Aligning for Action

LAN SUMMIT

Health Care Payment Learning & Action Network

Adopting Multi-Payer and All-Payer Payment Models in States

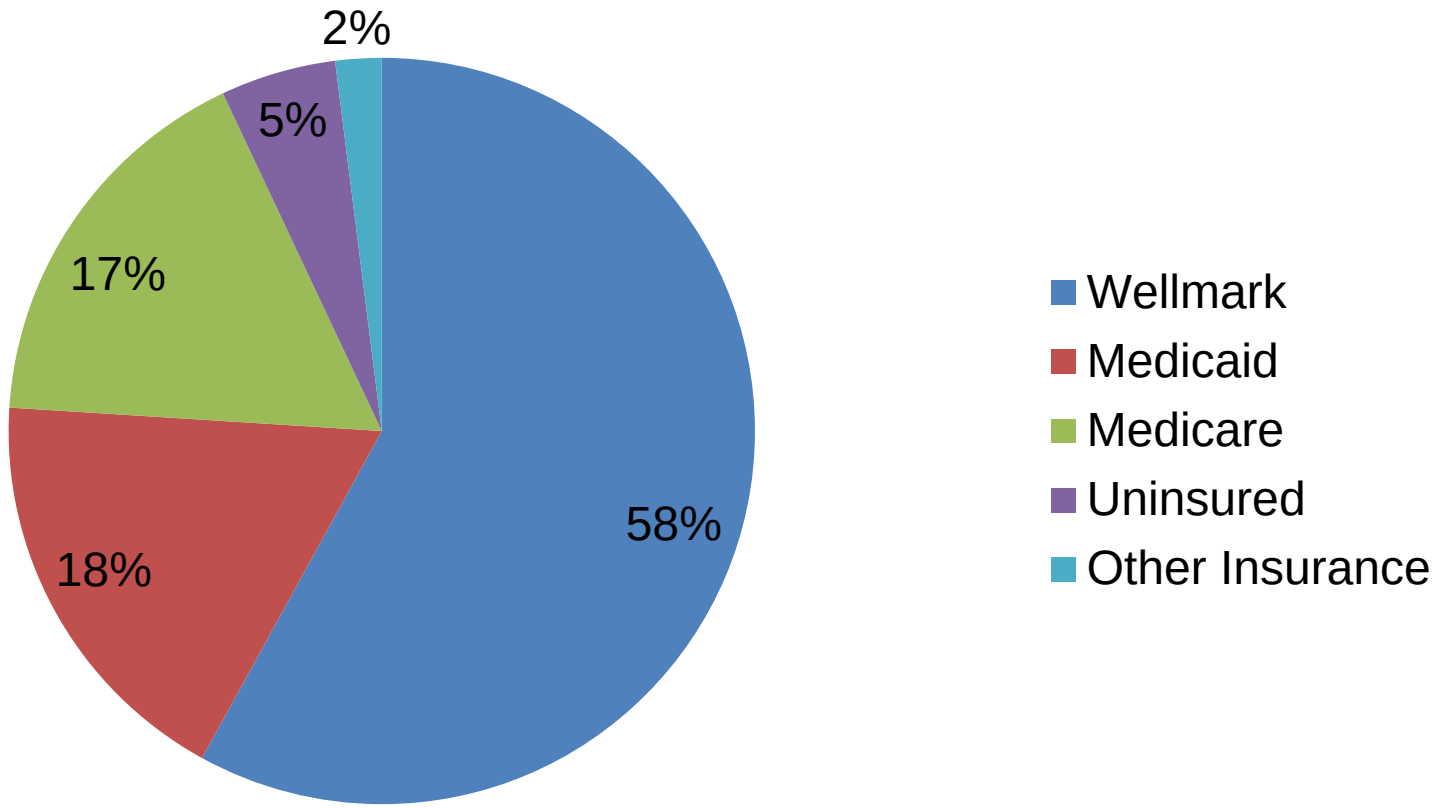
Medicaid and Private Payer Alignment for APMs

Marni Bussell – SIM Project Director

October 25, 2016

Landscape - Iowa

3.12 Million Lives



Sources:
https://www.census.gov/quickfacts/table/PST045215/19/accessible
http://dhs.iowa.gov/sites/default/files/IAHealthLink-Announcement-NOI.pdf
http://kff.org/other/state-indicator/hospital-supplementary-enrollees/

