State Strategies:
Medicaid Value-Based Payment for LTSS

May 16, 2017
Webinar Presenter:
State Health and Value Strategies

Dan Meuse
Deputy Director
dmeuse@princeton.edu
The Robert Wood Johnson Foundation’s State Health and Value Strategies Program

- Supports state efforts to **enhance the quality and value** of health care by improving population health and reforming health care delivery.

- **Works directly with states**—including Medicaid agencies, governors’ offices, and more—to promote peer-to-peer learning.

- **Connects states with technical assistance experts** to develop tools for new quality improvement and cost management initiatives.

- **Collaborates with other funders and stakeholders** to produce issue briefs and host convenings, focusing on best practices for states.
Webinar Presenters:

Gretchen Ulbee
Manager of Special Needs Purchasing
MN DHS

Seon Rockwell
Director of Innovation and Strategy
VA DMAS
Webinar Facilitator:

Erin Taylor

Bailit Health
etaylor@bailit-health.com
Logistics

• This webinar is being recorded.
  – The recording and slides will be available following the webinar.

• Telephone lines will remain muted.
  – We want everyone to be able to hear our presenters!

• Questions can be submitted electronically at any time.
Asking Questions Electronically

- Right click on the Chat button in the top right of the WebEx program.

- Type your question in the chat box. Select “All Panelists” and click “Send.”

- The Q&A function can also be used in a similar way.
Overview

• State attention to value-based payment for LTSS
• State levers
• State spotlight: Minnesota
• State spotlight: Virginia
Overview

Americans needing long-term care will more than double by 2050.

Medicaid is the primary payer of LTSS.

Source: U.S. Senate Commission on Long-Term Care, 2013

Source: National Health Policy Forum, based on data from 2011 National Health Expenditure Accounts
Overview

Total Medicaid Expenditures (2014)

Total federal and state Medicaid spending: $471 billion

LTSS spending: 32%

Managed care spending on LTSS increased from 5% in 2009 to 15% in 2014, driven by an increase in state implementation of MLTSS programs

Source: Truven Health Analytics, April 2016
State Levers

**Grants or capacity-building investments** to support entry and readiness

**Structure MLTSS contracts** to direct or encourage value-based payment models (e.g., data and reporting requirements, payment targets)

Waiver terms and requests for **DSRIP funds** to support LTSS infrastructure development

**Special Needs Plans contracting authority** to further integrate and align financing and delivery
Medicaid Value-Based Payment for LTSS – Minnesota’s Approach

Gretchen Ulbee, Manager of Special Needs Purchasing
May 16, 2017
Minnesota Spotlight

- Overview of Minnesota Senior Health Options (MSHO)
- Minnesota DHS Value-Based Payment Strategy
- Supports for Successful Value-Based Payment Models
- Example ICSPs
- Next Steps
Overview of MSHO

• Minnesota Medicaid-eligible seniors are required to enroll in Medicaid managed care

• Seniors may opt to receive Medicare with the same health plan providing their Medicaid coverage (MSHO)
  • Integration of Medicare by MIPPA contract
  • Requires coordination of benefits across programs

• All Medicare and Medicaid primary and acute care services, dental, behavioral health, LTSS, HCBS waivers services, 180 days NF, Part D
  • Seniors are in all settings and levels of care
Making the Most of the Integration Opportunity

• Decisions made by primary, acute and post-acute care providers paid under Medicare continue to drive State Medicaid and LTSS costs
  • circular shifting between hospitals and NF
  • primary care incentives to place difficult patients in NF
• Opportunities to impact provider incentives and practice patterns are lost when FFS payment models are perpetuated within capitated programs
Value-Based Payment Objectives

• Move away from FFS at provider levels
• Align service delivery arrangements across settings
• Create provider-level incentives
• Use D-SNP platform to leverage Medicare involvement in payment reform
Integrated Care System Partnerships (ICSPs)

