HEALTHY CONNECTIONS VALUE CARE PROGRAM UPDATE

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Agenda

- High level overview Healthy Connections Value Care (HCVC) Program
  - Program Requirements
  - Overview Total Cost of Care Model
  - Overview Quality Measures and Methodology
  - Review Program Changes
  - Options for HC PCP’s to participate
- Next steps

Why we need a new payment system

- Current payment system is not sustainable
  - Last year's Medicaid budget exceeded $2.4 billion and next year's is forecast to exceed $2.5 billion
- Medicaid in Idaho needs a better system of care that ties payments to quality
- The Dept. has been working diligently with Idaho hospitals, primary care providers and health plans to build a more accountable Medicaid program
  - Matt Wimmer, Medicaid Administrator - The government alone can only be a part of the solution and we have been working with healthcare providers to share the responsibility for delivering better health at a reasonable price
- Important to move forward "together now" with provide led/collaborative payment reform as movement underway by others to address issue

What is Healthy Connections Value (HCVC) Care?

- HCVC is a value and risk based reimbursement model with a yearend settlement payment based on financial and quality performance
- Goal – Work together under a provider/led collaborative model to improve quality and control costs
- Current payment structure remains in place:
  - Fee for service payments
  - HC PMPM (tier) payments to all HC Clinics

HCVC Program Entities

- Accountable Primary Care Organizations: Primary-care clinic providers who improve total cost of care and quality performance for their attributed Medicaid patients can earn a portion of those savings, or are held accountable for a level of risk.

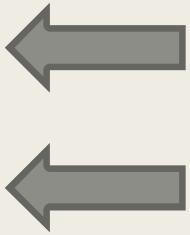
- Accountable Hospital Care Organizations: An integrated network of providers that includes an acute care hospital serving large numbers of Medicaid patients who improve total cost of care and quality performance can earn a portion of those savings, or are held accountable for a level of risk.

HCVC Program General Characteristics

- Contracting entities classified into two categories, Primary Care based Organizations and Hospital based Organizations.
- Value and risk based reimbursement model with a year end settlement payment based on financial and quality performance.
- Financial performance, gain share and loss share based on a Total Cost of Care (TCOC) model.
- Quality performance evaluated primarily on a HEDIS based model
- TCOC calculated on covered lives attributed to the Contracting Entity based on Healthy Connections Service Location PCP assignment.

Year	Accountable Primary Care Organizations	Accountable Hospital Care Organizations
2019 – 2020	- Voluntary Participation - Open to practices with 1,000 lives or more - Participation requires limited risk of existing Primary Care Reimbursement (Healthy Connections payment) - Sharing of savings contingent on performance on quality measures and financial performance - Quality measures developed in collaboration with prospective accountable care partners	- Voluntary Participation - Open to organizations with 10,000 lives or more as attributed through owned or partner primary care - Participation requires transition to budget based reimbursement including limited risk - Sharing of savings contingent on performance on quality measures and financial performance - Quality measures developed in collaboration with prospective accountable care partners
2020 – 2021	- Voluntary Participation - Risk level increases - Quality measures adjusted based on collaborative input from all accountable care partners	- Voluntary Participation - Risk level increases - Quality measures adjusted based on collaborative input from all accountable care partners
2021 – 2022	- Mandatory participation - All primary care providers serving 10,000 members or more must accept an accountable primary care contract - Risk level increases - Quality measures adjusted based on collaborative input from all accountable care partners	- Mandatory – for Hospital system with primary care networks must accept an accountable hospital care contract - Risk level increases - Quality measures adjusted based on collaborative input from all accountable care partners

