Measuring Value and Performance

Promoting value in Medicaid

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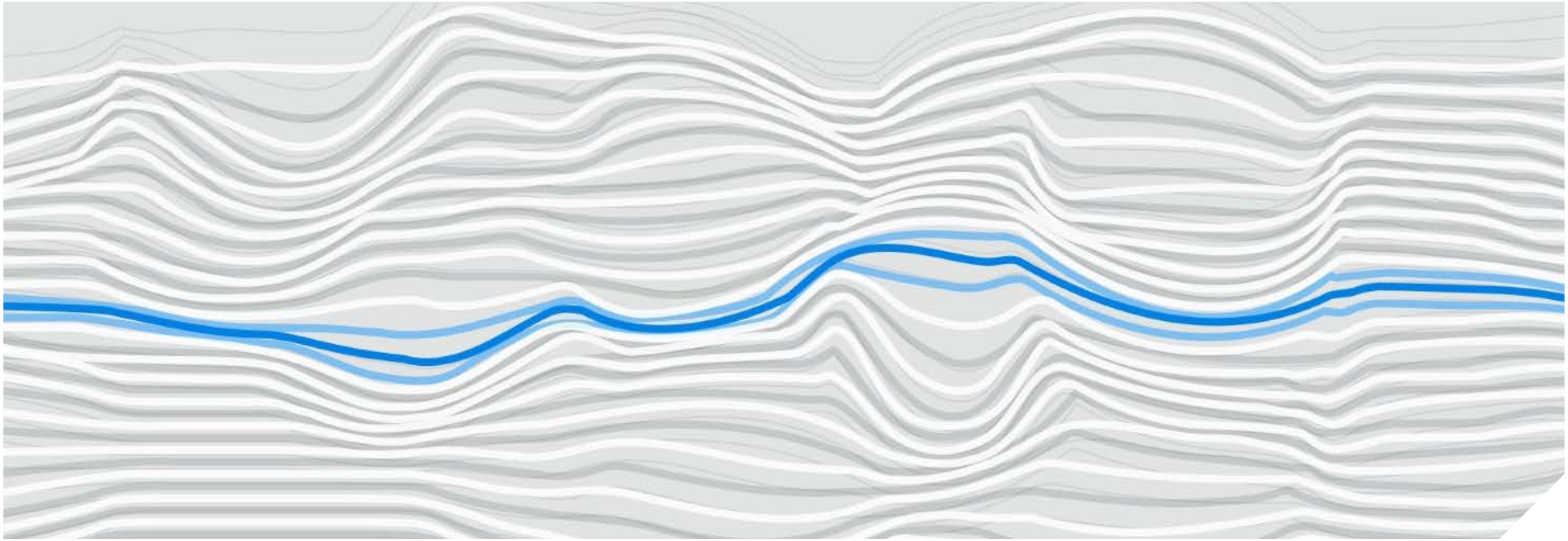
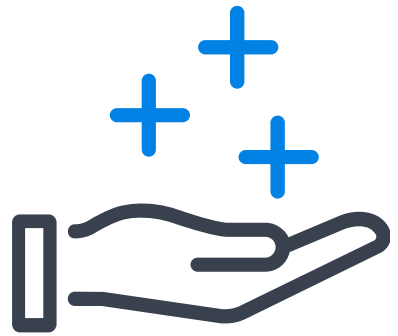
17 JULY 2019



Agenda

Introduction

- **Focus on value has led to changes in Medicaid payments and programs**
  - Changes in how payments are made
  - Increased focus on measurement of quality
- **Key takeaways:**
  1. How do you show the value in program and payment changes?
  2. What are states doing?
  3. What role can social determinants of health play?



Focus on value

Defining value and quality

Increased focus on value

In payments to providers and MCOs

- CMS, State legislatures, and taxpayers all increasingly focused on how Medicaid dollars are spent
- CMS 2016 Medicaid Mega Rule
  - 42 CFR 438.204 requires a Managed Care Quality Strategy
    - One component is the assessment of the quality and appropriateness of care and services furnished to all Medicaid enrollees under MCO contracts
  - 42 CFR 438.334 requires a Medicaid managed care quality rating system
- CMS scorecard developed to increase public transparency about Medicaid and CHIP's administration and outcomes

Value

"Health outcomes achieved per dollar of cost"

— Redefining Health Care: Creating Value-based Competition on Results

Quality

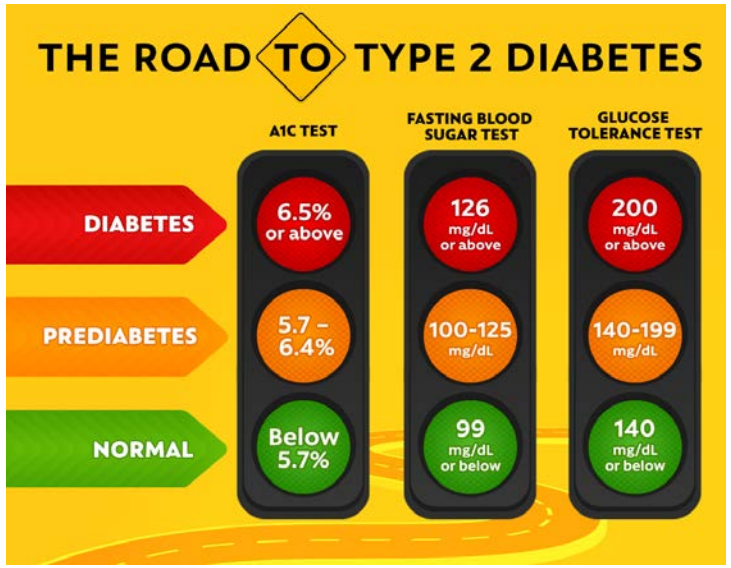
"The degree to which health care services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge"

— Institute of Medicine

Measuring quality

Types of quality measurement

Structural



Process

Outcomes

Source: https://www.ahrq.gov/talkingquality/measures/types.html

Quality measurement challenges

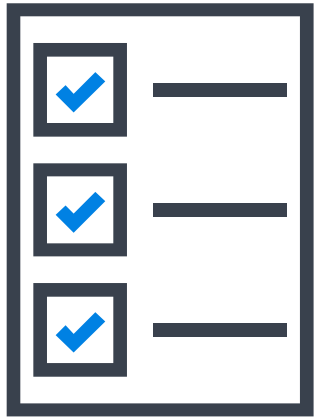
Measure selection

- Standardization
- Comparability
- Availability
- Timeliness
- Relevance
- Experience
- Stability
- Evaluability
- Distinguishable
- Credibility

What is the quality measurement goal?

Improved decision making for consumers?

Improved accountability and transparency for healthcare delivery system?



