2018 Medicaid Program
Moving from Volume to Value

Medical Care Advisory Committee

April 19, 2017

IDAHO DEPARTMENT OF HEALTH & WELFARE

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

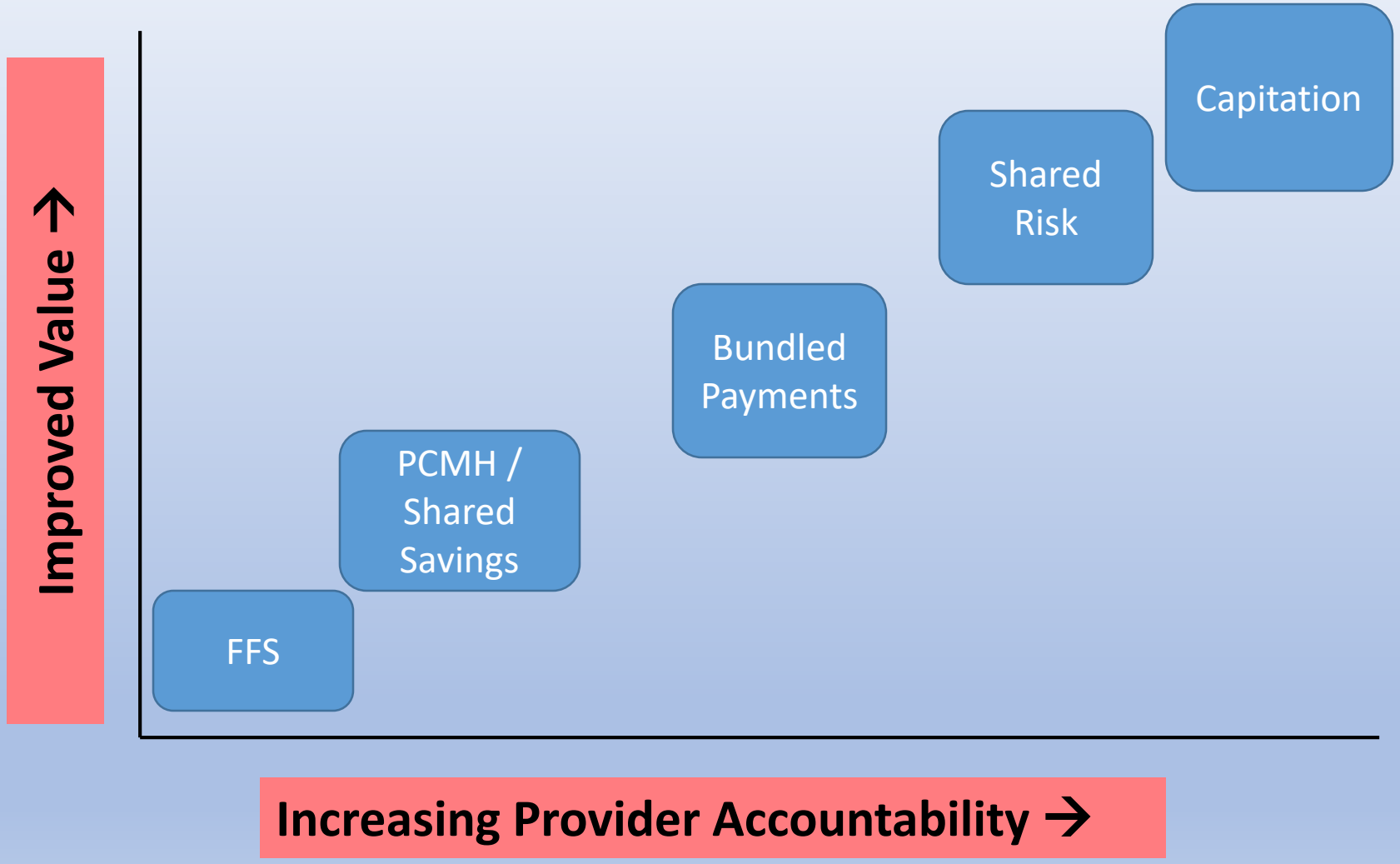
- Healthcare has become unaffordable
- Our payment system encourages spending
- We generally reimburse treatments, not management or prevention
- The wrong party may be managing resources (should be providers)
- Healthcare providers who lower cost reduce their own income
- We pay the same price for high 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

