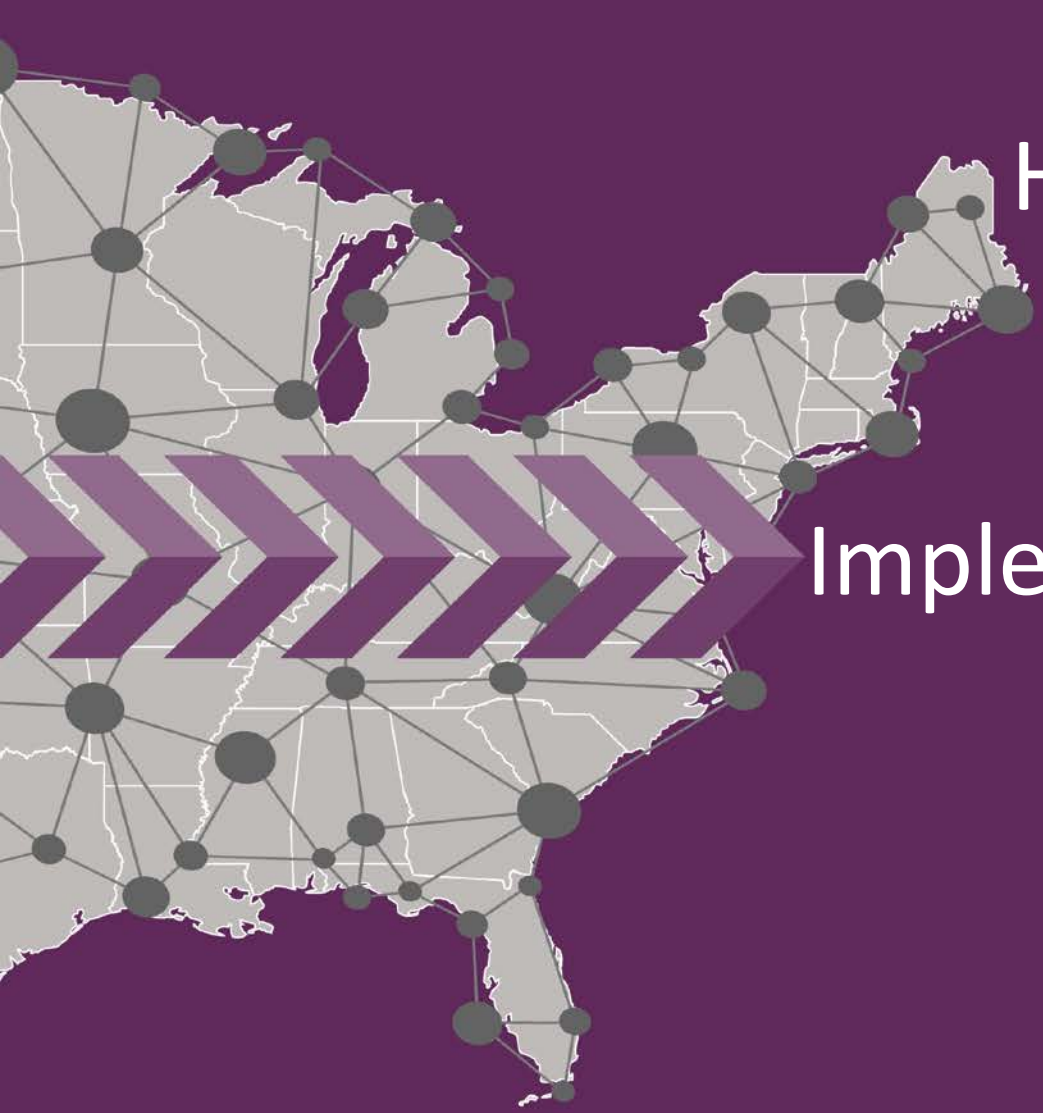

How State Programs are Defining and Tracking MCO Implementation of APMs

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STATE Health & Value STRATEGIES

