Improving Outcomes and Reducing Costs: Reform Experiences in Other States

Mark McClellan, MD, PhD
Director, Initiatives on Value and Innovation in Health Care
Senior Fellow, Economic Studies
Brookings Institution

August 2015

Overview

- **To Improve Population Health, Reduce Health Care Costs (The Right Way)**
- **Aligning Payment With Higher-Value Health Care**
- **Illustrative Experiences from Other States: Utah, Arkansas, New Jersey**
  - **Population Health Accountability and Medicaid Managed Care**
  - **Episode-Based Provider Payment and Delivery Reform**
  - **Shifting From Uncompensated Care Payments**
- **Implications for Texas 1115 Waiver**
- **Presentations of Other State Experiences**

Determinants of Population Health

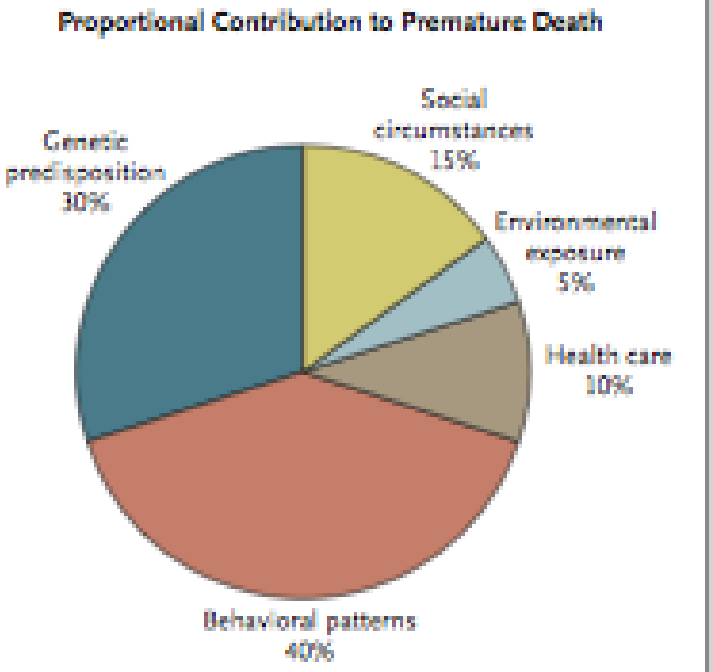


Figure 1. Determinants of Health and Their Contribution to Premature Death.

Adapted from McGinnis et al.[10]