Moving From Volume to Value



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

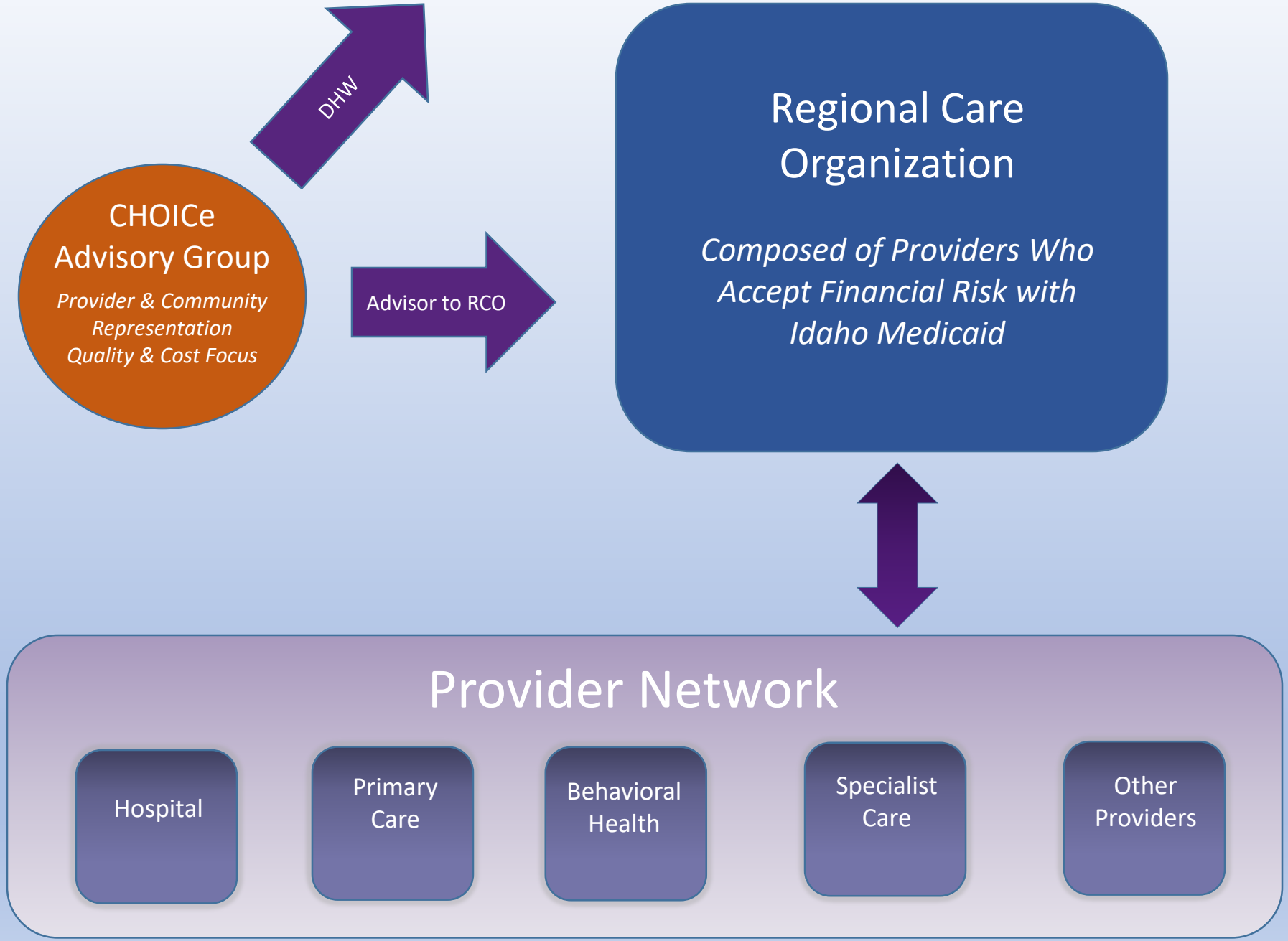
Healthy Connections

- Regional Care
- PCMH
- Episodes of Care

Fee For Service

Managed Care

(O/P Behavioral Health & Dental


DHW
CHOICe Advisory Group
Provider & Community Representation
Quality & Cost Focus
Advisor to RCO
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