



The University of Texas at Austin
Dell Medical School

Federal and Other State Perspectives

September 4, 2019

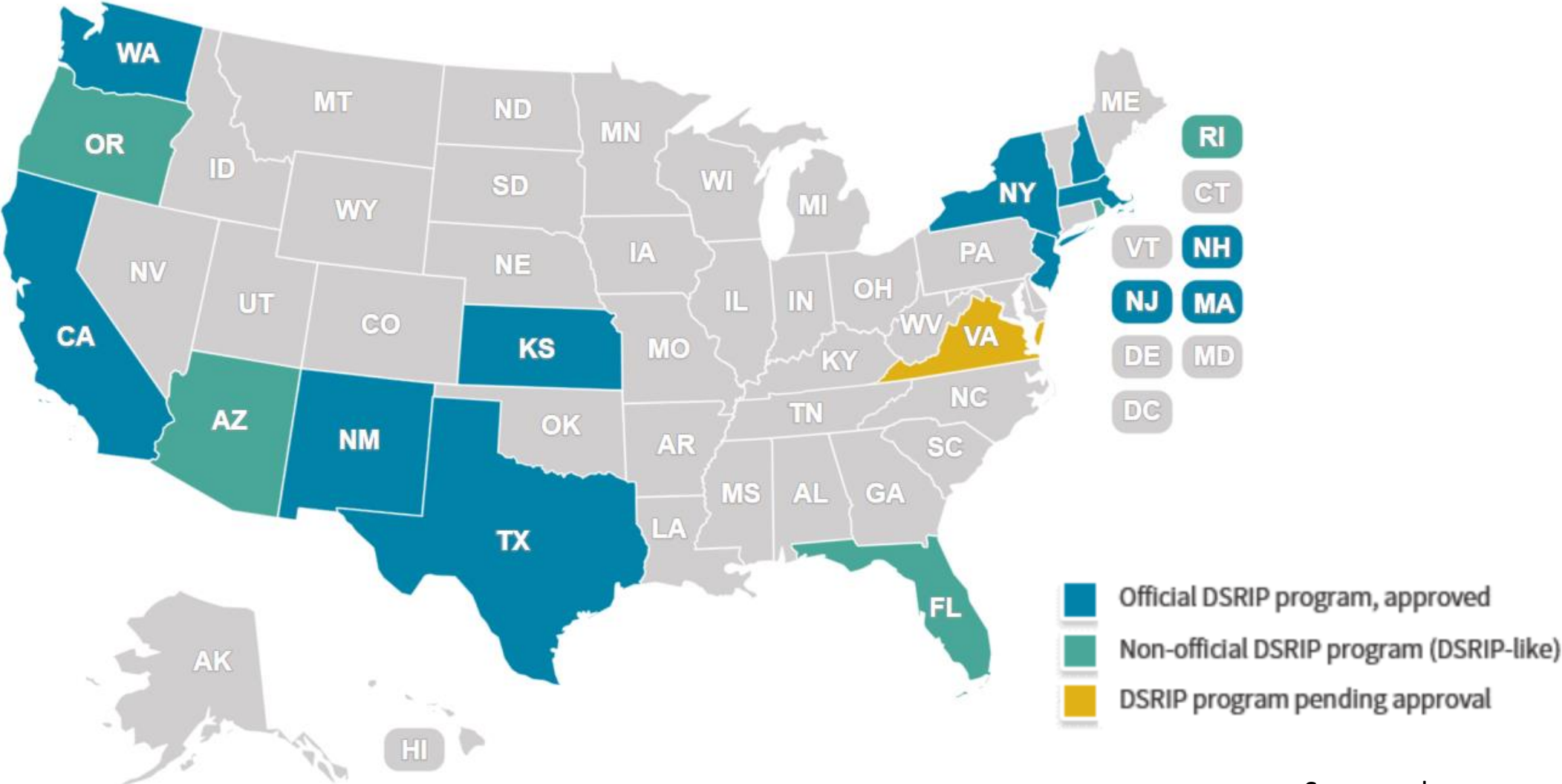
Dr. Mark McClellan

Dell Medical School and Duke-Margolis Center for Health Policy

Delivery System Reform Incentive Payments (DSRIP) and the National Push Toward Value Based Care: Federal Context

- 12 states had DSRIP or DSRIP-like programs approved from 2010-2017
- Each DSRIP program is unique, but CMS is emphasizing:
 - Medicaid payment and delivery system transformation
 - Supporting provider partnerships and networks, rather than only hospitals
 - Achieving outcomes at both the state and provider levels
 - Sustaining DSRIP investments through value-based purchasing strategies in managed care

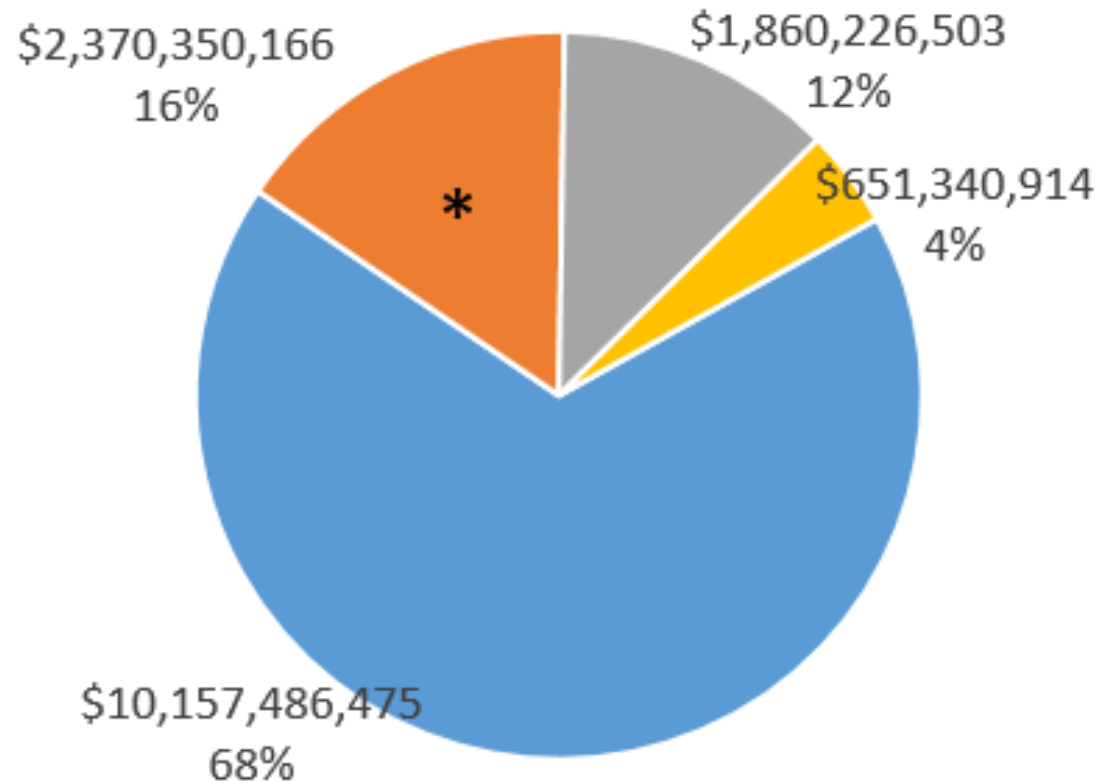
States with DSRIP and DSRIP-Like Programs (10/2016)



Source: chcs.org

Texas providers earned over \$15.1 billion in DSRIP funds through January 2019

Payments by DSRIP Provider by Type through January 2019



- Hospitals
- Community Mental Health Centers
- Physician Practices
- Local Health Departments

*Note: Almost 1/3 of Community Centers' mental health budgets now comes from the federal share of DSRIP payments.