Driving Innovation Across States

A grantee of the Robert Wood Johnson Foundation

About State Health Value Strategies

State Health and Value Strategies (SHVS) assists states in their efforts to transform health and health care by providing targeted technical assistance to state officials and agencies. The program is a grantee of the Robert Wood Johnson Foundation, led by staff at Princeton University's Woodrow Wilson School of Public and International Affairs. The program connects states with experts and peers to undertake health care transformation initiatives. By engaging state officials, the program provides lessons learned, highlights successful strategies, and brings together states with experts in the field. Learn more at www.shvs.org.

Questions? Email Heather Howard at heatherh@Princeton.edu.

Webinar Presenter:
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Logistics

- This webinar is being recorded.
  - The recording and slides will be available following the webinar.
- Telephone lines will remain muted.
  - We want everyone to be able to hear our presenters!
- Questions can be submitted electronically at any time using the Q&A function.

About Bailit Health

- Bailit Health is a consulting firm founded in 1997.
- We assist states, health plans, employer purchasers, and others with the design and implementation of strategies to improve health care quality and reduce cost growth.
- We offer many services, some of which include:
  - strategic program design for public and private health care purchasers,
  - design and implementation of value-based payment models,
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  - design and facilitation of large-scale multi-stakeholder processes.
- Over the last 21 years, we have supported 35 states and the District of Columbia in this work.
- For more information, visit: http://www.bailit-health.com

Webinar Presenter:

Beth Waldman
Senior Consultant
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State Participants:

- Matt Ferrara, TX Health and Human Services Commission (HHSC)

- Cory King, RI Office of the Health Insurance Commissioner (OHIC)

Issue Brief

- This brief focuses on different ways in which states may set standard APM definitions and reports to track MCO progress toward meeting state goals.

- Released February 6th and available here: www.shvs.org

Overview

- Why are we talking about APM reporting?
- Real-world examples of reporting structures being used by state agencies to assess levels of provider payments that are linked to APMs
- Descriptions from two states about their approach and the successes and challenges they have had in tracking health plan usage of APMs

Why Are We Talking About MCOs and APM Reporting?

- More states are requiring MCOs to increase APM use to motivate and support delivery system reform and reward higher-value providers
- States need to create ways to monitor whether MCOs are meeting these APM requirements and understand challenges