Source: https://www.ahrq.gov/talkingquality/measures/measure-questions.html

Quality measurement challenges

Data sources

Criteria	Administrative Data	Patient Medical Records	Standardized Clinical Data	Patient Survey / Comments
Acquisition cost	■	■	■	■
Clinical detail	■	■	■	■
False conclusions	■	■	■	■
Timeliness	■	■	■	■
Existing availability	■	■	■	■
Uniformity	■	■	■	■

■ Advantage ■ Neutral ■ Disadvantage

Source: https://www.ahrq.gov/talkingquality/measures/understand/index.html

Quality measurement challenges

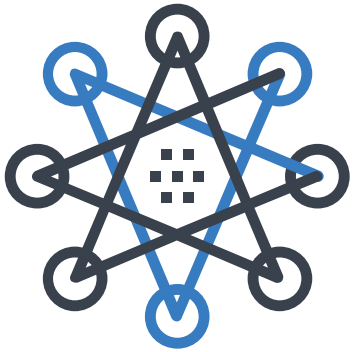
Impact of population acuity and SDOH

Health outcomes =

Examples of quality measurement

CMS State Scorecard: Timeline and purpose

- CMS Administrator Seema Verma announced the creation of the Scorecard at the National Association of Medicaid Directors (NAMD) 2017 Fall Conference
- The first version was published June 4, 2018, and will be updated annually
- **Stated goals:**
  - Tracking and displaying progress within the Medicaid program through meaningful data and improved transparency on an annual basis
  - Facilitation of the development of best practices that lead to positive health outcomes
  - Hold states and federal government accountable



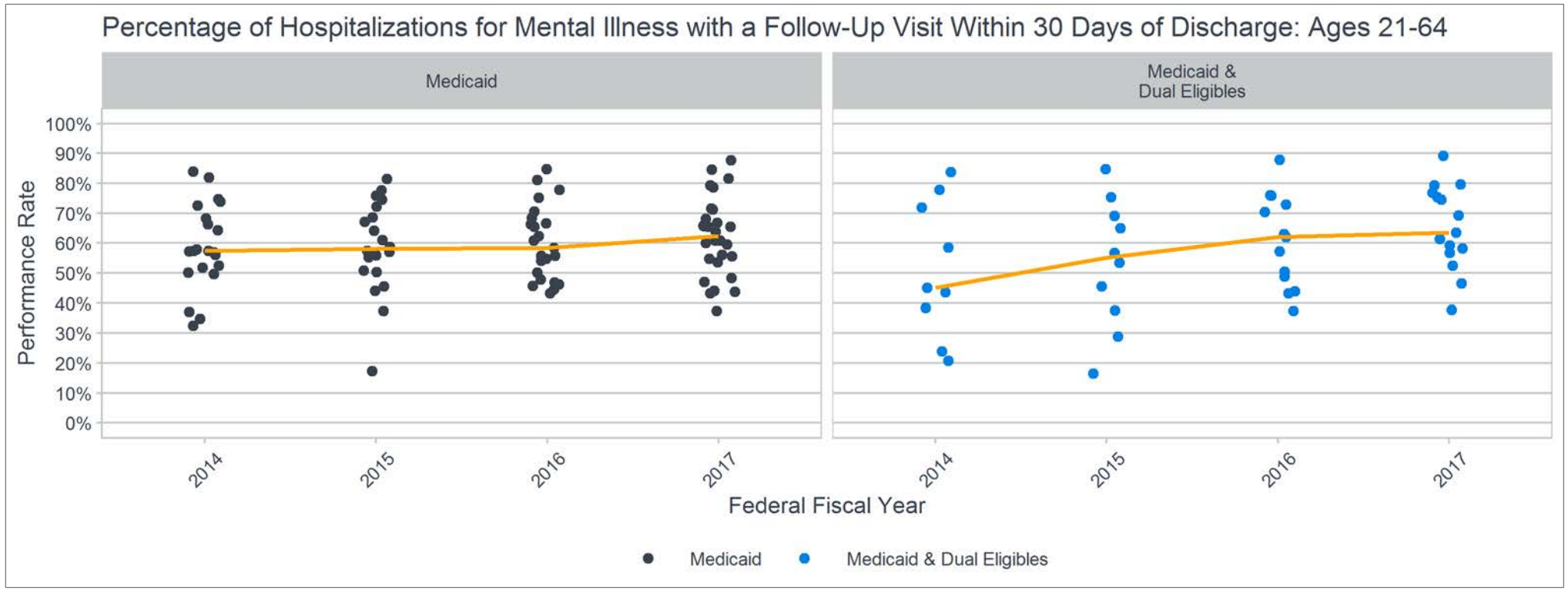
Sources:

1. https://www.cms.gov/newsroom/fact-sheets/speech-remarks-administrator-seema-verma-national-association-medicaid-directors-namd-2017-fall
2. https://www.cms.gov/newsroom/press-releases/cms-unveils-scorecard-deliver-new-level-transparency-within-medicaid-and-chip-program

Examples of current quality measurement

CMS Scorecard: Hospitalizations for mental illness

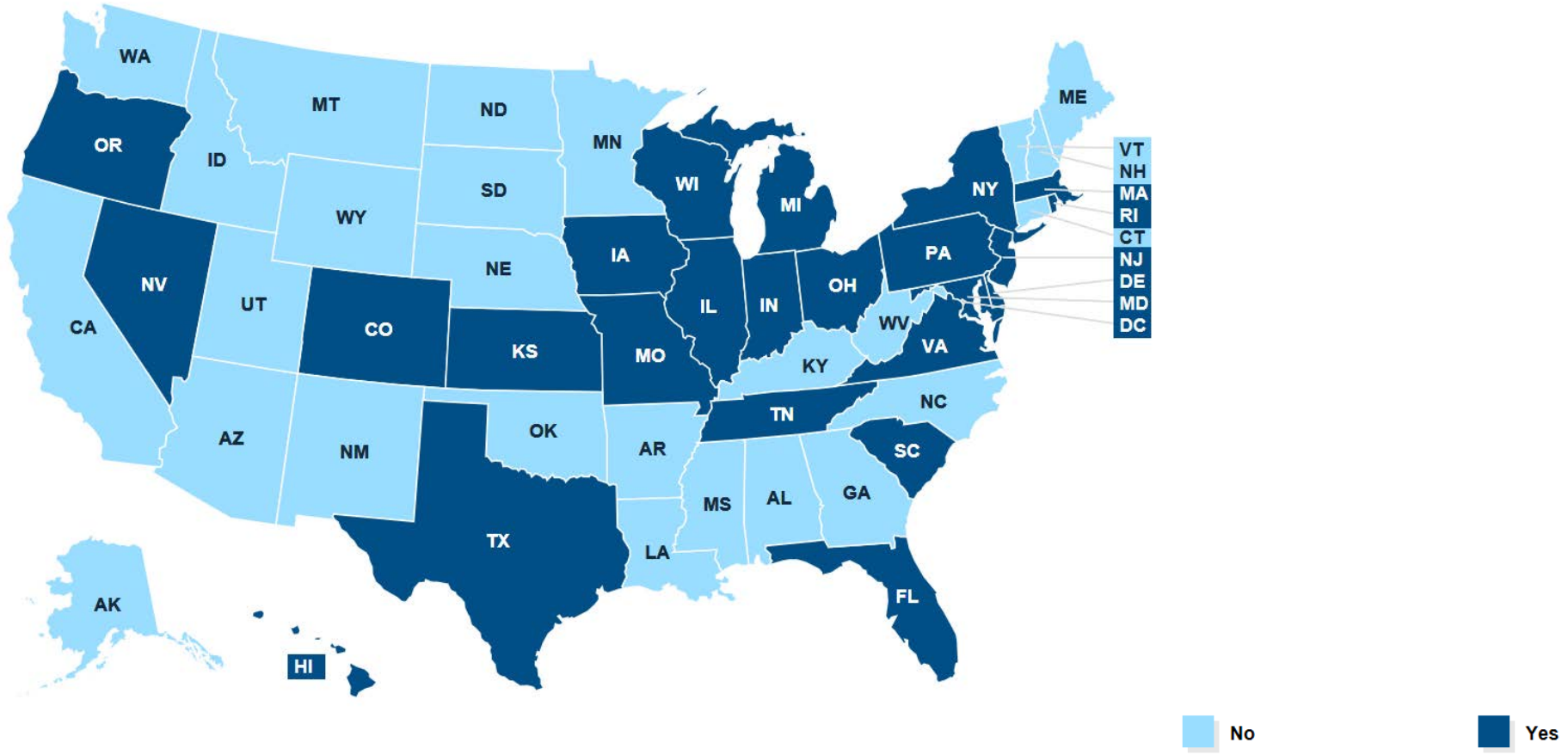
- Closer look at BH 03 – Percentage of hospitalizations for mental illness with a follow-up visit within 30 days of discharge: ages 21-64
  - Median performance shows improvement over time