In fiscal year 2017, almost 1/3 of Texas Medicaid payments to hospitals (\$4.2 billion) was from the federal share of DSRIP and other supplemental payment programs.

Major Areas of Population Health Improvement Addressed by DSRIP

- Increased access to integrated primary, preventive and behavioral care – e.g., for adults with serious mental illness
- Pregnancy and maternal health
- Chronic care management – e.g., diabetes and heart disease
- Care coordination and navigation for complex patients – e.g., care transitions, emergency department diversion
- Health promotion and community-level disease prevention
- Other local health improvement priorities

Evolving National Payment Reform Environment To Support Care Reform and Better Population Health

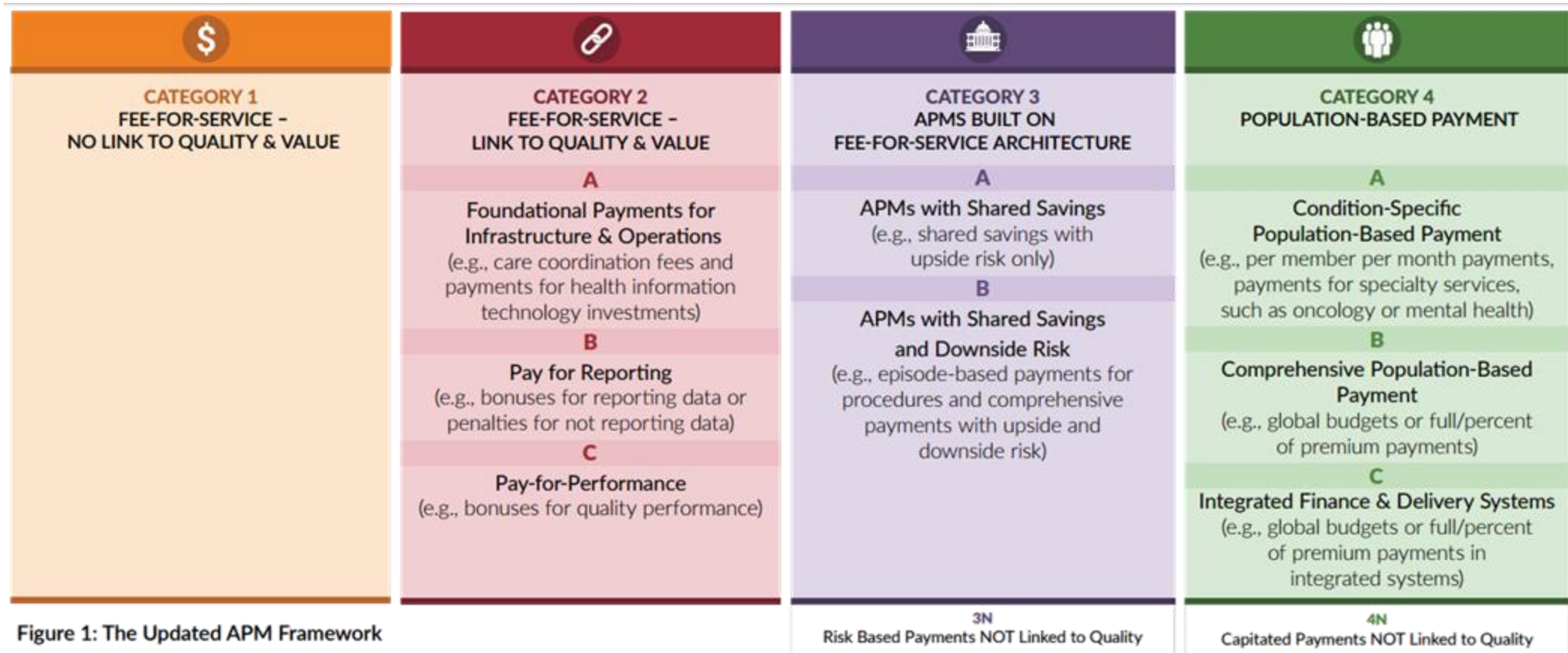


Figure 1: The Updated APM Framework

Evolving National Payment Reform Environment

CMS Advanced Alternative Payment Models

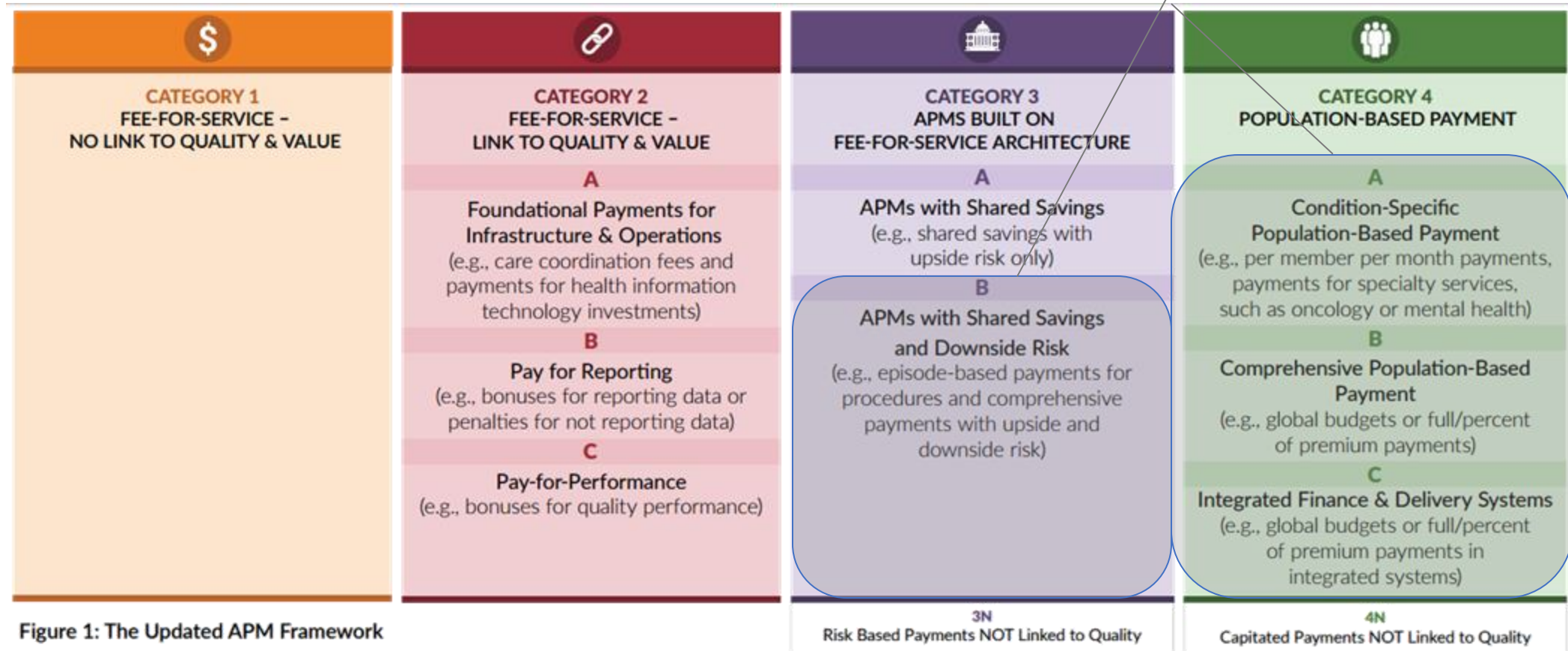
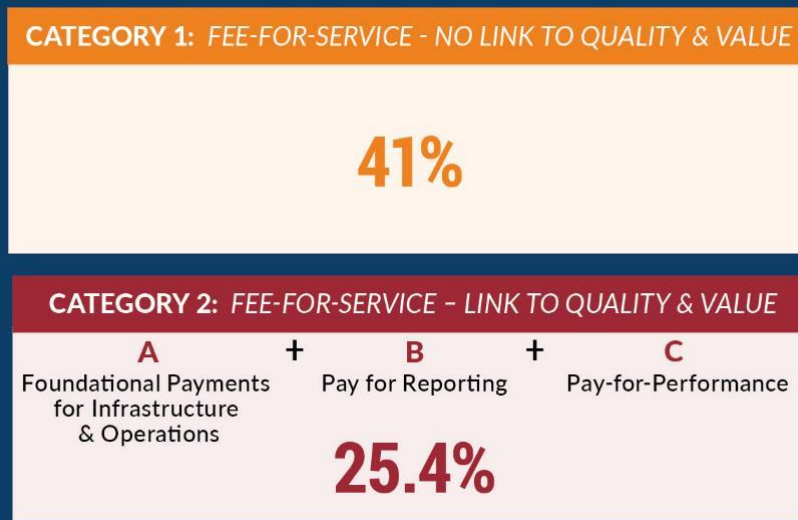


Figure 1: The Updated APM Framework

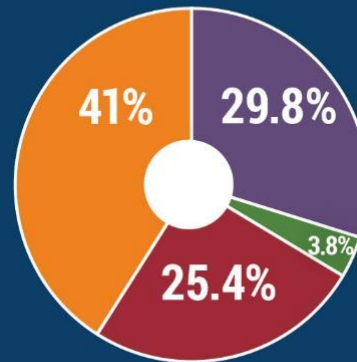
Source: US Health Care Payment Learning and Action Network, www.hcp-lan.org

HCP-LAN Alternative Payment Model Adoption Survey 2018

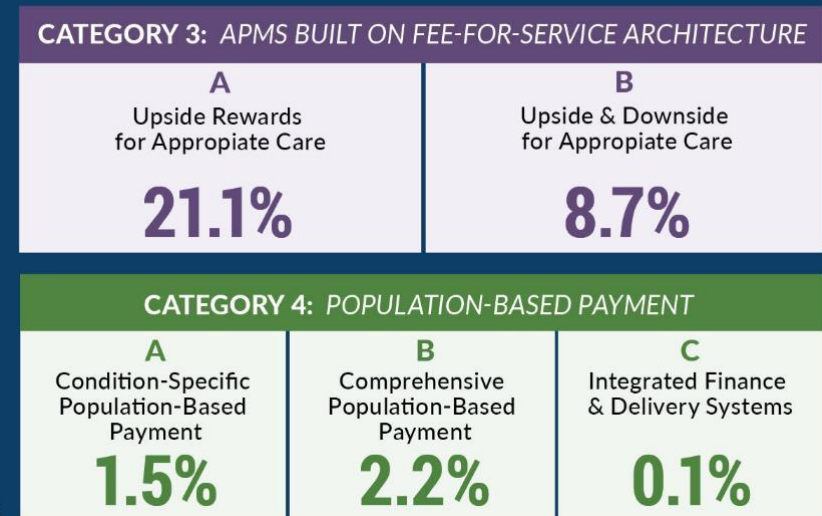
59% of U.S. health care payments in 2017 flowed through Category 2-4 Models,
And 12.5% of payments flowed through Category 3B&4 Models



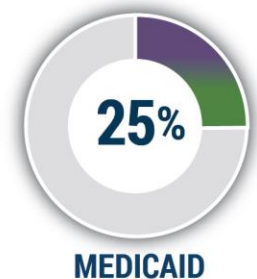