History of APMs in Iowa

- 2012 – Wellmark started an ACO program with Shared Savings/Shared Loss (SS/SL)
- 2012 - Medicare engaged Iowa providers in Pioneer ACO program and in MSSP
- 2014 - Medicaid began an ACO incentive program with intent to move to SS/SL in 2016
- 2015 – SIM reported 44% of Medicaid and 53 % of Wellmark PCPs engaged in VBP

Alignment

Medicaid aligned with the dominate private payer to establish a quality framework in Iowa for VBP:

- Value Index Score (VIS)
  - 16 measures across 6 domains
  - 12 months of claims/encounter data (refreshed monthly)
  - Creates a longitudinal record for each member
  - Attributes members to PCPs
  - PCPs attributed to ACOs/APM networks

Medicaid and Wellmark ACO Programs

Similarities
Both programs use VIS with the same risk adjustment methodology
Both programs use the same dashboard infrastructure (user toggles between payer/population)
Both programs use the same attribution methodology (Rolling, updated every month)
Both attempting to increase the total number of lives in VBP strategies

Medicaid ACO vs. Wellmark ACO

Differences
Wellmark started in 2012 vs. Medicaid started in 2014
Medicaid engaged five health systems vs. Wellmark engaged 15 health systems (there is both overlap and differences in the ACO networks between the two programs)
Medicaid paid a quarterly incentive vs. Wellmark use of upside and downside risk (paid annually)
Medicaid started ACO program using all six VIS domains to measure quality vs. Wellmark who phased in the six domains over time

Modernization Journey for Medicaid

In January 2015, Iowa announced a strategic shift to modernize Medicaid

- Moving from mostly FFS to all encompassing managed care approach
- Three statewide MCOs began service April 1, 2016
- Medicaid replaced direct agency to provider ACO contracts with VBP requirements placed on MCOs

- Medicaid working to develop an Advanced APM model by 2019
  - Aligning clinical quality measures with Wellmark
  - Allowing providers to achieve the 5% bonus with the Other Payer AAPM option

Achievements

Medicaid paid out just over 2 million in quality incentives (VIS) in 2014 and 2015 combined*

- VIS for PCPs in a VBP was 58.7% compared to 37.7 for those not in VBP
- 28% of ACO attributed lives completed an exam and HRA, compared 5% of Medicaid overall complete a wellness exam

