

Implementing Prevention Strategies to Support State Medicaid Value-Based Payment Reforms

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IN BRIEF

Implementing evidence-based prevention strategies, such as those included in the Centers for Disease Control and Prevention's (CDC) 6|18 Initiative, can help states achieve value-based payment (VBP) goals. State officials can align prevention strategies with VBP goals through a variety of mechanisms, including: (1) tying prevention-related metrics to VBP arrangements; (2) incorporating population health priorities into managed care quality withholds or incentive pools; and (3) engaging providers in prevention activities under VBP delivery systems. Through support from the Robert Wood Johnson Foundation, the Center for Health Care Strategies (CHCS) is working with states to implement prevention strategies under CDC's 6|18 Initiative. This brief draws from state-based 6|18 Initiative implementation efforts to help Medicaid and public health officials make the case for investing in prevention strategies and aligning these efforts to achieve state VBP goals.

As health care costs continue to rise without clear improvements in outcomes, many state Medicaid programs are turning away from traditional fee-for-service reimbursement for health plans and providers and toward value-based payment (VBP) efforts. VBP strategies aim to refocus the health care delivery system on quality instead of volume, with an emphasis on improving health outcomes and appropriate health care service use. By pursuing areas of alignment between state-specific VBP priorities and prevention strategies, states may accelerate the achievement of their population health goals. This brief, which draws from the experiences of states implementing CDC's 6|18 Initiative prevention strategies, is intended to help guide state Medicaid and public health officials in understanding practical opportunities to accomplish such alignment.¹

Opportunities for Aligning Prevention Strategies with VBP Arrangements

The brief examines three potential opportunities for aligning prevention strategies with Medicaid VBP arrangements. States can: (1) tie prevention-related metrics to VBP arrangements; (2) incorporate population health priorities into managed care quality withholds or incentive pools; and (3) engage providers in prevention activities under VBP delivery systems.

Tie Prevention-Related Quality Metrics to VBP Arrangements

Under most Medicaid VBP strategies, a proportion of payments are dependent on a health plan or provider's ability to achieve specific quality benchmarks. Pay-for-performance programs, for example, link provider bonuses to the achievement of specific performance levels for pre-

determined metrics. VBP models such as shared savings, bundled payment arrangements, and population-based payments (see “Overview of VBP Arrangements” sidebar below) rely on quality metrics to ensure that health care quality is high, or at least not compromised, in the pursuit of reducing medical costs. The CDC’s 6|18 Initiative offers practical evidence-based strategies to help states address six high-burden health conditions: tobacco use, high blood pressure, inappropriate antibiotic use, asthma, unintended pregnancies, and diabetes. CDC’s 6|18 Initiative aligns with the goals of VBP and population health goals, as chosen interventions have a clear evidence base for both addressing rising health care costs and improving health outcomes. Table 1 provides examples of metrics related to prevention strategies under CDC’s 6|18 Initiative.

Overview of Value-Based Payment Arrangements

Following are payment arrangements that states can use to support goals of: (1) providing quality health care; (2) curbing health care costs and (3) improving population health:

- **Pay-for-performance (P4P)** offers providers a bonus for improvements in health outcomes or in some cases, a penalty for adverse population health outcomes.
- **Shared savings and shared savings/risk arrangements** allow providers to “share” in a portion of the savings if quality patient care is provided at an amount lower than the targeted total cost of care. In shared savings/risk arrangements, if spending is above the cost target, providers may have to return money to Medicaid.
- **Bundled payment arrangements** encourage providers to spend a discrete amount of money for an “episode of care” and avoid exceeding the cost of the bundle relative to a total cost of care benchmark. Some bundled payments pay providers on a fee-for-service basis and retrospectively reconcile expenditures against a cost target. A prospective bundled payment arrangement pays providers a fixed cost based on a pre-determined rate.
- **Population-based payment or global budgets** represent a fixed budget based on membership (per member per month). Providers paid with a global budget arrangements often have flexibility to invest in interventions to improve population health outcomes. Providers in population-based payment arrangements must meet or exceed quality standards, demonstrating population improvements on certain metrics.