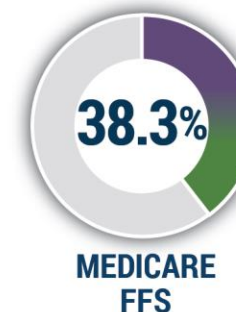
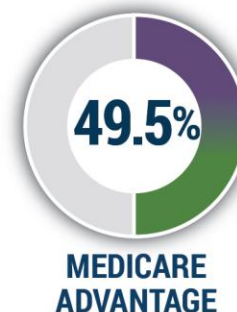
AGGREGATED DATA



Based on 61 plans, 3 states, Medicare FFS



Share by Payer in Category
3&4 models



Opportunities for National Support for Payment Reform

- Medicare Initiatives

- Direct contracting and advanced medical homes: risk-adjusted payments for primary care or all Medicare services, with some downside risk (8% of practice revenues) and substantial upside benefit
 - Versions for smaller practices with benchmarks on hospitalization rates
 - Versions for specialized populations
- Bundled episode payments for specialized care
- Accountable care organizations, with downside risk
- Prevention, community care, transportation payment reforms
- Value-based insurance design support

Opportunities for National Support for Payment Reform-2

- Medicaid Initiatives

- Support for payment reforms and accountability for improved population health in Medicaid waivers – multiyear benchmarks, risk adjustment to provide stronger incentives for care improvement in complex populations
- Building more payments and initiatives into Medicaid managed care organization contracts and capitation rates
- Flexibility to address social drivers of poor health and high medical costs – particularly within context of Medicaid managed care and advanced alternative payment models (NC waiver pilots and potential CMMI pilots to help plans and providers determine best ways to implement such reforms)