• Multiple financial and delivery models tied to defined quality metrics are developed by D-SNPs
• MCOs and provider partners develop arrangements and submit proposals to state
• Must have four arrangements, one of which must include LTSS
• State contract includes requirements to report on quality metrics and financial performance
Incorporating Quality Measurement

• Convened a clinical work group of MCO Medical Directors and QA staff
• Held discussions with state, local and national measurement experts (e.g., NCQA, Minnesota Community Measurement, Stratis Health)
• Engaged providers and other stakeholders in measure development process
Incorporating Quality Measurement (cont’d)

• Aimed to align measures as much as possible across health plans to minimize provider burden
• Identified measure sets prior to implementation
• Sample of selected measures

<table>
<thead>
<tr>
<th>Advanced care planning</th>
<th>Fall with fracture</th>
<th>Inpatient admissions/readmissions</th>
<th>Physician Orders for Life Sustaining Treatment (POLST) documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anti-depressant medication management</td>
<td>Fall risk management</td>
<td>Management of high risk medications</td>
<td>Pressure ulcers</td>
</tr>
<tr>
<td>Care of older adults</td>
<td>Flu shot</td>
<td>Medication reconciliation post-discharge</td>
<td>Use of antipsychotics for people with dementia</td>
</tr>
<tr>
<td>ED utilization</td>
<td>Follow-up after hospitalization for mental illness</td>
<td>Plan all-cause readmissions</td>
<td>Use of high risk medications in the elderly</td>
</tr>
</tbody>
</table>
Example ICSPs

- Sub-capitation for all Medicare and MLTSS services with upside and downside risk
  - May include downstream gain sharing with LTC providers
- PMPM for care coordination and management with financial incentive for quality performance
- Pay-for-performance
  - Long-term care facilities
  - Education and referral related to medication management therapy and advanced care planning
Supports for Successful VBP

• Collaborate on limited set of measures to focus results
• Match provider scope, expectations to ability of provider to impact change and take risk: (e.g. many MLTSS providers can’t impact health outcomes but P4P might leverage cooperation in needed areas to improve Star ratings)
• Leverage broader contracts to include duals: (e.g. hospitals may not serve enough duals to be interested in dual specific contracts)
• Facilitate data sharing with providers
Next steps for MDHS

• Simplify reporting requirements
• Quantify reach of VBP efforts across programs for seniors and people with disabilities
• Focus on LTSS and behavioral health integration
• Engage providers and stakeholders
• Enhanced data sharing
VALUE-BASED PAYMENTS FOR LONG-TERM SERVICES AND SUPPORTS (LTSS)

Transforming Payments in Virginia Medicaid

Seon Rockwell
Director of Innovation and Strategy
Ensure Virginia’s Medicaid Enrollees Receive Quality Health Care

Virginia Medicaid Strategy

Superior Care

Cost Effective

Continuous Improvement
Expenditures are disproportionate to the population where services for older adults and individuals with disabilities drive a significant portion of Medicaid costs.

- 23% of the Medicaid population drives 68% of total expenditures.
- Enrolled: 1.3 M
- Spent: $8.41 B
Virginia’s Medicaid Program

Major Initiatives

1. Complete Duals Demonstration

2. Launch phased in implementation of MLTSS (CCC Plus) in August 2017

3. Procure new technology changes

4. Procure managed care for pregnant women & children (Medallion 4.0) in 2017

90% of Virginia Medicaid enrollees will soon be in managed care (currently 75%)
Virginia’s Vision for Value-Based Payments

Everyone is paid for consistently doing the right thing

- Incentivize patient-centered care that achieves quality outcomes
- Balance and align penalties and rewards
- Create efficiencies and bend the cost curve

Guiding Principles

- Support providers with the tools and information they need to transition to VBP
- Structure incentives to achieve defined performance outcomes
- Plan and implement change incrementally and consistently
Align Accountability Across Payers & Providers with Financial Incentives

MCO contracts include accountability for quality, outcomes, and patient satisfaction metrics

Provider contracts include accountability for quality, outcomes, and patient satisfaction metrics

