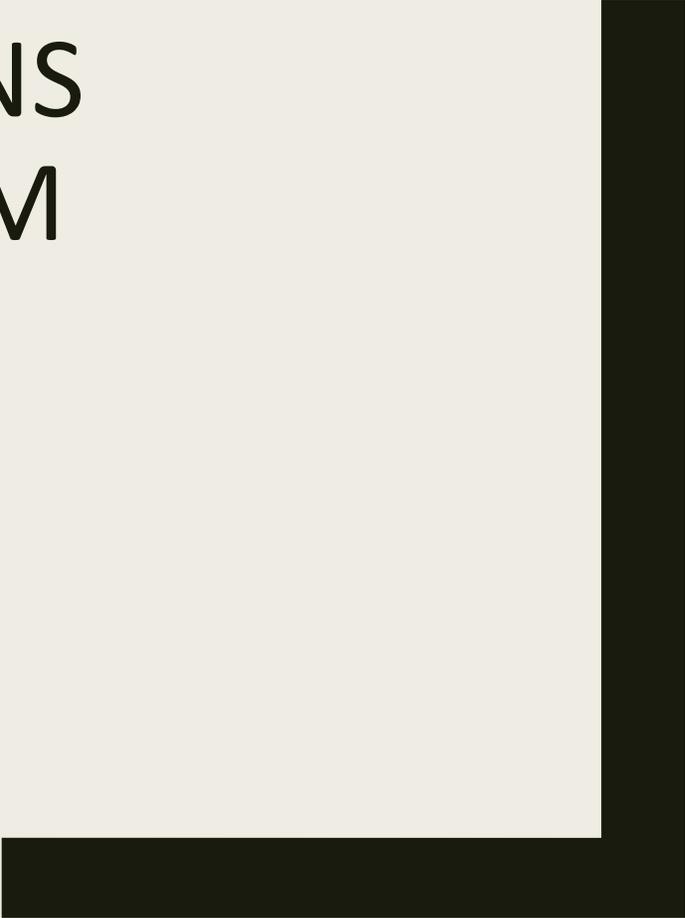




HEALTHY CONNECTIONS  
VALUE CARE PROGRAM

JANUARY 2020



# Why we need a new payment system

- Current payment system is not sustainable
  - *Last year's Medicaid budget exceeded \$2.4 billion and total costs for the Idaho Medicaid program in state fiscal year 2020 will exceed \$2.8 billion.*
  - *Medicaid costs grew by 7% between state fiscal years 2018 to 2019 even while the average number of Medicaid eligible individuals decreased by 4%.*
- Medicaid in Idaho needs a better system of care that ties payments to quality and cost effectiveness
- Goal – Work together under a provider/led collaborative model to improve quality and control costs
  - *The Dept. has been working diligently with Idaho hospitals, primary care providers and health plans to build a more accountable Medicaid program*

# Healthy Connections Value Care (HCVC) Program Entities

Contracting entities or Value Care Organizations (VCO) are classified into two categories:

- ***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 must include 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.

# What is HCVC ?

- HCVC is a value and risk based arrangement incorporated into the current Medicaid program where VCOs are evaluated annually on the basis of quality and cost with the potential to share in program savings or contribute to program losses.
- Current Medicaid program remains in place, health benefits, provider network, authorization process Healthy Connections PCP assignment and management Fee, Physician and hospital fee schedules all remain unchanged
- Only change is that participating VCO hospitals (enrolling as AHCO) will have a modified or eliminated cost settlement for services provided to HCVC participants