Opportunities for National Support for Payment Reform-3

- Multi-Payer Initiatives

- Tools, technical guidance, and other resources for states to use to support value-based care models (including additional HCP-LAN resources)
- Increased data liquidity and sharing across payers, providers, and consumers (NC initiatives)
- Potential steps to support alignment across Medicare, Medicaid, and commercial initiatives on performance measurement and payment

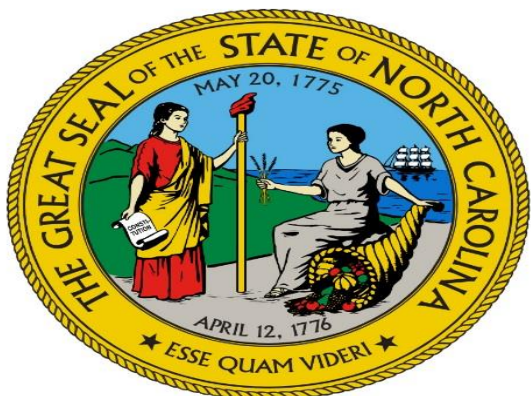
Texas Planning for Post-DSRIP

- How best to sustain DSRIP successes and move to more systematic, population health improvement efforts?
 - Texas has used DSRIP to improve health and avoid costly complications among vulnerable populations
 - Federal initiatives (and other states) aim to build on such steps through further payment reforms, shifting from fee-for-service toward person-focused payment and care models
 - CMS also continues to tighten supplemental payments, with more payments encompassed in managed care capitation rates – including in other DSRIP states
- Cindy Mann JD, Manatt Health – Overview of state experiences and trends
- Betsey Tilson, MD MPH – NC initiatives and supports for improving population health

UT Dell Medical Resources for Texas Health Care Reform

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<https://dellmed.utexas.edu/health-and-care/improving-the-system/informing-health-policy>



NC Department of Health and Human Services

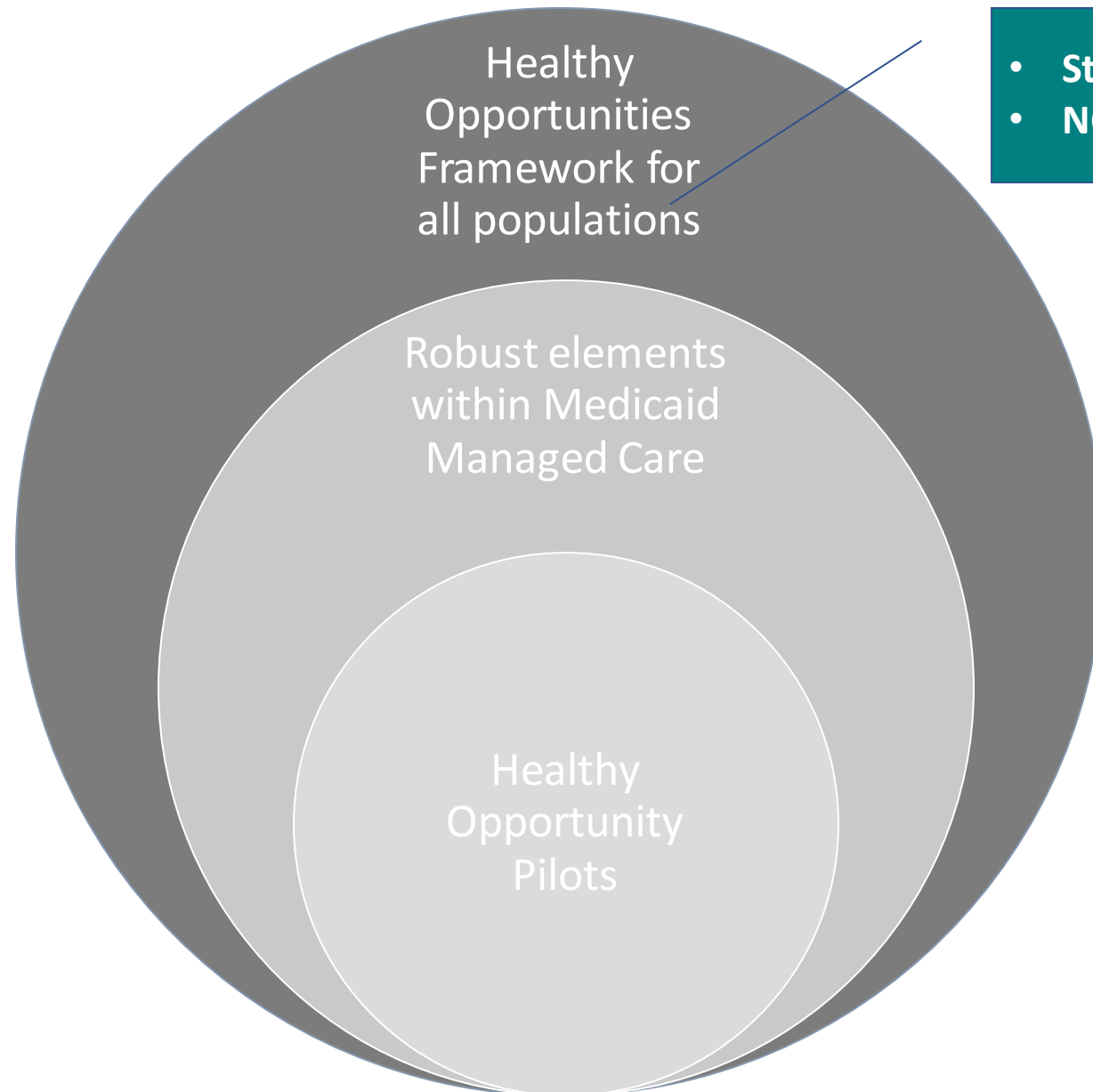
Buying Health:

**All North Carolinians (and Texans)
should have the Opportunity for Health**

Elizabeth Cuervo Tilson, MD, MPH
State Health Director/Chief Medical Officer

September 4, 2019

Healthy Opportunities Landscape



- Standardized Screening Questions
- NCCARE360

What is NCCARE360?

NCCARE360 is the first statewide coordinated network that includes a robust repository of shared resources and a shared technology platform to connect healthcare and human services providers together to collectively provide the opportunity for health to North Carolinians.

