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Leveraging Medicaid Managed Care to Advance Value-Based Purchasing

November 27, 2018

Today's Agenda and Presenters

- Context for Shift to Value-Based Payments (VBP) in Medicaid Managed Care
- States' VBP Policies: Overview and Key Takeaways
- Looking Ahead: VBP Moving Forward

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Context

Managed Care is the Dominant Delivery Model in Medicaid

Seeking greater budget predictability, improved quality and reduced costs, states are relying heavily on Medicaid managed care plans to deliver coverage for a wider range of services to a broader set of beneficiaries

- **39 states (including DC) currently contract with comprehensive, risk-based Medicaid managed care (MMC) plans**; 1 state is in the process of developing a capitated MMC program
- **Today, the majority of Medicaid beneficiaries are covered through a MMC plan**
- **Most of the 31 states (including DC) that had expanded Medicaid as of July 2018 cover their newly eligible population through MMC**; only 3 (Alaska, Connecticut, and Montana) use a fee-for-service system exclusively; 3 others use alternative approaches (Arkansas' "private option", Colorado's Accountable Care Collaborative program, Vermont's Department of Vermont Health Access program), some of which model managed care

States with Medicaid Managed Care Programs

Most states utilize comprehensive full-risk managed care to administer their Medicaid programs

**North Carolina is currently in the process of shifting from a FFS state with a PCCM program, to a full-risk Medicaid managed care state. Their Medicaid managed care program is due to go live November 2019.*

Managed Care Covering More People, More Services

States are expanding the use of managed care to cover new Medicaid populations *and* new benefits/services

New Managed Care Populations

- Managed care traditionally served mothers and children—a relatively young and healthy group
- **States increasingly "carving in" higher-needs, higher-cost beneficiaries, such as:**
  - Dual-eligible beneficiaries
  - Individuals with long-term care needs
  - Individuals with behavioral health needs (e.g., serious mental illness, substance abuse disorders)
  - Developmentally disabled individuals

New Managed Care Benefits

- **States "carving in" new benefits, such as:**
  - Long-term services and supports (LTSS)
    - Long-term stays in skilled nursing facilities
    - Hospice care
    - Personal care services
    - Home health services
  - Behavioral health services
    - Mental health services
    - Substance use disorder services
  - Pharmacy benefits
  - School-based health center services

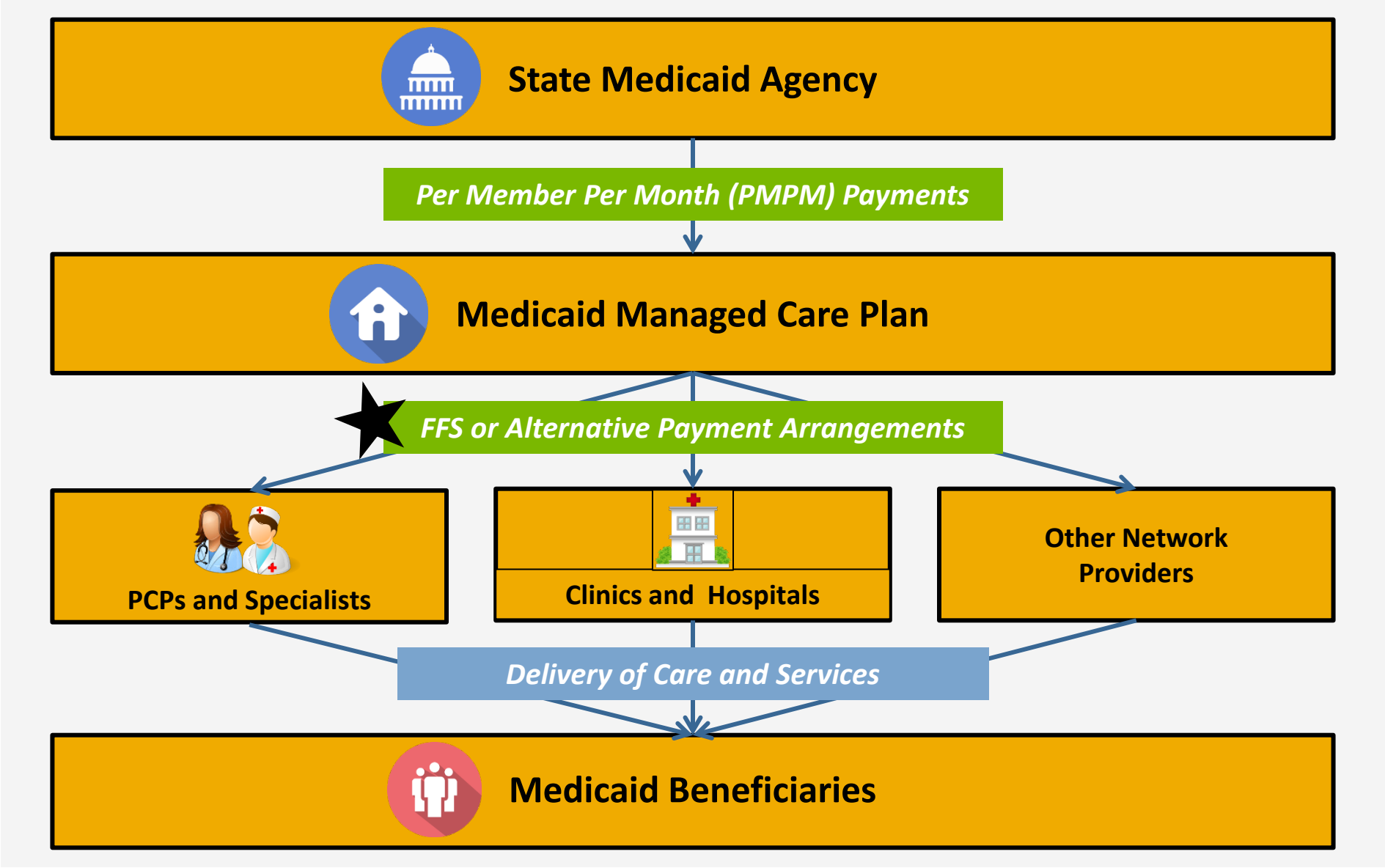
States Looking to Advance Priorities through Managed Care