Linking quality to MCO payments

State pay for performance methodologies

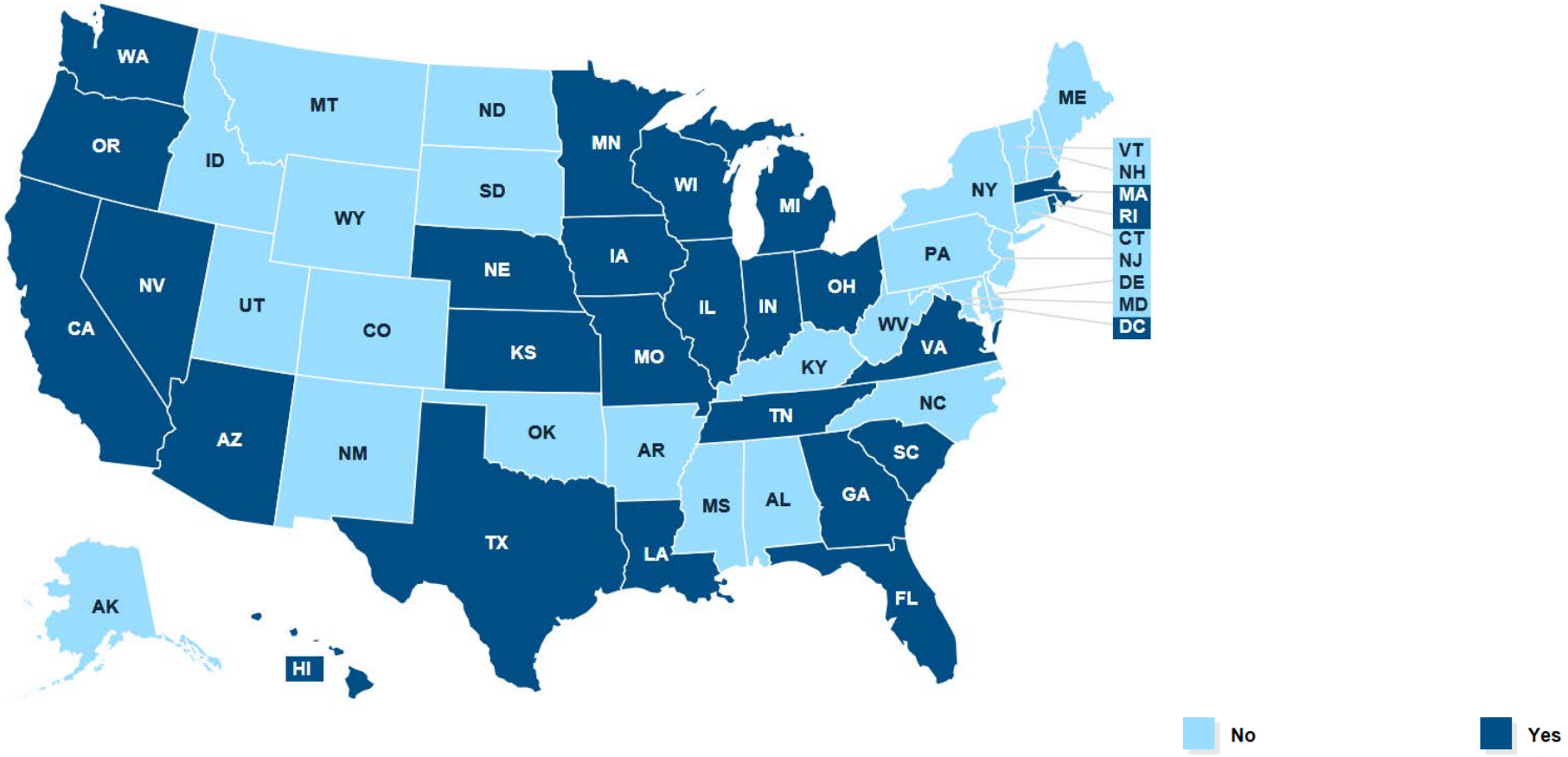
Managed care performance bonus payments, SFY 2018



Source: https://www.kff.org/medicaid/state-indicator/medicaid-managed-care-quality-initiatives/