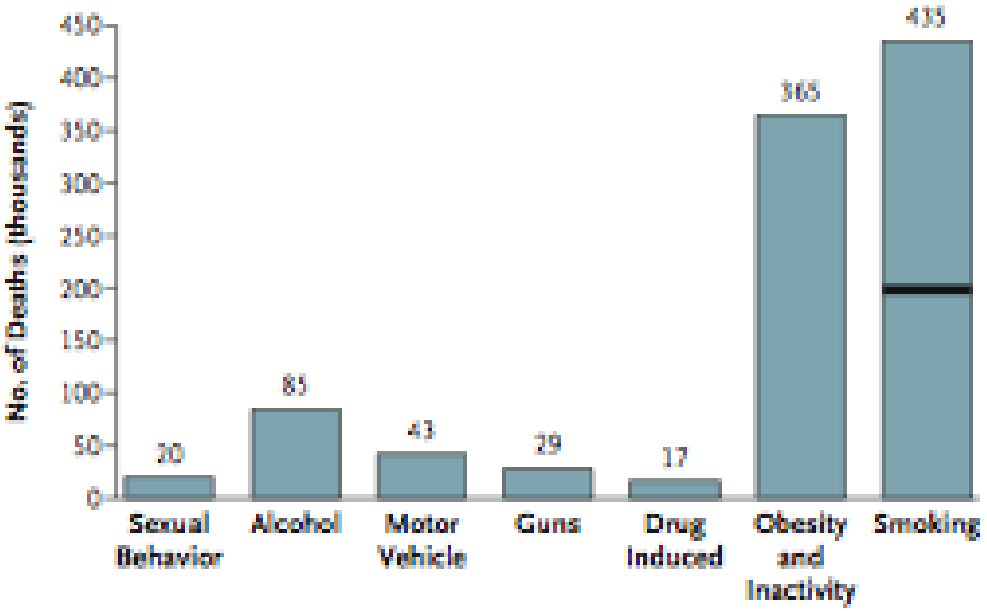
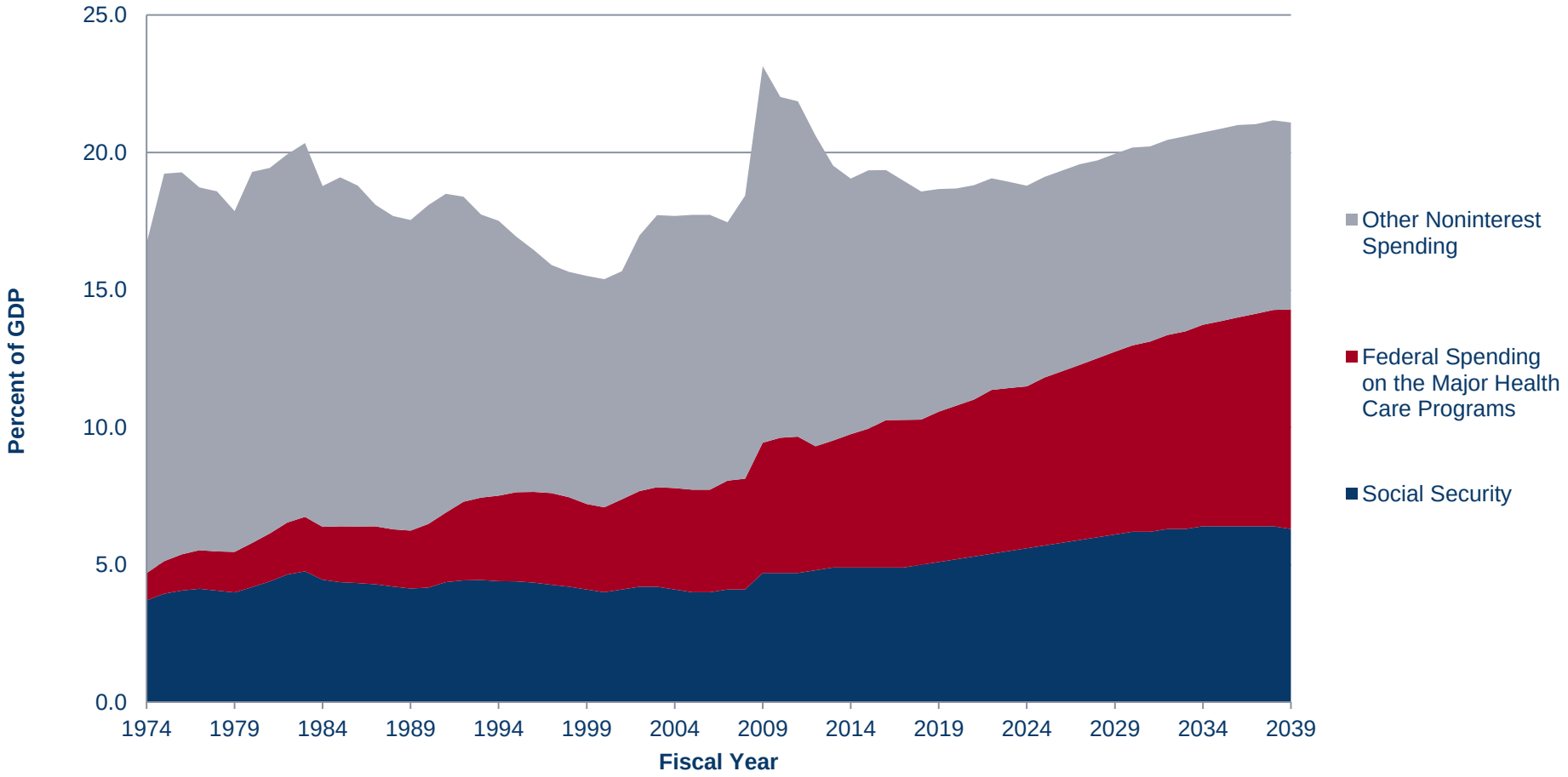


Figure 2. Numbers of U.S. Deaths from Behavioral Causes, 2000.