- **States leveraging their MMC programs to advance state goals** (e.g., combatting opioid epidemic, improving access to and integration of behavioral health services, tackling LTSS reform)
- **Increasing focus on getting more out of MMC plans:**
  - More aggressive procurement terms
  - More directive contracts (e.g., ***requirements to enter into VBP contracts with providers*****,** contract with care management entities, implement waiver policies, deploy social determinants of health interventions, etc.)
  - Greater use of withholds, incentive payments, rate adjustments and/or margin augmentations
  - Medical loss ratio (MLR) requirements

Focus of today's webinar

Payment to Providers Has Remained Largely Fee-for-Service

Despite states' move to capitated Medicaid managed care, most plan payments to providers are still made through fee-for-service (FFS) arrangements—though there are some exceptions



States Seeking to Change This by Directing Plan Payments to Providers

- Motivated by notion that increasing provider accountability for cost and quality of care will **boost delivery system performance**, **achieve "Triple Aim,"** and **help with tightening state budgets**
- Enabled by **federal regulations*** that allow states to *require* plans to use particular payment methodologies with providers, pay providers at prescribed payment levels, and/or participate in delivery system reforms

Value-Based Payment Methods

States may require plans to use VBP arrangements with network providers

Minimum or Maximum Payment Levels

States may require plans to adopt minimum payment levels or provide a uniform dollar or percent increase for providers of a particular service

Delivery System Reform Initiatives

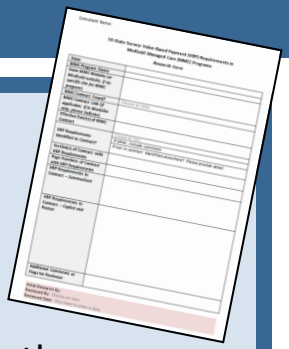
States may require plans to participate in multi-payer or Medicaid-specific delivery system reforms or performance improvement initiatives

*42 CFR 438.6(c)

State VBP Policies

Manatt Health Conducted a Survey of State VBP Policies

To understand how states are directing plan payments to providers, Manatt Health reviewed all 39 MMC states' contracts and related sources