NCCARE360 Partners:



NCDHHS



United Way
of North Carolina



Expound



UNITE US

NCCARE360

Creating a Collaborative Network through Shared Technology Platform

A **coordinated network** connects providers (such as health care providers, insurers, or community organizations) through a shared technology platform to:

- **Communicate** in real-time
- Make **electronic referrals**
- Securely share client information
- Track **outcomes together**



Started January 2019

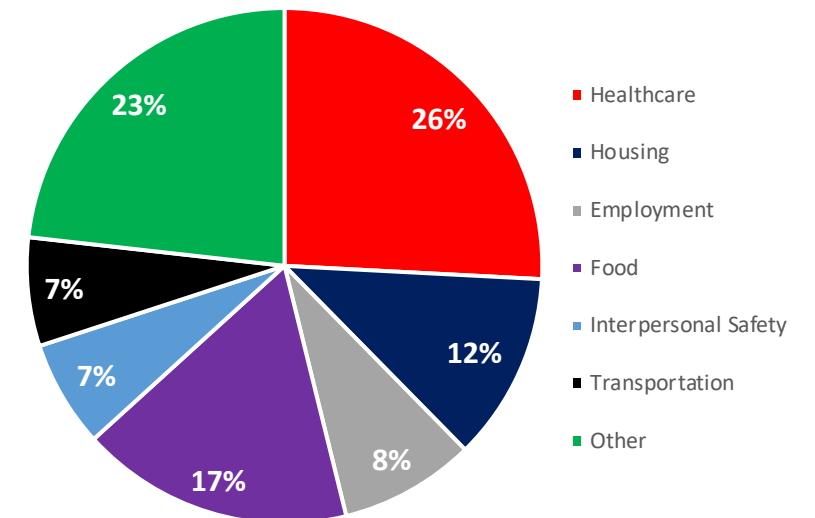
NCCARE360 On-boarding Status Update (as of 8/23/19)

15	Counties launched
30	Counties started on implementation
1529	Organizations engaged in socialization process (77 counties)
318	Organizations with NCCARE360 licenses
1405	Active Users
691	Referrals Sent
335	Clients Impacted

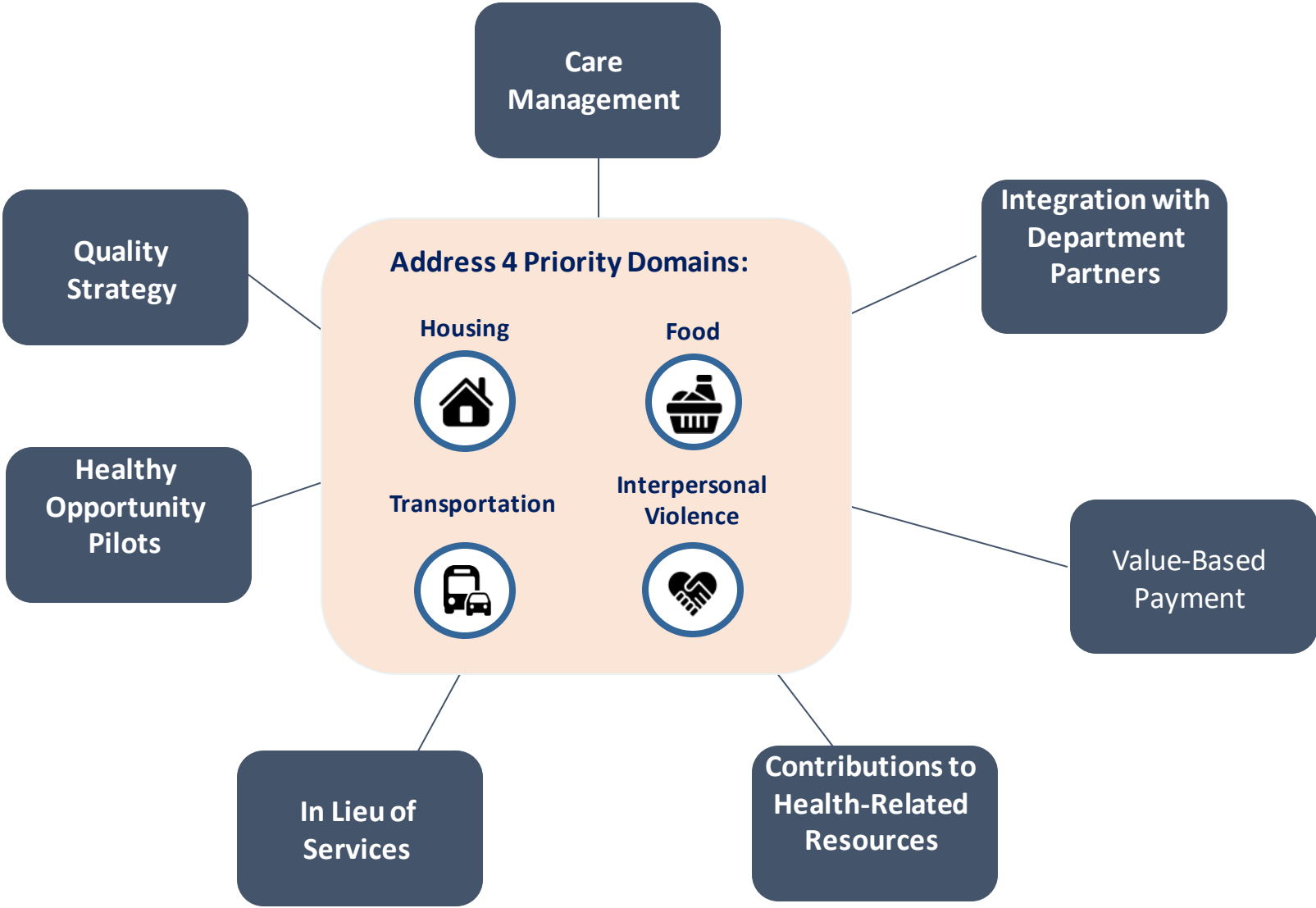
2-1-1 Resource Verification (as of 8/21/19)