Three approaches to APM Reporting

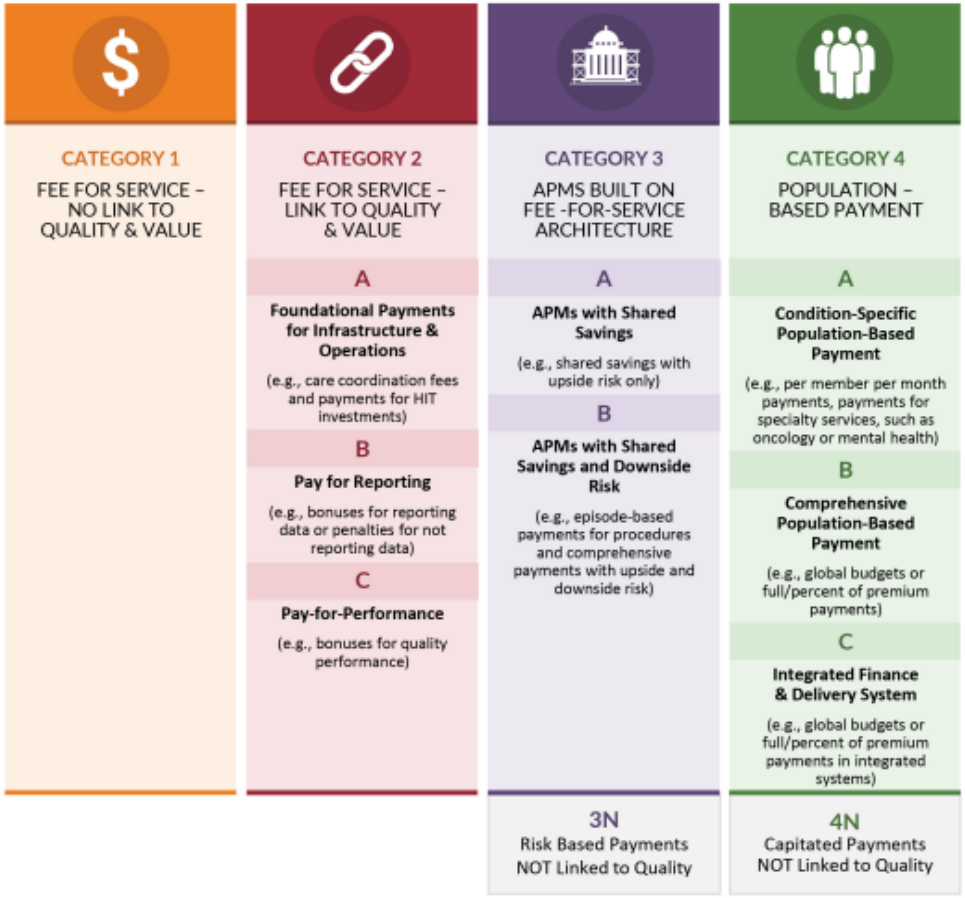
1. Leverage the Health Care Payment and Learning Action Network (LAN) reporting model
2. Utilize Catalyst for Payment Reform's reporting model
3. Develop a state-based approach

Health Care Payment and Learning Action Network (LAN)

- The LAN is a national effort funded by the Centers for Medicare & Medicaid Services (CMS) to accelerate APM adoption.

- The LAN provides guidance, education, and measurement of APMs. Its website is full of resources applicable to state purchasers: https://hcp-lan.org/

LAN APM Framework



- The LAN APM Framework was created by public and private stakeholders as a way of establishing a standardized and nationally accepted method to measure progress toward greater penetration of APMs.

The LAN's Voluntary Reporting Tool

Aggregated Metrics (Comparison between Category 1 and Categories 2-4)				
#	Numerator	Numerator Value	Denominator	Denominator Value
15	Total dollars paid to providers through legacy payments (including FFS without a quality component and DRGs) payments in CY 2016 or most recent 12 months.	0	Total dollars paid to providers (in and out of network) for Medicaid beneficiaries in CY 2016 or most recent 12 months.	0
16	Total dollars paid to providers through payment reforms in Categories 2-4 in CY 2016 or most recent 12 months	0	Total dollars paid to providers (in and out of network) for Medicaid beneficiaries in CY 2016 or most recent 12 months.	0
17	Total dollars paid to providers through payment reforms in Categories 3 and 4 in CY 2016 or most recent 12 months.	0	Total dollars paid to providers (in and out of network) for Medicaid beneficiaries in CY 2016 or most recent 12 months.	0

The LAN Approach

- Measures APM adoption based on percentage of provider payments in each LAN sub-category and aggregates by category
  - Use of dominant APM where overlapping strategies (which happens often!)

How States Have Modified the LAN Tool

- **Michigan DHHS:**
  - Uses the LAN baseline report to measure adoption and progress in APM adoption by Medicaid MCOs, but adds a new tab that measures the amount and percentage of provider payment that rewarded value and was linked to quality ("small numerator").
  - Defines the "dominant" APM as that category with the most potential for payment linked to value

How States Have Modified the LAN Tool

- **Washington HCA:**
  - Conducted a baseline survey of both MCOs and providers based on the LAN
  - Collects information on Medicaid and other product lines
  - Requires regional reporting of APMs (uses the term “VBP”)
  - Requires reporting on number of covered lives included/affected by APM arrangements.

