



## **REQUEST FOR INFORMATION**

**Issue date:** November 22, 2019

**Closing date:** January 3<sup>rd</sup>, 2020

**Subject:** Value-Based Purchasing for Idaho Medicaid

### **I. Introduction**

The Idaho Department of Health and Welfare (IDHW), Division of Medicaid is requesting information related to continuing to transform the Idaho Medicaid program from one that pays for the volume of services delivered to one that pays for value by incenting and rewarding positive health outcomes for our participants. This is a request for information only, not a solicitation. No award will be made based upon the information received from this Request for Information (RFI).

Information obtained from responses to this RFI may be used to identify options and refine requirements for future Value-Based Purchasing (VBP) opportunities, including potential Requests for Proposal (RFPs); to design health system program improvements; to assist in projecting budget or savings opportunities for implementing new VBP options; and to identify potential providers and vendors who may be interested in participating in new or existing VBP models and/or submitting a future competitive proposal.

## II. Background

In recent years, Idaho has been making measured progress in transforming its health care system, including Medicaid, away from traditional volume-based payments to value-based payments that support positive participant health outcomes and cost savings. The need to move toward VBP is recognized and supported nationally and it is generally accepted that the fee-for-service payment model leads to fragmented care rather than patient-centered, whole-person care.

In 2014, Idaho received a 4-year, \$40 million federal transformation grant to implement its Statewide Healthcare Innovation Plan (SHIP) focused, in part, on transforming primary care practices across the state into patient-centered medical homes. These efforts have led to some significant successes. In 2019, Idaho Medicaid has a high performing primary care system by many measures. For example:

- Over 90% of primary care providers licensed in the state are enrolled to provide services to Medicaid participants.
- Well-developed processes connect participants with a Healthy Connections primary care provider as their usual source of care. More than 70% of participants proactively choose their providers while the remainder are assigned (with the ability to change to a different provider upon request).
- Tiered primary care case management payment system based on participant health acuity and provider status as a recognized primary care medical home. Since the inception of the Healthy Connections Patient-Centered Medical Home Tier Program, the number of participants served in a Tier III or IV clinic, providing care coordination, has increased from 24% to 64% (approximately 150,000 participants).

Even with these successes, Idaho has not realized the expected increases in quality outcomes and decreases in utilization of high cost services envisioned for the Healthy Connections program. Instead, like many other state Medicaid programs, commercial insurance plans and Medicare, Idaho faces unsustainable health care cost growth.

Medicaid spending grew 7% from state fiscal year 2018 (7/2017 – 6/2018) to state fiscal year 2019 (7/2018 – 6/2019). Over the same period the average number of Medicaid eligible individuals decreased by 11,000 people, or 4%. The total cost for the Medicaid program in state fiscal year 2020 will exceed \$2.8 billion. With the increasing cost of healthcare, an aging population, and a voter-approved ballot initiative for Medicaid expansion, Idaho has an immediate need for reform to control costs without reducing quality of care.

Leadership from IDHW have recognized this need and have been collaborating with Idaho hospitals, primary care providers, and health plans to build a more accountable Medicaid program. Together these groups have identified an accountable Medicaid program as one that identifies clearly defined priority health outcomes and targets for improvement. It is proactive with respect to its budget and has reasonable targets for growth. It knows what outcomes it is paying for and welcomes responsibility for delivering on its goals. It recognizes that government and health care providers must work collaboratively to share responsibility for delivering better health at a reasonable price.