Among the deaths from smoking, the horizontal bar indicates the approximately 200,000 people who had mental illness or a problem with substance abuse. Adapted from Mokdad et al.[12]

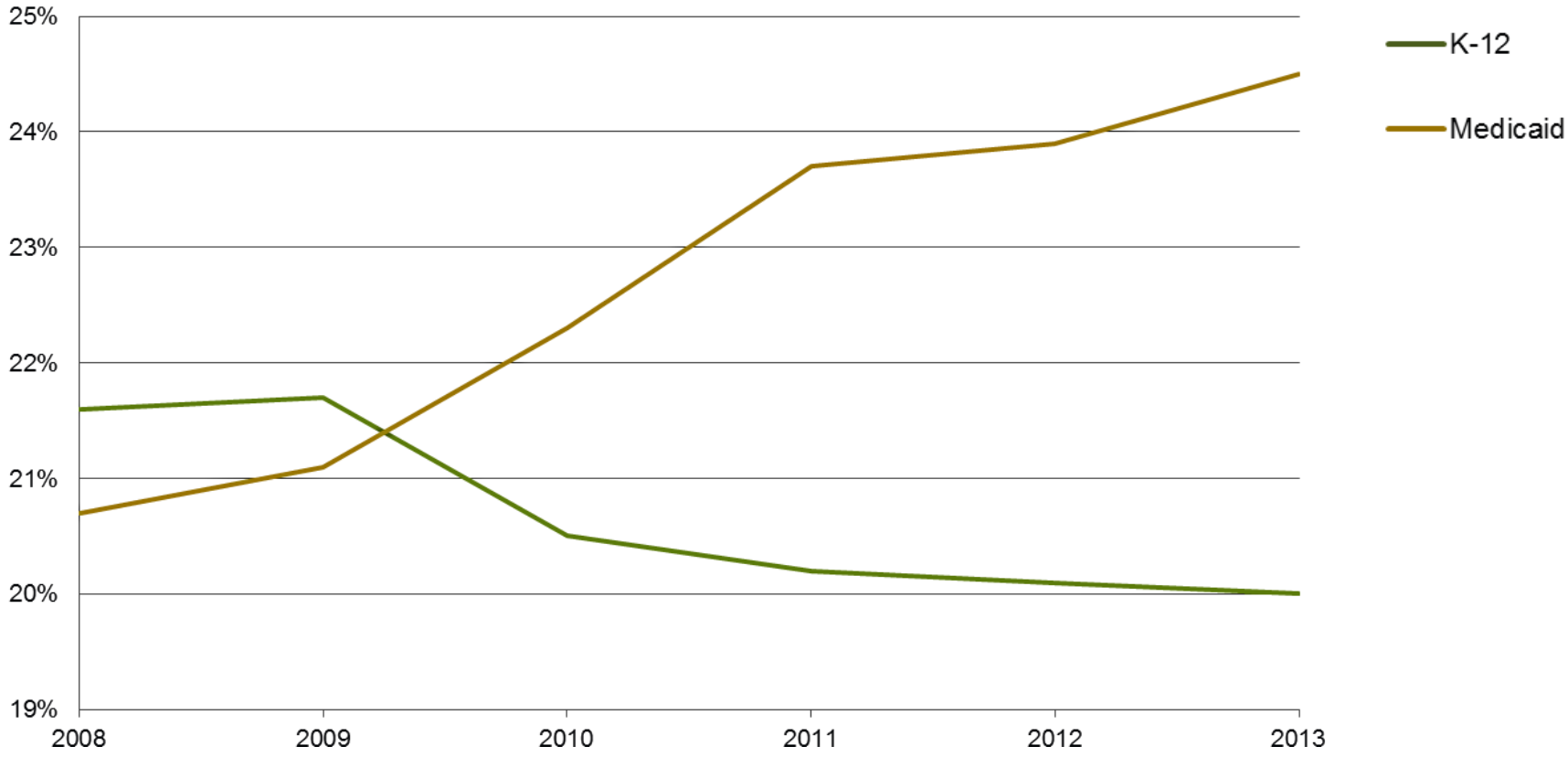
Source: Steven A. Schroeder, New England Journal of Medicine, Sept 20, 2007

Long-Term Federal Spending Projections, 1974-2039



Source: Congressional Budget Office, 2014 Long-Term Budget Outlook.