State pay for performance methodologies

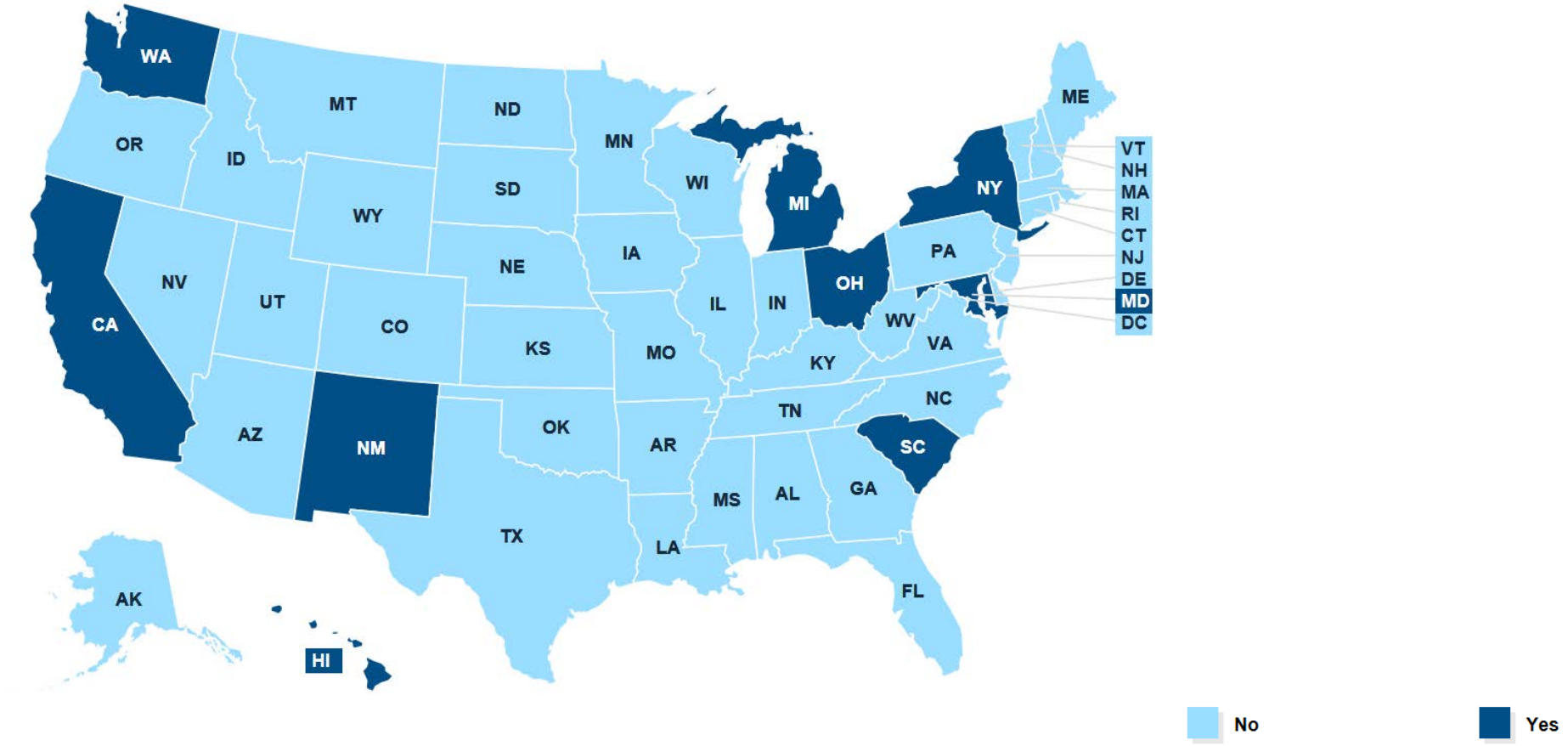
Managed care withholds, SFY 2018



Source: https://www.kff.org/medicaid/state-indicator/medicaid-managed-care-quality-initiatives/

State pay for performance methodologies

Auto-assignment algorithm includes quality performance measures, SFY 2018



Source: https://www.kff.org/medicaid/state-indicator/medicaid-managed-care-quality-initiatives/

Incentive payments vs. Withholds

Key considerations

	Incentive	Withhold
Limited to 5% of capitation revenue	■	
Included in denominator of MLR calculation		■
Additional state investment	■	
Measures linked to state quality strategy	■	■

State of Oregon

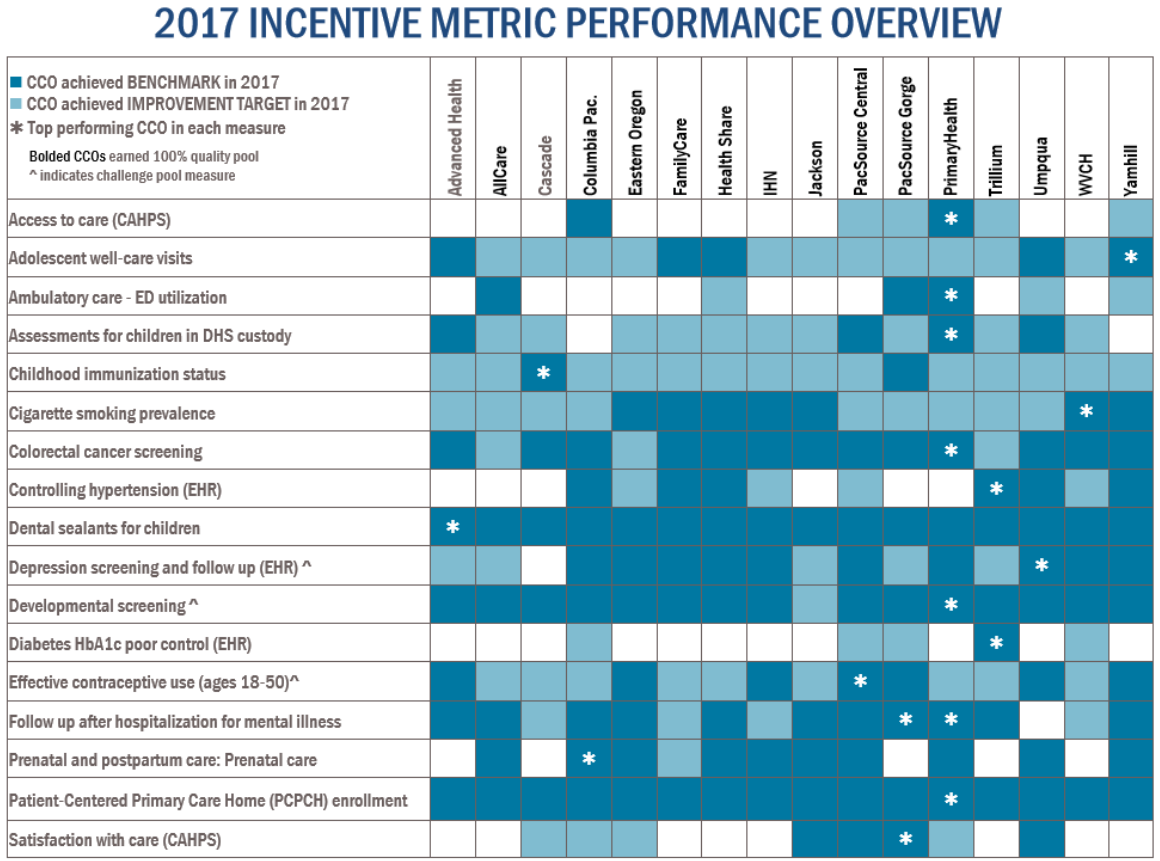
Quality pool methodology

Quality pool funding. Set at 4.25% of aggregate Coordinating Care Organization (CCO) payments (incentive).

Stage one distribution. Maximum amount of dollars for which a CCO is eligible allocated based on plan performance on incentive measures (benchmark or improvement target).

Quality Pool Distribution Table		
Number of targets met for non-PCPCH measures (achieving benchmark / improvement target, & reporting requirements for EHR measures)	Quality Pool Amount if MEET or EXCEED PCPCH Measure Threshold Score of 0.60	Quality Pool Amount if PCPCH Measure Score ≤0.60 (i.e., do not meet PCPCH measure threshold)
at least 12	100%	90%
at least 11	80%	70%
at least 10	70%	60%
at least 8	60%	50%
at least 6	50%	40%
at least 4	40%	30%
at least 3	30%	20%
at least 2	20%	10%
at least 1	10%	5%
0	5%	No quality pool payment

Stage two distribution. Remaining funds distributed to CCOs meeting four "challenge" measures. CCO can earn more than 4.25% of revenue in aggregate.