# Terms and Conditions

Terms & Conditions	Accountable Primary Care Organization	Accountable Hospital Care Organization
<ul style="list-style-type: none"> <li>➤ Option #1 – Symmetrical minimum required Risk Share</li> <li>➤ Maximum Savings or Risk Share</li> </ul>	<p>Symmetrical Option #1:</p> <p>Year 1: 10% of Savings or Loss</p> <p>Year 2: 15% of Savings or Loss</p> <p>Year 3: 25% of Savings or Loss</p> <p>80%</p>	<p>Symmetrical Option #1:</p> <p>Year 1: 10% of Savings or Loss</p> <p>Year 2: 25% of Savings or Loss</p> <p>Year 3: 50% of Savings or Loss</p> <p>80%</p>
<ul style="list-style-type: none"> <li>➤ Option #2 – Asymmetrical Minimum/Maximum Risk Share</li> </ul>	<p>Year 1: 40% of Savings and 20% Loss</p> <p>Year 2: 40% of Savings and 20% Loss</p> <p>Year 3: Mandatory Option 1 Year 3 terms</p>	<p>Year 1: 40% of Savings and 20% Loss</p> <p>Year 2: 40% of Savings and 20% Loss</p> <p>Year 3: Mandatory Option 1 Year 3 terms</p>
<p>Maximum Savings or Risk Limit</p>	<p>Not to exceed 50% of VCO HC Mgmt. Fee</p>	<p>Not to exceed 15% of VCO Target PMPM</p>

Continued on next page

# Terms and Conditions – Continued

Terms & Conditions	Accountable Primary Care Organization	Accountable Hospital Care Organization
Quality Measures	Applicable Quality Measures	Applicable Quality Measures
PCCM Payment	Same as current	Same as current
Minimum Members	1,000 (excluding duals and Expansion)	10,000 (excluding duals and Expansion)
Term of Agreement	3 year	3 year
Stop Loss (annual) Threshold	\$100,000 per member	\$100,000 per member
Stop Loss Co-payment	20% Co-Payment of amount between \$100,000 and \$500,000. Cost >\$500,000 no co-payment	20% Co-Payment of amount between \$100,000 and \$500,000 Cost >\$500,000 no co-payment
Minimum Savings/Loss Threshold	Performance-Year Savings/Loss must exceed a minimum (TBD.05 – 1.0%) of the Gross Target to trigger VCO's savings or loss	Performance-Year Savings/Loss must exceed a minimum (TBD.05 – 1.0%) of the Gross Target to trigger VCO's savings or loss
Member Attribution	7+ months assigned to VCO	7+ months assigned to VCO
Target Development	Individual	Individual

# HCVC Attribution Model

- Participants will be Attributed to a VCO based on the Participant's Assignment to a VCO-participating Healthy Connections Service Location
- In order for a Participant to be Attributed to a VCO in the Base Year and in a Performance Year, the Participant must be Assigned to the VCO a minimum of seven (7) months.
- Any claim incurred during a month a member is not assigned to any Healthy Connections Service Location will be excluded from the TCOC calculation

## Example: 12 months of Healthy Connections Program eligibility

- 7 months Assigned to VCO 1
- 5 months Assigned to VCO 2

Participant would be Attributed to VCO 1 for the entire 12-month period and all claims would be Attributed to VCO 1 and included in the TCOC calculation.

Assigned – timeframe member is “enrolled” with a Healthy Connection Service Location

Attributed –timeframe a members is “attributed” to a VCO for purposes of calculating the Total Cost of Care

# Healthy Connections Total Cost of Care Formula

- VCO Target - For each year of the three year agreement, the target will be based on the VCO's individual performance for State Fiscal Year (SFY) 2019 and trended forward each year
- Performance Year – First performance year will be State Fiscal Year 2021
- $$\frac{\text{2019 Fiscal Year VCO PMPM}}{\text{2019 Fiscal Year VCO Risk Score}} = \text{Standardized VCO PMPM Target}$$
- $$\text{Standardized VCO PMPM Target} \times \text{*Trend Factor} \times \text{Performance Year (SFY2021) VCO Risk Score} = \text{VCO Gross Target PMPM}$$
- $$\text{VCO Gross Target PMPM} - \text{VCO Performance Year (SFY2021) Actual Paid PMPM} = \text{Gross Savings (Loss) PMPM}$$

\*The **trend** factor will be based on the Milliman Medical Index (MMI) and applied to the Base Year PMPM to trend costs forward in setting the Gross Target PMPM for each Performance Year.

