Transforming Medicaid
Lessons from Pioneering States

NCSL's Legislative Conference

Deborah Bachrach
August 20, 2014

Drivers of Reform

Health Care Cost Growth

In fiscal 2011, before implementation of the ACA's Medicaid expansion, Medicaid comprised over 23 percent of total state expenditures.

National Health Expenditures from 1960-2012
**Triple Aim**

- Better Care
- Better Health
- Lower Costs

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**Medicaid Expansion**

Medicaid is broken; Reform comes first.

Expansion requires reform; Reform requires expansion.

- Expansion States
- Non-Expansion States

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**Reform Strategies**
Medicaid is Becoming a Strategic Purchaser

Medicaid: From Funder to Purchaser to Leader

- Medicaid expansion brings the program squarely into health insurance market; concerns regarding sustainability of growing program
- Increased use of managed care, including for ABD populations & more aggressive contracting requirements
- Focus on provider accountability and delivery of integrated services for physical and behavioral health care & social supports
- Alignment of public coverage with private insurance; convergence of Medicaid and the Marketplace

States Approaches to Reform Vary Widely

Transformers
Medicaid program is valued component of insurance system and the state has a vision for improving quality, achieving better health and outcomes and reducing costs. The state is a leader of reform efforts across payers.

Fast Followers
These states are actively testing reforms but do not yet have a comprehensive vision and plan for the program’s future.

Legacy Innovators
These states are pursuing reforms to improve the functioning of their programs. However, they are not approaching Medicaid as an agent of change in the larger insurance market and do not seek to expand Medicaid’s role.

Fiscalists
These States are primarily driven by the need to balance budgets. Reforms, to the extent they are occurring, are less focused on improving the functioning of the Medicaid system and more about reducing costs and/or increasing transparency.

Federal Funding is Supporting Medicaid Reform

- State Innovation Models (SIM): CMS awarded over $300 million in SIM grants to States to support the development of multi-payer payment and delivery system transformation.
- CMMI’s Health Care Innovation Awards (HCIA): provide three-year grants to transform financial and clinical models and test models that improve population health. To date, $2B in funding has been announced.
- 1115 Demonstration Waivers & DSRIP: Several states are pursuing 1115 waivers that include Delivery System Reform Incentive Payment (DSRIP) pools that tie investments in provider-led delivery system reforms to improvements in quality, population health, and cost containment.
- Coverage Expansion: Many states are expanding Medicaid to ensure sustainability of broader delivery system and payment reforms. With expansion, Medicaid becomes the single largest payer.
Twenty-Five States Have Been Awarded SIM Grants

Six States Have Been Awarded DSRIP Funding

A Final Observation
From Medicaid to All-Payer Reform
Attributes of Successful State Transformation Initiatives

- Leadership
- Stakeholder Participation
- Common Principles
- Ambitious but Realistic Reforms
- Use of State Levers to Drive Multi-Payer Reform
- Expanded Coverage
- Funding

Thank you

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Transforming Medicaid:
Lessons
from South Carolina

National Conference of State Legislatures
Legislative Summit
Anthony Keck, Director | August 20, 2014
South Carolina Department of Health and Human Services

Meet Our Current Commitments
• Full enrollment
• Competitive rates
• Robust benefits
• Decreased disability wait lists

Find & Meaningfully Connect
• Hotspot geography, conditions, populations
• Healthy Outcomes
• Healthy Connections Checkup
Fill Service & Financing Gaps

- Handshake strategies
- DSH reform
- ACA waiver in 2017

Health Reform in Arkansas:
Payment Improvement

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UAMS Professor of Medicine and Public Health
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Arkansas is one of six states CMS awarded model-testing grant

- The CMS State Innovation Models (SIM) Initiative is providing funding to the States of Arkansas
  - $42 million in expansion and test this initiative over the next 42 months
  - Funding covers specialty-based care delivery, patient-centered medical homes, and health homes

- The States view this grant as an indication of CMS engagement with the initiative and believe that it could be a model more broadly applied in the country

2011

Developing Vision
Medicaid and private insurers believe paying for patient results, rather than just individual patient services, is the best option to control costs and improve quality.

- Transition to system that financially rewards value and patient outcomes and encourages coordinated care
- Reduce payment levels for all providers regardless of their quality of care or efficiency in managing costs
- Pass growing costs on to consumers through higher premiums, deductibles and co-pays (private payers), or higher taxes (Medicaid)
- Intensify payer intervention in clinical decisions to manage use of expensive services (e.g. through prior authorizations) based on prescriptive clinical guidelines
- Eliminate coverage of expensive services, or eligibility

Payers recognize the value of working together to improve our system, with close involvement from other stakeholders...

Coordinated multi-payer leadership...