- **Goal was to compile, summarize and analyze each state's VBP policies in Medicaid managed care**
- **Survey covers *comprehensive* risk-based managed care programs**
  - Includes MMC programs that cover *at least* the state's physical health services, no matter the Medicaid population (i.e., plans covering physical health services only, or plans covering physical health services plus some other set of services)
  - Excludes plans that cover a more narrow set of services and plans for dual-eligible populations only
- **Produced state-specific summaries that capture:**
  - The different MMC programs in a given state (as applicable)
  - The state's MMC contract effective dates
  - Whether a state has VBP requirements, and if so, for which programs
  - A summary of any VBP requirements that captures related policies too (e.g., financial penalties or rewards tied to compliance with VBP requirements)
  - Links to and locations of VBP requirements (e.g., within state contracts, in state statute, in other state documentation)
- **State-specific summaries available on *Insights@ManattHealth***
- **Survey being updated throughout year, as new contracts become available**

Sample of Information on *Insights@ManattHealth*

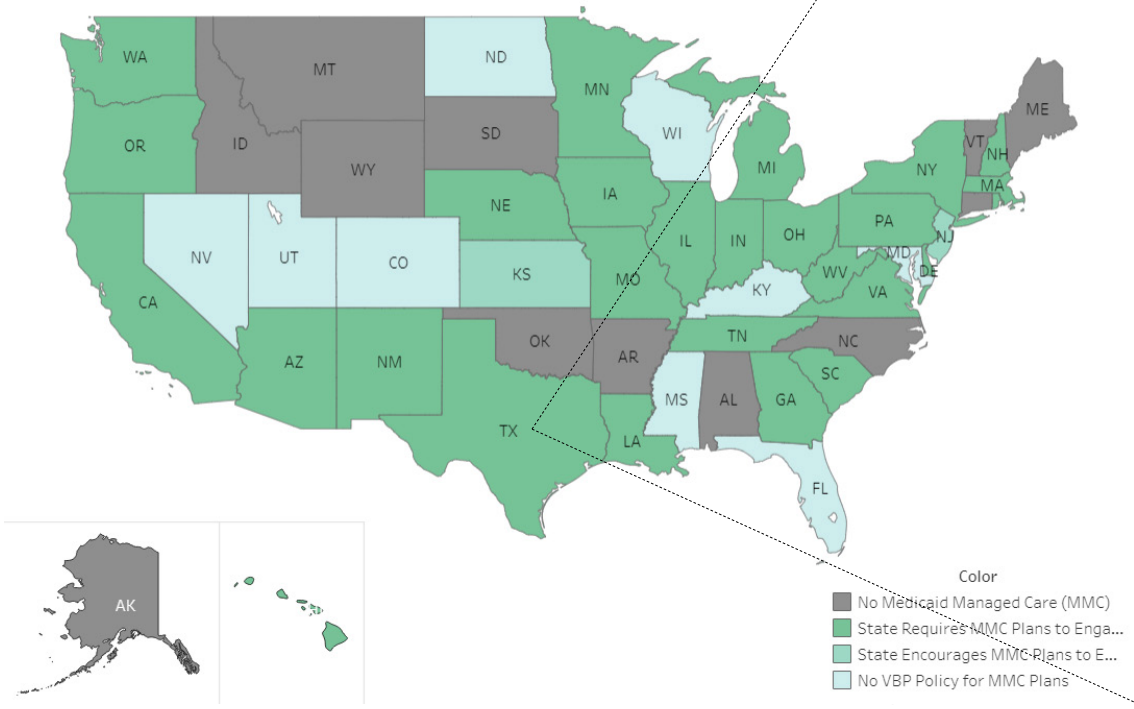
Value-Based Payment (VBP) Requirements in State Medicaid Managed Care Programs

March 30, 2018

As health care costs continue to rise and stakeholders maintain focus on improving quality of care and outcomes, state Medicaid agencies, like other payers, are turning to VBP to inject greater value into their Medicaid programs. VBP can mean different things to different stakeholders, but it generally signifies a departure from traditional fee-for-service payment systems, which reward volume of services, to payment models that pay providers for the *value* of services, defined as the delivery of high-quality, cost-effective care.

To this end, states that use comprehensive, risk-based managed care as their primary Medicaid delivery system are leveraging their contracts with managed care plans to advance payment reforms, including by requiring plans to expand the deployment of meaningful VBP arrangements in their provider networks, increase the proportion of plan payments that are value-based, and enhance the level of risk assumed by providers.

Open a state summary page by clicking the state on the map.