# EXAMPLE – APCO Risk Share

<b>Accountable Primary Care Organization</b>	<b>APCO - Savings 1,000 Members</b>	<b>APCO - Loss 1,000 Members</b>
VCO Target PMPM – SAMPLE	\$275.00	\$275.00
VCO Actual Spend PMPM	\$265.00	\$285.00
Actual Savings/Loss	\$10.00	(\$10.00)
VCO Annual PCCM Payment	\$84,000	\$84,000
Maximum Savings/Loss – up to 50% Annual PCCM Payment	\$42,000	\$42,000
Elected risk share – 25% of savings/loss (Minimum 1 <sup>st</sup> year, 10%)	\$2.50	(\$2.50)
*Potential annual VCO Savings (Savings x Members x 12 months)	\$30,000	(\$30,000)

# EXAMPLE – AHCO Risk Share

<b>Accountable Hospital Care Organization</b>	<b>AHCO - Savings 10,000 Members</b>	<b>AHCO - Loss 10,000 Members</b>
VCO Target PMPM - SAMPLE	\$275.00	\$275.00
VCO Actual Spend PMPM	\$265.00	\$285.00
Actual Savings/Loss	\$10.00	(\$10.00)
Maximum Savings/Loss – up to 15% Target	\$41.25	\$41.25
Elected risk share – 25% of savings/loss (Minimum 1 <sup>st</sup> year, 10%)	\$2.50	(\$2.50)
*Potential annual VCO Savings (Savings x Members x 12 months)	\$300,000	(\$300,000)

# HCVC – Services excluded from TCOC

## 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:

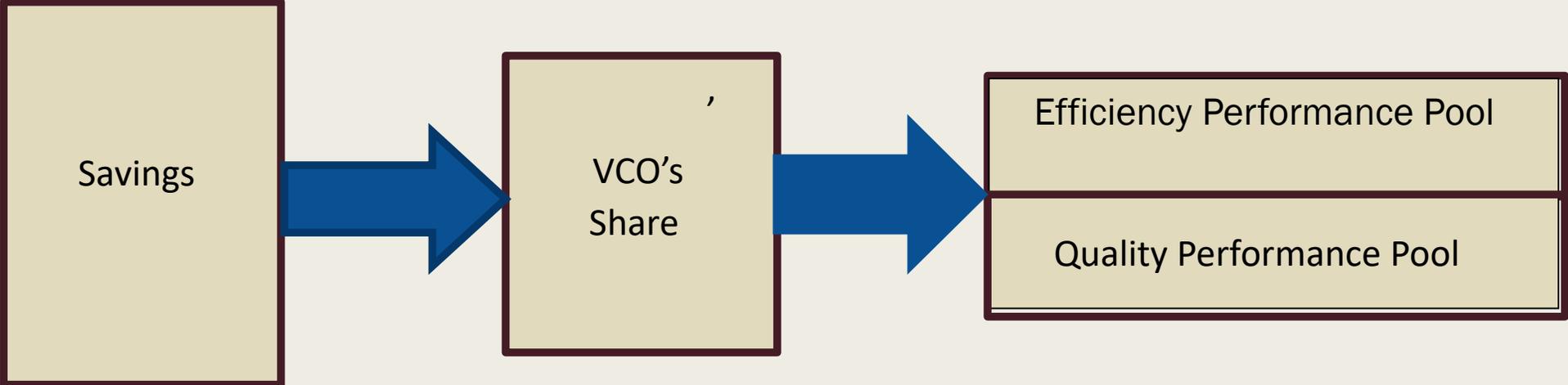
Dual Eligible Participants

Medicaid Expansion Participants

# Evolution HCVC Risk Path

- Current Medicaid trend at 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 savings/loss will be symmetrical and loss share will increase each year of the contract. There will also be a limited option for asymmetrical savings/loss in years 1-2.