A state can adopt prevention strategies that align with its population health priorities. Massachusetts officials, for example, achieved alignment between the state’s 6|18 Initiative tobacco cessation efforts and its new Medicaid accountable care organization (ACO) program² by incorporating tobacco cessation quality measures into its ACO shared savings model. States pursuing prevention strategies can also work to improve outcomes on existing quality metrics. For example, under the CDC’s 6|18 Initiative, Maryland is seeking to expand access to the Diabetes Prevention Program.³ Investing in this community-based prevention strategy can help Maryland hospitals achieve better results on a progress measure included in the state’s all-payer hospital model to “reduce diabetes-related emergency department visits.”⁴

Exhibit 1. Examples of Quality Measures Related to Prevention Strategies under CDC’s 6 | 18 Initiative*

6 18 Condition	Example of Quality Measures
Asthma	<ul style="list-style-type: none"> ■ NQF 1799 Medication Management for People with Asthma ■ NQF 1800 Asthma Medication Ratio
Diabetes	<ul style="list-style-type: none"> ■ CMS: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan ■ Core Quality Measures Collaborative (ACO & PCMH / Primary Care Measures): Adult Body Mass Assessment (ABA)
Antibiotic Resistance	<ul style="list-style-type: none"> ■ HEDIS: Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis (AAB)
Hypertension	<ul style="list-style-type: none"> ■ HEDIS: Controlling High Blood Pressure (<140/90)
Tobacco	<ul style="list-style-type: none"> ■ NQF 0027: Medical Assistance with Tobacco Cessation ■ NQF 0028: Tobacco use: Screening and Cessation Intervention ■ Oregon Coordinated Care Organization (CCO) Performance Measure: Cigarette Smoking Prevalence (bundled measure)⁵
Unintended Pregnancy	<ul style="list-style-type: none"> ■ NQF #2902-Postpartum Most & Moderately Effective Methods ■ NQF #2903- Most & Moderately Effective Methods ■ NQF #2904-Access to Long-Acting Reversible Contraception ■ Oregon CCO Performance Measure: “Effective Contraceptive Use among Women at Risk of Unintended Pregnancy”⁶

*Not an exhaustive list of quality measures related to 6 | 18 condition areas.

Incorporate Population Health Priorities into Managed Care Quality Withholds or Incentive Pools

Some states are implementing quality withhold arrangements with Medicaid managed care organizations (MCOs). Under these arrangements, the state withholds money from an MCO’s capitation payment, returning the funds only if the MCO performs well on specific quality metrics. States can promote adoption of prevention activities as a way to help MCOs meet Medicaid quality withhold benchmarks. Washington State, for example, has a quality withhold program for its Medicaid MCOs that includes measures for diabetes, hypertension, and medication management for children with asthma. Investing in prevention strategies, such as those under CDC’s 6 | 18 Initiative, may allow MCOs to more easily meet these metrics, and as a result, gain a greater portion of their withheld funds.

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Other states may implement “quality incentive pools” that allow MCOs to compete for dollars based on their performance on pre-determined measures. These pools are typically funded by a quality withhold. For example, Oregon’s Medicaid program has a quality pool for its Coordinated Care Organizations (CCOs) that includes a metric for “Effective Contraceptive Use among Women at Risk of Unintended Pregnancy.” CCOs that meet the benchmark for this measure (in 2017, the benchmark was set at 50 percent of women at risk of unintended pregnancy using an effective

contraceptive method) will be eligible for a higher percentage of quality pool funds.⁷ Implementing policies under CDC's 6|18 Initiative to enhance access to long-acting reversible contraception would not only help CCOs more easily reach the 50 percent benchmark, but would also signal to providers the state's commitment to addressing unintended pregnancies.

