Advancing Delivery and Payment Reform in Managed Care Provider Networks: Opportunities for State Purchasers

June 8, 2015

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Welcome

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Webinar Logistics

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  ▶ An email with this information will also be sent to all participants

• Due to the large number of participants, we will not be able to open the phone lines for questions; please use the Q&A feature instead.
Webinar Logistics

- Roll over the green bar at the top of the page and left click on Q&A.

- Type your question in the box.
  Click on “All Panelists” in the “Ask” box.
Robert Wood Johnson Foundation’s State Health and Value Strategies Program

• Committed to providing technical assistance to support state efforts to enhance the quality and value of health care by improving population health and reforming the delivery of care services

• Connects states with their peers and experts to develop tools to undertake new quality improvement and cost management initiatives

• Places an emphasis on building system capacity, engaging stakeholders, and promoting payment and other purchasing reforms

I. Introductions

II. Overview: State Levers and Contracting Approaches

III. State Perspectives: Arizona and Tennessee

IV. Questions
Introductions

Tricia McGinnis  
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Center for Health Care Strategies

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Project Manager  
Arizona Health Care Cost Containment System

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Director of Strategic Planning and Innovation  
Tennessee Division of Health Care Finance and Administration
About the Center for Health Care Strategies

A non-profit health policy resource center dedicated to advancing access, quality, and cost-effectiveness in publicly financed health care
I. Introductions

II. Overview: State Levers and Contracting Approaches

III. State Perspectives: Arizona and Tennessee

IV. Questions
**Value-Based Purchasing (VBP)** = Broad set of payment strategies that link financial incentives to providers’ performance on a set of defined measures of quality and/or cost or resource use.
Opportunities and Challenges of Implementing VBP in Managed Care

Opportunities: Leverage

• State-led purchasing via managed care accounts for ~ 35% of the market
• 40% of the commercial market in VBP
• HHS goal of 85% of Medicare spend in VBP by 2016

Challenges: Provider Uptake

• State purchasers historically have had lower rates
• Maintaining access among fragile provider networks
• Limitations of data and analytics
Continuum of Plan-Facing VBP Implementation Approaches

- Plan-defined models and parameters
- Pilot projects

- Menu of models
- Alignment on program components (e.g. metrics, eligibility)
- Specify % of spending covered

- Require adoption of specific models
- Specify payment methods and other parameters
State Levers for VBP Implementation via Managed Care

<table>
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<tr>
<th>Encourage</th>
<th>Incent</th>
<th>Require</th>
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<tr>
<td>• RFP questions</td>
<td>• Contractual incentives or penalties for adoption</td>
<td>• Contractual requirements</td>
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<td>• Contractual supports</td>
<td>• Rate-setting incentives</td>
<td>• Legislation</td>
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<tr>
<td>• Quality/efficiency transparency</td>
<td>• Patient assignment rules</td>
<td>• Regulatory requirements</td>
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Managed Care VBP Best Practices

- Use RFPs to identify plans that will be good partners.
- Use contracts to drive delivery and payment reforms.
- Design a contracting strategy to give plans more leverage.
- Set policies that give state purchasers more negotiating power.
- Develop legislation, regulations, and policies to drive reforms.
- Increase the transparency of quality and efficiency information.
New Mexico’s Approach

- Plans required to implement VBP projects under the Medicaid Centennial Care Waiver

Implementation Approach:

- Health plans submitted VBP proposals for review
- Based on submissions and state needs, NM selected patient-centered medical home (PCMH) and accountable care organization (ACO) projects
- Plans have flexibility over model and payment design
- State identified a uniform measure set aligned with existing plan reporting requirements
- State established a uniform evaluation and reporting plan to measure effectiveness
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Arizona Managed Medicaid

- **AHCCCS**: Arizona Health Care Cost Containment System Medicaid Managed Care since 1982
- Acute Care: 8 MCOs, assigned geographically
- Arizona Long Term Care System [EPD & DD]: 3 MCOs assigned geographically includes acute, behavioral health, and long term care services
- 4 of the MCOs are owned by, or part of large health systems
- 3 MCOs have organizational relationships with health system sponsored ACOs

Reaching across Arizona to provide comprehensive quality health care for those in need
Value Based Payment Initiative: Innovation through Competition

Acute, CRS, Integrated Behavioral Health/ LTSS, DD

- Contracted MCOs must have a % of provider payments in “value based arrangements”
- If the value based payment requirement is met, the MCO is eligible for a quality distribution-1% of their capitation
- The quality distribution is based on both the performance measured against performance standards and their ranking against other MCOs
- % of provider payments in a VBP arrangement started at 5% in 1st year---goes to 50% by October 2017
- 6 Quality Measures: ED use, Readmissions, (3) Well Child Visits, Children’s Dental
Key Considerations

• Coordination of Care Coordination: Don’t want to pay more than once
• The Risk-Accountability Continuum
• Data-Connectivity Challenges: HIE Participation
• Agency Systems and Infrastructure
• Learning Culture-Partnership-Ownership
• MCO Innovation <> Provider Capacity
What Else?

