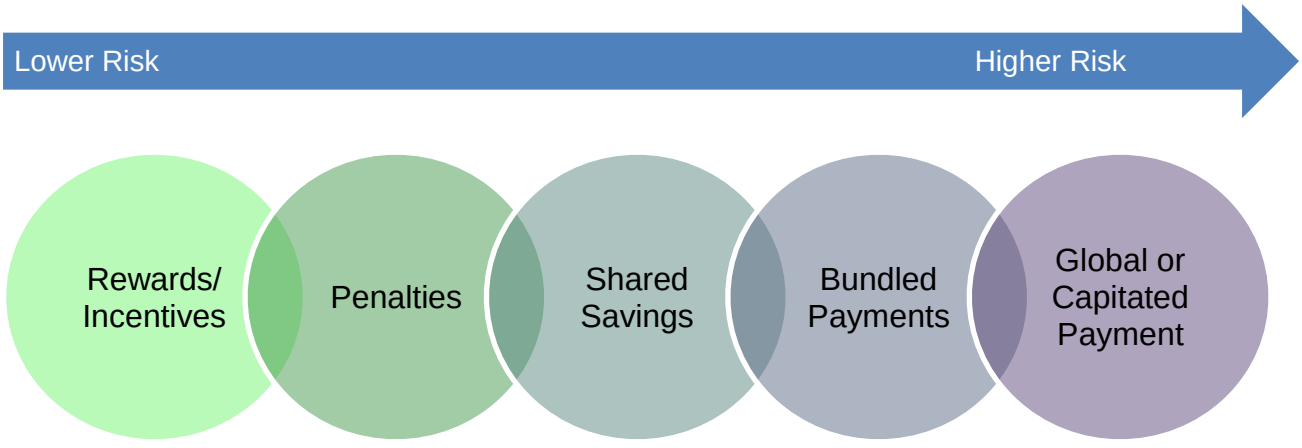
Centennial Care Value-Based Purchasing Brief

Background

The need to improve quality and efficiency in state Medicaid programs has led to implementation of a variety of payment reform efforts across the nation. As states face increasing pressures to maximize the value of their Medicaid spending while enrollment continues to increase, many are seeking strategies that will move the delivery system away from payments on a fee for service basis to paying for improved healthcare outcomes for recipients. The most costly Medicaid members with complex medical needs are served, for the most part, by a system that is not incentivized to improve care coordination or healthcare outcomes.

In its 1115 waiver that authorizes Centennial Care, New Mexico included payment reform as a key goal for its Medicaid managed care program. The Centennial Care contractual agreements required the Managed Care Organizations (MCOs) to pilot payment reform projects that focused on paying for value rather than volume of services. In 2015, the MCOs launched 10 pilot projects with an aim to begin to move the delivery system toward payment for improved quality. The New Mexico Human Services Department (HSD) collaborated with the MCOs to develop key performance measures for the projects in an effort to achieve better alignment for the providers, primarily utilizing a set of HEDIS measures in combination with several efficiency metrics, such as decreasing inpatient readmission rates.

In their value-based payment arrangements, the Centennial Care MCOs are expected to expand pay for value strategies within their provider networks using a variety of value-based purchasing models. Models are generally defined based on the level of up-side or down-side risk incurred within the arrangements.



Value-based purchasing models at the lower risk of the spectrum include incentives or pay for performance where providers are rewarded for hitting defined quality of care goals. Shared savings

models reward providers for meeting quality of care outcomes that save money for the program. Providers generally share in a portion of the savings realized. Risk models include capitated payments for providers who incur full or partial risk in caring for their population or panel of members. Bundled or global payment options reimburse providers an agreed upon rate that includes all services provided to address a specific condition. Examples of bundled payments are maternity care and joint replacement surgeries).

In their recent publication summarizing state approaches to value-based payment models in Medicaid, the Center for Health Care Strategies outlined five approaches states are using within their Managed Care Contracts[1]:

1. Requiring MCOs to adopt standardized value-based purchasing models
2. Requiring MCOs to make a specific percentage of provider payments through approved VBP arrangements *(a current initiative with Centennial Care MCO contracts)*
3. Require MCOs to move toward more sophisticated (more risk based) VBP arrangements over the life of the contract *(a current initiative with Centennial Care MCO contracts)*
4. Require MCOs to actively participate in a multi-payer VBP alignment initiative
5. Require MCOs to launch VBP pilot projects subject to state approval *(a current initiative with Centennial Care MCO contracts)*

Delivery system reforms within Centennial Care include shared savings and bonus payment arrangements with Patient Centered Medical Home practices and Federally-Qualified Health , Centers, which reward providers for achieving agreed-upon quality measures and improved member experience with the practice; provider-delivered, comprehensive care coordination through Health Homes targeted to members with Serious Mental Illness and Severe Emotional Disturbance; bundled payment arrangements for episodes of care, such as maternity and orthopedic services; subcapitated arrangements for providers willing to assume greater risk; and the Safety Net Care Pool that includes the Hospital Quality Improvement Incentive and Uncompensated Care Pool.

VBP Project	Type of Payment Reform			Project Description
	Bundled Payment	**P4P-Shared Savings**	**Some Risk**	
Accountable Care-Link Model		**X**		ACO-like model with shared savings for improving quality and reducing total cost of care.
Bundled Payment for Episodes	**X**			Bundles for bariatric surgery and maternity.
Subcapitated Payment for Defined Population			**X**	For primary care and multi-specialty groups that have care management infrastructure; subcapitation allows both upside/downside risks for defined population.