State Expenditures on Medicaid and K-12 education



Source: NASBO State Expenditure Reports

Texas Medicaid 1115 Waiver

Three Major Components

- Medicaid Managed Care (STAR, STAR+PLUS, Dental)
- Uncompensated Care Pool for Hospital Uncompensated Care
- Delivery System Reform Incentive Payments (DSRIP) Through Regional Health Partnerships

Overall aim: Transition to better-coordinated, higher-value care through quality-based payment systems, achieving better regional population outcomes for the same or lower total (Federal + state/local) spending

High-Value Health Care

- **Effective treatments for unmet health needs**
- **Innovations to better target use of medical technologies to patients who will benefit**
- **Wireless/ remote personal health tools and supports, telemedicine**
- **New delivery sites, methods and better-integrated provider teams**
- **Non- medical strategies for health improvement – including additional targeted assistance to high-risk individuals, and support for accessing social and community services to prevent complications**

High-Value Health Care

OFTEN COST INCREASING

- **Effective treatments for unmet health needs**

POTENTIALLY COST DECREASING

- **Innovations to better target use of medical technologies to patients who will benefit**
- **Wireless/ remote personal health tools and supports, telemedicine**
- **New delivery sites, methods and better-integrated provider teams**
- **Non- medical strategies for health improvement – including additional targeted assistance to high-risk individuals, and support for accessing social and community services to prevent complications**

High-Value Health Care

OFTEN COST INCREASING – USUALLY REIMBURSED IN MEDICAID

- **Effective treatments for unmet health needs**

POTENTIALLY COST DECREASING – OFTEN NOT REIMBURSED

- **Innovations to better target use of medical technologies to patients who will benefit**
- **Wireless/ remote personal health tools and supports, telemedicine**
- **New delivery sites, methods and better-integrated provider teams**
- **Non- medical strategies for health improvement – including additional targeted assistance to high-risk individuals, and support for accessing social and community services to prevent complications**

CMS Framework for Provider Payment Reform

	Category 1: Fee for Service – No Link to Value	Category 2: Fee for Service – Link to Quality	Category 3: Alternative Payment Models Built on Fee-for-Service Architecture	Category 4: Population-Based Payment
Description	▪ Payments are based on volume of services and not linked to quality or efficiency	▪ At least a portion of payments vary based on the quality or efficiency of health care delivery	▪ Some payment is linked to the effective management of a population or an episode of care ▪ Payments still triggered by delivery of services, but opportunities for shared savings or 2-sided risk	▪ Payment is not directly triggered by service delivery so volume is not linked to payment ▪ Clinicians and organizations are paid and responsible for the care of a beneficiary for a long period (e.g., ≥1 year)
Medicare Fee-for-Service examples	▪ Limited in Medicare fee-for-service ▪ Majority of Medicare payments now are linked to quality	▪ Hospital value-based purchasing ▪ Physician Value Modifier ▪ Readmissions / Hospital Acquired Condition Reduction Program	▪ Accountable Care Organizations ▪ Medical homes ▪ Bundled payments ▪ Comprehensive Primary Care initiative ▪ Comprehensive ESRD ▪ Medicare-Medicaid Financial Alignment Initiative Fee-For-Service Model	▪ Eligible Pioneer Accountable Care Organizations in years 3-5 ▪ Maryland hospitals ▪ Next-Generation ACOs with partial capitation

Source: Rajkumar R, Conway PH, Tavenner M. CMS — engaging multiple payers in payment reform. JAMA 2014; 311: 1967-8.

