The Landscape of Medicaid Value-based Purchasing

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Overview

• Background

• State Medicaid Landscape of Value-based Purchasing

• The Intersection with Federal Initiatives

• Takeaways
National Association of Medicaid Directors

- Standalone association
- 56 Medicaid directors, including DC and territories
- Our mission:
  - Represent the consensus voice of state Medicaid Directors to federal policymakers
  - Support sharing of best practices around key state priorities
Medicaid Landscape

- Federal/state partnership
- States operate their Medicaid program within broad federal rules
- Responsible for 72 million Americans
- State-to-state variation in program
- Shared goal of improving outcomes and delivering value
Medicaid Value-based Purchasing

- NAMD/Bailit Health report on Medicaid value-based purchasing
- Developed through partnership with The Commonwealth Fund
- Mixed methods approach
- Findings based on information from 34 of states and sample of 5 Medicaid managed care organizations
Value-based purchasing generally refers to the use of alternative payment models that hold providers accountable for quality of care and costs.
Medicaid Value-based Purchasing

- Overarching findings:
  - Broad payment reform happening nationally
  - How alternative payment models are being implemented varies by state
  - Occurring through managed care organizations and direct contracting with providers
  - Initial focus typically in primary and acute care; some states beginning to focus on long-term care
  - States with State Innovation Model grants and Delivery System Reform Incentive Payment Programs tend to be further along
Value-based purchasing in this delivery system is changing the way the state pays providers.
Value-based Purchasing in a Managed Care Delivery System

Value-based purchasing in this delivery system is changing the way MCOs pay providers.
MCOs and Medicaid Value-based Purchasing

- 72% of Medicaid beneficiaries in managed care
- Many states require or encourage MCOs to increase use of value-based purchasing
- State approaches vary:
  - Promote use of alternative payment models by MCOs
  - Medicaid agency provides financial incentives for MCOs to use alternative payment models
  - Contractually require MCOs to implement MCO-defined alternative payment models
  - Medicaid agency designs an alternative payment model and contractually requires MCOs to implement it
Most Common Medicaid Alternative Payment Models

- **Additional Payments to Providers in Support of Delivery System Reform**
  - Per member per month payment on top of fee-for-service payments for care management or to fund practice transformation
  - Typically supports patient-centered medical homes and/or Health Homes

- **Episode-based Payments**
  - Provider financially accountable for a defined and discrete set of services over limited time
  - Focused on identifying and improving clinical pathways

- **Population-based Payments**
  - Providers responsible for a comprehensive set of services for a patient population
  - Potential to share in savings/risk based on actual costs & quality
### Most Common Alternative Payment Models

<table>
<thead>
<tr>
<th>Model</th>
<th>States Currently Implemented</th>
<th>States Currently Considered Implementing</th>
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<tr>
<td>Additional Payment in Support of Delivery System Reform</td>
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<td>4</td>
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<tr>
<td>We expect many more states to have implemented this model but did not report it in our survey</td>
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<tr>
<td>Episode-Based Payment</td>
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<tr>
<td>Population-Based Payment</td>
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<td>2</td>
</tr>
<tr>
<td>2 states are making significant changes or expanding their population-based payment model</td>
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Challenges in Medicaid Value-based Purchasing

- Complexity
- PPS for Safety-net Providers
- Data Sharing
- State Operational Capacity
- Quality Alignment
- Provider Readiness
Opportunities in Medicaid Value-based Purchasing

- Multi-payer Alignment
- Long-term Services and Supports
- Social Determinants
- Behavioral Health Integration
Federal Value-based Purchasing Activities

- Happening in parallel to state-based innovation
  - CMS goal of moving 50 percent of fee-for-service Medicare payments into value-based arrangements by 2018
  - Various models underway and in development in Medicare
- Misalignment will leave providers to struggle with multiple different approaches to achieve the same ends
- Alignment between state-based and federal value-based purchasing can accelerate transformation, reduce provider confusion
Federal Value-based Purchasing Activities

- **MACRA Advanced APM program**
  - Participation in qualifying Medicaid models can help provider achieve Medicare bonus payment
  - Qualifying Medicaid models need to meet certain requirements, including putting providers at financial risk

- **Center for Medicare and Medicaid Innovation multi-payer models**
  - State Innovation Model program
  - Comprehensive Primary Care Plus (CPC+) model

- **HHS Health Care Payment Learning and Action Network (LAN)**
  - Body of national and state experts seeking to advance use of alternative payment models and multi-payer alignment
  - Alternative payment model framework
LAN Alternative Payment Model Framework

Figure 1. APM Framework (At-A-Glance)

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
- A: APMs with Upside Gainsharing

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

Category 4
Population-Based Payment
- A: Condition-Specific Population-Based Payment
- B: Comprehensive Population-Based Payment
Takeaways

- Widespread movement in state Medicaid programs to overhaul provider payment from volume to value-based arrangements
- Managed care plans are playing a key role in value-based purchasing efforts
- Increasing need for federal and state collaboration to address multi-payer alignment in value-based purchasing
Questions?

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