- Creates consistent incentives and standardized reporting rules and tools
- Enables change in practice patterns as program applies to many patients
- Generates enough scale to justify investments in new infrastructure and operational models
- Helps motivate patients to play a larger role in their health and health care
The populations that we serve require care falling into three domains:

<table>
<thead>
<tr>
<th>Patient populations within scope (examples)</th>
<th>Care/payment models</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Healthy, at-risk</td>
<td>Population-based: medical homes responsible for care coordination, rewarded for quality, utilization, and savings against total cost of care</td>
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<tr>
<td>• Chronic, e.g., CHF, COPD, Diabetes</td>
<td>Episode-based: retrospective risk sharing with one or more providers, rewarded for quality and savings relative to benchmark cost per episode</td>
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<tr>
<td>• Acute medical, e.g., AMI, CHF, Pneumonia, Acute procedural, e.g., CABG, Hip replacement</td>
<td>Combination of population- and episode-based models: health homes responsible for care coordination; episode-based payment for supportive care services</td>
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<td>• Developmental disabilities</td>
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<td>• Long-term care</td>
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<td>• Severe and persistent mental illness</td>
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</table>

How episodes work for patients and providers (2/2):

1. Outliers removed and adjusted for risk and hospital per diem
2. Cost and quality metrics based on latest and best clinical evidence, nationally recognized clinical guidelines and local considerations
3. Review claims from the performance period to identify a 'Principal Accountable Provider' (PAP) for each episode
4. Compare average costs to predetermined "commendable" and "acceptable" levels
5. Based on results, providers will:
   - Share savings: if average costs below commendable levels and quality targets are met
   - Pay part of excess costs: if average costs are above acceptable level
   - See no change in payment: if average costs are between commendable and acceptable levels
6. PAPs that meet quality standards and have average costs below the commendable threshold will share in savings up to a limit
7. High: Pay portion of excess costs
8. Acceptable: No change in payment to providers
9. Low: Share additional savings as share of savings
10. Pay additional providers as share of savings

Gain sharing limit

Individual providers, in order from highest to lowest average cost
2012 Implementation

For Medicaid, work has occurred on 24 Episodes, with 13 having gone live

<table>
<thead>
<tr>
<th>Episode</th>
<th>Provider Average Episode Cost Per Principal Accountable Provider</th>
<th>Source: Arkansas Medicaid claims paid, SFY10</th>
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</thead>
<tbody>
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Antibiotics prescription rate
- Below episode average
- Above episode average

Gain sharing limit is 2% for all episodes.
Draft ADHD thresholds

![Graph showing ADHD provider cost distribution]

**Average cost per provider**

- Level I acceptable: $7,112
- Level I commendable: $1,211
- Level II gain sharing limit: $1,367
- Level II acceptable: $970
- Level II gain sharing limit: $1,150

1. Each vertical bar represents the average cost and prescription rate for a group of 3 providers, sorted from highest to lowest average cost.

SOURCE: Episodes ending in SFY10, data includes Arkansas Medicaid claims paid FY09 - SFY10.
Rate of Antibiotic Scripts per 100 Valid Episodes

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<th>URI U</th>
<th>URI P</th>
<th>URI S</th>
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<tr>
<td>First 9 months of 2011</td>
<td>48.12635</td>
<td>81.74514</td>
<td>98.99453</td>
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<tr>
<td>First 9 months of 2012</td>
<td>48.75099</td>
<td>78.95943</td>
<td>98.67569</td>
</tr>
<tr>
<td>First 9 months of 2013</td>
<td>39.54913</td>
<td>75.16196</td>
<td>95.91151</td>
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</table>

State unveils health care’s kudos, raps
40% of doctors, clinics kept costs down, to get reward.
Coverage Expansion

“The Private Option”
- Private, Qualified Health Plans to Expand Coverage
  - Integrated, Market Based
  - Gradual Expansion
    - Revising Waiver for Parents Below 17% FPL
    - Pilot Health Savings Account Project
- Designed to Sustain Coverage With Income Fluctuation
  - Reduce “Churn” (~1/3 of Adults Below 200% FPL)
- 225,000 Additional Enrollees to Private Market
- Integration into Payment Reform

Private Option Benefits
- Premium Assistance for Silver Level Policy
  - Cost Sharing Consistent with Medicaid and Marketplace
- 10 Essential Health Benefits (EHBs)
- Medicaid to Provide Additional Coverage
  - Non Emergency Transportation
  - Dental/Vision for 19/20 Year Olds
- One Insurance Card
- Use QHP Coverage Appeals Process
- Auto Assignment if No Selection at Enrollment
Waiver Provisions

- Annual 5% Cap on Cost Sharing
- FQHCs and RHCs Reimbursed at Market Rates as per QHC and Incentives From Payment Improvement
- Premium Assistance Mandatory
- Freedom of Choice Limited to QHP Providers
- Limit Drug Coverage to QHP Formulary
- Drug PA process 72 Hours

Clinical leadership
- Physician "champions" role model change
- Practice leaders (clinical and office) support and enable improvement