Aligned metrics and accountability incentivizes both MCOs and Providers to deliver high-quality and efficient patient care
Managed Long-Term Services and Supports RFP

DMAS leveraged the RFP to:

- Assess health plan experience with VBP
- Begin communicating DMAS’ VBP vision
- Establish HCP-LAN as the framework
- Signal expectation for health plans to progressively increase risk-bearing VBP contractual agreements with providers

Example Performance Targets

- Percent of Payments in VBP
- Percent of LTSS in the community
- Potentially Preventable Events
- Management of Episodes of Care

RFP Expectations

- DMAS plans to set targets for the percent of MCO payments under VBP arrangements
- DMAS expects MCOs to increase the percent of VBP at least 5% each year
Key MLTSS RFP Questions

Value Based Payment questions are Based on HCP-LAN framework

1. Current Experience with VBP & APMs

<table>
<thead>
<tr>
<th>Current Use</th>
<th>Medicaid</th>
<th>Commercial</th>
<th>Medicare</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Type</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>VBP by HCP-LAN category</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of medical expenses for each APM model</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Types of Services (primary and acute, BH, LTSS, and others)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Description of numerator/denominator</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2. APM strategies to be most effective for Medicaid ABD population and dually-eligible persons

- **Category 1** Fee for Service – No Link to Quality & Value
  - A: Foundational Payments for Infrastructure & Operations
  - B: Pay for Reporting
  - C: Rewards for Performance
  - D: Rewards and Penalties for Performance

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

- **Category 3** APMs Built on Fee-for-Service Architecture
  - A: APMs with Upside Gainsharing
  - B: APMs with Upside Gainsharing/Downside Risk

- **Category 4** Population-Based Payment
  - A: Condition-Specific Population-Based Payment
  - B: Comprehensive Population-Based Payment
Key MLTSS RFP Questions (continued)

3 Proposed VBP Plan for Implementation

- Development of Provider Readiness for VBP
- Relationship to commercial VBP strategy and Medicare in Virginia health care marketplace
- Methods and frequency for collecting and providing data from providers
- Objectives for APM implementation – scope, provider performance, and timeline for implementation related to each proposed APM model approach
Virginia RFP Learnings

- Payment is still mostly tied to utilization
- Health plans have limited experience designing APMs for LTSS
- Limited provider readiness for APMs (most still in HCP-LAN Category 1)

Limited LTSS VBP Experience

LTSS Not Traditionally Part of the Continuum

Barriers to Collaboration

- Limited infrastructure to facilitate information sharing and collaboration
- Lack of provider partnerships limits capacity for care transitions and care coordination

Social determinants frequently excluded

DMAS also identified the importance of establishing a baseline year
VA Managed LTSS Contract

**Annual VBP Plan**
- Current State Review
- Provider Readiness and Performance
- Review and Communication
- Strategy and Alignment

**VBP Status Report**
- VBP Category (HCP-LAN)
- Description, Goals, Measurable Results
- Description of Targeted Providers
- Description of Targeted Members
- Total Payments to Providers
- Total Potential Payment Adjustment
- Potential Overlaps with other VBP programs or initiatives

**HCP-LAN Data Submission**
- HCP-LAN Data Submission
DMAS Framework for Next Steps

1. **Policy Decisions**
   - Outline policy priorities for VBP
   - Work through policy determinations
   - Finalize policy decisions

2. **Roadmap Design**
   - Determine VBP goals and objectives
   - Select key MCO and provider performance indicators
   - Identify potential financial support for provider infrastructure

3. **Stakeholder Engagement**
   - Outline strategy for ongoing stakeholder communications
   - Use lessons learned to refine VBP Roadmap

Process is not entirely linear as some activities occur in parallel.
Discussion and Questions

Gretchen Ulbee
Seon Rockwell
Dan Meuse
Erin Taylor
Resources

• Webinar materials will be emailed to participants and made available on the SHVS website
  – http://statenetwork.org/resource/?tag=shran,s hvs&topic=&type=