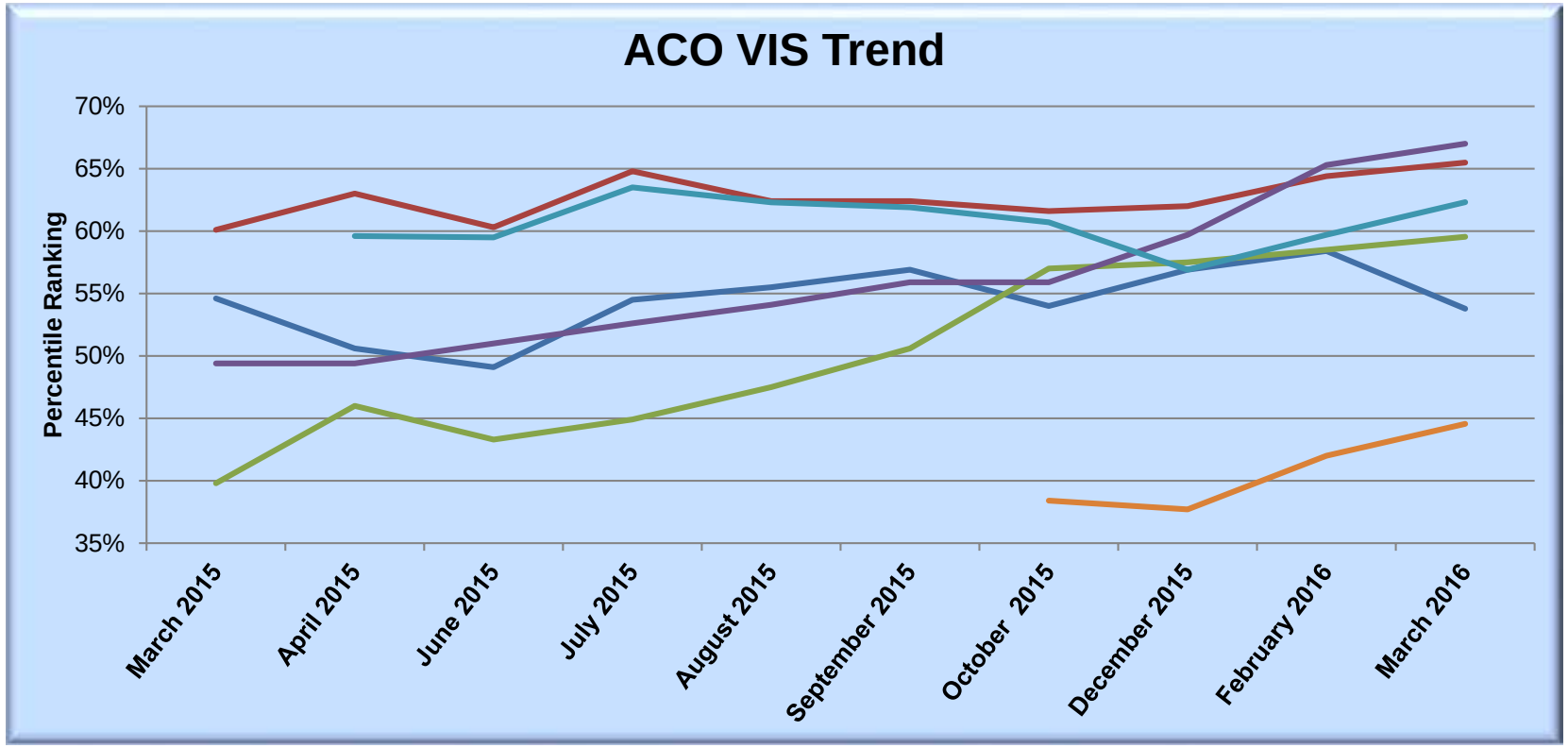
Wellmark saved 35 million in 2015**

- 11of 13 ACOs received shared savings checks totaling 11.4 million
- Increases in PCP visits, mammograms, well-child visits, and colon-cancer screenings reported
- Reduction of Readmissions by 22%, ED by 4%

* https://dhs.iowa.gov/sites/default/files/ACO_Wellness_Program_Outcomes_Paper.pdf
** https://www.wellmark.com/about/newsroom/2016/07/26/grand-blue-mile-defending-champions-set-to-return

Iowa Wellness Plan ACO Outcomes

VIS Improvement Overtime (Medicaid Data):



Value-Based Purchasing through SIM and Medicaid Modernization

The Medicaid Agency supports ACOs and other value oriented provider networks engaged in VBP models by:

- Sharing claims data
- Distributing monthly quality reporting data (Dashboard reports and measurement of Total Cost of Care)
- Providing real-time alerts (ADTs through the SWAN)
- Facilitating monthly calls (at a minimum) with Provider Organizations
- Sharing eNewsletters focusing on Quality Scores and Innovations to support the move to value

Next Steps for Medicaid VBP

- Ensure alignment across MCOs consistent with current contractual requirements
- Review options to align VBP in Medicaid with Wellmark contract and with MACRA requirements
- Continue to refine how quality is defined in VBP:
  - Add Vulnerable Populations
  - Collect clinical quality measures (CQMs and eventually eCQMs)
    - Determine infrastructure and approach for CQM collection – *is this a statewide strategy?*
  - Integrate administrative claims data and other quality data to inform value

