tr>
<td><strong>Metrics</strong></td>
<td>Revenue improvement</td>
<td>Quality</td>
<td>Better health</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Reduced hospitalization</td>
<td>Improved quality of life</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Reduced disparities</td>
<td>Reduced costs</td>
</tr>
<tr>
<td><strong>Governance</strong></td>
<td>Informal relationships &amp; referrals</td>
<td>Joint partnerships between organizations (e.g., mental health &amp; behavioral health)</td>
<td>New community accountability linking ALL</td>
</tr>
</tbody>
</table>
Key element: Payment Reform

Medicare and Medicaid payment reforms

- Global budgets based on initial revenue/expenditure target and then increased at agreed-upon-rate rather than historical trend
- Patient centered health homes – care coordination $s at the clinic/practice level as opposed at the MCO level
- Accountability is paramount
- There are opportunities for shared savings when patients remain healthy and avoid high-cost care (Don’t pay for never events – already implemented Medicare version. Looking to expand)
- Episode-based reimbursement; bundled payments
- Use evidenced-based care with pay for performance
Use multi-payer initiatives:

- Build on Multi-payer efforts – especially with other state contracts (Public Employees; School districts)
  - Quality measurement efforts
  - Administrative simplification
    - Claims payment
    - Credentialing
  - Involved in multi-payer efforts on Patient Ctrd Hlth Homes
  - Standard hospital payment methodology
  - System re-design (state convenes for anti-trust concerns)
- Working with Insurance Commissioner on driving to health care reform/system design goals
- Work with other systems of care: Behavioral health
Challenges

• Change is difficult
• Time is short
• Federal approvals are necessary
• Transitioning from current models while maintaining access to care and community infrastructure
• Starting with Medicaid – balancing needs of vulnerable populations and more commercial insurer models.
Questions?
Judy Mohr Peterson
Judy.Mohr-Peterson@state.or.us

For more information:

www.health.oregon.gov