[1] Leddy, T. McGinnis, T. Howe, G.; Center for Health Care Strategies Inc. “Value-Based Payments in Medicaid Managed Care: An Overview of State Approaches”; Brief, February 2016. http://www.chcs.org/resource/value-based-payments-in-medicaid-managed-care-an-overview-of-state-approaches/

Three-tiered Reimbursement for PCMHs		X		PMPM increases for base care coordination; date transfer to HIE; telehealth; use of EHRs; and performing HRAs. A total performance incentive per member payment is possible if the targets for every measure are met.
Bundled Payments for Targeted Admission Episodes	X			Working to bundle payments for pneumonia and colonoscopies.
PCMH Shared Savings		X		Builds upon current PCMH pay-for-performance model that rewards quality by adding shared savings targets after total medical costs are below a budget threshold.
Obstetrics Gain Sharing		X		Reducing unnecessary primary C-section by developing savings targets that reward appropriate use of C-sections. Obstetricians can earn enhanced payment for meeting metrics related to reducing unwarranted C-sections.

To continue to advance value-based purchasing initiatives, HSD has included new contractual requirements in its 2017 MCO agreements, see Appendix A. In CY17, MCOs are required to spend a minimum of 16% of provider payments in VBP arrangements. Within the 16% HSD identified minimums across the spectrum of three VBP levels in order to ensure flexibility for providers that may not have the level of sophistication or resources needed to bear risk while providing opportunities for those providers that do.

After completing a series of site visits with providers participating in the VBP arrangements, it was evident to HSD that providers wanted flexibility within the VBP options and, in order to bear greater risk, needed comprehensive data and agreed-upon calculations of total cost of care. The MCOs are addressing those needs by regularly meeting with providers and sharing data, including score cards, claims data and, in some cases, providing a software program that enables providers to view utilization and expenditure data for attributed patients.

Defining Value

In order to effectively pay for value, the Centennial Care program is working to refine what “value” means for the program and how that value will be measured to ensure quality of care. This means identifying the appropriate metrics and measures, data sources and reporting strategies that are necessary to monitor VBP arrangements with an eye to our overarching goal of driving administrative simplicity and alignment where possible. Areas that Centennial Care is targeting as value areas are those topics being vetting through the subcommittee process and include:

- Care Coordination
- Physical and behavioral health integration
- Long-term services and supports
- Improving transitions of care
- Population Health

Key Considerations

Advancing value-based purchasing models is a change for the Medicaid program and participating providers. Key consideration areas include:

- **Health Care Providers and MCOs**
  - Engaging and supporting providers in migration to risk
  - Data analytics
  - Data sharing
  - Attribution of members and
  - Member engagement in improving health
  - Flexibility—not all providers are able to take on risk
  - Multi-Payer alignment on payment and measurement of quality
  - Lack of single convener across payers/delivery System
- **Improving Provider Readiness**
  - Capital Investments (including software / technology)
  - Technical Assistance
  - Clear and Consistent Path forward with reasonable milestones
  - Provider feedback / engagement in process
- Data Reporting Quality and Consistency
  - MCO ability to share information with providers
  - Providers' ability and capacity to utilize data and reporting
- **State policy development and monitoring**
  - No clear pathway to engage with CMS to work on alignment of federal and state VBP strategies and quality metrics
  - Resources and expertise at state to monitor VBP
  - How best to evaluate VBP models
- **Identifying ideal VBP strategies for behavioral health and LTSS providers**

Additional Challenges and Barriers

- Continued Use of FFS Payment in Reform Models
- Simply adding P4P bonuses to FFS structure
- Data for Setting Payment Amounts—need transparency around costs
- Provider accountability for costs not within their control
- Patient Engagement—providers must know their patients to be successful
- Member churn within provider practices
- Current Reforms Favor Larger Providers and require minimum number of members
- Transitional Payment Systems
- Staffing / Resource Challenges—State / Provider

Appendis A

VBP in Delivery System Improvement Targets – Centennial Care MCO Contract Language

Value-Based Purchasing

The CONTRACTOR must implement value-based purchasing as outlined in the table below. In order to meet the target, the CONTRACTOR must have met the percentages established below in all three levels; however, CONTRACTORs with more advanced VBP strategies may substitute higher percentages in Level 2 and/or Level 3 for lower percentages in Level 1 as long as the overall target of 16% of payments in VBP arrangements is met for the calendar year.

VBP LEVEL 1	VBP LEVEL 2	VBP LEVEL 3
A minimum of 5% of all CONTRACTOR provider payments* for dates of service between January 1, 2017 and December 31, 2017 will meet the following criteria:	A minimum of 8% of all CONTRACTOR provider payments* for dates of service between January 1, 2017 and December 31, 2017 will meet the following criteria:	A minimum of 3% of all CONTRACTOR provider payments for dates of service between January 1, 2017 and December 31, 2017 will meet the following criteria:
• Fee schedule based with bonus or incentives and/or withhold (at least 5% of provider payment)—available when outcome / quality scores meet agreed-upon targets.	• Fee schedule based, upside-only shared savings— available when outcome / quality scores meet agreed-upon targets (may include downside risk), and • Two or more bundled payments for episodes of care.	• Fee schedule based or capitation with risk sharing (at least 5% for upside and downside risk); and/or • Global or capitated payments with full risk.

Additional requirements for VBP in CY17

- At least 3% of the overall 16% in VBP contracting must be with high volume hospitals and require readmission reduction targets of at least 5% of the hospital's baseline.
- CONTRACTOR must include behavioral health community providers in its VBP arrangements.
- CONTRACTOR must include payments to behavioral health community providers in calculating the percentage of overall spend in its VBP arrangements.

MCOs may exclude provider payments for dually-eligible members from the calculation.