Source: https://www.oregon.gov/oha/HPA/ANALYTICS/CCOData/2018-Reference-Instructions-quality-pool-methodology.pdf

Milliman

Linking quality to provider payments

Linking quality to provider payments

Value-based purchasing and alternative payment models

Value-Based Purchasing (VBP)

Holding providers accountable for cost and quality outcomes

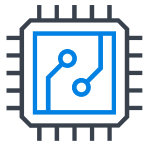
Alternative Payment Model (APM)

A payment methodology that incentivizes value instead of volume

Three keys to successful implementation of APMs in Medicaid programs:

Commitment

1. Developing and implementing APMs is difficult and complex



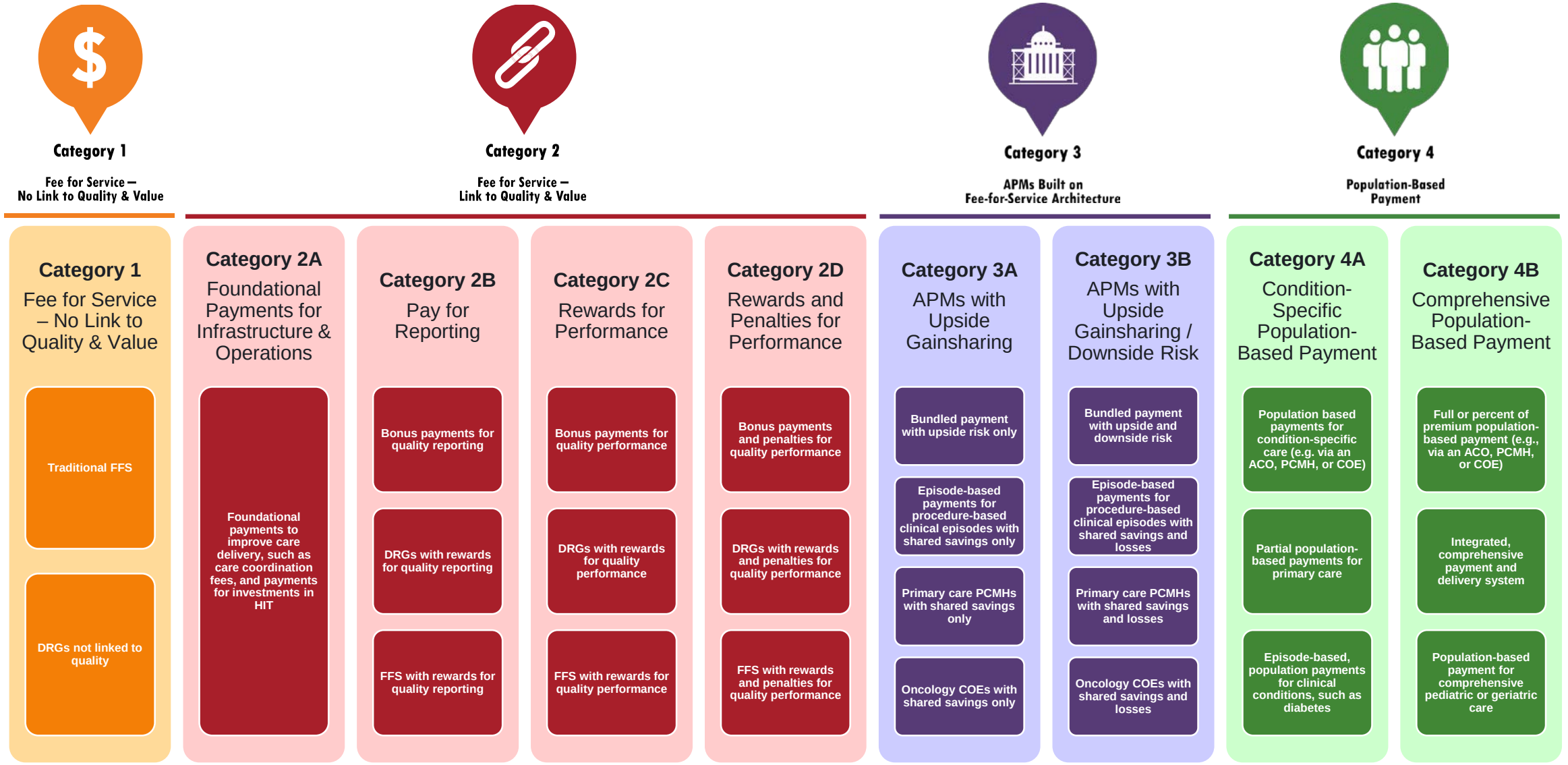
Data

2. High quality and timely data is required to focus care improvements and evaluate performance

Collaboration

3. Engaging with stakeholders, particularly providers, in the design process will promote success

HCP-LAN Alternative Payment Model (APM) framework



Continuum of payment methodologies: DRGs to episodes

Category 1

Fee for Service – No Link to Quality & Value

Category 2

Fee for Service – Link to Quality & Value

Category 3

APMs Built on Fee-for-Service Architecture

Category 4

Population-Based Payment

Category 1
Fee for Service – No Link to Quality & Value

- Traditional FFS
- DRGs not linked to quality

Category 2A
Foundational Payments for Infrastructure & Operations

- Foundational payments to improve care delivery, such as care coordination fees, and payments for investments in HIT

Category 2B
Pay for Reporting

- Bonus payments for quality reporting
- DRGs with rewards for quality reporting
- FFS with rewards for quality reporting

Category 2C
Rewards for Performance

- Bonus payments for quality performance
- DRGs with rewards for quality performance
- FFS with rewards for quality performance

Category 2D
Rewards and Penalties for Performance

- Bonus payments and penalties for quality performance
- DRGs with rewards and penalties for quality performance
- FFS with rewards and penalties for quality performance

Category 3A
APMs with Upside Gainsharing

- Bundled payment with upside risk only
- Episode-based payments for procedure-based clinical episodes with shared savings only
- Primary care PCMHs with shared savings only
- Oncology COEs with shared savings only

Category 3B
APMs with Upside Gainsharing / Downside Risk

- Bundled payment with upside and downside risk
- Episode-based payments for procedure-based clinical episodes with shared savings and losses
- Primary care PCMHs with shared savings and losses
- Oncology COEs with shared savings and losses

Category 4A
Condition-Specific Population-Based Payment

- Population based payments for condition-specific care (e.g. via an ACO, PCMH, or COE)
- Partial population-based payments for primary care
- Episode-based, population payments for clinical conditions, such as diabetes

Category 4B
Comprehensive Population-Based Payment

- Full or percent of premium population-based payment (e.g., via an ACO, PCMH, or COE)
- Integrated, comprehensive payment and delivery system
- Population-based payment for comprehensive pediatric or geriatric care

Diagnosis Related Groups (DRGs)

- DRGs are used by payers and providers to classify hospital inpatient stays into clinically meaningful diagnostic groups
- DRGs are a mechanism for making a single prospective case rate payment for a hospital inpatient stay at the claim header level. DRG-based payment systems:
  - Incentivize hospitals to manage their cost structure and provide efficient delivery of care
  - Provide the basis for evaluating variation in service mix, cost structures, and patient outcomes (including readmissions) across hospitals
  - Support pragmatic, data-driven payment policy development and program evaluation

Readmission-based quality incentives

Layering readmission-based quality incentives on top of DRG-based payment systems