Alternative Quality-Based Payment Models for Health Care Providers

Episode Based

Payment linked to quality and cost for a **specified episode of care**

Examples:

- Elective procedure episodes
- Hospital admission episodes
- Primary care medical home

Whole Person

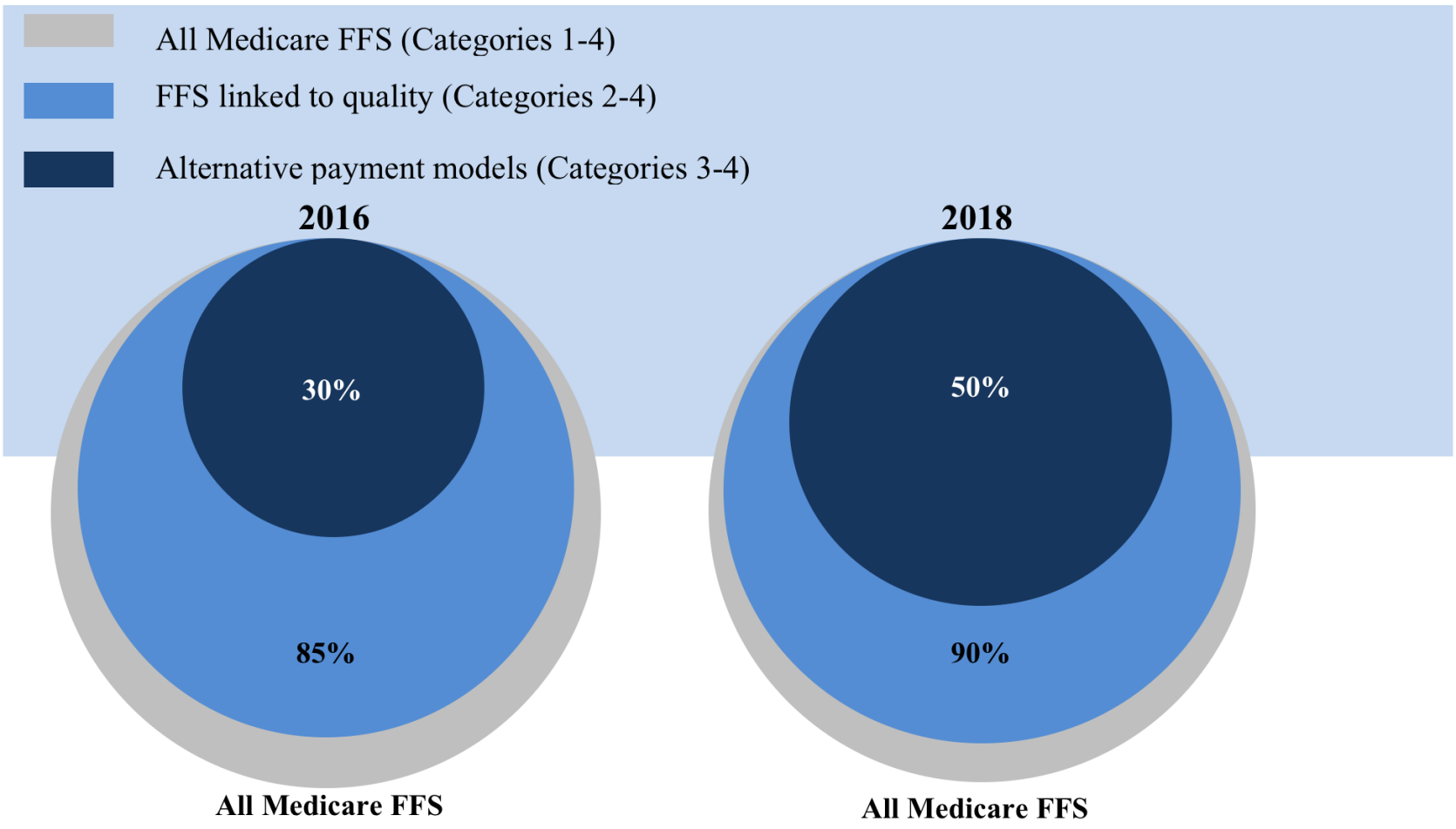
Payment linked to quality and cost for a **specified population**

Examples:

- Accountable care organizations
- Capitated care with pop. health accountability
- Medical home with pop. Health accountability
- Comprehensive care for high-risk patients

CMS Provider Payment Reform Goals

Target percentage of Medicare FFS payments linked to quality and alternative payment models in 2016 and 2018



Texas Medicaid 1115 Waiver

Three Major Components

- Medicaid Managed Care (STAR, STAR+PLUS, Dental)
- Uncompensated Care Pool for Hospital Uncompensated Care
- Delivery System Reform Incentive Payments (DSRIP) Through Regional Health Partnerships