Catalyst for Payment Reform (CPR)

- Developed NY Scorecard to cover commercial and Medicaid markets in NY
- Included five Medicaid reporting domains:
  1. public dollars paid,
  2. APMs used,
  3. members reached by APM activities,
  4. provider participation, and
  5. performance on the all-cause readmission measure
- Currently working on Scorecard 2.0 with three states (Colorado, New Jersey & Virginia)

State-Based Approaches: Massachusetts

- APM reporting across payers
  - Includes Medicare Advantage, Medicaid, and 10 largest commercial insurers
- Narrower definition of APMs
  - Requires some financial risk (global budgets, limited budgets, and episodes)
- Measures % of members (rather than % of provider payments)
- Additional monitoring by Medicaid of APM use by its MCOs
  - Broader definition of APM (shared savings included)
  - Report list of APM contracts and associated providers
  - Total amount paid in absolute dollar and as percentage of premium

State Considerations in Developing an APM Tracking Model

- What is the state's goal in implementing APMs?
  - Is the state focused on the big picture? (e.g., % of provider payments in APMs by 2021)
  - Is the state focused on how APM payments impact providers? (e.g., what percentage of total provider contract is value-based)
  - Is the state focused on particular delivery system models or priority areas? (e.g., increased PCMH, behavioral health integration)
  - Is the state trying to align APM models across payers?

State Considerations in Developing an APM Tracking Model

- How does the state plan to monitor progress towards its ultimate goals of cost savings and improved quality outcomes?
  - Are APMs making a difference in improving the targeted outcomes?
  - Are providers assuming downside risk? Is it meaningful and appropriate?
  - Are there issues with financial stability of providers participating in APMs?

SPOTLIGHT: TEXAS

Texas HHSC

- Uses the LAN categories, but developed its own reporting tool which looks at overall VBP adoption and risk-based VBP adoption
- Requires plans to include narrative regarding approaches and description of proposed or planned VBPs that have not been implemented to date

Early Stages

- Began with assessment of MCO VBP efforts in 2013
- This led to “soft” contract requirements in 2014 –to include data collection
- Data collection efforts evolved as agency’s understanding of what it wanted evolved
- These activities signaled to MCOs generally our direction
- Coupled with one-on-one web meetings with MCOs to discuss progress, opportunities and barriers

Current

- Requirements for MCOs
  - CY2018: 25% of provider payments must be in any kind of VBP. 10% must be risk based VBP
  - CY2021: 50% of provider payments must be in any kind of VBP. 25% must be risk based VBP
  - Dental, 2018: 25% -2%. 2021: 50%-10%
- Final (relative term) version of the data collection tool incorporated into FY18 MCO contracts

Data Collected and How it will be Measured

- For each VBP/APM…
  - Type of APM
  - LAN Category
  - Level of financial risk
  - Program in which it is deployed
  - Provider/service type
  - Estimated number of members impacted
  - Estimated number of Total $ subsumed under VBP/APM

Data Collected and How it will be Measured

- $ Amount of incentive/disincentive portion
- Performance measured utilized in VBP/APM
- Evaluation schedule
- Incentive schedule
- Medical expense (verified with FSRs)
- Include a narrative portion to help confirm the VBP/APM type that helps state agency better understand the models
- Narrative on proposed or future models not yet deployed
- MCO certification
  - Accuracy
  - Encountering by providers
  - Coding of VBP/APM on encounters (financial arrangement code)

Reporting

- July 1st of each year, for previous calendar year
- Calendar year aligned with MCO Pay for Quality (premiums at risk) Program
- PMPM penalties for failure to hit target, with exceptions (exceptional performance on preventable ED visits and hospitalizations)

Measuring Progress

- Targets are the motivator, but not the goal
- Preventable ED visits, inpatient stays, select HEDIS measures within MCO Pay for Quality (premiums at risk) Program , experience of care are the measurements/outcomes we are interested in.