- Behavioral-Physical Health Integration
- Other VBP Initiatives
- Sustainability: MCOs’ VBP Costs
- Assessing Value in VBP Arrangements
Links

- ACUTE CARE PROGRAM VALUE-BASED PURCHASING INITIATIVE
  http://www.azahcccs.gov/shared/ACOM/ACOMApproved.aspx

- LONG TERM CARE SYSTEM ELDERLY AND PHYSICALLY/DISABLED PROGRAM PAYMENT REFORM INITIATIVE
  http://www.azahcccs.gov/shared/Downloads/ACOM/PolicyFiles/300/318_A.xlsx
Tennessee Health Care Innovation Initiative

Advancing Delivery and Payment Reform in Managed Care Provider Networks: Opportunities for State Purchasers

June 8, 2015

We are **deeply committed** to reforming the way that we pay for healthcare in Tennessee

Our goal is to **pay for outcomes and for quality care**, and to reward strongly performing physicians

We plan to have episodes and population-based payment models account for the **majority of healthcare spend** within the next three to five years

“I believe Tennessee can also be a model for what true health care reform looks like.”

“It’s my hope that we can provide quality health care for more Tennesseans while transforming the relationship among health care users, providers, and payers. If Tennessee can do that, we all win.”

– Governor Haslam’s address to a joint session of the state Legislature, March 2013
National movement toward value-based payment

Forty percent of commercial sector payments to doctors and hospitals now flow through value-oriented payment methods.

- Catalyst for Payment Reform

“HHS has set a goal of tying 30 percent of traditional, or fee-for-service, Medicare payments to quality or value through alternative payment models, such as Accountable Care Organizations (ACOs) or bundled payment arrangements by the end of 2016, and tying 50 percent of payments to these models by the end of 2018.”

“Looking forward, we project that 20% to 25% of our medical costs will run through some form of value-based network contract in 2014 and are committed to increasing that participation percentage to 45% by 2017”

“Thirty-seven Blue Plans have more than 350 value-based programs in market or in development, with more than 215,000 participating providers providing care to nearly 24 million members.”

“Cigna has been at the forefront of the accountable care organization movement since 2008 and now has 114 Cigna Collaborative Care arrangements with large physician groups that span 28 states, reach more than 1.2 million commercial customers and encompass more than 48,000 doctors.”

"...increase value-based payments to doctors and hospitals by 20% this year to north of $43 billion...ended the year at about $36 billion of spend in value-based arrangements and we're looking to drive that north of $43 billion in 2015”

“We hope to have 75 percent of primary care physicians in our networks participating in this population health model by 2016."
## Tennessee’s Three Strategies

<table>
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<tr>
<th>Source of value</th>
<th>Strategy elements</th>
<th>Examples</th>
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| ▪ Maintaining a person’s health overtime  
▪ Coordinating care by specialists  
▪ Avoiding episode events when appropriate | ▪ Patient Centered Medical Homes  
▪ Health homes for people with serious and persistent mental illness  
▪ Care coordination tool with Hospital and ED admission provider alerts | ▪ Encouraging primary prevention for healthy consumers and coordinated care for the chronically ill  
▪ Coordinating primary and behavioral health for people with SPMI |
| ▪ Achieving a specific patient objective, including associated upstream and downstream cost and quality | ▪ Retrospective Episodes of Care | ▪ Wave 1: Perinatal, joint replacement, asthma exacerbation  
▪ Wave 2: COPD, colonoscopy, cholecystectomy, PCI  
▪ 75 episodes by 2019 |
| ▪ Provide long-term services and supports (LTSS) that are high quality in the areas that matter most to recipients | ▪ Quality and acuity adjusted payments for LTSS services  
▪ Value-based purchasing for enhanced respiratory care  
▪ Workforce development | ▪ Aligning payment with value and quality for nursing facilities (NFs) and home and community based care (HCBS)  
▪ Training for providers |
## Contracting approach

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<tr>
<th>Contract</th>
<th>TennCare</th>
<th>State Employee Health Plan</th>
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<tr>
<td># of members</td>
<td>~ 1.3 million</td>
<td>~ 270,000</td>
</tr>
<tr>
<td>Value based payment required for members?</td>
<td>✓</td>
<td>✓ by January 1, 2017</td>
</tr>
<tr>
<td>Participating Insurers</td>
<td>BCBST, United, and Amerigroup</td>
<td>Unknown (incumbents: Cigna and BCBST)</td>
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| Language on broader commercial implementation | RFP Question: “What are your plans to adopt episode based payment models population based payment models in other books of business and/or other geographies, and at what pace?” | **2017**: 50% of fully insured members & 10% self insured ASO members  
**2019**: 60% of fully insured members & 15% self insured ASO members |
| Link to contract or RFP | [http://www.tn.gov/tenncare/forms/MCOStatewideContract.pdf](http://www.tn.gov/tenncare/forms/MCOStatewideContract.pdf) | [http://tn.gov/generalserv/cpo/sourcing_sub/NewestFiles/31786-00125%20Amd%204.pdf](http://tn.gov/generalserv/cpo/sourcing_sub/NewestFiles/31786-00125%20Amd%204.pdf) |
Major payers in Tennessee have committed to have 80% of members across all books of business cared for through a population-based model within five years.

Tennessee’s timeline for PCMH and Health Home rollout:

<table>
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<th>Year</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
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<td>Q3 – Q4: PCMH and Health Home Technical Advisory Groups meet to advise on design elements of the program</td>
<td>Q3: Launch multi-payer PCMH pilot for a minimum of 12 practices</td>
<td>Q3: Practice transformation training begins</td>
<td>Q3: Expand multi-payer PCMH to pilot practices plus one grand region</td>
<td>Q3: Expand multi-payer PCMH statewide</td>
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Episodes of care: 75 in 5 years

Source: TennCare and State Commercial Plans claims data, episode diagnostic model, team analysis
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