Overall aim: Transition to better-coordinated, higher-value care through quality-based payment systems, achieving better regional population outcomes for the same or lower total (Federal + state/local) spending

Achieving better outcomes and lower costs through *population-based* payment reform: Utah and Medicaid Managed Care ACOs

- 1115 Waiver approved 2012, implemented 2013 in 4 most populous counties (75% of population)
- MMC ACO Qualifications
  - Meet quality standards: HEDIS, CAHPS, Utah Medicaid-specific quality targets
  - Bear risk through all-inclusive, risk-adjusted, fixed PMPM payment: initial rates based on historical costs, future rates tied to state general fund growth (ACO plans keep savings)
  - Innovations in provider contracting and where/what care is delivered: medical homes, care coordination, care redesign supported by sub-cap, shared savings
- Incentives for clients to better manage own health: differential cost sharing based on service, incentives for following medical guidance

Achieving better outcomes and lower costs through *population-based* payment reform: Utah and Medicaid Managed Care ACOs

- Early results show improvement in quality and reductions in spending growth
  - 2% annual growth rate for 2013 and 2014
  - All four participating Medicaid ACOs exceeded quality target measures
- Program expanded into 9 additional counties
- Future reforms planned
  - Continued encouragement/support for payment reforms for providers participating in each Medicaid ACO
  - Integrate behavioral health and long-term services and supports

Source: Michael Hales, Utah Dept. of Health

Achieving better outcomes and lower costs through *episode-based* payment reform: Arkansas Health Care Payment Improvement Initiative

- Multi-payer initiative (Medicaid, state employees, two largest private insurers, Walmart) initiated statewide in 2012
  - Initially included primary care medical home, five high-opportunity episodes (pregnancy, ADHD, hip/knee replacement, CHF, URI)
  - More added 2013-2014 (colonoscopy, cholecystectomy, tonsillectomy, ODD, CABG, PCI, asthma, COPD, neonatal conditions)
- Provider payment shift to broader episodes
  - Build from existing administrative billing systems, used to identify Principal Accountable Provider for episode
  - PAP shares in savings or excess costs relative to predetermined benchmark
  - Each episode linked to quality metrics, derived from existing data where possible (e.g., perinatal utilization reflecting complications) or targeted clinical data (e.g., guideline-concordant care for ADHD)
  - Start with baseline report and supporting data to give providers opportunity to adjust practice
  - Early results: significant number of winners and losers in first year; substantial measured improvements in quality

Texas Medicaid 1115 Waiver

Three Major Components

- Medicaid Managed Care (STAR, STAR+PLUS, Dental)
- Uncompensated Care Pool for Hospital Uncompensated Care
- Delivery System Reform Incentive Payments (DSRIP) Through Regional Health Partnerships

Overall aim: Transition to better-coordinated, higher-value care through quality-based payment systems, achieving better regional population outcomes for the same or lower total (Federal + state/local) spending

Achieving better outcomes and lower costs through redirecting uncompensated care spending in a region: New Jersey Medicaid Reform

- Camden Coalition
  - Evaluation led by Dr. Jeff Brenner characterized “hot spotter” patients who accounted for a large share of (uncompensated) hospital costs
  - With support from area hospitals (financial, data), Camden Coalition identified social service, housing, behavioral health, and other interventions targeted to these patients to help avoid complications
  - Enabled net reduction in hospital uncompensated care costs
- New Jersey Medicaid Accountable Care Pilot
  - Bipartisan 2011 legislation incorporated in 2012 Medicaid waiver, alongside shift to Medicaid managed care organizations (95% of beneficiaries now)
  - Medicaid “ACOs” must be community/regionally-based, including hospitals, clinics, private practitioners, behavioral providers, dentists, social service organizations, consumer groups serving Medicaid beneficiaries in a region
  - Have received state/foundation support
  - Contracting with Medicaid managed care organizations for services
  - CMS MCO regulation clarified that regional initiatives may work with MCOs to “support state efforts to deliver higher-quality care in a cost-effective way”

Texas Medicaid 1115 Waiver

Three Major Components

- Medicaid Managed Care (STAR, STAR+PLUS, Dental)
- Uncompensated Care Pool for Hospital Uncompensated Care
- Delivery System Reform Incentive Payments (DSRIP) Through Regional Health Partnerships