SPOTLIGHT: RHODE ISLAND

Rhode Island Office of the Health Insurance Commissioner – Affordability Standards

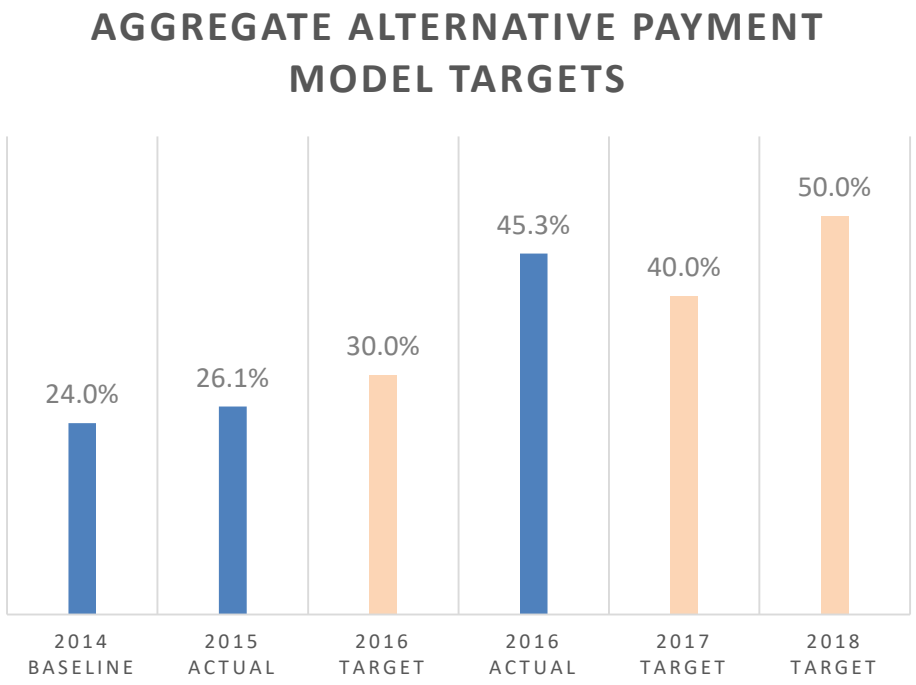
- Beyond the traditional duties of health insurance regulation and oversight, OHIC sets regulatory requirements for commercial insurers that are designed to improve the health care system as a whole.
- OHIC's approach to APM adoption and monitoring has followed a 4-step process.

Step 1.	**Define APMs, review baseline data, and establish targets.**	Achieve buy-in from health care community and settle on a common language and expectations.
Step 2.	**Align polices with Medicaid program and State Innovation Model grant.**	Work toward critical mass in adoption of APMs.
Step 3.	**Develop reporting process for health insurers.**	Review reports with insurers to ensure accuracy and consistency in reporting.
Step 4.	**Build on prior experience and iterate to achieve policy that can react to the dynamics of the market.**	Reconvene stakeholders, reassess policy direction and specify supportive activities for APM adoption.

APM Targets & Compliance Monitoring

OHIC's Affordability Standards call for significant reductions in the use of fee-for-service payment as a payment methodology by commercial insurers.

- **Aggregate APM Target:** Overall 50% of an insurer's annual commercial insured medical spend shall be in the form of APM payments by 2018.
- OHIC also sets a **Non-FFS Target** and a **Risk-Based Contract Target** that utilizes on a definition of "minimum downside risk."
- OHIC convenes its APM Advisory Committee each fall to reassess the targets and to advise the Commissioner on policies supportive of APM adoption.



Questions?

Resources:

Recent Webinar:

- Categorizing Value-Based Payment Models According to the LAN Alternative Payment Model Framework
  - Webinar slides and recording posted here:
  - **https://www.shvs.org/resource/categorizing-value-based-payment-models-according-to-the-lan/**

Two New Issue Briefs:

- Categorizing Value-Based Payment Models According to the LAN Alternative Payment Model Framework
- State Approaches for Defining and Tracking MCO Implementation of APMs

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Thank You

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