State	Excludes Planned and Unrelated Readmissions	Readmission Window	Reward or Penalty	Performance Benchmark
Massachusetts	Yes	30-day	Penalty	Statewide and hospital-specific (maximum rate reduction of 4.4%)
New York	Yes	14-day	Penalty	Statewide
Texas	Yes	15-day	Penalty	Statewide
Wisconsin	Yes	30-day	Both	Statewide
Maryland	Yes	30-day	Both	Statewide and hospital-specific

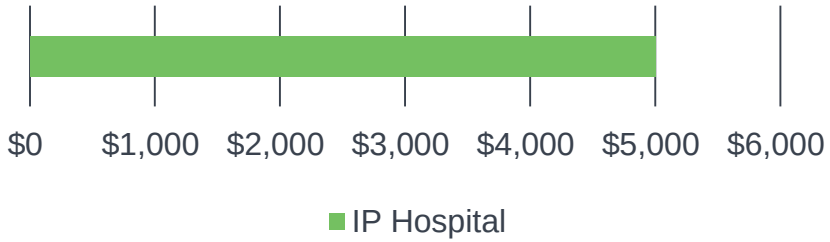
Episode-based payments

From DRG case rates to episode-based payments

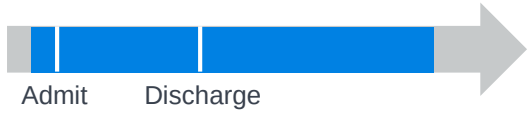
DRG case rate

Start	Admission (or 72 hours prior)
End	Discharge
Covered Providers	Hospital

Illustrative FFS Spend

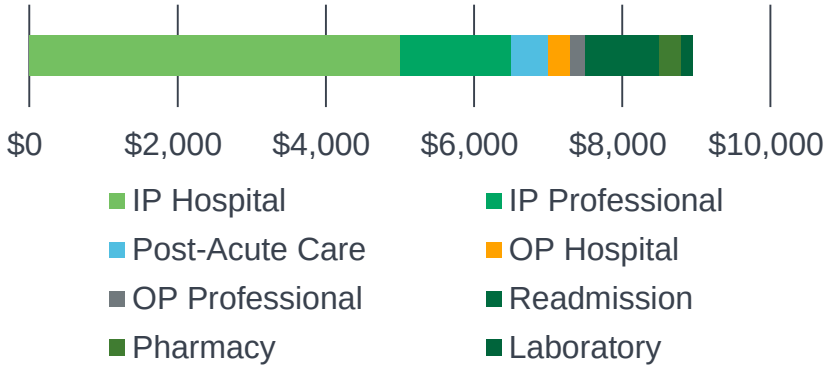


Episode-based payment



Start	Varies
End	Varies
Covered Providers	Hospital, professional, post-acute care, pharmacy, lab

Illustrative FFS Spend



Social Determinants of Health (SDOH) measurement

Social Determinants of Health (SDOH)

"The conditions in which people are born, grow, live, work and age" – World Health Organization

Economic Stability	Neighborhood and Physical Environment	Education	Food	Community and Social Context	Health Care System
Employment	Housing	Literacy	Hunger	Social integration	Health coverage
Income	Transportation	Language	Access to healthy options	Support systems	Provider availability
Expenses	Safety	Early childhood education		Community engagement	Provider linguistic and cultural competency
Debt	Parks	Vocational training		Discrimination	
Medical bills	Playgrounds	Higher education		Stress	Quality of care
Support	Walkability				
	Zip code / geography				

Health Outcomes

Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations

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KFF

Why SDOH matter in Medicaid programs

Medicaid enrollees are more likely to struggle with basic needs

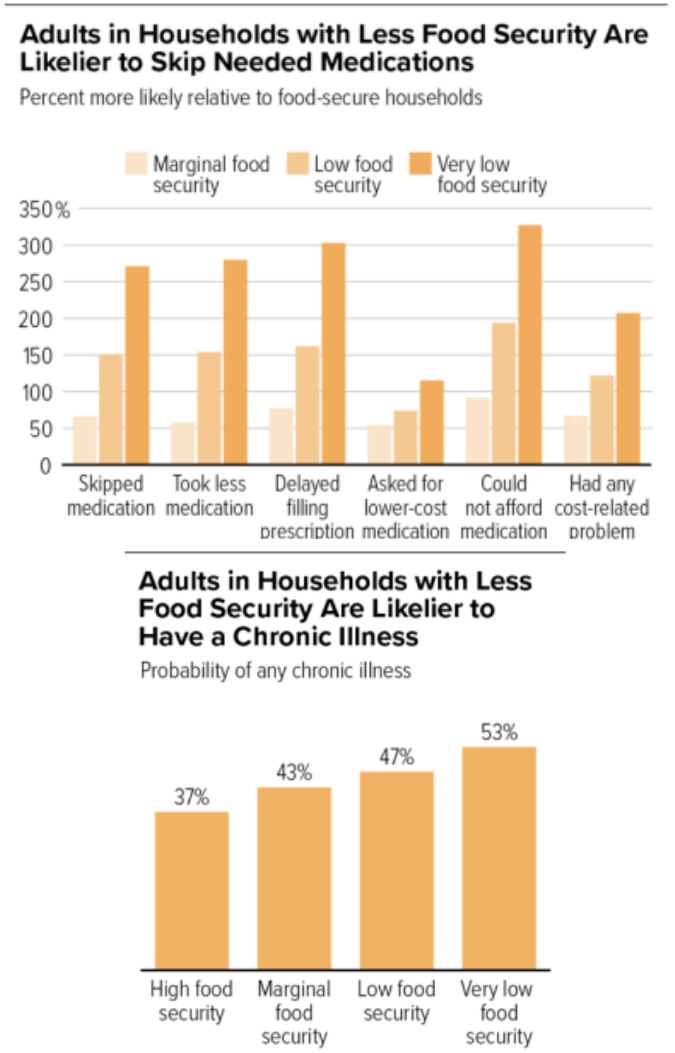
Social Determinant	Impact in the Medicaid Population
Education	Thirty-six percent (36%) of individuals covered by Medicaid have less than a high school education.[13] Low educational levels are associated with an increased risk for major disease, disability, and mortality due to poor health literacy, unhealthy behaviors, income (relationship to poverty status), and other resources tied to income and/or employment.[4,11]
Transportation	Medicaid enrollees may have more difficulty accessing non-emergency transportation to covered services than people who are privately insured (MACPAC 2018).[12] This affects the ability of individuals to obtain routine and preventive care.
Social Context	Low income is often associated with high-stress environments and social interactions. For example, intimate partner violence is linked to a host of physical and behavioral health conditions and is associated with increased morbidity and use of clinical services.[14] Other types of violence may be prevalent in the communities where Medicaid populations reside. Behaviors such as smoking and alcohol/substance misuse, which are linked to chronic disease, are common within Medicaid populations.[13]
Housing Quality and Instability	Low-income individuals live in areas with substandard housing and within communities that do not promote health.[8] Availability of affordable housing affects low-income communities, putting them at or near the brink of homelessness with just one unforeseen financial episode. Approximately 7% of homeless individuals live in rural areas, and many others are at risk of homelessness.[15]
Food Insecurity	The U.S. Department of Agriculture defines "food insecurity" as a reduction in the availability of high-quality food and the variety of food. Also, "food insecurity" refers to the availability of resources to purchase food and the involuntary reduction of food intake.[16] Food insecurity increases the risk of chronic disease and developmental disorders in children.
Poverty	According to the U.S. Census Bureau, the official poverty rate in 2017 was 12.3%, at approximately 40 million individuals. Those with at least a bachelor's degree had the lowest rate of poverty.[17] Poverty is linked to numerous other social risk factors, including housing quality, food insecurity, and education, with their respective impacts on health outcomes. Individuals with low incomes have higher rates of mortality.