Engage Providers in Prevention Activities under VBP Delivery Systems

Providers in risk-based VBP arrangements may reap benefits from implementing a prevention strategy that controls costs and improves patients' health. Due to the risk that providers take on in more advanced VBP models, prevention strategies that help to rein in spending while improving health outcomes can result in providers receiving higher payments or incentives (e.g., receiving a portion of savings under a shared savings model) and/or avoiding financial penalties (e.g., recouping all withheld funds under a withhold model), while ensuring high quality care. For example, as a result of asthma control policies implemented under CDC's 6|18 Initiative, providers may better manage patients with uncontrolled asthma, resulting in fewer hospitalizations and emergency department visits — ultimately leading to health system cost reductions that would trickle down to a provider under a VBP arrangement with a shared savings component.

States can use a number of mechanisms to demonstrate to providers the mutually reinforcing benefits and opportunities associated with adopting evidence-based prevention interventions while participating in a VBP arrangement — including through MCO contracting and provider education. To encourage or require participation in concurrent prevention and VBP activities, states can direct MCOs to enter into contracts with their providers that simultaneously promote prevention strategies and VBP payment models. For example, a state may contractually require MCOs that are using risk-based provider contracts to also implement an asthma medication management intervention or a 6|18 Initiative tobacco control intervention. To educate providers about how adopting prevention strategies can make them more successful under VBP arrangements, states can work with MCOs to highlight this topic in regular provider-focused communications. States can also conduct direct outreach to provider organizations like state or local hospital associations and primary care associations and develop content on this subject for provider meetings, conferences, and continuing medical education programs.

Lastly, states can encourage MCOs and providers to use care coordination payments to fund prevention strategies. Care coordination payments — generally per-member-per-month payments to cover activities outside of a face-to-face visit that improve care delivery and health outcomes — are often embedded into VBP delivery system models such as ACOs and patient-centered medical homes. Through existing communications channels (e.g., state provider bulletins), states can help providers recognize that they can use a portion of care coordination funds to pay for evidence-based prevention interventions. States could also use contractual requirements as a lever to require providers receiving care coordination funds to use a portion of those funds to implement prevention strategies that align with the state's population health goals.

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Strategies for Aligning Prevention Strategies with VBP Initiatives

1. Examine the state's VBP approach

States often describe their Medicaid VBP approaches in MCO contracts or in a VBP roadmap or overview document. As a first step in aligning prevention strategies with VBP initiatives, Medicaid and public health officials undertaking prevention efforts can determine if participation in state VBP programs is mandatory or voluntary for MCOs and their providers. Understanding these parameters will help state officials gauge state leadership's commitment to VBP, as well as provider flexibility and motivation for implementing an evidence-based prevention intervention under a VBP arrangement.

2. Get involved in the decision-making process

State officials working to implement evidence-based prevention interventions can attend stakeholder meetings on new VBP arrangements and highlight the potential of prevention strategies to amplify state VBP efforts. Medicaid officials may inform their state's quality improvement advisory groups, which are often tasked with improving the quality of care for Medicaid beneficiaries, on how evidence-based prevention interventions may bolster a provider or plan's ability to meet VBP metric requirements. They may also demonstrate to key decision-makers the merits of implementing public health strategies within a VBP program and the importance of partnering with public health to accomplish this objective. While public health officials may not always be at the table for payment reform discussions, they can add valuable perspectives about population health priorities and improvement strategies. A state official invested in implementing prevention strategies may benefit from developing an outreach or communications plan targeting decision-makers, then evaluating the impact of these communication efforts.