State Innovation Model

Payment Reform Strategy

October 25, 2016

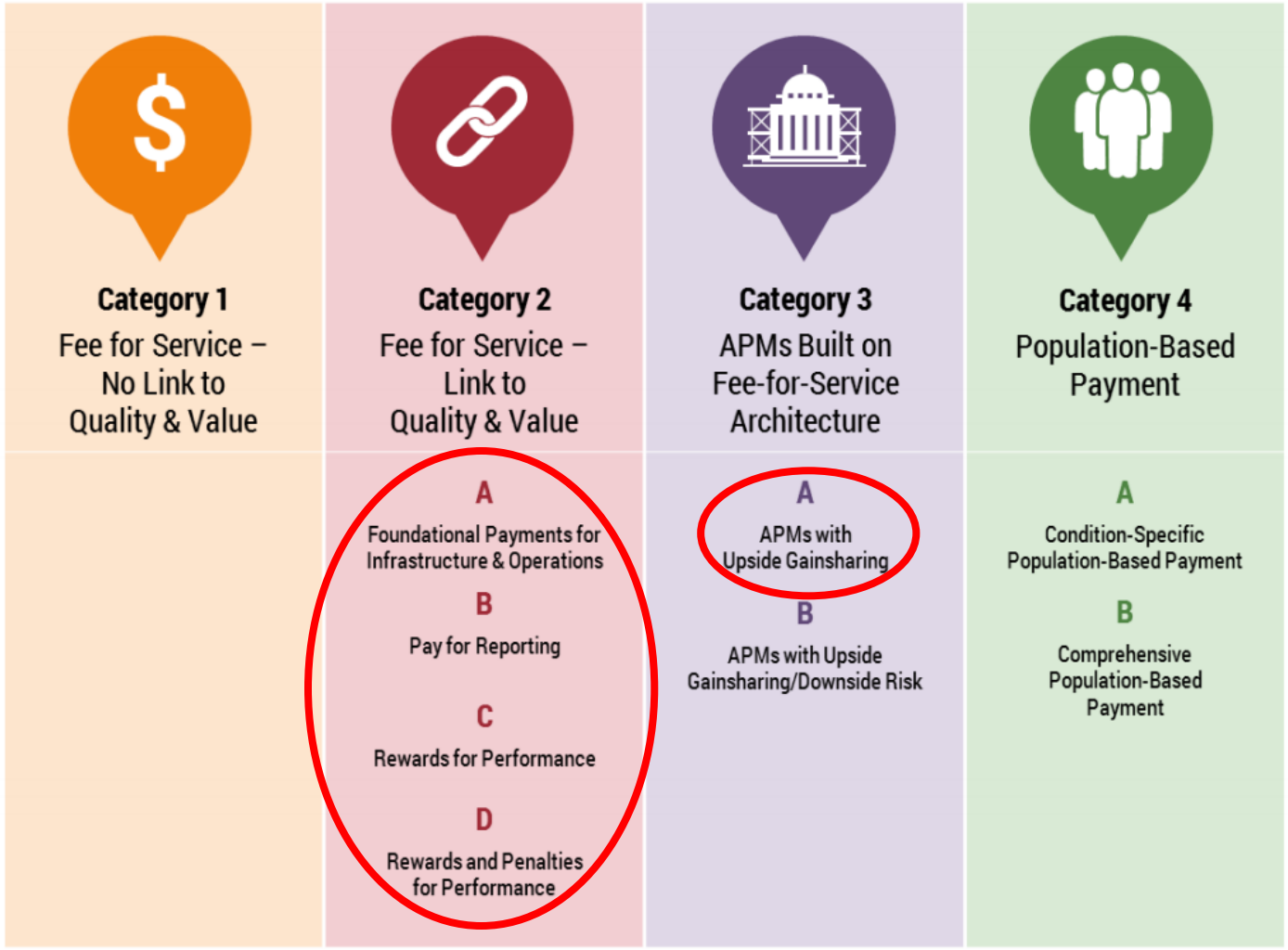
Putting people first, with the goal of helping all Michiganders lead healthier and more productive lives, no matter their stage in life.

Michigan Blueprint for Health Innovation: Payment Reform Vision in 2012

The *Blueprint's* Conceptual Payment Framework:

Model Element	Payment Options
Patient Centered Medical Home	• Care management payments (risk-adjusted) • Practice transformation payments • Pay-for-performance incentives
Accountable Systems of Care	• Same as above • Shared savings upside only • Shared savings upside/downside • Partial capitation for defined services • Global payment for high cost conditions