Source: Institute for Medicaid Innovation. (2019). "Innovations and Opportunities to Address Social Determinants of Health in Medicaid Managed Care."

Table 1. Types of Housing Instability and Related Health Conditions

Housing Issue	Examples	Related Health Conditions
Homelessness	» Total lack of shelter » Residence in transitional or emergency shelters	» Increased rates of chronic and infectious conditions (e.g., diabetes, asthma, COPD and tuberculosis) » Mental health issues, including depression and elevated stress » Developmental delays in children
Lack of affordable housing	» Severe rent burden » Overcrowding » Eviction or foreclosure » Frequent moves	» Stress, depression and anxiety disorders » Poor self-reported health » Delayed or diminished access to medications and medical care
Poor housing conditions	» Structural issues » Allergens like mold, asbestos or pests » Chemical exposures » Leaks or problems with insulation, heating and cooling	» Asthma or other respiratory issues » Allergic reactions » Lead poisoning, harm to brain development » Other chemical or carcinogenic exposures » Falls and other injuries due to structural issues

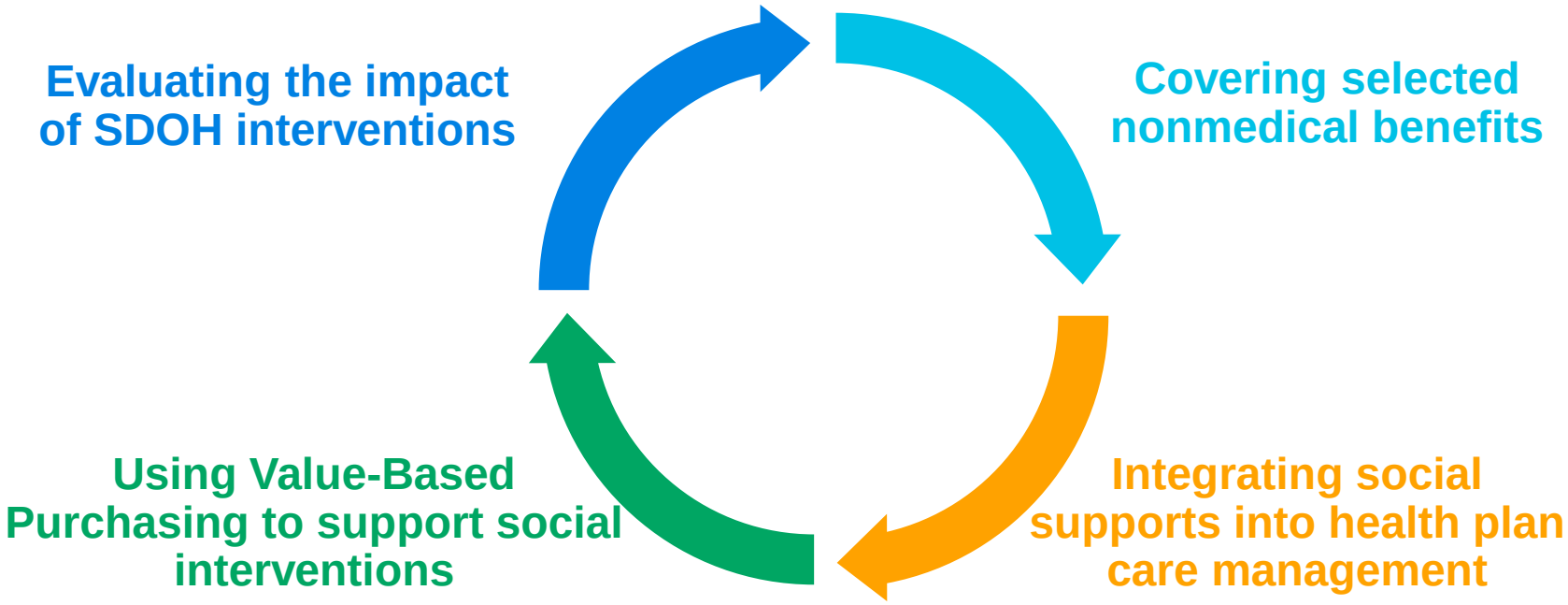
Source: HRET, 2017.



Source: Carlson S, Keith-Jennings B. Center on Budget and Policy Priorities. January 17, 2018.

Considerations for Medicaid programs

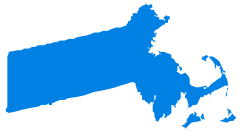
Addressing social determinants of health



Source: RWJF, 2019.

Accounting for SDOH in Value-Based Purchasing

Case studies



Massachusetts

Managed care risk adjustment

- Housing Instability
- Neighborhood Stress Score

Hawaii

Managed care risk adjustment

- Homelessness indicator
- Additive adjustment to risk score

Medicare

Hospital readmissions reduction program

- Proportion of a hospital's patients who are dually eligible

Other program considerations

Linking value to program design

MCO contracting options

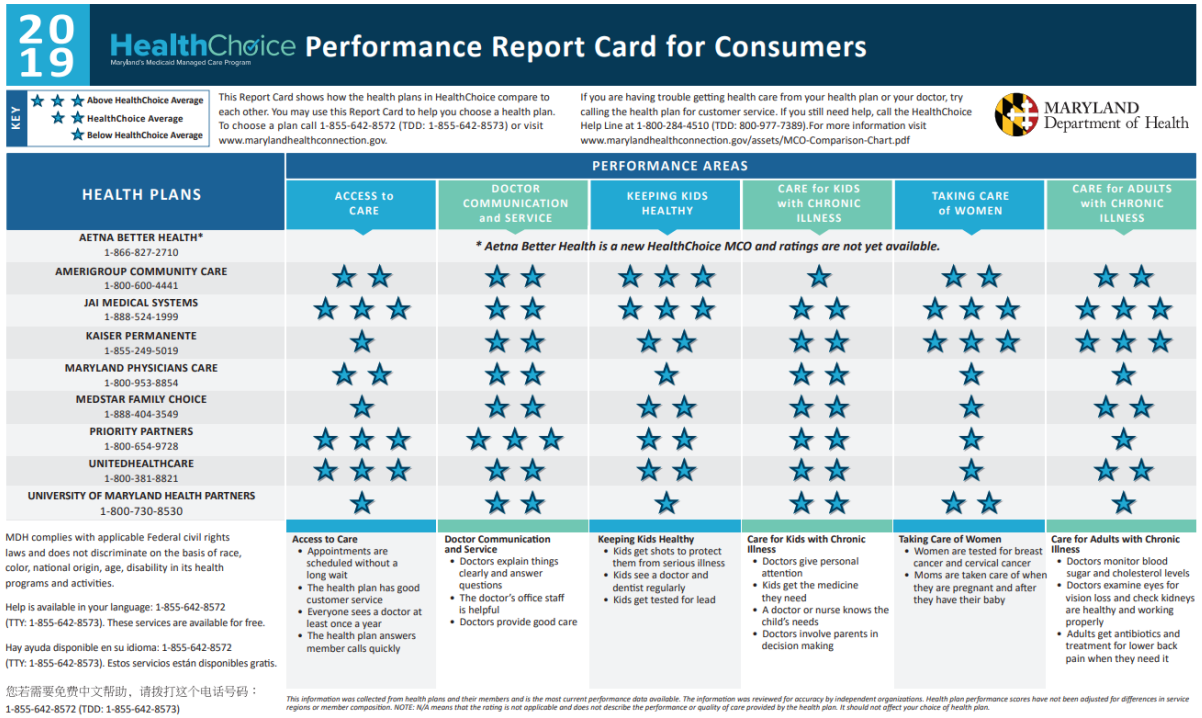
- Network requirements
- Data reporting requirements
- NCQA accreditation
- Set minimum quality ratings for MCOs to keep contracts
  - MCOs can also expand this to create a quality rating system for providers (e.g., Healthfirst in NY)
- Performance Improvement Projects (PIPs)
  - MCOs are federally required to conduct PIPs
  - States can mandate PIPs or add penalties to the PIP goals set by MCOs
- Care management/case management