Value-Based Payment (VBP) Requirements in Texas's Medicaid Managed Care Program

Date: 03.30.18

Program Name(s):

- STAR (covers children, newborns, pregnant women and some families)
- STAR+PLUS (covers individuals who have disabilities or are ages 65 or older)
- STAR+PLUS Medicaid Rural Service Area (covers rural areas with limited providers)
- STAR Kids (covers children and youth with disabilities)
- STAR Health (covers children who receive Medicaid coverage through the Texas Department of Family and Protective Services)

Program Website(s): https://hhs.texas.gov/services/health/medicaid-chip/programs/medical-dental-plans

Program Contract(s):

- Uniform Contract:[1] https://hhs.texas.gov/sites/default/files//documents/services/health/medicaid-chip/programs/contracts/uniform-managed-care-contract.pdf
- All Contracts: https://hhs.texas.gov/services/health/medicaid-chip/provider-information/managed-care-contracts-manuals

Contract Effective Date(s): September 1, 2017

VBP Requirements Identified in the Contract? Yes

Summary of the State's VBP Requirements:

Across its Medicaid managed care programs, Texas requires managed care plans to transition payments to providers from traditional fee-for-service arrangements to alternative payment models (APMs) and develop and execute written, state-approved plans for expanding VBP with network providers. Per the contract, APMs should be designed to "improve health outcomes for members, empower members and improve experience of care, lower healthcare cost trends, and incentivize providers." Plans must meet the following APM-related requirements:

- **Annual APM Targets:** Achieve minimum levels of APMs (calculated as percentages or ratios of all provider payments) and risk-based APM ratios, as follows:
  - In Calendar Year (CY) 2018:
    - Achieve an overall APM ratio of at least 25% of provider payments
    - Achieve a risk-based APM ratio of at least 10% of provider payments
  - In CY 2019: Achieve increase of 125% compared to CY 2018 targets
  - In CY 2020: Achieve an increase of 125% compared to CY 2019 targets
  - In CY 2021:
    - Achieve an overall APM ratio of at least 50% of provider payments
    - Achieve a risk-based APM ratio of at least 25% of provider payments

Failure to meet these APM targets results in penalties of up to $0.10 per member per month for the period of measurement. Plans not meeting APM targets may also be subject to corrective action plans.

- **APM Reporting:** Submit to the state an annual inventory of APMs with providers, to calculate APM ratios.
- **Data Sharing:** Implement processes to regularly share data and performance reports with providers.
- **APM Evaluation:** Dedicate resources to evaluate the impact of APMs on utilization, quality, and cost, as well as return on investment.
- **Gain Sharing Pilots:** Submit to the state gain-sharing pilot programs that would reward providers for decreasing inappropriate utilization of services. Proposals must include mechanisms through which the plan will provide incentive payments to hospitals and physicians for high-quality care and must stipulate the quality metrics required for incentives, provider recruitment strategies, and a proposed structure for payment.