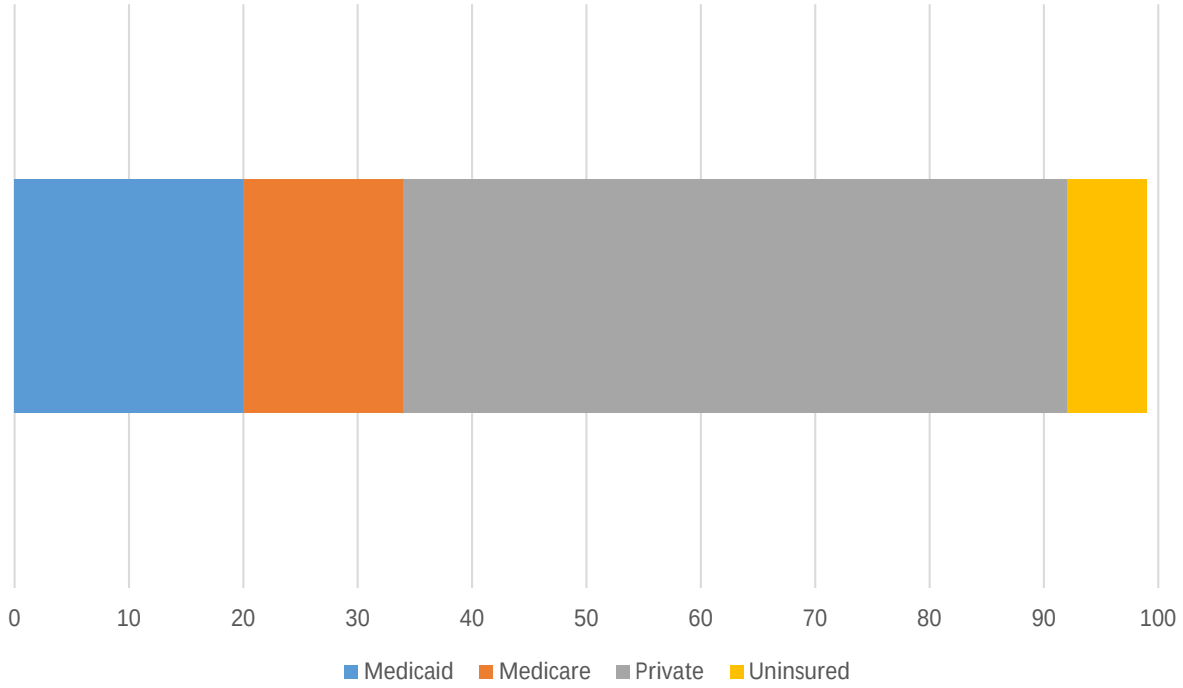
Health Care Payment Learning & Action Network Framework



Putting people first, with the goal of helping all Michiganders lead healthier and more productive lives, no matter their stage in life.

Multi-Payer Partnership Is Key

- Michigan's Overall Payer Mix
  - Private- Employer: 52%
  - Private- Non-Group: 6%
  - Medicaid: 20%
  - Medicare: 14%
  - Uninsured: 7%
- Each of Michigan's payer mix categories (with the exception of the uninsured) is comprised of multiple health insurance providers



Findings from Payment Reform Stakeholder Engagement: February 2015 to April 2016

- Strong MDHHS commitment to sustain and expand PCMH, including support for and coordination between MCO care managers and practice-based care managers.
- Strong MDHHS commitment to begin defining and encouraging the development and adoption of payment that moves away from fee-for-service.
- ASC would be resource-intensive to develop and regulate responsibly on behalf of our health plan partners managing financial risk.
- Payer / provider marketplace already developing innovative approaches to move away from fee-for-service.
- Prescriptive approach not conducive to supporting and enhancing the market-driven payment innovations already underway.