MCO contracting

Other ways to incentivize MCO quality

- **Auto-assignment logic**
  - Incorporating quality into the auto-assignment logic can reward higher performing MCOs
  - South Carolina:
    - Uses a star ratings system to rank managed care plans
    - Star ratings are shared publicly with new members as they enroll
    - Plans with higher ratings receive a larger share of auto-assigned beneficiaries
- **Consumer report cards**
  - Consumer report cards can be used to steer members to higher performing MCOs
  - May be able to rely on publicly available data, such as NCQA's health insurance plan ratings specific to Medicaid

- Maryland created its own performance report card, ranking all MCOs from 1-3 as follows:



2019 HealthChoice Performance Report Card for Consumers

Maryland's Medicaid Managed Care Program

KEY: ★★★ Above HealthChoice Average; ★★ HealthChoice Average; ★ Below HealthChoice Average

This Report Card shows how the health plans in HealthChoice compare to each other. You may use this Report Card to help you choose a health plan. To choose a plan call 1-855-642-8572 (TDD: 1-855-642-8573) or visit www.marylandhealthconnection.gov.

If you are having trouble getting health care from your health plan or your doctor, try calling the health plan for customer service. If you still need help, call the HealthChoice Help Line at 1-800-284-4510 (TDD: 800-977-7389).For more information visit www.marylandhealthconnection.gov/assets/MCO-Comparison-Chart.pdf

MARYLAND Department of Health

HEALTH PLANS	PERFORMANCE AREAS: ACCESS to CARE	DOCTOR COMMUNICATION and SERVICE	KEEPING KIDS HEALTHY	CARE for KIDS with CHRONIC ILLNESS	TAKING CARE of WOMEN	CARE for ADULTS with CHRONIC ILLNESS
AETNA BETTER HEALTH* 1-866-827-2710	* Aetna Better Health is a new HealthChoice MCO and ratings are not yet available.					
AMERIGROUP COMMUNITY CARE 1-800-600-4441	★★	★★	★★★	★	★★	★★
JAI MEDICAL SYSTEMS 1-888-524-1999	★★★	★★	★★★	★★	★★★	★★★
KAISER PERMANENTE 1-855-249-5019	★	★★	★★	★★	★★★	★★★
MARYLAND PHYSICIANS CARE 1-800-953-8854	★★	★★	★	★★	★	★
MEDSTAR FAMILY CHOICE 1-888-404-3549	★	★★	★★	★★	★	★★
PRIORITY PARTNERS 1-800-654-9728	★★★	★★★	★★	★★	★	★
UNITEDHEALTHCARE 1-800-381-8821	★★★	★★	★★	★★	★	★★
UNIVERSITY OF MARYLAND HEALTH PARTNERS 1-800-730-8530	★	★★	★	★★	★★	★

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Access to Care
- Appointments are scheduled without a long wait
- The health plan has good customer service
- Everyone sees a doctor at least once a year
- The health plan answers member calls quickly

Doctor Communication and Service
- Doctors explain things clearly and answer questions
- The doctor's office staff is helpful
- Doctors provide good care

Keeping Kids Healthy
- Kids get shots to protect them from serious illness
- Kids see a doctor and dentist regularly
- Kids get tested for lead

Care for Kids with Chronic Illness
- Doctors give personal attention
- Kids get the medicine they need
- A doctor or nurse knows the child's needs
- Doctors involve parents in decision making

Taking Care of Women
- Women are tested for breast cancer and cervical cancer
- Moms are taken care of when they are pregnant and after they have their baby

Care for Adults with Chronic Illness
- Doctors monitor blood sugar and cholesterol levels
- Doctors examine eyes for vision loss and check kidneys are healthy and working properly
- Adults get antibiotics and treatment for lower back pain when they need it

This information was collected from health plans and their members and is the most current performance data available. The information was reviewed for accuracy by independent organizations. Health plan performance scores have not been adjusted for differences in service regions or member composition. NOTE: N/A means that the rating is not applicable and does not describe the performance or quality of care provided by the health plan. It should not affect your choice of health plan.

Benefit design

Value in covered services

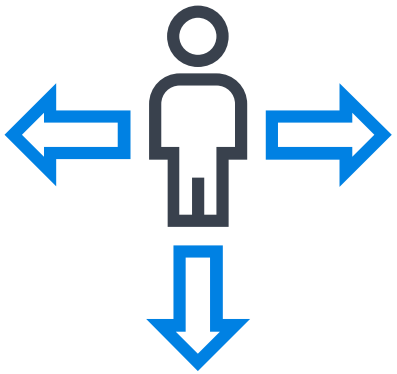
- **Behavioral health service integration**
  - Movement by states to integrate behavioral health and physical health to address patient-centeredness
  - Milliman research indicates savings could reach 3% in Medicaid populations nationally
  - Example:
    - Washington currently integrating all behavioral health and physical health benefits in its Apple Health program
- **Pharmacy services**
  - Whether carved in or out, states can potentially improve value in pharmaceutical services through the use of a state formulary
- **In lieu of services**
  - Can count towards medical costs in the MLRs
  - Provide opportunities for MCOs to cover nontraditional services

Future expectations

Future expectations

Where do we go from here?

- **Value-based payments and state-directed payments**
  - CMS will continue to steer states towards value-based and state-directed payments
  - Will CMS review quality metrics or add stronger requirements for associated quality measures?
- **Program integrity**
  - An increased focus on program integrity will lead to expansion of publicly availability quality metrics
  - Will CMS use its scorecard to evaluate states?
- **Measurement of quality**
  - Increased focus on SDOH, including a potential CMS model for reviewing unmet needs
  - Will new measures evolve to replace the process and outcomes measures currently used?



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Thank you

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