	Accountable Primary Care	Accountable Hospital Care
Shared Savings	___% of savings Up to ___% of paid claims	___% of savings Up to ___% of paid claims
Shared Losses	____% HC Case Management Payment up to ____% Loss	____% of loss Up to ___% of paid claims
Minimum Quality Gate	Yes	Yes
Quality Measures	Applicable Value Care Measures	Applicable Value Care Measures
PCCM Payment	Same as current	Same as current
Minimum Members	1,000 (excluding duals)	10,000 (excluding duals)
Term of Agreement	3 year	3 year
Stop Loss (annual)	$100,000 per member	$100,000 per member
Member Assignment	Fixed Enrollment HC Process	Fixed Enrollment HC Process
Benchmark Development	HCVC Region	HCVC Region
Community Investment	5% of Shared Savings	5% of Shared Savings



Evolution HCVC Risk Path

- Current Medicaid trend in excess of 7% - not sustainable
- Annual HC Primary Care Case Management Payment - $18 M
  - This payment not effecting trend as anticipated
- Accountable Primary Care Organization risk path:
  - Moving HC Case Management fee to a performance based model
    - In event of loss, % HC Case Management fee at risk
- Accountable Hospital Care Organization risk path:
  - In event of loss, held accountable for a % of actual loss
- Share of Loss TBD and loss share will increase each year of the contract

Healthy Connections Total Cost of Care Formula

- $\frac{\text{2018 Calendar Year Regional PMPM}}{\text{2018 Calendar Year Regional Risk Score}}$ = Standardized Regional PMPM Benchmark
- Standardized Regional PMPM Benchmark X Performance Year (SFY20) VCO Risk Score = VCO Gross Target PMPM Benchmark
- VCO Gross Target PMPM Benchmark - VCO Performance Year (SFY20) Actual Paid PMPM = Gross Savings (Loss) PMPM
- Share of Loss TBD and loss share will increase each year of the contract

Healthy Connections Total Cost of Care Formula cont.

- If Savings, VCO share of Savings TBD but Savings share will increase each year of contract.
- If Savings, VCO Savings will be split equally into an Efficiency Pool and a Quality Pool for Settlement Payout.
- Efficiency Pool distribution will be paid out in full provided a minimum Quality Threshold is met.
- Quality Pool distribution will be based on performance on specific mutually agreed to Value Measures

HCVC – Program Exclusions

Total Cost of Care Exclusions:

- Pharmacy
- Managed Care Products
  (O/P behavioral health, Dental, Non-Emergent Medical Transport)
- Nursing Home & Intermediate Care Facilities
- Long-term Supports & Services

(Home & Community Based Services – AABD & DD Waiver, HCBS, for aged or individuals with disabilities)

Excluded Participants:

- Dual Eligible Participants
- Medicaid Expansion Participants (if it occurs)

