State-Based Multi-Payer Initiatives

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avalere.com
Momentum Continuing in 2015: HHS has Announced Goals to Shift Payments from Volume to Value

NEARLY HALF OF ALL FEE-FOR-SERVICE PAYMENTS WILL BE MADE UNDER ALTERNATIVE PAYMENT MODELS BY 2018

**FFS Tied to Quality:** At least a portion of payments vary based on the quality or efficiency of health care delivery (e.g. Hospital VBP, Physician Value-Based Modifier)

**Alternative Payment Models:** Some or all payment linked to effective management of a population or episode of care (e.g. ACOs, medical homes, bundled payment)
CMMI Is Sponsoring Multi-Payer Model Initiatives

**Comprehensive Primary Care Practice Initiative**
- The 4-year demo began in fall 2012 with 497 primary care practices including 2,347 providers serving 315,000 Medicare beneficiaries
- Practices selected based on HIT, recognition for advanced primary care (e.g., by NCQA), and involvement in transformation initiatives
- CMMI pays practices ordinary FFS rates plus $20 in PMPM care management fees in years 1-2 and $15 PMPM in years 3-4
- Practices can also share in any savings achieved with CMMI during years 3-4
- Practices must enter into similar arrangements with other payers (e.g., commercial, Medicaid)

**Multi-Payer Advanced Primary Care Initiative**
- Demonstration began in 2011
- Conducted and coordinated by participating states and includes Medicaid and substantial participation from private health insurers
- Originally planned to be a three-year demonstration in each state
- Pays a monthly care management fee for beneficiaries receiving primary care from advanced primary care practices (APC)
- Each participating state offers APCs community support linkages to state health promotion and disease prevention initiatives

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<thead>
<tr>
<th>State</th>
<th>Practices</th>
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<tr>
<td>CO</td>
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<td>NY</td>
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<td>NJ</td>
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<tr>
<td>OK</td>
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<tr>
<td>OR</td>
<td>67</td>
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<td>OH</td>
<td>61</td>
</tr>
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<td>KY</td>
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NCQA recognizes PCMHs according to three levels. Only those organizations that excel at all six standards are eligible for Level III.
WHAT ARE THE SIM AWARDS?

- Awards for states to design, test, and implement multi-payer health models
- Targets Medicare, Medicaid, and CHIP beneficiaries. CMMI awarded $300 million to 25 states in its first round and over $665 million thus far in its second round. To receive a SIM Award, states must:

Round 1 State Innovation Model Awardees

Model Design Awardees
Convenes stakeholders to create comprehensive State Health Care Innovation Plans

$300 M

Model Pre-Test Awardees
Continues development of State Health Care Innovation Plans

25 States

Model Test Awardees
Implements and tests State Health Care Innovation Plans

1. ttp://innovation.cms.gov/initiatives/state-innovations/
Round 2 State Innovation Model Awardees

Model Design Awardees
Convenes stakeholders to create comprehensive State Health Care Innovation Plans.

Model Pre-Test Awardees
Continues development of State Health Care Innovation Plans

Model Test Awardees
Implements and tests State Health Care Innovation Plans

$665 M

28 States

Additional Model Design Awardees Include: DC, American Samoa, Puerto Rico, and Commonwealth of Northern Mariana Islands
Source: http://innovation.cms.gov/initiatives/state-innovations/
# Notable State-Based Multi-Payer Models: Overview

<table>
<thead>
<tr>
<th>Participating Payers</th>
<th>Payment Model</th>
<th>Quality Standards</th>
<th>Most Notable Trait</th>
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</table>
| Vermont              | • Medicare and Medicaid  
• Three commercial insurers  
• Two self-insured employers (IBM and the state) | • FFS + PMPM Fees  
• Community Health Teams: Paid for by all payers at rate of $350k/yr per 20,000 people served | • Evaluated on 30 nationally endorsed quality measures  
• No homegrown measures | • Emphasis on bolstering primary care practice capacity as well as provide multi-payer financed community health focused supports |
| Michigan             | • Medicare and Medicaid Managed Care  
• BCBSM, BCN, Priority Health | • FFS + PMPM Fees  
• Additional Care Management Codes | • Required accreditation standards  
• Mostly aligned quality measures | • Enhanced support and analysis of multi-payer claims data for providers |
| Arkansas             | • Medicaid and state employees  
• Arkansas BCBS, Centene, and QualChoice of Arkansas | • FFS with retrospective bundle risk/gain for episodes  
• FFS + PMPM with total cost of care gain for PCMH | • Quality performance threshold necessary to share in savings | • Multi-payer shared savings initiative |
| New York             | • Medicare, Medicaid FFS, Medicaid Managed Care  
• Commercial Payers and Self-insured | • FFS + PMPY fees  
• Frequency and methodology of enhanced fees vary by payer | • Common Set of performance and quality measures | • Multi-payer initiative whose impetus is to attract and retain primary care workforce |
| Wisconsin            | • Medicaid, state purchasers, private employers, private health plans | • N/A | • Condensed set of 14 common ambulatory and hospital level measures across payers | • Multi-payer collaboration strictly on quality measurement |
Relative Scope of State-Based Multi-Payer Initiatives

- **Accountable for Quality**
  - WI

- **Accountable for Quality and Offers FFS-Based Payment Incentives**
  - NY
  - MI

- **Value-Based Payments with Quality Thresholds**
  - VT
  - AR

- **Traditional Fee-For-Service**
  - Traditional Fee-For-Service Initiative

- **Volume-Based Initiative**

- **Value-Based Initiative**
Vermont BluePrint for Health

LAUNCHED IN 2006

● **Key Components of Model**
  o Advanced Primary Care Medical (APC) Practices
  o Community Health Teams
  o Risk Stratification and Medicaid Care Coordinators
  o Support and Services at Home (SASH) Teams
  o HIT infrastructure investments