Organizations verified	1985
Programs Verified	6272

Engaged Organizations by Service

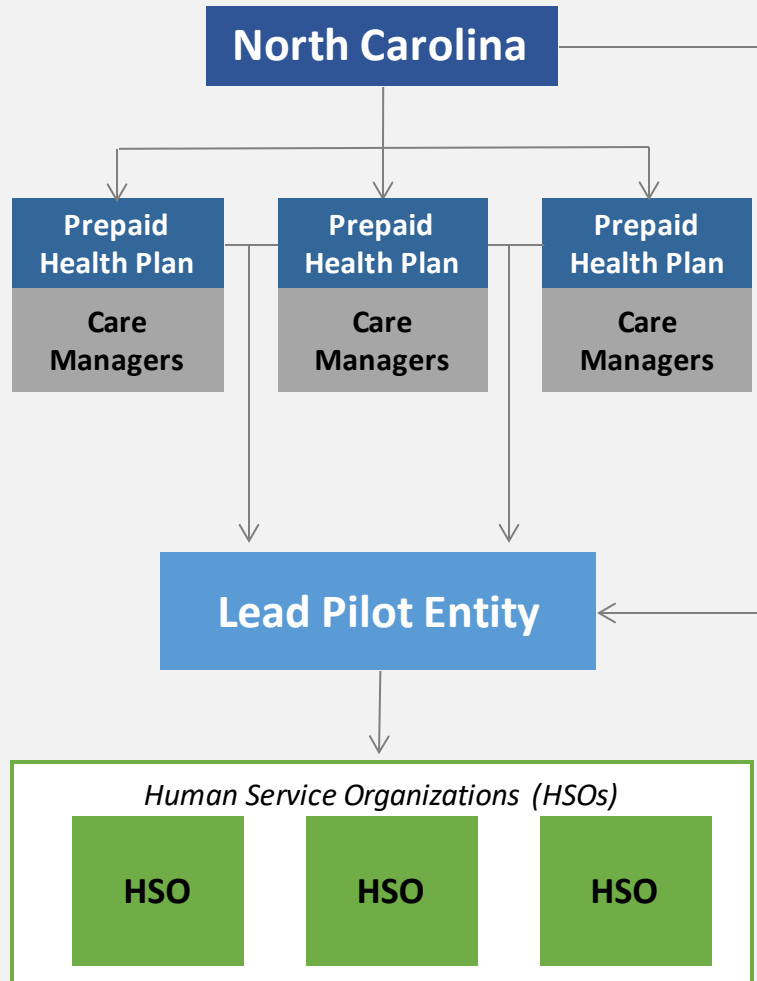


Robust Elements within Medicaid Managed Care



Healthy Opportunities Pilots

Sample Regional Pilot

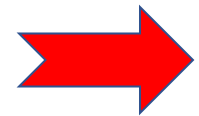


Pilot Overview

- The Healthy Opportunities Pilots will test the impact of providing selected evidence-based interventions to high health and social risk Medicaid enrollees.
- Over the next five years, the pilots will provide up to \$650 million in Medicaid funding for capacity building and pilot services in two to four areas of the state that are related to housing, food, transportation and interpersonal safety and directly impact the health outcomes and healthcare costs of enrollees.
- Pilots will allow for the establishment and evaluation of a systematic approach to integrating and financing evidence-based, non-medical services into the delivery of healthcare.

Process/Time Line

- Oct 2018: Approved as part of 1115 Demonstration Waiver Approval
- Feb 2019: White Paper on Pilot Design/Request for Information on service definitions and cost elements
- Spring 2019: Multiple forums for further input and market research
- July 2019
 - Further guidance on Lead Pilot Entity (LPE)/Non-binding Statement of Interest
 - Refined Pilot Service Definitions, Methodology for fee schedule for public comment
- August 2019: CMS Approved Evaluation Plan – Rapid Cycle and Summative
- September 1: Revised Service Definitions and Fee schedule submitted to CMS
- Fall 2019: Request for Proposals (RFP) to determine LPEs/Pilot Regions
- Early 2020: Award LPEs/Pilot Regions
- Most of 2020: Capacity building for LPEs and regions
- Early 2021- October 2024: Service Delivery



Market Research for Service Definitions and Fee Schedule	Rate setting inputs
Consultation with other states	Labor: Wages, employee-related expenses
Request for Information Feb 2019	Staffing Ratios: Case Loads
Manatt/Commonwealth Fund Expert Advisory Panel	Non-billable personnel time: e.g., training, documentation)
Focus Groups	Transportation: Time and mileage for service providers
Expert Interviews and NC DHHS Consultations	Program supplies
Existing Data sources on cost inputs (e.g. Labor Bureau)	Indirect costs: Administrative staff costs and overhead
Benchmark analysis for similar services	
Public Feedback on Revised definitions and fee structure methodology July 2019	

Proposed Services

Food	Housing	Transportation	Interpersonal Violence /Toxic Stress	Cross-Domain
<u>Food and Nutrition Access Case Management Services</u>	<u>Housing Navigation, Support and Sustaining Services</u>	<u>Reimbursement for Health-Related Public Transportation</u>	<u>IPV Case Management Services</u>	<u>Holistic High Intensity Enhanced Case Management</u>
<u>Evidence-Based Group Nutrition Class</u>	<u>Inspection for Housing Safety and Quality</u>	<u>Reimbursement for Health-Related Private Transportation</u>	<u>Violence Intervention Services</u>	<u>Medical Respite</u>
<u>Diabetes Prevention Program</u>	<u>Housing Move-In Support</u>	<u>Transportation PMPM Add-On for Case Management Services</u>	<u>Evidence-Based Parenting Curriculum</u>	<u>Linkages to Health-Related Legal Supports</u>
<u>Fruit and Vegetable Prescription</u>	<u>Essential Utility Set-Up</u>		<u>Home Visiting Services</u>	
<u>Healthy Food Box (For Pick-Up)</u>	<u>Home Remediation Services</u>			
<u>Healthy Food Box (Delivered)</u>	<u>Home Accessibility Modifications</u>			
<u>Healthy Meal (For Pick-Up)</u>	<u>Healthy Home Goods</u>			
<u>Healthy Meal (Home Delivered)</u>	<u>One-Time Payment for Security Deposit and First Month's Rent</u>			
<u>Medically Tailored Home Delivered Meal</u>	<u>Short-Term Post Hospitalization Housing</u>			

Fee-Schedule/Value-Based Payments

- Initial Fee schedule to include Fee-for-service, Cost-based reimbursement, Bundled payments/PMPMs
- Evolution of future fee-schedules to include less fee for service/more bundles as we gather more data
- Overlying advancing value-based payment

Year 1	Year 2	Year 3	Year 4	Year 5
Incentive payments for successful implementation	Incentive payments for delivering pilot services	Withhold payments to ensure enrollees unmet resource needs are met	Withhold payments linked to health outcomes	Shared savings payments*

*Costs savings based on subset of pilot enrollees whose services are likely to result in decreased medical expenses in the short-term. Assures pilot entities are not penalized for approving effective, evidence-based upstream interventions that result in a financial return on investment over the longer-term

State Trends: Payment and Delivery System Reform

Cindy Mann
Partner, Manatt Health
cmann@manatt.com

September 4, 2019

Challenges:

- **High uninsured rate**
- **UCC pool is shrinking**
- **DSRIP funding renewed, but phased out**
- **Increased oversight of supplemental payments**

Opportunities:



Coverage improvements



Advancing **value-based payment (VBP)** models



Addressing the **social determinants of health (SDOH)**

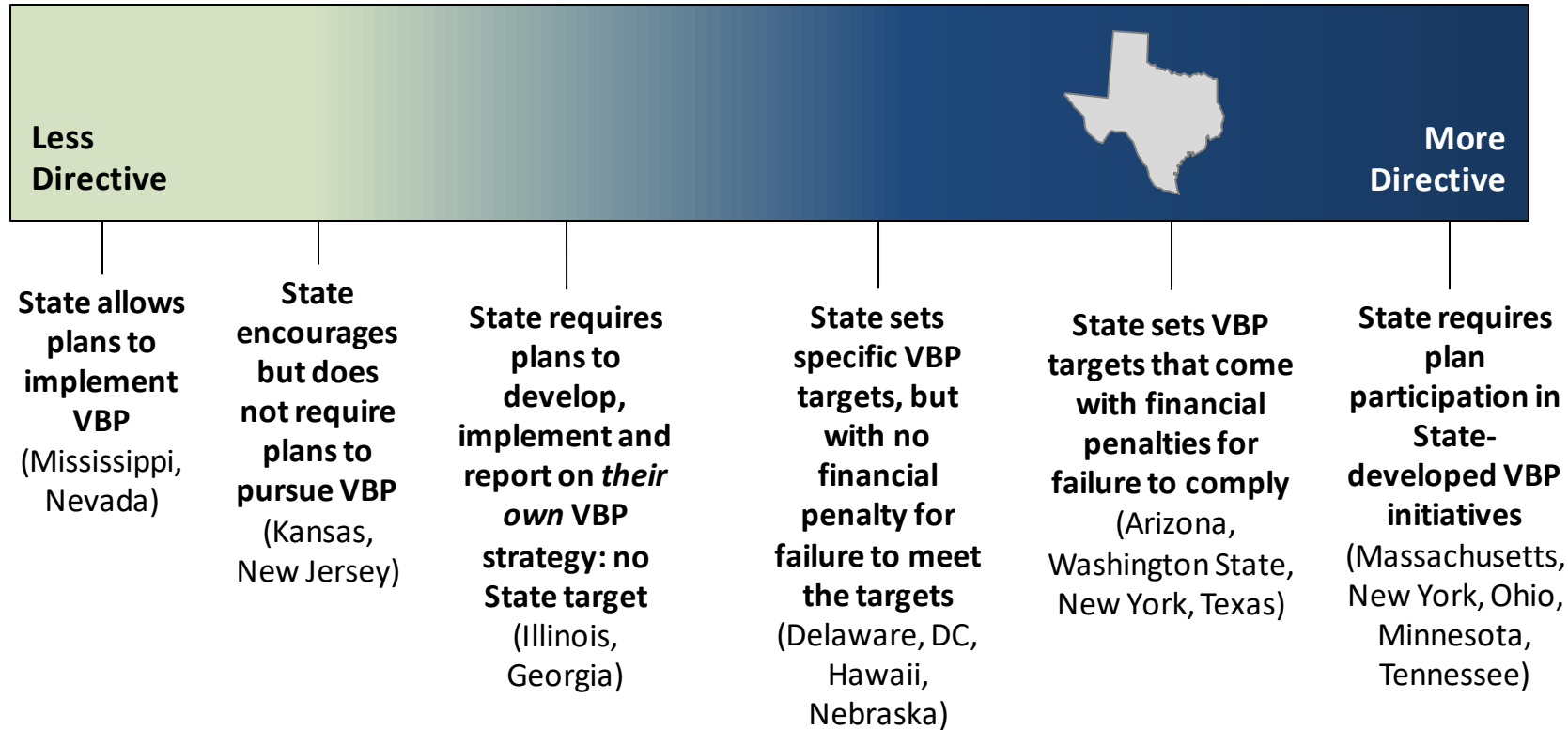


Reforming **supplemental payments**

This presentation provides an overview of trends related to these three opportunity areas



States are Increasingly Requiring Plans to Implement VBP Models...




This slide does not address how VBP is defined or the VBP targets in the states listed



... are Defining VBP More Specifically...

Many states use the Health Care Payment Learning & Action Network (HCP-LAN) framework to define what counts as “value-based payment”

<p>CATEGORY 1 FEE-FOR-SERVICE - NO LINK TO QUALITY & VALUE</p>	<p>CATEGORY 2 FEE-FOR-SERVICE - LINK TO QUALITY & VALUE</p> <p>A Foundational Payments for Infrastructure & Operations (e.g., care coordination fees and payments for health information technology investments)</p> <p>B Pay for Reporting (e.g., bonuses for reporting data or penalties for not reporting data)</p> <p>C Pay-for-Performance (e.g., bonuses for quality performance)</p>	<p>CATEGORY 3 APMS BUILT ON FEE-FOR-SERVICE ARCHITECTURE</p> <p>A APMs with Shared Savings (e.g., shared savings with upside risk only)</p> <p>B APMs with Shared Savings and Downside Risk (e.g., episode-based payments for procedures and comprehensive payments with upside and downside risk)</p>	<p>CATEGORY 4 POPULATION-BASED PAYMENT</p> <p>A Condition-Specific Population-Based Payment (e.g., per member per month payments, payments for specialty services, such as oncology or mental health)</p> <p>B Comprehensive Population-Based Payment (e.g., global budgets or full/percent of premium payments)</p> <p>C Integrated Finance & Delivery Systems (e.g., global budgets or full/percent of premium payments in integrated systems)</p>
		<p>3N Risk Based Payments NOT Linked to Quality</p>	<p>4N Capitated Payments NOT Linked to Quality</p>

 Texas uses the HCP-LAN framework to define two categories of VBP:

- (1) VBP = 2A+
- (2) “Risk-based” VBP = 3B+



... and are Raising the Bar for the Level of Risk and Portion of Payments Expected in VBP Arrangements...

	<u>2018 or 2019</u>	<u>2020 or 2021</u>
Arizona	Percentage of payments in Category 2C+ <ul style="list-style-type: none"> Acute Care: 50% LTC/ Elderly, Disabled (E/D): 35% IDD acute service subcontractors: 20% IDD LTSS: 5% 	Percentage of payments in Category 2C+ <ul style="list-style-type: none"> Acute Care: 70% LTC, E/D: 70% IDD acute service subcontractors: 60% IDD LTSS: 35%
Texas	<ul style="list-style-type: none"> 25% of medical spend in VBP (HCP-LAN 2A+) <ul style="list-style-type: none"> ➤ 10% in “risk-based VBP” (HCP-LAN 3B+) 	<ul style="list-style-type: none"> 50% of medical spend in VBP (HCP-LAN 2A+) <ul style="list-style-type: none"> ➤ 25% in “risk-based VBP” (HCP-LAN 3B+)
Washington	<ul style="list-style-type: none"> 50% payments in HCP-LAN 2C+ <ul style="list-style-type: none"> ➤ 10% in 3A+ 	<ul style="list-style-type: none"> 90% of payments in HCP-LAN 2C+ <ul style="list-style-type: none"> ➤ 50% in 3A+
Massachusetts	60% of <i>members</i> must receive care in arrangements that are equivalent to HCP-LAN 3+	70% of <i>members</i> must receive care in arrangements that are equivalent to HCP-LAN 3+
New York	10% of <i>total expenditures</i> * in HCP-LAN 3A+	<ul style="list-style-type: none"> 80% of <i>total expenditures</i>* in HCP-LAN 3A+ <ul style="list-style-type: none"> ➤ 35% in 3B+

*Excludes high cost drugs, dental, vision, transplant, financially strained providers and payments for non-attributed patients