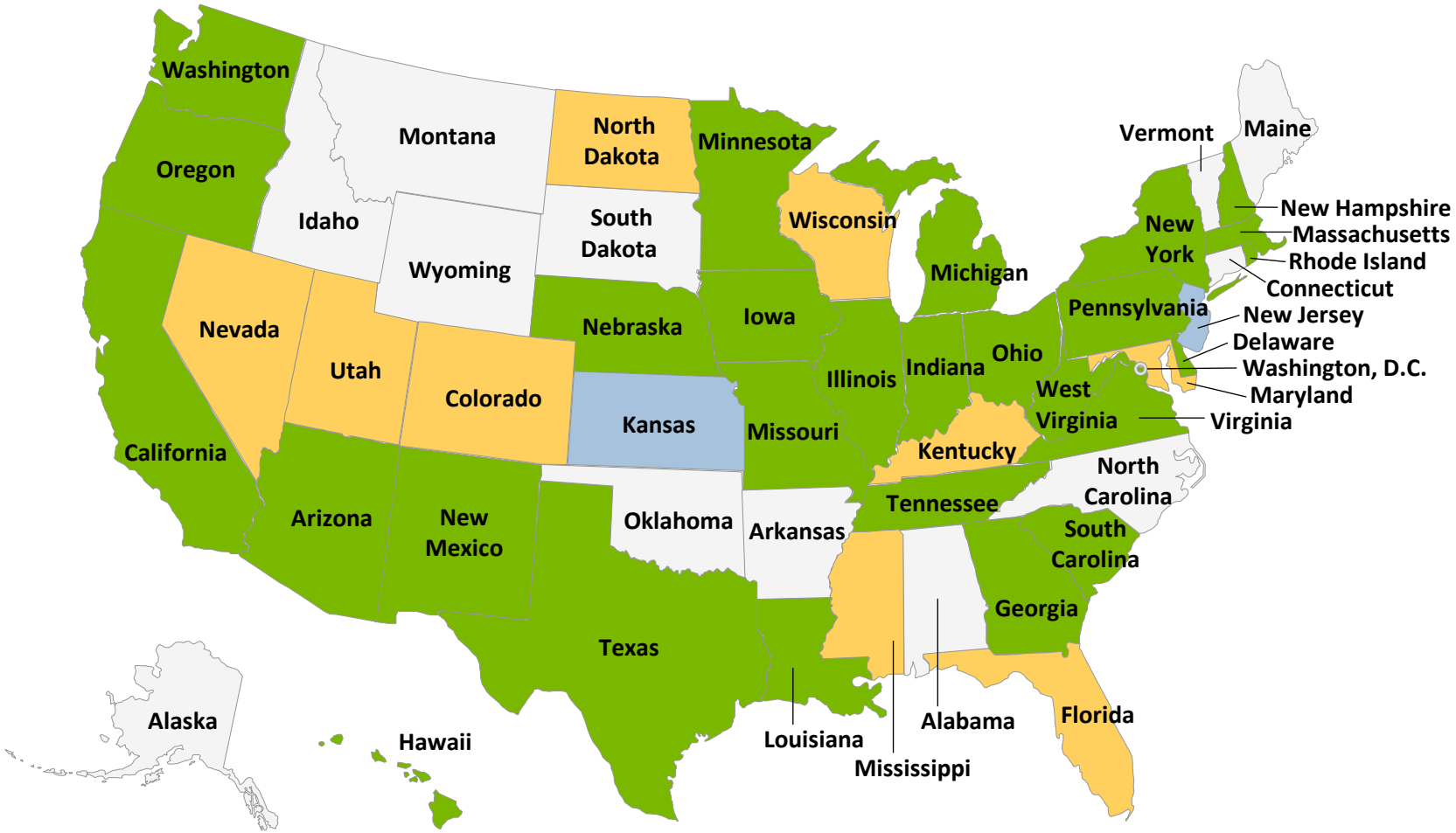
Citations:

Uniform Managed Care Contract:

- Section 4.3.5.7 – Provider Incentives (page 141 of PDF)
- Section 8.1.7.8.2 – Managed Care Organization (MCO) Alternative Payment Models with Providers (page 270 of PDF)
- Attachment B-3 – Medicaid and CHIP Managed Care Services RFP, Deliverables/Liquidated Damages Matrix: 15.2: Contract Attachment B-1, RFP §8.1.7.8.2 – MCO Alternative Payment Models with Providers (page 14 of Attachment, page 448 of PDF)

Key Finding: Most States Now Have VBP Policies in MMC

28 states *require* plans to engage in VBP; two other states' contracts explicitly encourage VBP adoption



Source: Manatt Health 50-State Survey on VBP Policies in Medicaid Managed Care, 2018.

Key Finding: State VBP Policies Vary

State contracts that *allow* plans to implement VBP (e.g., Mississippi, Nevada)

State contracts that *encourage* but do not require plans to pursue VBP (e.g., Kansas, New Jersey)

State requirements of plans to develop, implement and report on their own VBP strategy (e.g., Illinois, Georgia, Oregon)

States setting specific VBP targets, but with no financial penalty for failure to comply (e.g., Delaware, DC, Hawaii, Nebraska)

States setting VBP targets that come with financial penalties for failure to comply, for example:

Arizona's program-specific VBP targets and related withhold

Washington State's VBP targets and related withhold

New York's VBP targets and VBP rate adjustments

Texas' VBP targets and associated PMPM penalties

States requiring plan participation in VBP-related initiatives, for example:

Massachusetts' ACO program requirements

New York's VBP Innovator Program

Minnesota's Integrated Health Partnerships (IHP) requirements

Tennessee's episode-based payment program

Analysis of States' VBP Policies

- **18 states set specific VBP targets for plans to meet, either annually or over the course of contract**
- **13 states financially incentivize plans to adopt VBP and penalize lack of adoption**
- **12 states require plans to develop, implement and report on a VBP strategy**
- **At least 10 states require plans to participate in state-directed payment reform programs, with varying levels of direction and oversight**
- **8 states use the Health Care Payment Learning and Action Network (HCP LAN) Alternative Payment Model (APM) Framework in their VBP requirements**
- **Many states reference physician incentive plans in their VBP policies; 6 states' policies merely *allow* plans to implement physician incentive plans** (rather than *require* physician incentive plans or VBP adoption though some other means)
- **At least 6 states have some other type of VBP policy**

Deeper Dive: VBP Targets for Plans

- **18 states set specific VBP targets for plans to meet, either annually or over the course of contract**
  - 10 have VBP targets measured as **% of plan expenditures or payments to providers** made through VBP
  - 5 states' targets measure **% of members whose care is compensated through VBP**
  - 2 states' targets measure **% of plan contracts** that include VBP
  - 1 state measures **% of plans' premium revenue** spent in VBP arrangements
- **States with these policies in place:**
  - Arizona, California, DC, Delaware, Hawaii, Iowa, Massachusetts, Nebraska, New Hampshire, New Mexico, New York, Ohio, Rhode Island, Pennsylvania, South Carolina, Texas, Washington, West Virginia

State Example: Arizona

In calendar year 2018, plans must meet the following APM targets, calculated as a percentage of total Medicaid expenditures. (APMs are defined as HCP-LAN APM Framework Categories 2B and higher).

- Acute Care Program: 50%
- Arizona Long Term Care System (ALTCS) Elderly/Physically Disabled (E/PD) Program: 35%
- ALTCS Individuals with Developmental Disabilities (IDD) Program:
  - Sub-contractors for acute services: 20%
  - LTSS: 5%
- Children's Rehab Services (CRS) Program: 50%
- Regional Behavioral Health Authorities (RHBAs):
  - Integrated RBHAs for individuals with serious mental illness: 25%
  - Non-integrated, BH-only RBHAs for other individuals with BH needs: 10%

These targets increase each year

For Acute Care Program, ALTCS IDD, CRS, Integrated RBHA plans, a minimum of 25% of the APM target noted above must be with an organization that includes primary care providers.

Deeper Dive: Financial Incentives/Penalties for VBP

- **13 states financially incentivize plans to adopt VBP and penalize lack of adoption**
  - Most have a withhold or incentive program that conditions a portion of plans' premium on meeting VBP requirement(s), such as a VBP target or VBP reporting requirement
  - One state, New York, adjusts plans' rates based on the amount and level of VBP contracting and contract performance on cost and quality.
  - One state, Texas, institutes a per-member-per-month penalty on plans that do not meet its VBP targets
  - Another state, Tennessee, penalizes plans for not participating in the state's payment reform initiative
- **States with these policies in place:**
  - Arizona, Georgia, Iowa, Louisiana, Missouri, New Hampshire, New Mexico, New York, Pennsylvania, South Carolina, Tennessee, Texas, Washington

State Example: New Mexico

- New Mexico places **1.5% of plans' premium at risk** based on their ability to meet certain quality and performance measures—among them the state's VBP targets (which are calculated as a % of payments to providers and involve state-specific definitions of VBP).
- The state uses a **point-based system to calculate how much of the 1.5% withhold a plan earns back** in a given year; points are deducted if a plan fails to meet any of the VBP targets, does not include a mix of provider types (e.g., physical health, behavioral health, long-term care) in VBP contracts, or fails to meet VBP reporting requirements.
- Plans that do *not* meet the VBP targets may make **reinvestment proposals** to the state that involve the plan spending the amount of the penalty on "system improvement activities for provider network development and enhancement activities that will directly benefit members"

Deeper Dive: State-Directed Payment Reform Programs

- **At least 10 states require plans to participate in state-directed payment reform programs, with varying levels of direction and oversight**