● **Quality Measurement Strategy**
  o List of ~30 nationally endorsed quality measures
  o Emphasis on ease of collection

● **Early Results**
  o By September 2012, 64% of state’s residents and 29% of Medicaid enrollees in APC Practices
  o Reductions in ED use and hospital admissions, but no net savings

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In addition to coordinating payment models, the combined resources afforded by multi-payer collaborations can be used to finance community-based health teams and supports.
Michigan Primary Care Transformation Project
JANUARY 2012-DECEMBER 2014

- Participating Payers
  - Medicare and Medicaid Managed Care Plans
  - BCBS Michigan, Blue Care Network of Michigan, Priority Health

- Payment Methodology
  - Commercial and Medicaid pay FFS + $7.76 PMPM
  - Medicare pays FFS + $9.76 PMPM

- Qualification Standards
  - Practices must be either BCBSM Medical Homes or NCQA Level 2 or 3 PCMHs

- Performance Metrics
  - Semi-annual performance measure sets updated every six months
  - Payers with preexisting incentive programs permitted to retain them

- Michigan Data Collaborative
  - Provides online, dynamic dashboards and reports to physician organizations

Insights gained from multi-payer data and analytics are essential in empowering providers to make informed care delivery changes

2.http://www.med.umich.edu/mdc/
Arkansas Health Care Payment Improvement Initiative

2011-PRESENT

- **Unique Traits About Arkansas**
  - 60% of physicians in practices of 5 or fewer physicians

- **Dual Emphasis**
  - Population-based care delivery
  - Episode-based care delivery

- **Payment Model**
  - PMPM Care Coordination fees
  - Opportunities for Shared Savings

- **Quality Component**
  - Two quality performance thresholds, “commendable” and “acceptable”
  - Only “commendable” providers can share in savings
  - Provides multi-payer analytics to inform care

Multi-Payer Alignment can be reached on ambitious programs holding providers accountable for cost of care

New York: Adirondack Region Medical Home Pilot

JANUARY 2010-DECEMBER 2014

- **Impetus**
  - Crisis in region’s ability to attract and retain PCPs

- **Participating Payers**
  - Medicare, Medicaid FFS, Medicaid Managed Care, Commercial Payers, State Employees

- **Attribution Methodology**
  - Standard Attribution and assignment algorithm for non-HMO plans; PCP assignment for HMO

- **Qualification Standards**
  - Must obtain NCQA Level 2 or Level 3 within 18 months

- **Aligned Set of Quality Metrics**

Multi-Payer initiatives can serve important purposes beyond those outlined by the Triple Aim, such as attracting and retaining strong primary care workforce in rural areas
Wisconsin State Value Committee

ESTABLISHED 2011

- **Goals of State Value Committee**
  - Aimed to align ambulatory and hospital performance measures across public and private payers
  - Started with 200 potential measures
  - After 18 months, selected 14 ambulatory and hospital measures

- **Structure of State Value Committee**
  - 35 representatives from private employers, Medicaid and other state purchasers, providers, health plans, and consumers
  - Leadership Council of 15 voting members
  - Measurement Advisory committee, which reports to Leadership Council

The Wisconsin State Value Committee was successful in coordinating quality measures largely due to strong leadership, its convening of multiple stakeholders and inputs, and dedicated management to sustain day-to-day operations

## Commercial Innovation in Alternative Payment Models

### BCBS-MA’S ALTERNATIVE QUALITY CONTRACT

<table>
<thead>
<tr>
<th>Segment</th>
<th>Description</th>
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<tbody>
<tr>
<td><strong>Global Budget</strong></td>
<td>• Covers all medical expenses for group’s patient population&lt;br&gt;• Set to curb spending growth relative to expected levels&lt;br&gt;• Level of risk varies by contract; most groups share savings and losses with BCBSMA</td>
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<tr>
<td><strong>Performance</strong></td>
<td>• Opportunity for significant incentives based on performance against quality measures&lt;br&gt;• The better a group’s performance, the greater share of any savings-and the smaller share of any losses-the group receives</td>
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<td><strong>Long Term Contract</strong></td>
<td>• 3-5 year contract with fixed spending, quality targets</td>
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<td><strong>Information on Spending, Quality; Regular Clinical Support</strong></td>
<td>• Group Specific reporting and analysis, dedicated support team to review performance and discuss improvement goals and strategies, periodic educational and best-practice sharing forums</td>
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Commercial Innovation in Alternative Payment Models

BCBS-MA’S ALTERNATIVE QUALITY CONTRACT

Average Change in Spending per Enrollee, 2009 AQC Cohort vs. Control Group

- Total: -$62.21
- Evaluation and Management: $3.42
- Procedures: -$17.62
- Imaging: -$10.97
- Tests: -$7.83
- Durable Medical Equipment: -$1.57
- Other: -$5.54

Commercial Innovation in Alternative Payment Models

BCBS-MA’S ALTERNATIVE QUALITY CONTRACT

Average Performance on Outcome Measures, 2009 AQC Cohort vs. Control Group

Key Lessons Learned From The Alternative Quality Contract

- Changing behavior requires providers have “skin in the game,” but payers need to meet them where they are today
- Providers need detailed cost and quality information and clinical support to take on risk
- Payers, either individual payers or multi-payer collaborations, need significant local presence/market share to successfully implement innovation payment models
- Providers can implement meaningful change, but need time, consistent goals, and a similar commitment from payers to do so