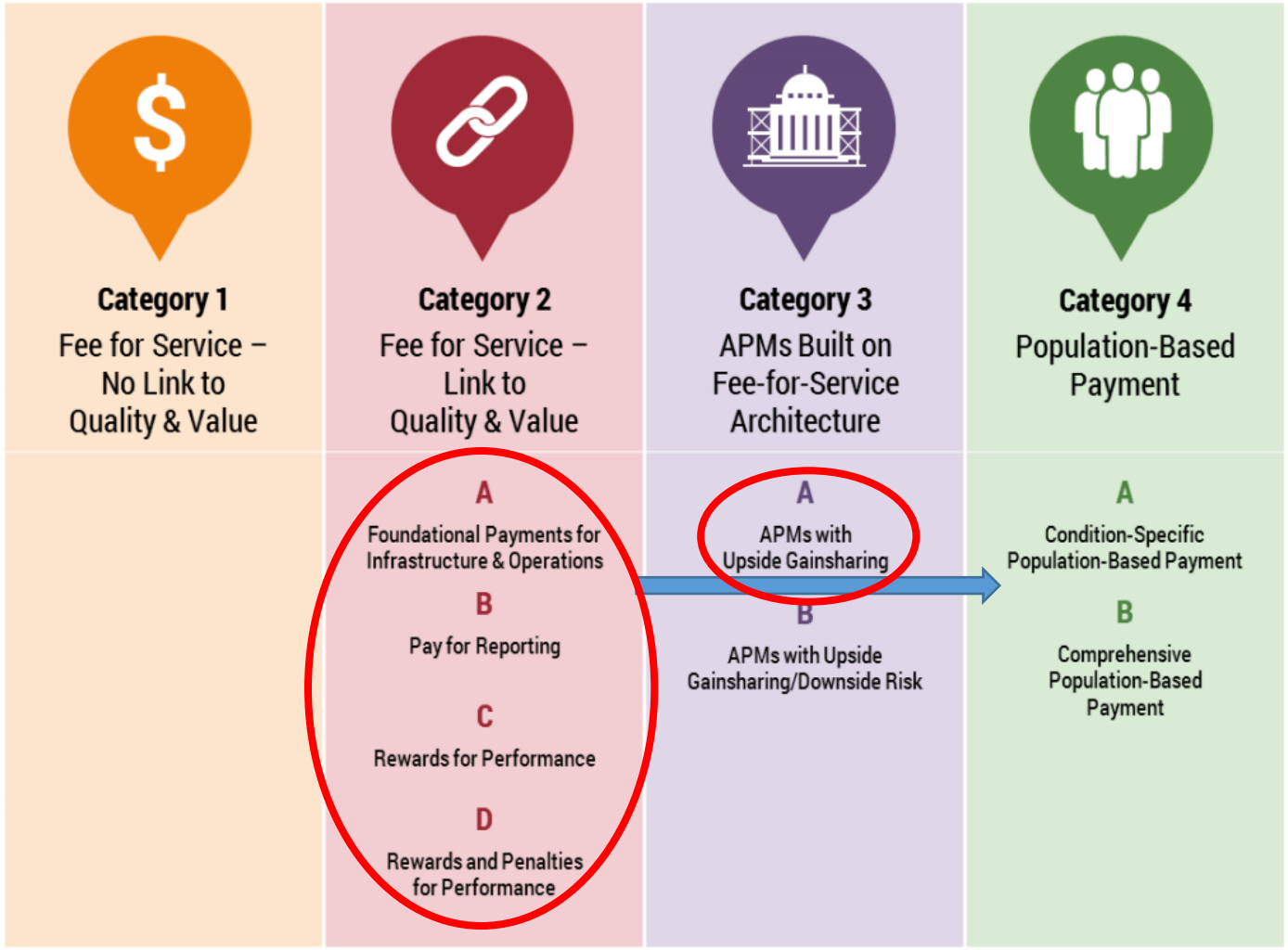
Impact of CMS Announcements on SIM Payment Reform Strategy

- Comprehensive Primary Care Plus (CPC+)
  - Monitor Medicare and Commercial adoption of CPC+
  - Align Medicaid health plans with CPC+ practices
- Medicare Alignment in Multi-Payer Models Under the SIM Initiative
  - Continue stakeholder progress
  - Revise strategy and timeline

Impact of CMS Announcements on SIM Payment Reform Strategy

- Medicare Access and CHIP Reauthorization Act (MACRA)
  - Definition for Advanced Alternative Payment Models (APMs), providing more tangible detail for potential payment reform models and raising the bar for APM qualification
  - Provider incentives for increasing their payments through APMs
  - Direct tie between performance scoring and payment
  - Alignment of multiple transformation efforts in a consolidated approach (quality improvement, cost reduction, HIT advancement, practice improvement)

