2018 Medicaid Program
Moving from Volume to Value

Medical Care Advisory Committee
April 19, 2017
In the US Costs are High, but not Quality

• Healthcare costs in the US are the highest on the planet (248% more per person)

  However

• Outcomes are last for:
  • Life expectancy
  • Infant mortality
  • Percent of population with two or more chronic conditions (aged 65+)
  • ...

How We Pay For Care Is Part Of The Problem

• Fee-for-service payments encourage volume and complexity
• Payments don’t change based on quality or effectiveness
• Physicians make most spending decisions, but have little reason to manage cost
Limitations of our Market-Based Approach

• Markets work best with:

  • Many buyers and sellers

  • Symmetry of information
    (buyers and sellers have equal knowledge)

  • Transparent data for quality and cost
With Healthcare Who is the Buyer?

• The “buyer” functions are jumbled between providers, patients and insurers:
  • Decide a good or service is needed *(Patient)*
  • Understand all available options *(Physician)*
  • Possess enough information to calculate “value” *(No one)*
  • Make a final decision *(Physician / patient)*
  • Pay for the service *(Insurer)*
Limitations of Benefit Design & Utilization Management

• 5% of patients account for 49% of spending (25% account for 83% of spending)

• Most healthcare spending is well above any reasonable deductible level

• Increased “skin-in-the-game” through higher deductibles and co-payments only works for lowest spenders

• Centralized prior-authorization has modest impact
Why a New Payment System is Needed

• Healthcare has become unaffordable
• Our payment system encourages spending
• We generally reimburse treatments, not management or prevention
• The wrong party may be managing resources (should be providers)
• Healthcare providers who lower cost reduce their own income
• We pay the same price for high and low quality
• “Value” (the interaction between quality and price) is not calculated

*To Start Paying For What We Want and Stop Paying For What We Don’t*
2018 Medicaid Program Goals:

• Provider-Based Program
• Lower Total Cost
• Shared Savings & Shared Risk Models
• Pay For Value
• Community Involvement Through Local Advisory Group
Increasing Provider Accountability

Improved Value

Moving From Volume to Value

Increasing Provider Accountability

FFS

PCMH / Shared Savings

Bundled Payments

Shared Risk

Capitation
Healthy Connections Value Care
Three Options For Population Care

• Medicaid participant selects a PCP or one is assigned via attribution
• Medicaid participant assigned a risk score
• Physician elects participation in one of three program tracks:

1. **Regional Care Organization Program**
   Physicians and hospitals join together to create a regional system of care, take on risk and receive rewards for delivering better health.

2. **Patient Centered Medical Home Program**
   PMPM payment options ranging from clinics just starting their transformation to nationally accredited PCMH practices. These providers will contract directly with Medicaid.

3. **Episodes of Care**
   An incentive program for specialists who deliver certain discrete episodes of care
2018 Medicaid Options for Providers

Healthy Connections
- Regional Care
- PCMH
- Episodes of Care

Fee For Service

Managed Care
(O/P Behavioral Health & Dental)
CHOICe Advisory Group
Provider & Community Representation Quality & Cost Focus

Regional Care Organization
*Composed of Providers Who Accept Financial Risk with Idaho Medicaid*

Provider Network
- Hospital
- Primary Care
- Behavioral Health
- Specialist Care
- Other Providers
Healthy Connections Value Care
Settlement & Performance Basics

• Spending budgets established prior to each year
• Annual settlements comparing actual to budget
• Quality thresholds must be met before incentives are paid
• Data sharing through Idaho Health Data Exchange
• Performance metrics supplied by Medicaid with comparisons to regional and statewide data