Example: Massachusetts

- In addition to VBP targets, the state launched a **new Medicaid ACO program** in March 2018, involving 3 types of MassHealth ACOs:
  - **Partnership Plans** (joint MCO and ACO prospective risk)
  - **Primary Care ACOs** (provider-only nearly full retrospective risk)
  - **MCO-Administered ACOs** (limited ACO retrospective risk with support from MCOs for care management)
- MCOs must contract with ≥ 1 MCO-Administered ACO (provided there is ≥1 in the region)
- The Partnership Plan ACO plan includes PCP-specific VBP requirements too—to ensure PCPs are held accountable for performance

Example: New York

- In addition to VBP targets and rate adjustments, New York administers a **"VBP Innovator Program"** for providers with experience taking risk
- VBP Innovator Program is a voluntary program for providers prepared for enter into higher level VBP arrangements; VBP Innovator providers are eligible for up to 95% of plans' premiums from the state (for an attributed population)
- Plans are notified of approved Innovator providers and must amend their subcontracts with these providers to include the parameters of the program (including the 95% pass-through)

Example: Tennessee

- Tennessee plans must participate in the state's multi-payer payment reform program, the **"Tennessee Health Care Innovation Initiative,"** which includes several components:
  - **Episode-based payments**
  - **Patient-centered medical homes**
  - **Care coordination program (Tennessee Health Link)**
- Plans must implement episode-based payments with network providers as directed by the state; if average cost of episode is below a pre-determined level, plan must pay lead provider a share of savings achieved; if average cost is *above*, lead provider pays part of excess cost

Deeper Dive: Other Types of VBP Policies

- **At least 6 states have some other type of VBP policy**

Example: Texas

In addition to annual VBP targets (that include % increases over prior years) and per-member-per-month penalties for not meeting VBP targets, Texas has several other requirements:

- **VBP Evaluation:** Dedicate resources to evaluate the impact of VBP arrangements on utilization, quality, and cost, as well as return on investment.
- **VBP Reporting:** Submit annual inventories of VBP arrangements with providers
- **Data Sharing:** Implement processes to regularly share data and performance reports with providers
- **Gain Sharing Pilots:** Develop and submit to the state gain-sharing pilot programs to reward providers for decreasing inappropriate utilization of services.

Example: Georgia

- Plans in Georgia must participate in a state-established Value-Based Purchasing Performance Management Team (PMT), made up of senior leadership from state agencies and plan representatives
- The PMT is responsible for planning, implementing, and executing the state's VBP program and overseeing plans' VBP efforts; the PMT reviews each plan's progress on a regular basis, meets with the plan at least quarterly, helps determine incentive payments, and assesses the need to modify VBP priority areas, measures and targets
- Each plan must submit "real-time information" on its VBP initiatives and provide ongoing and ad hoc reports to the state to show its progress against set milestones

VBP Moving Forward

Impact of VBP Policies Still Unclear

How successful these policies are at increasing value and reining in medical cost growth remains to be seen

- **States still grappling with how plans implement VBP policies—and how effective plan VBP activities actually are**
- **Developing VBP policies and reporting processes may be an easier first step to *meaningfully* increasing provider accountability and value of care**

"It's interpret-your-own-test-results day today."

Challenges to VBP Adoption in Medicaid Abound

- Medicaid payment rates to providers often perceived as too low to incent movement toward VBP
- Many providers (especially safety net providers) lack funds for upfront investment needed to succeed in VBP
- Poor understanding of capabilities needed to succeed in VBP (e.g., governance and organization, downstream provider engagement, care coordination/management, technology/analytics, links to social determinants of health)
- Lack of alignment of VBP programs, both within and among payer markets
- High administrative burden; contracting fatigue

Looking Ahead: VBP in 2019 and Beyond

- **State VBP policies in Medicaid managed care likely to continue to evolve**
  - States and plans looking at strategies to overcome barriers
  - 2019 will bring new alignment opportunity through MACRA's "All Payer Combination Option," in which providers can count participation in other payer VBP contracts toward their MACRA targets
- **Success of VBP policies likely to depend on level of sustained investment and resources made available by states**
  - States looking to quickly reduce program costs will be disappointed
- **As "early adopter" states reach later years of VBP policy implementation, expect to see higher levels of VBP (i.e., more risk to providers), more lessons learned**

Bottom line: We're still in "learning mode" with VBP—though we shouldn't expect that to slow or stop the movement toward greater and more directive VBP policies in Medicaid (and other payer programs)

Q & A

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