Health Care Payment Learning & Action Network Framework



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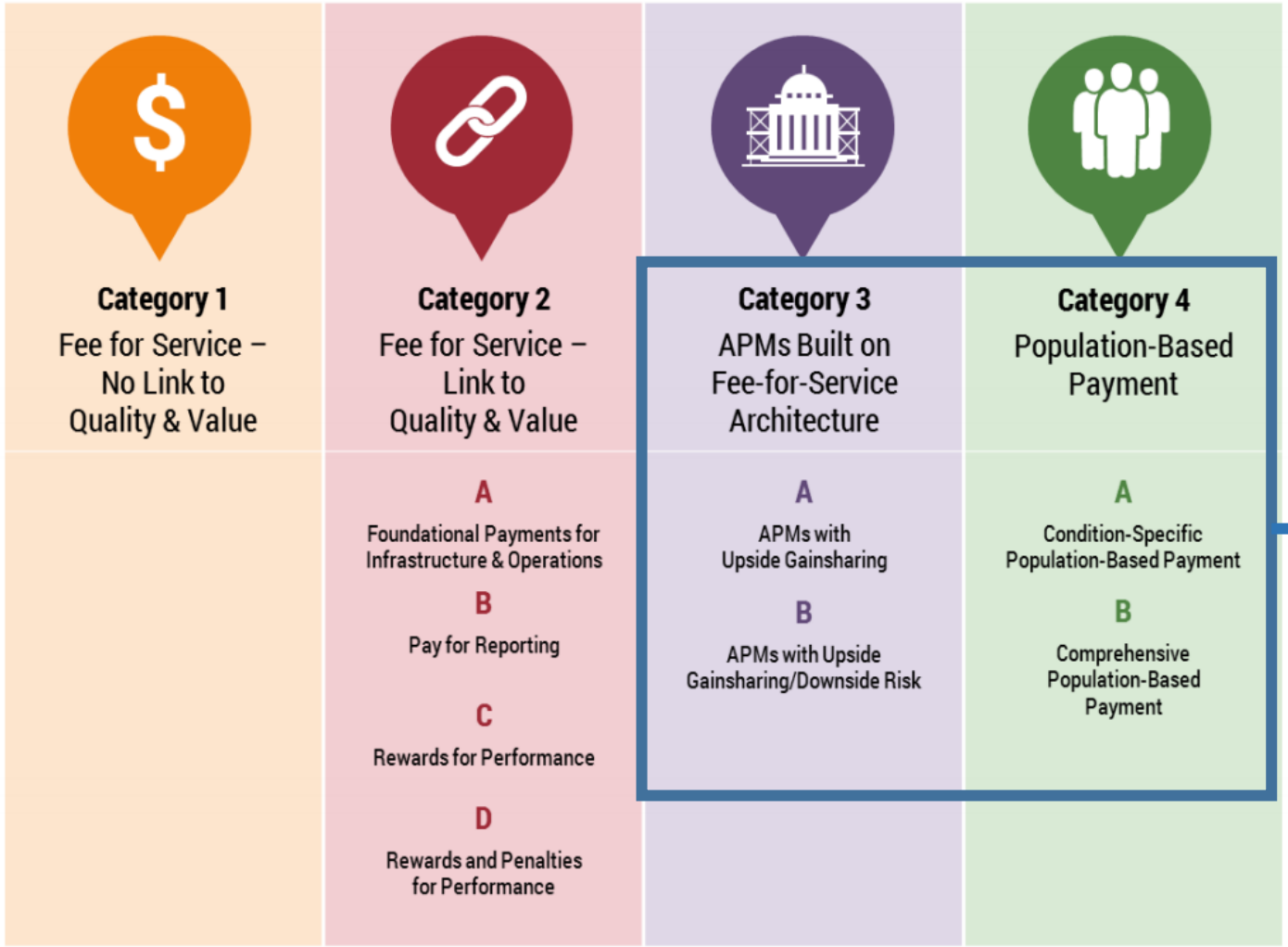
Health Care Payment Learning & Action Network Framework



Provider-facing Incentives available for Categories 3 and 4 APMs.

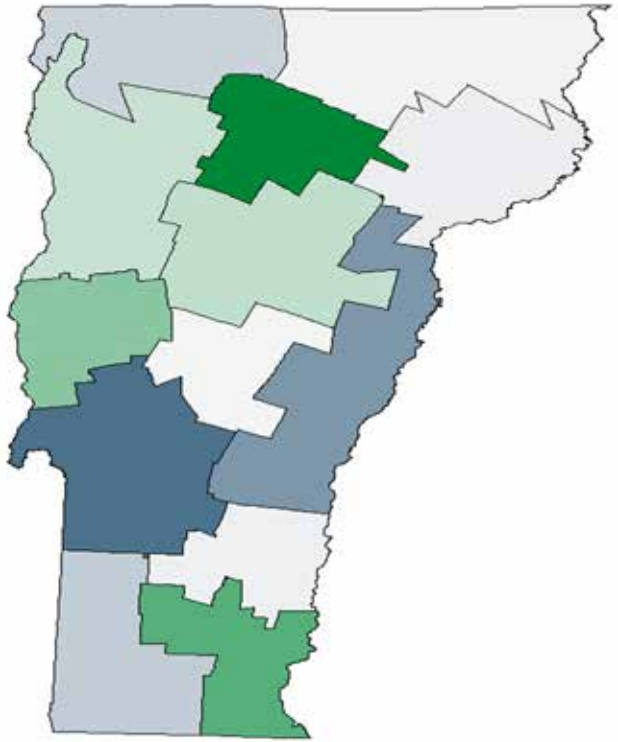
Broad Advanced Alternative Payment Model (APM) Approach