EXAMPLE - HCVC Shared Savings

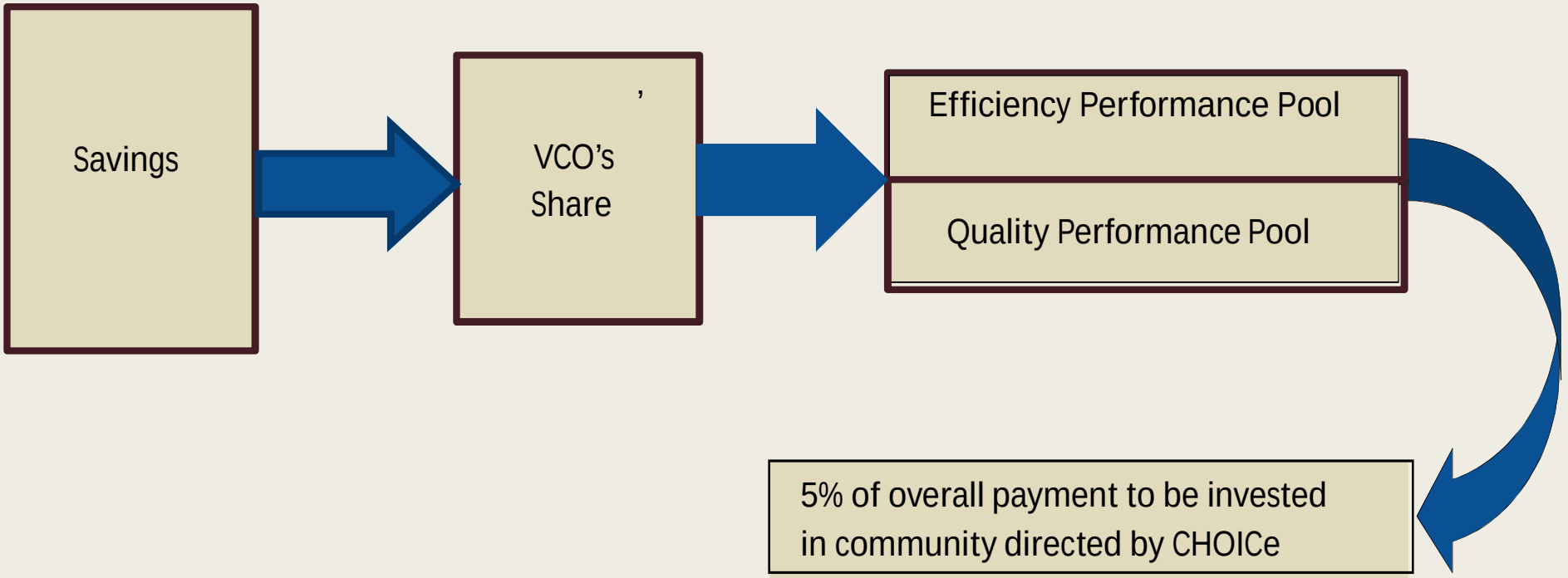
	APCO 1,000 Members	APCO 5,000 Members
VCO Target PMPM - SAMPLE	$275.00	$275.00
VCO Actual Spend PMPM	$265.00	$260.00
Actual Savings	$10.00	$15.00
Potential Savings (- 15% State Administrative Cost)	$8.50	$12.75
Maximum Savings – up to CAP of 5% (multiplied by actual spend)	$13.25	$13.00
Gross Savings	$8.50	$12.75
*Potential annual VCO Savings (Savings x Members x 12 months)	$102,000	$765,000

*VCO's will be obligated to use 5% of their overall shared saving payments to support community health management efforts.

EXAMPLE - HCVC Accountable Primary Care Risk

	1,000 Members Tier II	1,000 Members Tier IV	5,000 Members Tier II	5,000 Members Tier IV
VCO Target PMPM	$225	$225	$225	$225
VCO PMPM Spend	$235	$235	$235	$235
VCO Total Loss (amount x members x 12)	$120,000	$120,000	$600,000	$600,000
VCO Annual PCCM Payment	$40,000	$117,000	$165,000	$585,000
VCO 20% Risk PCCM Payment Cap	$8,000	$23,400	$33,000	$117,000
VCO Loss Cap 10%	$12,000	$12,000	$60,000	$60,000
VCO Risk Payment Amount	$8,000	$12,000	$33,000	$60,000

Value Care Payment Funding breakout



Continuous Improvement: Measure Set and Methodology will Evolve Over Time

- Idaho Medicaid will monitor and review the program's initial measures and methodology, in partnership with stakeholders to:
  - Assess if right combination of measures to incent improvement in quality, access and total cost of care for the Idaho Medicaid population
  - Ensure access is not impacted
  - Align with any shifts in national measure sets such as the Medicare quality programs for providers and hospitals
  - Track other gaps in care and behavioral health measures for future years' measure considerations
- As new measures are identified, it is likely that other measures will be retired from the list, either due to measurement concerns or progress.
- Measures will be updated annually prior to each performance year

Goals of the Value Care Program

- The goals of the program are to incentivize continuous improvement in measured performance areas:
  - Savings to be shared in the event of reduction in total cost of care
  - Efficiency and quality improvement will both be rewarded, each with a portion of the savings and with thresholds for performance payments
    - If no savings in total cost of care; no funding for the performance pools
    - All the organization's applicable measures are included in their performance measurement.
    - For each measure, performance against a baseline will be calculated, with incentive to increase incrementally with higher incremental performance toward a nationally-informed State target.
    - Efficiency performance payments will require at least maintaining quality of care
    - No quality incentive will be paid for performance on a measure that falls beneath its approved improvement target.