# Value Care Payment Funding breakout



# Performance Savings Payment Distribution

- *One half could be 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 through an “**quality pool**” of dollars which is based on their performance on the specific value measures.*

# Eligibility for 2020 Value Measure Performance Payments

- All the organization's applicable measures are included in their performance measurement
- For a measure to be considered "applicable," the VCO must have a minimum of 30 attributed participants qualifying in the denominator
- Maintain baseline on at least 70% of the measures to be eligible for the **efficiency pool** portion of shared savings
  - *Report only Quality Measures are excluded from efficiency pool*
- **Quality pool** performance is based on the improvement across the applicable value measures
  - *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.*

# Performance Improvement Target

- Each VCO's value measure improvement target will be published each year, based on the previous year's performance.
- **Statewide Goal**
  - *State and national benchmarks will be identified for each measure, as available.*
  - *These benchmarks will be set at the 90<sup>th</sup> percentile for the state or nationally, whichever is higher.*
- **Individualized Annual Improvement Target**
  - *All organizations start from where they are at baseline (State fiscal year 2019) with annual individual improvement targets from baseline to the statewide goal.*
  - *To meet a measure, an organization will need to reduce the gap between its baseline and the benchmark by at least 10% or demonstrate at least a 3% minimum improvement (floor) from their individual baseline (whichever is more) as they near the benchmark. 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 statewide goal benchmark to qualify for incentive payment. Stated as a formula

$$\frac{[\text{Statewide Goal}] - [\text{VCO Baseline}]}{10} = X$$

Then:  $[\text{VCO Baseline}] + [X] = \text{Improvement Target}$

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Example:  $\frac{[\text{Well Child State or National Benchmark} = 70] - [\text{VCO A's Baseline} = 30]}{10} = 40$

$$\text{VCO A's Improvement target} = \text{Baseline of } 30 + 4 = 34$$

The VCO must meet either the statewide goal 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/QIPReport051012final.pdf>

## EXAMPLE - HCVC Quality Measure Incremental Improvement- Dashboard

### Overall Summary

Measure	Baseline Score	Incremental Improvement Target	First Year Target	Statewide Goal**
Breast Cancer Screening*	40.0%	3.0%	43.0%	70.3%
Diabetes HbA1c Testing*	87.5%	3.0%	90.5%	91.0%
Wellness Visits (At least 5 by 15 months)	70.3%	3.0%	73.3%	76.9%
Wellness Visits Ages 3 to 6	49.6%	3.3%	52.9%	82.7%
Wellness Visits Adolescents Ages 12 to 21	29.9%	4.2%	34.0%	71.5%

Measures Under Review‡	Baseline Score
30 Day Readmission Rates for Ages 18 to 64	15%
Emergency Department Utilization per 1000 Member Months	47.74

- 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 is higher than the statewide goal, the VCO must only meet the statewide goal to be awarded the quality pool funds for this measure.

## HCVC Quality Measure Statewide Summary - Dashboard

### Statewide Measure Summary

Measure Name		Statewide Score	90th Percentile
Adult HbA1c		87.5%	91.0%
Well-Care 15 Months		70.3%	76.9%
Well-Care 3 to 6		49.6%	82.7%
Well-Care 12 to 21		29.9%	71.5%
Breast Cancer Screening		40.0%	70.3%

This sheet is intended to be informational only. It shows the performance score for the prior period in comparison to the Statewide Average and the National ██████████ 90th percentile.