Accountable Systems of Care Pilots	Broad APM Adoption
• Regulated construct • Resource intensive • Limited scale • Limits provider ability to receive Medicare incentives	• Market-driven approach to broader scale • Leverages existing and future clinical integration • State plays a policy and strategy role • Maximizes provider opportunity for participating in Medicare incentives

Broad Advanced Alternative Payment Model (APM) Approach

	Initiative Year 1 2017	**Initiative Year 2** 2018	**Initiative Year 3** **2019**
Broad APMs	Collect Michigan's APM baseline and establish goals	Progressively increase percentage of payment in APMs	

- Broad adoption of APMs will be allowable statewide
- APM adoption in Medicaid will be administered through the Medicaid managed care organization contract
- APM adoption by other payers will be encouraged through collaborative discussion and partnership



Adopting Multi-Payer and
All-Payer Payment Models in States

Vermont All-Payer Model Proposal

Al Gobeille, Chair, Green Mountain Care Board

LAN Fall Summit: October 25, 2016

VERMONT
GREEN MOUNTAIN CARE BOARD

All-Payer Model Foundation

- Act 48 of 2011: Established The Green Mountain Care Board (GMCB) and emphasized cost containment and quality improvement on a multi-payer basis. Primary responsibilities of the Board:
    - Oversight of multi-payer payment reform
    - Review and approval of hospital budgets
    - Insurance premium rate review
    - 2016: Board charged with ACO oversight: certification and budget review
- 2014: Board created an all-payer shared savings program based on Track 1 and aligned standards for Medicare, Medicaid, Commercial SSPs i.e.:
    - ACO governance and consumer representation
    - Attribution
    - Quality and performance standards
    - Distribution of savings
- Vermont's long-standing Medicaid 1115 waiver has allowed flexibility for Medicaid to partner in payment reform.

Vermont All-Payer Model Proposal

Vermont's All-Payer Model would be an agreement between the State and the Center for Medicare and Medicaid Services (CMS) to move away from fee-for-service on a statewide, multi-payer basis with Medicare's participation.

- Builds on aligned shared savings program and moves to a statewide, value-based, pre-paid model for Accountable Care Organizations (ACOs).
    - Initially includes Medicare Parts A and B services and their Medicaid and commercial equivalents
    - Sets all-payer growth target: 3.5%
    - Medicare growth target: 0.1-0.2% below national

- Creates scale targets for Vermonters aligned to an ACO. By 2022:
    - 70% of Vermont all-payer beneficiaries
    - 90% of Vermont Medicare beneficiaries

- Goals for improving the health of Vermonters:
    - Improve access to primary care
    - Reduce deaths due to suicide and drug overdose
    - Reduce prevalence and morbidity of chronic disease

How Did We Get Here?

Over 18 months:

- GMCB facilitated meetings of health care providers from three existing ACOs in the state, along with major payers, community-based service providers, and health care advocates.
  - Group created framework for operating a unified All-Payer Model, focused on improving access to primary care and the health of Vermonters

- With the direction of the Legislature, the GMCB and the Agency of Administration jointly developed an All-Payer Model proposal through negotiations with the Center for Medicare and Medicaid Innovation (CMMI).

- Concurrently, the Vermont Agencies of Administration and Human Services have been negotiating a complementary Medicaid 1115 Waiver renewal.

- 2016: The Legislature passed Act 113 establishing the criteria for the State to enter into an All-Payer Model agreement with CMS.

What's Next?

- Subject to the Open Meeting Law, The GMCB has conducted all of its discussions on the All-Payer Model in public.
- The Agency of Administration and GMCB have convened multiple public forums to gather feedback on the All-Payer Model proposal.
- The Governor, the Secretary of the Agency of Human Services and the Chair of the GMCB must all sign the All-Payer Model agreement with CMS.
- The Chair of the GMCB will sign only after an affirmative vote by the Board.
- A signed agreement is an invitation for willing payers and providers to participate; it launches implementation of a potentially historic health system transformation.