Promoting Prevention Strategies in a State Medicaid Value-Based Payment Environment



States may use the following approaches to increase the adoption of prevention strategies, such as those under the 6|18 Initiative, within their managed care VBP programs:

- ✓ **Encourage.** States can use their purchasing power to procure MCOs that will agree to implement prevention strategies as part of their VBP efforts.
- ✓ **Incent.** States may give MCOs contractual incentives for the implementation of prevention strategies in their VBP arrangements. These incentives may be nonfinancial (i.e., additional points toward an MCO's VBP benchmark requirements) or financial (i.e., bonuses, incentive payments, or a greater portion of shared savings.)
- ✓ **Require.** States may require MCOs to implement prevention strategies in their VBP arrangements through contractual requirements. As an example, states can require MCOs to auto-enroll their members in VBP delivery systems into evidence-based prevention strategies.

3. Emphasize the evidence-base behind chosen prevention strategies

Officials can work to emphasize the value of implementing evidence-based prevention strategies within a state VBP initiative. In doing so, state officials may cite the evidence base for prevention interventions' impact on health outcomes and costs. State officials can package the evidence base

into shorter fact sheets to make the information readily accessible to providers or decision-makers. If a state or Medicaid health plan is in the process of creating a new payment or incentive structure, Medicaid or public health officials can also offer suggestions, using the relevant evidence base, for metrics that are associated with prevention-related activities or outcomes.

Looking Ahead

State Medicaid programs are increasingly promoting payment reforms that reward quality health care and the appropriate use of health care resources. Evidence-based prevention interventions, such those included in CDC's 6|18 Initiative, align well with these payment reform efforts, as they improve health outcomes and control health care costs. Using the strategies described in this brief, states can demonstrate the complementary goals of evidence-based prevention interventions and Medicaid value-based payment initiatives, and then work to implement new Medicaid programs and policies that advance both preventive care and payment reform.

ADVANCING IMPLEMENTATION OF THE CDC'S 6 | 18 INITIATIVE

Through support from the Robert Wood Johnson Foundation, the Center for Health Care Strategies, in collaboration with a number of [partners](#), is coordinating technical assistance to facilitate state Medicaid and public health implementation of the Centers for Disease Control and Prevention's (CDC) 6|18 Initiative. The CDC's 6|18 Initiative promotes the adoption of evidence-based interventions that can improve health and control costs related to six high-burden, high-cost health conditions. For more information and additional resources, visit www.618resources.chcs.org.

ABOUT THE CENTER FOR HEALTH CARE STRATEGIES

The Center for Health Care Strategies (CHCS) is a nonprofit policy center dedicated to improving the health of low-income Americans. It works with state and federal agencies, health plans, providers, and community-based organizations to develop innovative programs that better serve people with complex and high-cost health care needs. For more information, visit www.chcs.org.

ENDNOTES

¹ To learn more about CDC's 6|18 Initiative, visit <https://www.cdc.gov/sixeighteen/>.

² ACOs assume responsibility for the health care needs of their population of patients and are often provider-led. ACOs typically use a shared savings or global budget payment arrangement. If ACOs spend more than their cost target, they may face financial consequences. However, ACOs may receive financial incentives if they provide quality care under their cost target.

³ For more information on the Diabetes Prevention Program see: Centers for Disease Control and Prevention, "National Diabetes Prevention Program" <https://www.cdc.gov/diabetes/prevention/index.html>.

⁴ Maryland All Payer Agreement: http://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_hospital/documents/chcf_all_payer_model_agreement.pdf, page 40. For more information on this measure see: <https://health.maryland.gov/ship/PDFs/Objective%2027.pdf>.

⁵ Oregon Health Authority. "Cigarette Smoking Prevalence (Bundled Measure)." December 2016. Available at: www.oregon.gov/oha/HPA/ANALYTICS/CCODData/Cigarette%20Smoking%20Prevalence%20Bundle%20-%202017.pdf.

⁶ Oregon Health Authority. "Effective Contraceptive Use among Women at Risk of Unintended Pregnancy Guidance Document." December 2014. Available at: <http://www.oregon.gov/oha/HPA/ANALYTICS/CCODData/Effective%20Contraceptive%20Use%20Guidance%20Document.pdf>.

⁷ Ibid.