Support for providers
- Monthly payments to support care coordination and practice transformation
- Pre-qualified vendors that providers can contract with for
  - Care coordination support
  - Practice transformation support
  - Performance reports and information

Arkansas PCMH strategy centers on three core elements:

- Incentives
  - Gain-sharing
  - Payments tied to meeting quality metrics
  - No downside risk

- Support for providers
  - Pre-qualified vendors that providers can contract with for
    - Care coordination support
    - Practice transformation support
    - Performance reports and information

- Clinical leadership
  - Physician "champions" role model change
  - Practice leaders (clinical and office) support and enable improvement
Providers can then receive support to invest in improvements, as well as incentives to improve quality and cost of care through:

- **Practice support**
  - Invest in primary care to improve quality and cost of care for all beneficiaries through:
    - Care coordination
    - Practice transformation

- **Shared savings**
  - Reward high quality care and cost efficiency by:
    - Focusing on improving quality of care
    - Incentivizing practices to effectively manage growth in costs

**Practice support**

- DHS/DMS will also provide performance reports and patient panel information to enable improvement.

**Shared savings**

- Invest in primary care to improve quality and cost of care for all beneficiaries through:
  - Care coordination
  - Practice transformation

- Reward high quality care and cost efficiency by:
  - Focusing on improving quality of care
  - Incentivizing practices to effectively manage growth in costs

**Activities tracked for practice support payments provide a framework for transformation**

<table>
<thead>
<tr>
<th>Activity</th>
<th>Commit to PCMH</th>
<th>Start your journey</th>
<th>Evolve your practices</th>
<th>Continue to evolve practices</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Identify office leaders for both care coordination and practice transformation</td>
<td>Month 0</td>
<td>Month 3</td>
<td>Month 6</td>
<td>Month 12</td>
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<td>2. Analyze operations of practice and opportunities to improve internal to PCMH</td>
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<tr>
<td>3. Develop strategies to improve care coordination and practice transformation improvements</td>
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<td>4. Identify top 10% of high priority patients needing help</td>
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<td>5. Identify and address medical neighborhood barriers to care coordination</td>
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<td>6. Provide 24/7 access to care</td>
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<td>7. Document approaches to expanding access to care</td>
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<td>8. Complete a short survey related to patients’ ability to receive timely care, appointments, and information from providers (including BH specialists)</td>
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<tr>
<td>9. Document approach to collaborating with hospitals and other providers</td>
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<td>10. Document approach to collaborating with patients who have not received care</td>
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<td>11. Document improvements in healthcare technology or tools that support patient care</td>
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<tr>
<td>12. Join SHARE to get inpatient discharge information from hospitals</td>
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<tr>
<td>13. Integrate EHR into practice workflows</td>
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**Identification of top 10% of high-priority beneficiaries**

- **Updates**
  - Due date for selection of high priority beneficiaries has been extended to Monday, April 7th
  - We have received several questions around the patient panel and beneficiary risk scores which will be discussed in the next section
3 Shared savings will reward eligible entities for performance on quality and cost of care

Providers receive greater of two shared savings methods if they have met performance on quality

A

B

What shared savings could mean for your practice

- Attributed beneficiaries: 6,000
- Risk-adjusted per beneficiary benchmark cost: $2,000
- Practice risk score: 1.0
- 2014 medium cost threshold: $2,032
- Per beneficiary payment: $1,800
- Annual incentive payment: $116
- Risk-adjusted cost of care: $696,000
- Practices must meet performance benchmarks on quality
- Incentive payments are based on the greater of two payment calculation methods
- Model is upside-only, providers do not risk share

Historical analysis (7/1/12-6/30/13) of quality metrics

PCMH historical results on quality metrics1,2

Delta to target, %

Adolescent wellness
Child wellness
Infant wellness
Diabetes
TSH
CHF
Breast cancer
Asthma

2014 Target

Historical results below target
Historical results at or above target

1 Based on 7/1/12 to 6/30/13 historical data; historical results not tied to payment
2 PCMHs with the same delta are represented as a single data point

Quality Measurement

- Administrative vs Clinical Data
- Administrative
  - HbA1C Testing
  - LDL Testing
  - Composite Values
  - Medication Possession Measurement
    - Oral Agents, Statins, Blood Pressure
  - Admission Rates for Short Term Diabetic Complications
Start of New Era?

- New Needs of CME
  - Comparative Effectiveness
  - Value of Therapy to Outcomes
- Coordinating Effective Team for Outcomes
  - Communication Between Providers, Patients
- Payers/Providers Battle Underuse, Overuse
- Effective Prevention
- Complication Avoidance
- Reward Effectiveness

More information on the Payment Improvement Initiative can be found at [www.paymentinitiative.org](http://www.paymentinitiative.org)
- Further detail on the initiative, PAP and portal
- Printable flyers for bulletin boards, staff offices, etc.
- Specific details on all episodes
- Contact information for each payer's support staff
- All previous workgroup materials