Measures Under Review		Statewide Score
30 Day Readmission Rates for Ages 18 to 64		8.9%
Emergency Department Utilization per 1000 Member Months		42.77

Healthy Connections Value Measures	Source	HCVC Program	Endorsed By
<b>(Adult) DIABETES HBA1C TEST</b> 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	APCO & AHCO	NQF 57; Owned by NCQA
<b>WELL CHILD VISITS (&gt;5) IN FIRST 15 MOS MCD CHILD</b> 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	APCO & AHCO	NQF 1392; Owned by NCQA
<b>WELL CHILD VISITS AGE 3 TO 6 YEARS MEDICAID CHILD</b> 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	APCO & AHCO	NQF 1516; Owned by NCQA
<b>WELL CARE VISITS ADOLESCENTS MEDICAID CHILD</b> 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	APCO & AHCO	HEDIS; Owned by NCQA
<b>BREAST CANCER SCREENING</b> 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	APCO & AHCO	NQF 2372
<b>Ambulatory Care Emergency Dept Visits</b> Calculates the number of emergency department (ED) visits per 1,000 enrolled months.	Claims	APCO & AHCO	HEDIS
<b>READMISSIONS WITHIN 30 DAYS AGE 18 TO 64</b> 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	APCO & AHCO	NCQA

Healthy Connections Value Measures	Source	HCVC Program	Endorsed By
* <b>Elective Delivery</b> - assesses patients with elective vaginal deliveries or elective cesarean births at $\geq 37$ and $< 39$ weeks of gestation completed.	Reported by VCO	AHCO	NQF 469; CDC; Owned by the Joint Commission
* <b>Catheter-associated urinary tract infections (CAUTI)</b> 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	AHCO	NQF 138; CDC Steward; Hospital Compare
* <b>Clostridium difficile (C-diff)</b> 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	AHCO	NQF 1717; NHSN/CDC Steward
<b>H CAHPS (Communication about medication)</b> Before giving you any new medicine, how often did hospital staff tell you what the medicine was for	Report by VCO	AHCO	CMS CAHPS Hospital Survey
<b>H CAHPS (Discharge Information)</b> 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	AHCO	CMS CAHPS Hospital Survey

\*AHCO's are required to report on the hospital clinical measures (Elective Deliveries, CAUTI & C-diff) to qualify for an incentive payment. The three hospital clinical measures will count as one Value Care Measure

# Quality Measure Performance and Payout

VCO with 7 Applicable Measures Example		
Percentage of targets of Applicable Value Care Measures Met (achieving statewide goal or improvement target)	Quality Performance Payment Amount	VCO A: (7 Applicable Measures) Number of Measures to Meet
<b>Met at least 70% of applicable measures</b>	<b>100%</b>	<b>5</b>
Met at least 60%	80%	4
Met at least 45%	60%	3
Met at least 30%	40%	2
Met at least 15%	20%	1
Met no targets	0	0

# Quality Measure Performance and Payout

VCO with 10 Applicable Measures Example		
Percentage of targets of Applicable Value Care Measures Met (achieving statewide goal or improvement target)	Quality Performance Payment Amount	VCO A: (10 Applicable Measures) Number of Measures to Meet
Met at least 70% of applicable measures	100%	7
Met at least 60%	86%	6
Met at least 50%	71%	5
Met at last 40%	57%	4
Met at least 30%	43%	3
Met at least 20%	29%	2
Met at least 10%	14%	1
Met no targets	0	0

# DHW will establish two Advisory Groups

- **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
  - CHOICe Advisory Groups will be considered that currently exist regionally and meet the noted objectives and goals.
- **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**
  - Advisory groups are non-governing and have no formal legal structure

# HCVC – Options to Participate

- **Accountable Primary Care Organization (Minimum 1,000 assigned lives)**
  - Contract directly with the Dept.
  - Contract with a network
  - Partner with other Primary Care Organizations to meet the minimum requirements Maintain independent practice status
    - Must form limited liability legal entity and sign Joint Operating Agreement
- **Accountable Hospital Care Organization (Minimum 10,000 assigned lives)**
  - Contract directly with the Department
- **Healthy Connections Organizations**
  - Remain contracted directly with the Dept. as a Healthy Connections Provider and not participate in the HCVC Program

# HCVC – Timeline

- January 15, 2020 – Estimated target PMPM data available
- February 10, 2020 – Final HCVC Contract Due Date
  - To include designation of affiliated Healthy Connections Service Locations
- July 1, 2020 – GO LIVE

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