Trends in State Medicaid Programs: Emerging Models and Innovations

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Social Security Act Amendments
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Medicaid is a Major and Growing Part of Health Coverage and Spending

Health Coverage, CY 2015

- Medicaid: 70.1 million
- Medicare: 54.3 million
- Employer Sponsored Insurance: 172.4 million
- CHIP: 6.2 million
- Uninsured: 27.3 million
- Other Private (including Marketplaces): 24 million

Health Expenditures, CY 2015

- Medicaid: $531 billion
- Medicare: $669 billion
- Employer Sponsored Insurance: $1,009 billion
- CHIP: $15 billion
- Other Public (including Marketplaces): $398 billion
- Other Private: $91 billion

Total = $2.7 trillion

Affordable Care Act: A New Federal View

• Three-Part Aim for health system reform
  – Better Care – more patient-centered, reliable, accessible, safe
  – Healthy People/Healthy Communities – support proven interventions to address behavioral, social and environmental determinants of health
  – Affordable Care – reduce cost of care for individuals, families, employers, government

• Medicare, Medicaid, the state/federally facilitated Marketplaces and employer-based coverage: a multi-payer view of reform
National Quality Strategy
March 2011

• Roadmap to achieve Three-Part Aim
• Six Priorities:
  – Making care safer
  – Ensuring each person is engaged
  – Promoting effective communication and coordination
  – Promoting most effective prevention, treatment practices
  – Working with communities to promote healthy living
  – Making quality care affordable through new models of care delivery
CMS Quality Strategy

• Includes development of quality measures:
  – Conditions that contribute to the morbidity and mortality of the most Medicare and Medicaid beneficiaries
  – Conditions that represent national public health priorities
  – Conditions that are common to health disparities
  – Conditions that disproportionately drive healthcare costs and could improve
  – Measures that would enable CMS, States, and the provider community to measure quality of care in new dimensions
  – Measures that include patient and/or caregiver engagement
Health Information Technology

- Office of National Coordinator (ONC) for Health Information Technology (HITECH) Strategic Plan

**Vision:** High-quality care, lower costs, healthy population and engaged people

**Mission:** Improve the health and well-being of individuals and communities through the use of technology and health information that is accessible when and where it matters most
ONC Strategic Goals (2015-2020)

1. Advance Person-Centered and Self- Managed Health

2. Transform Health Care Delivery and Community Health

3. Foster Research, Scientific Knowledge and Innovation

4. Enhance the Nation’s HIT Infrastructure
New Models of Care Delivery

• Integrated
  – At the individual level (one treatment plan, a collaborative treatment team)
  – At the provider level (primary, acute, behavioral health, LTSS)
  – At the payer level (Medicare-Medicaid, public-private: to drive incentives to desired outcomes)
  – At the community level (most integrated setting of care for people with chronic and disabling conditions)

• Accountable
  – Reducing cost of care
  – Achieving quality outcomes
Value-Based Purchasing

- Using payment reform tied to quality metrics to drive service delivery reform
  - At the practice level
  - At a system level
- Managed Care Organizations
- Accountable Care Organizations
- Episode of Care Payments
- Shared Savings Arrangements
Concentration of Medicaid Spending

Source: Medicaid Statistical Information System Claims Data for FY 2008
Accelerating Innovation

• Centers for Medicare and Medicaid Innovation
  – Duals Demonstrations: integrate Medicare and Medicaid at state level
  – State Innovation Models funding: big system reforms, multi-payer, value-based payment reforms, PCMH
  – Also supporting transformation at practice level

• Medicaid Section 1115 demonstrations
  – Delivery System Reform Incentive Payment (DSRIP)

• Innovation Acceleration Program (IAP)
  – Substance Use Disorder system improvements
  – Complex Populations

• Section 1332 ACA waivers
Core Principles in Original 1965 Legislation

- State-wideness
- Comparability
- Amount
- Duration
- Scope
- Freedom of Choice (of providers)
- Any Willing Provider
Medicaid – Reinvention Now

Forces driving change:
• Medicaid now larger than Medicare
• Taking precious state resources from other essential public services (e.g., education and public safety)
• Health care cost trends exceed growth in personal income and state revenue
• Recognition that fee-for-service payments are a barrier to cost control and better care
• Fractured service delivery begging for improved coordination and integration
• We aren’t getting the outcomes we want
Current Medicaid Innovation Themes

• Use markets and financing as levers for Medicaid reform
• Reorganize health services delivery systems
• Use Medicaid as a catalyst to reform the larger state health system
• One enduring, immutable truth – every state Medicaid program is different
Markets and Financing

- Use of private market
- Payment reform [i.e., down on volume (FFS) and up with value focused on quality and outcomes]
- Consumerism – engaging and incentivizing the beneficiary in the purchasing process
- Healthy behavior incentives – financial benefits of various kinds for desired health behaviors including services utilization
Use of Private Market

• The Marketplace as the source for health insurance coverage
• Purchase employer sponsored coverage where offered using Medicaid funding
• Creating a Medicaid marketplace (building price into health plan procurement)
• Serious questions about the whether the private market is more cost effective than Medicaid
Private Market States

• Arkansas – Private option
• New Hampshire - used the Marketplace for its ACA expansion in ways that appear to parallel Arkansas; this included exclusion of medically frail beneficiaries
• Montana - would use a TPA and largely access the commercial system (application just submitted on September 15, 2015)
Payment Reform