Overall aim: Transition to better-coordinated, higher-value care through quality-based payment systems, achieving better regional population outcomes for the same or lower total (Federal + state/local) spending

Major DSRIP Initiatives

Improved Outcomes for Defined Populations

- Access to Primary Care
- Promotion and Disease Prevention

Improved Access to Specialized Care

- More Efficient Access to Specialists
- Improved Access to Behavioral Health Care
- Support for Primary-Specialty-Behavioral Care Coordination

Payment Reform: Volume+UC Payments to Value

Regional Partnership

- **Shared vision and leadership**
- **Data, analytics, and technical support**
- **Meaningful, consistent performance measures derived from care data**
- **Rapid evaluation and learning/ exchange for expansion of successful reforms**

ACO/Shared Accountability Payments

- Basis for MCO capitated payments
- Pays more for population-level improvements in quality and reduced per-capita cost trends
- Encourages coordination across continuum of care
- Can support and help align “piecewise” steps through DSRIP initiatives

Payment Reform: Volume+UC Payments to Value

Regional Partnership

- **Shared vision and leadership**
- **Data, analytics, and technical support**
- **Meaningful, consistent performance measures derived from care data**
- **Rapid evaluation and learning/ exchange for expansion of successful reforms**

Health Homes for Primary Care

- Supports care coord, prevention, chronic disease mgmt, and other key primary-care activities
- Rewards reductions in primary care-related cost trends

ACO/Shared Accountability Payments

- Basis for MCO capitated payments
- Pays more for population-level improvements in quality and reduced per-capita cost trends
- Encourages coordination across continuum of care
- Can support and help align “piecewise” steps through DSRIP initiatives

Payment Reform: Volume+UC Payments to Value

Regional Partnership

- **Shared vision and leadership**
- **Data, analytics, and technical support**
- **Meaningful, consistent performance measures derived from care data**
- **Rapid evaluation and learning/ exchange for expansion of successful reforms**

Health Homes for Primary Care

- Supports care coord, prevention, chronic disease mgmt, and other key primary-care activities
- Rewards reductions in primary care-related cost trends

Episode Payments for Specialty, Behavioral, and Long-Term Care

- Aligned, broader payments for providers involved in specialty care
- Support greater efficiency and quality within the episode of care

ACO/Shared Accountability Payments

- Basis for MCO capitated payments
- Pays more for population-level improvements in quality and reduced per-capita cost trends
- Encourages coordination across continuum of care
- Can support and help align “piecewise” steps through DSRIP initiatives

Payment Reform: Volume+UC Payments to Value

Regional Partnership

- **Shared vision and leadership**
- **Data, analytics, and technical support**
- **Meaningful, consistent performance measures derived from care data**
- **Rapid evaluation and learning/ exchange for expansion of successful reforms**

Health Homes for Primary Care

- Supports care coord, prevention, chronic disease mgmt, and other key primary-care activities
- Rewards reductions in primary care-related cost trends

Episode Payments for Specialty, Behavioral, and Long-Term Care

- Aligned, broader payments for providers involved in specialty care
- Support greater efficiency and quality within the episode of care

ACO/Shared Accountability Payments

- Basis for MCO capitated payments
- Pays more for population-level improvements in quality and reduced per-capita cost trends
- Encourages coordination across continuum of care
- Can support and help align “piecewise” steps through DSRIP initiatives

Accountable Care with Social and Community Services

- Supports coordination and provision of social and community services for patients who can benefit
- May include setting up joint funding and accountability
- Community or organizational level

Transition to Well-Coordinated, High-Value Care: Other State Experiences

Medicaid Managed Care with Accountability for Value

Initiatives to Shift Hospital Uncompensated Care Payments to Better Patient Management for Medicaid and Uninsured Patients

DSRIP Initiatives as Pathway to Efficient, Community-Based Access to Needed Care

Transition to Well-Coordinated, High-Value Care: Other State Experiences

Arizona: Tom Betlach, Arizona Medicaid Director and President, National Association of Medicaid Directors

California: Toby Douglas, Former Director, California Department of Health Care Services

New York: Gregory Allen, Director, Division of Program Development and Management, New York Medicaid