Other Notes: States exempt various services (e.g., LTSS) and/or populations (e.g., duals) from their VBP expenditure calculations. States also have varying rules for the expenditures included in the numerator and denominator of VBP calculations, and some states use their own framework for these targets (which is cross-walked to the HCP-LAN categories in this chart)



States are Requiring MCO Investment in Social Interventions

	Sampling of States with SDOH Provisions in MCO Contracts																
	AZ	CO	IL	LA	MA	MI	MN	NV	NH	NM	NY	NC	RI	TN	VA	WA	WI
SDOH definition		●			●	●			●			●			●	●	●
Screening	●		●	●			●*		●	●*	●*	●	●	●*	●	●	●
Data development, collection, evaluation						●			●			●				●	●
Quality metrics, strategy, or screening; SDOH-related withholds		●	●	●		●			●	●	●	●		●	●		●
Partnerships with community health workers, CBOs, etc.		●	●	●	●	●	●	●	●	●	●	●	●		●	●	●
Care management services	●	●	●		●	●	●	●	●	●	●	●	●	●	●	●	●
SDOH initiatives, reporting		●		●	●	●		●	●	●	●	●	●		●	●	●

- SDOH provision present in MCO contract
- * Contingent on population



“Next Generation” Strategies to Integrate SDOH

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Medicaid programs, managed care plans, and providers are driving the next generation of efforts to address social service needs within an integrated care delivery platform—in pursuit of “whole person care”



Moving beyond screenings and referrals to systematic efforts to provide enrollees needed social supports



Expanding the scope of SDOH interventions to more areas, populations and social issues



Building a **stronger network of community-based organizations** and collaborations with providers



Aligning **financial incentives** to support SDOH interventions

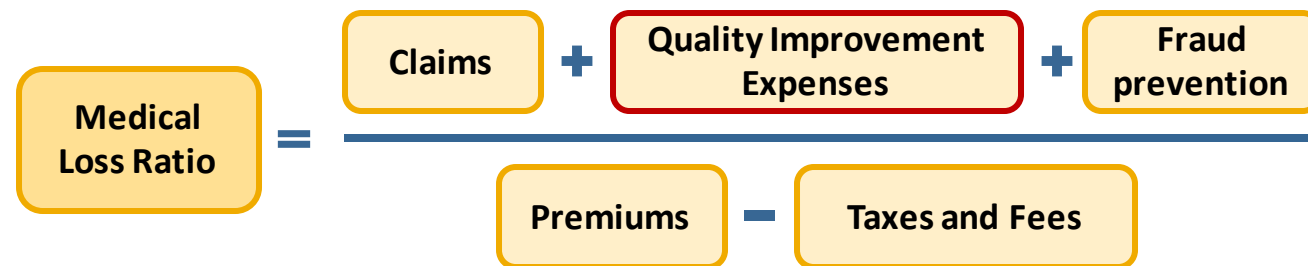


Evaluating the effectiveness of SDOH interventions and greater use of SDOH data

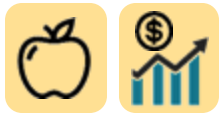


Assessing the Impact of SDOH Activities on Medical Loss Ratio (MLR)

The way SDOH-related activities are counted in MLR calculations can impact uptake



- States must set capitation rates at a level that leads plans to project an MLR of at least 85%.
- If funding social interventions makes it more difficult for MCOs to meet this 85% threshold (i.e., if investments are treated as profits or administrative costs), MCOs may be discouraged from making such investments.
- Certain SDOH-related activities may be counted in the numerator (i.e., as quality improvement expenses)
 - For example, while funds for value-added services are not included in a plan’s capitation rate, they can be included in the MLR numerator if services are part of a quality initiative.



Strategies to Address “Premium Slide”

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- VBP and strategies to address SDOH may reduce health care utilization and related costs over time (e.g., by reducing emergency room visits)
- Lower health care costs could have the consequence of lowering MCOs’ capitation rates in a phenomenon called premium slide
- **Getting to a win-win: Shared-savings/incentive payments recognizing that investments are necessary to bring down health care costs can help address “premium slide”**
 - Incentive payments allow States and MCOs to share savings in recognition of MCO investments
- Other rate setting modifications could help (e.g., risk adjuster)



Supplemental Payments are at Risk

Federal-Level Risks

MEDICAID:
Federal Guidance Needed to Address Concerns About Distribution of Supplemental Payments
 GAO-16-108: Published: Feb 5, 2016. Publicly Released: Mar 7, 2016.

Highlights
 Improving Transparency and Accountability of Supplemental Payments and State Financing Methods
 Highlights of GAO-16-195T, a testimony before the Subcommittee on Health, Committee on Energy and Commerce, House of Representatives

Department of Health & Human Services
OFFICE OF INSPECTOR GENERAL
 REVIEW OF MEDICAID DISPROPORTIONATE SHARE HOSPITAL PAYMENT DISTRIBUTION

HEALTH | JOURNAL REPORTS: HEALTH CARE
Should Medicaid Be Converted to a Block-Grant Program?
 Supporters of the change say it would cut costs and provide better care for the needy. Critics say it would force states to cut eligibility and benefits.

MEDICAID:
States' Use and Distribution of Supplemental Payments to Hospitals
 GAO-19-603: Published: Jul 19, 2019. Publicly Released: Jul 29, 2019.

State-Level Risks

Worry grows in Missouri over proposed Medicaid cuts, effects on nursing homes, elderly
 By Samantha Liss St. Louis Post-Dispatch Jul 6, 2017

Forbes / Pharma & Healthcare / #TrumpsAmerica
 APR 13, 2017 @ 08:08 AM 5,375
States Moving More Medicaid Patients To Managed Care

Risks vary by the type of supplemental payment and by the source of financing of the non-federal share



Some States are Building UPL Payments into MCO Capitation Rates

State	Description
Rate Floors	
North Carolina	<ul style="list-style-type: none">▪ As part of North Carolina’s transition to Medicaid managed care, the State plans to fold most of its supplemental payments into managed care capitation rates.▪ MCOs will be required to pay hospitals minimum, hospital-specific inpatient per-discharge payments and approximately 100% of the costs of outpatient encounters.▪ After a transition period, MCOs and providers will be permitted to negotiate rates.
Directed Payments	
Michigan	<p>Michigan recently received CMS approval for a directed payment that pays hospitals an additional 70% of each hospital’s negotiated rate. Under the methodology:</p> <ul style="list-style-type: none">▪ MCOs and hospitals individually negotiate per-unit payment rates.▪ Hospitals bill for services and are paid by MCOs at negotiated rate.▪ On a quarterly basis, state calculates (approximately) 70% of the negotiated per-unit rate for each hospital.▪ State pays MCOs amount needed to pay each hospital an additional 70% of its negotiated per-unit rate multiplied by its actual utilization.▪ MCOs pass on the 70% increase to each hospital.

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