• Move away from fee-for-service
• Health plan specific incentives for quality and outcomes which assumes a desired level of value-based payments to plan’s providers
• Mandating plans to implement value-based payments to providers
• Value-based payments vary greatly along a continuum – from financial rewards for achievement of specific quality metrics to more global payment mechanisms that entail substantial provider risk
• State special financing is a complication
Payment Reform - continued

• Major infrastructure issues relating to provider organization and data quality
• Assumes organization of providers to manage financial risk and collectively impact quality and outcomes (e.g., ACOs)
• Data and reporting critical for performance measurement
• Risk adjustment is always a challenging issue given very different population profiles for different providers – requires volumes that exceed individual provider’s
Consumerism

• Skin in the game
• HSA-like accounts – educating beneficiaries to contribute to and manage health purchasing
• Beneficiaries as prudent purchasers
• Higher cost sharing to reinforce the cost of health care; serve as a check on utilization
• Value-Based Insurance Design (VBID) as a “clinically nuanced” approach to cost sharing in health insurance (high co-pays for low value services and no co-pays for high value)
Healthy Behavior Rewards/Penalties

• Incentives for engaging in a healthy behavior program - completing a health risk assessment; initiating care with your primary care physician; committing to personal healthy behavior goals
• Financial rewards for effective utilization of health care services (generic drugs; no non-urgent ED use)
• Financial rewards for achievement of healthy behavior goals
• Financial rewards could take the form of lower cost-sharing or a modest gift card (depends on income of beneficiary)
• Penalties for lack of engagement or follow through on healthy behavior program; inappropriate utilization patterns – takes the form of reduced benefits and/or no relief from cost-sharing
Consumerism/Healthy Behavior States

• Healthy Indiana
• Healthy Michigan
• Healthy Iowa
Vertical Alignment

- Payer
- Provider
- Beneficiary
Reorganize the Health Care Delivery System

• Expansion of managed care delivery systems
• Integration of long-term care, behavioral health care and dental care into managed care framework
• Development of Accountable Care Organizations and variants
• Development of health homes and patient-centered medical homes
• Alignment with Medicare and other payers
Extend Service Delivery System

- Recognize and address social determinants of health (everything affects everything)
- Incorporate community health workers
- Coordinate with the human services system addressing housing, nutrition, transportation, and health literacy
- Consider payment for non-traditional services
Medicaid as Catalyst for State Health System Reform

• Oregon – Integrated, coordinated service delivery system
• Vermont – Single-payer its successor
• New York – DSRIP as a catalyst to reduce avoidable hospitalizations through creation of regional Performing Provider Systems that integrate and coordinate care with additional support of behavioral health and other community-based services
• Texas – DSRIP to create Regional Healthcare Partnerships and transition to quality-based payment systems
The Vision for the Coordinated Care Model in Oregon

• Use the state as an active purchaser of health care to drive delivery system reform
• Start with Medicaid and spread the model to public employees and educators through contracting standards
• Then spread to Qualified Health Plans through certification
• At that point, the state will have enough market share to influence the market
Delivery System Redesign: The Coordinated Care Model in Oregon

- Local Accountability & Governance
- Global Budget with Fixed Rate of Per Capita Growth
- Integrated and Coordinated Care
- At Risk for Quality (Metrics)
- Flexibility
Quality Strategy in One State: Being At Risk for Quality (Metrics)

- Statutorily created Metrics & Scoring Committee establishes CCO incentive metrics, benchmarks & improvement goals

- CCO Incentive Measures
  - Annual assessment of performance on 17 incentive measures
  - Quality pool paid to CCOs for performance
  - 3% of global budget held at risk for quality
  - All of the money is distributed every year
  - Currently, measures largely process-based and focused on quality primary care
Quality Strategy: System Supports for Reform

• Recognized support beyond financial incentives necessary for transformation to really occur, so created a Transformation Center office within OHA

• Goal was to increase the rate and spread of transformation in Oregon’s health system
  – Transformation Center’s role is not to be the experts, but to help good ideas travel faster
  – Built a learning network that connects CCOs, providers and communities to each other

• Funded through Oregon’s 1115 waiver as well as its State Innovation Model (SIM) grant
Transformation Center Activities

- CCO Innovator Agents
- Learning Collaboratives
- Support for CACs
- Support Transformation Plans
  - Health System Transformation Fund Grants
- Support Community Health Improvement Plans
- Annual Summit and regional conferences
- Council of Clinical Innovators
- Technical Assistance Bank
Understanding State Medicaid Reform

Because every state Medicaid program is different, every reform initiative will be different. The key to understanding is to answer two fundamental questions:

• What is the core idea and what problem is it solving?
• How is it being paid for?
Considerations for Success of State Medicaid Reform

Given that every state Medicaid program is different, reform initiatives will play out differently in states. Success will depend on various factors.

• Does the State’s history support the reform path?
• Is it a sustainable path?
• Does it meet the triple aim? Improve health, improve health care, reduce costs
State Characteristics to Consider

What are state Medicaid characteristics?

- History in coverage and organization (i.e., MCO and for how long)
- Expansion yes or no
- R or D
- Urban or rural
- Rich or poor
- Financing dependence on provider taxes or IGTs
- Nature of private insurance market
- Primarily non-profit or for-profit health systems
Pace of Change – Hang On