Performance Savings Payment Distribution

- A small percentage of the shared savings will be retained by the Department to support the administration of the program and data analytics.

- Of the remaining portion of the savings:
  - One half could be the earned through an “efficiency pool” of dollars which rewards lowering costs as long as quality of care is maintained.
  - The other half can be earned based on their performance on the specific value measures. These are focused on quality improvement and efficiency. This would be the “quality pool” of dollars
  - The participating entities will be obligated to use 5% of their overall shared saving payments to support community health management efforts. Those investments will be directed in partnership with the regional Community Health Outcomes Improvement Councils (CHOICe).

Eligibility for 2019 Value Measure Performance Payments if Savings Available

The 2019 threshold requirements, whether in the Healthy Connections Value Care accountable primary care or the accountable hospital portion will be:

- Demonstrated savings when compared with the previous measurement year
- Have at least 30 assigned participants for a measure to qualify for consideration of that measure
- Maintain baseline on at least 50% of the measures to be eligible for the **efficiency pool** portion of shared savings
- **Quality pool** performance is based on the improvement across the applicable value measures

Performance Improvement Target

- Each VCO's value measure improvement target will be published each year, based on the previous year's performance.
- Aspirational Goal Benchmark
  - State and national benchmarks will be identified for each measure, as available.
  - These benchmarks will be set at the 90th percentile for the state or nationally, whichever is higher.
- Individualized Annual Improvement Target
  - All organizations start from where they are at baseline (calendar year 2018) with annual individual improvement targets from baseline to the aspirational goal.
  - To meet a measure, an organization will need to demonstrate at least a 3% minimum improvement (floor) from their individual baseline. Improvement targets encourage continued, incremental year-over-year improvement toward the statewide benchmark over time.

Improvement Target

The improvement targets are based on the Minnesota Department of Health's Quality Incentive Payment System ("Minnesota method" or "basic formula")*. This method requires at least a 10 percent reduction in the gap between baseline and the aspirational goal benchmark to qualify for incentive payment. Stated as a formula

$$\frac{\text{[State Benchmark] – [VCO Baseline]}}{10} = X$$

Then: **[VCO Baseline] + [X] = Improvement Target**

Example: $\frac{\text{[Well Child State or National Benchmark = 70] – [VCO A's Baseline = 30]}}{10} = 4$

VCO A's Improvement target = Baseline of 30 + 4 = 34

The VCO must meet either the aspirational benchmark of 70% percent **OR** the improvement target of 34% percent to be awarded quality performance payment funds for this measure.

*More info re Minnesota method: http://www.health.state.mn.us/healthreform/measurement/QIPSReport051012final.pdf

Improvement Target must be at least the minimal Floor for Improvement

- A 3% “floor” or a minimum level of improvement is required before a VCO would meet the improvement target and be awarded the quality pool funds associated with that measure.
- If the improvement target calculation for a VCO results in a percent improvement that is less than the floor, the floor takes precedence and is applied instead of the improvement target calculation

Initial calculation* due to minimum floor	Improvement target	New Improvement target
$\frac{[70.0] - [50.6]}{10} = 1.94$	50.6 + 1.94 = 52.94	$50.6 + \frac{3.0}{} = 53.6$

*Based on State’s Aspirational goal = 70%; VCO B’s baseline = 50.6%

What if the adjusted improvement target beats the statewide aspirational target?

Example with the breast cancer screening measure: if the state benchmark is set at 68.0 percent and a VCO has a baseline of 66.7

Initial calculation	Improvement target	New improvement target with floor applied
$\frac{[68.0] - [66.7]}{10} = 0.13$	66.7 + 0.13 = 66.8	66.7 +3 = 69.7

The calculated improvement target (69.7 percent) is higher than the established benchmark (68.0 percent). The VCO must only meet the benchmark of 68.0 percent to be awarded the quality pool funds for this measure. It does not need to meet the calculated improvement target when the improvement target is higher than the benchmark to qualify.

VCO with 13 Applicable Measures Example		
Percentage of targets of Applicable Value Care Measures Met (achieving benchmark or improvement target)	Quality Performance Payment Amount	VCO A: (13 Applicable Measures) Number of Measures to Meet
Met at least 75% of applicable measures	**100%**	**10**
Met at least 70%	80%	9
Met at least 60%	70%	8
Met at least 50%	60%	7
Met at least 45%	55%	6
Met at least 40%	50%	5
Met at least 30%	40%	4
Met at least 20%	30%	3
Met at least 15%	20%	2
Met at least 10%	10%	1
Met no targets	0	0

VCO with 9 Applicable Measures Example		
Percentage of targets of Applicable Value Care Measures Met (achieving benchmark / improvement target)	Quality Performance Payment Amount	VCO A: (9 Applicable Measures) Number of Measures to Meet
Met at least 75% of applicable measures	**100%**	**7**
Met at least 60%	70%	6
Met at least 50%	60%	5
Met at least 40%	50%	4
Met at least 30%	40%	3
Met at least 20%	20%	2
Met at least 10%	10%	1
Met no targets	0	0

VCO with 5 Applicable Measures Example		
Percentage of targets of Applicable Value Care Measures Met (achieving benchmark / improvement target)	Quality Performance Payment Amount	VCO A: (5 Applicable Measures) Number of Measures to Meet
Met at least 75% of applicable measures	**100%**	4
Met at least 60%	75%	3
Met at least 40%	50%	2
Met at least 20%	25%	1
Met no targets	0	0

Healthy Connections Value Measures	Source	IBM Watson #	Endorsed By
(Adult) DIABETES HBA1C TEST indicates whether a patient with type 1 or type 2 diabetes, aged 18 to 75 years, had a hemoglobin A1c test performed. This excludes patients with a diagnosis of gestational diabetes or steroid-induced diabetes.	Claims	93	NQF 57; Owned by NCQA
WELL CHILD VISITS (>5) IN FIRST 15 MOS MCD CHILD indicates the percentage of children, who turned 15 months old, and had more than five well-child visits with a primary care practitioner (PCP) during their first 15 months of life.	Claims	638	NQF 1392; Owned by NCQA
WELL CHILD VISITS AGE 3 TO 6 YEARS MEDICAID CHILD indicates the percentage of children, aged 3 to 6 years, who received one or more well-child visits with a primary care practitioner (PCP) during the measurement year.	Claims	632	NQF 1516; Owned by NCQA
WELL CARE VISITS ADOLESCENTS MEDICAID CHILD indicates the percentage of adolescents, aged 12 to 21 years, who had at least one comprehensive well-care visit with a primary care physician (PCP) or a gynecologist during the measurement year.	Claims	615	HEDIS; Owned by NCQA
INFLUENZA VACCINE indicates whether a Participant, aged 6 months and older, received an influenza vaccination during the latest complete October 1 through March 31 block of time. This excludes people with an allergy to eggs or a previous adverse reaction to the influenza vaccine.	Claims	179	NQF 041
BREAST CANCER SCREENING indicates whether a woman member, aged 52 to 74 years, had a mammogram done from 27 months prior to the measurement period to the end of the measurement period. This excludes women who had a bilateral mastectomy or two unilateral mastectomies.	Claims	90	NQF 2372

Ambulatory Care Emergency Dept Visits Calculates the number of emergency department (ED) visits per 1,000 enrolled months.	Claims	Non-Rule Measure	HEDIS
READMISSIONS WITHIN 30 DAYS AGE 18 TO 64 calculates the percentage of acute inpatient stays during the reporting time period, for patients aged 18 years and older, that were followed by an acute readmission for any diagnosis within 30 days of discharge.	Claims	Non-Rule Measure	NCQA
Elective Delivery - assesses patients with elective vaginal deliveries or elective cesarean births at >= 37 and < 39 weeks of gestation completed.	Reported by VCO	n/a	NQF 469; CDC; Owned by the Joint Commission
Catheter-associated urinary tract infections (CAUTI) Standardized Infection Ratio (SIR) of healthcare-associated, catheter-associated urinary tract infections (UTI) will be calculated among patients in bedded inpatient care locations, except level II or level III neonatal intensive care units (NICU). This includes acute care general hospitals, long-term acute care hospitals, rehabilitation hospitals, oncology hospitals, and behavior health hospitals	Report by VCO	n/a	NQF 138; CDC Steward; Hospital Compare
Clostridium difficile (C-diff) Standardized infection ratio (SIR) and Adjusted Ranking Metric (ARM) of hospital-onset CDI Laboratory-identified events (Lab ID events) among all inpatients in the facility, excluding well-baby nurseries and neonatal intensive care units (NICUs).	Report by VCO	n/a	NQF 1717; NHSN/CDC Steward
H CAHPS (Communication about medication) Before giving you any new medicine, how often did hospital staff tell you what the medicine was for	Report by VCO	n/a	CMS CAHPS Hospital Survey
H CAHPS (Discharge Information) During this hospital stay, did doctors, nurses or other hospital staff talk with you about whether you would have the help you needed when you left the hospital?	Report by VCO	n/a	CMS CAHPS Hospital Survey

DHW will establish two Advisory Groups in each region

- CHOICe (Community Health Outcome Improvement Coalition)
  - Accountable for identifying opportunities to improve health and wellness, create health equity and address the social determinants of health in their communities
  - VCO's will be obligated to use 5% of their overall shared saving payments to support community health management efforts. Those investments will be directed in partnership with CHOICe
- Regional Care Collaboratives
  - Accountable for identifying healthcare needs across the region and seeking collaborations to improve cost, quality, utilization and data sharing.
  - Medical providers who hold value-care contracts
- Advisory Group Management
  - DHW will facilitate the meeting, manage the agenda and establish topics for discussion
  - Advisory groups are non-governing and have no formal legal structure

HCVC – Options to participate

- Organization or Network - You can participate in the Medicaid HCVC program with organizations or networks that you know and trust

- Maintain independent practice status and contract directly with the Department or affiliate with other providers to meet minimum member requirements
  - Must form limited liability legal entity and sign Joint Operating Agreement

- Participate now
  - Important to move forward “together now” with a provider led/collaborative payment reform model, as movement underway by others to address issue
  - Opportunity to be rewarded for PCMH transformation efforts to date

Upcoming Dates

- March – Final HCVC contract available
- March – HC PCP Fixed Enrollment information issued
- April - HC Member Fixed Enrollment notices sent
- March-May – Execution new HC Coordinated Care Agreements
- April 30, 2019 – last day to submit HCVC contract for 7/1/19 go live
- July 1, 2019 – Healthy Connections Value Care & Fixed Enrollment – go live

Next Steps

- E-mail MedicaidValueCare@dhw.Idaho.gov for the following:
  - To provide input on draft HCVC program design
  - To submit your statement of interest to participate effective 7/1/2019
    - Once available, a cost/quality dashboard report will be sent to the clinic
  - To indicate interest in affiliating with other HC Independent providers to participate in HCVC Program
    - View HC Provider Network Listing at www.heatlhyconnections.Idaho.gov

Contact Information

- HCVC Program E-Mail – MedicaidValueCare@dhw.Idaho.gov
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  - Phone (208) 665-8844
- Healthy Connections website www.healthyconnections.Idaho.gov

Thank you, thank you for your time and interest –
YOUR INPUT IN THE FINAL DESIGN PHASE OF THE HCVC PROGRAM IS CRITICAL AS WE MOVE FORWARD TOGETHER TO BUILD A MORE ACCOUNTABLE MEDICAID PROGRAM