**Ultimately, the goal is that all partners participating in the Idaho Medicaid program will have both incentives and disincentives related to health outcomes and targeted cost trends.**

### III. Guiding Principles for VBP Transformation

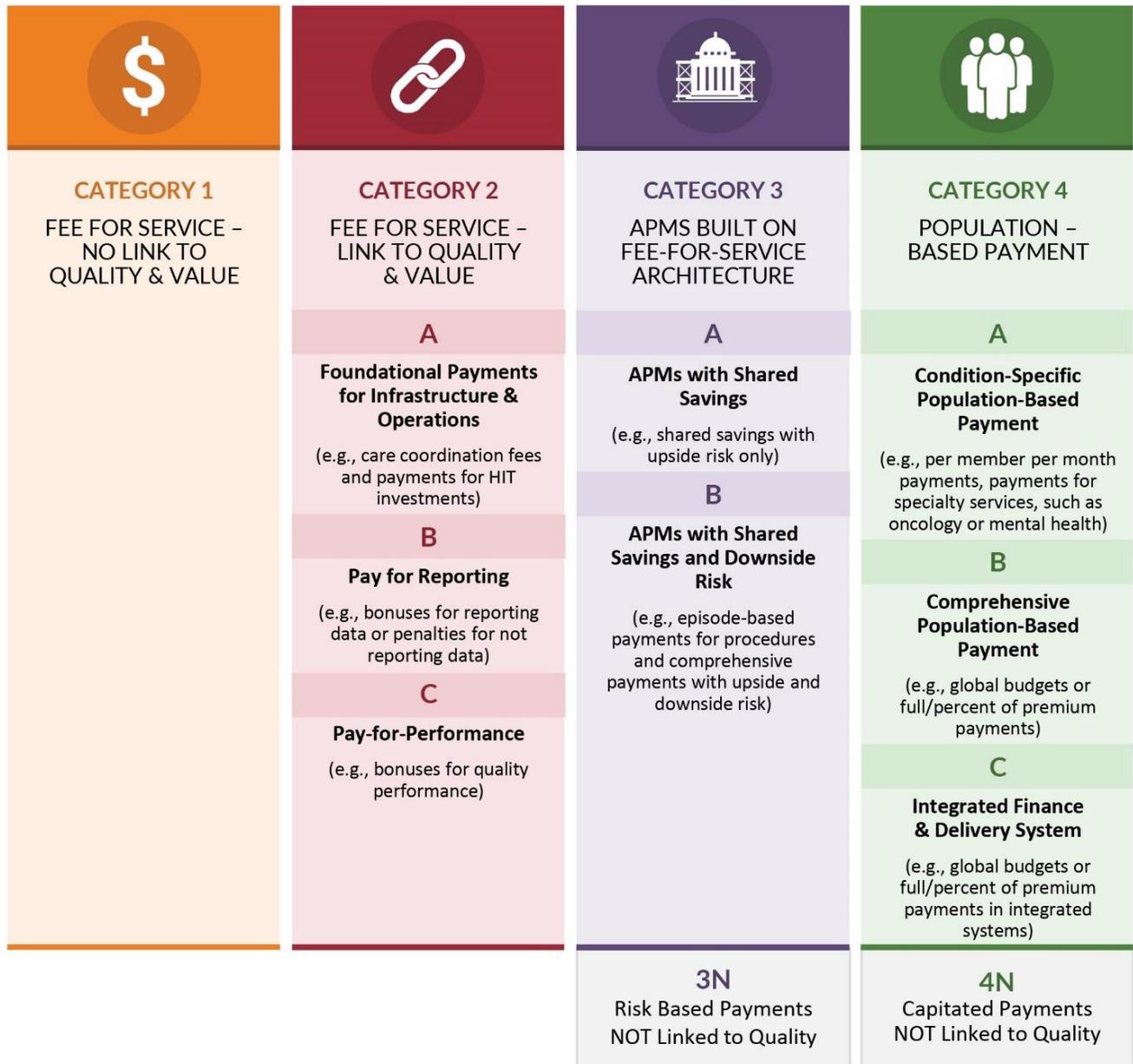
As Idaho Medicaid considers, develops, approves, tests, and implements new strategies for VBP, it plans to use a set of agreed upon principles to guide the decision-making process. Under consideration for these guiding principles are the following:

- A. Deliver to the triple aim of better care for participants, better health for communities, and lower costs.
- B. Patient-centered care that is highly coordinated. Empower participants, their families, and caregivers to take ownership of their health and ensure they have the flexibility and information to make choices as they seek care.
- C. Provider choice and incentives. Prioritize voluntary models that reduce burdensome requirements and unnecessary regulations to allow providers to focus on providing high-quality health care to participants while still assuring accountability for the use of limited health care dollars.
- D. Promote choice and competition in the market based on quality, outcomes, and costs.
- E. Transparent model and pricing design and data-driven evaluation. Draw on partnerships and collaborations with stakeholders and communities to harness ideas from a broad range of organizations and individuals across the state to address both local and statewide health priorities to advance population health.

## IV. Existing and Potential VBP Models

The Health Care Payment Learning and Action Network (HCP-LAN or LAN) has developed the following framework to describe payment approaches currently in use for health care purchasing. As you move from left to right on the framework, the linkage between the payment and the value and quality associated with that purchase increases. Several states and commercial plans are currently using this framework to guide their transformation to value based purchasing.

### Alternative Payment Models (APM) Framework



It is important to recognize that the framework is focused very specifically on payments to providers, and not to health plans. Most payments to providers made by Idaho Medicaid or through one of its managed care organizations do not have a direct linkage between the payment and the quality or outcome of the service and fall in the Category 1 column. Idaho is like most states across the country in that respect.

Also like many states, Idaho does structure managed care contracts to incentivize quality at the plan level but does not require plans to involve providers in value-based payment arrangements. Most of Idaho's managed care payments fall into category 4N under the framework for those reasons, although some managed care plans have begun to explore value-based payments at the provider level.

Idaho does operate some programs, with value-based payments currently in place or in development. In addition, Idaho has an opportunity to consider and develop additional strategies that are being implemented in other states.

For example:

**A. Foundational Payments for Infrastructure and Operations (LAN category 2A)**

The Healthy Connections Primary Care Case Management program pays primary care providers a monthly management fee for each participant enrolled with the practice. The amount of the monthly payment varies based on the health conditions of participants served and the level of access and Patient-Centered Medical Home recognition achieved by the practice. More information available at: [www.healthyconnections.idaho.gov](http://www.healthyconnections.idaho.gov).

**B. Pay for Reporting (LAN category 2B)**

Some states have structured payments to incentivize providers for reporting quality data without any link to actual performance. Idaho explored this approach under its Health Homes program before transitioning efforts to its patient centered medical home program and the Healthy Connections Value Care program described below.

**C. Pay for Performance (LAN category 2C)**

This payment strategy incentivizes providers for performance on quality outcomes. Providers may alternatively or additionally be penalized for poor performance. This value-based payment strategy ties payment to quality only and not to the cost of care.

**D. Bundled Payments for the Comprehensive Treatment of Specific Procedures (LAN category 3A)**

Some states have structured payments to providers that include responsibility for the total cost and quality of care for a given procedure or limited aspect of care (such as births or orthopedic procedures) or for a given condition, such as diabetes or cancer care. These models are adaptable to fee for service or managed care approaches and offer options that can be targeted to specific needs.

### **E. Alternative Payment Model with both Shared Savings and Downside Risk (LAN category 3B)**

This value-based strategy rewards providers by sharing a portion of the savings they generate against a cost target or by meeting utilization targets, if quality targets are met. Additionally, payers recoup from providers a portion of the losses that result when cost or utilization targets are not met.

Idaho Medicaid has invested in this strategy under its Healthy Connections Value Care (HCVC) Program. It will reward providers who reduce cost while maintaining or improving quality and holds providers financially accountable when they do not. In 2020, Idaho Medicaid will begin voluntarily enrolling Value Care Organizations (VCOs) in the HCVC Program. A VCO is defined as:

- Accountable Primary Care Organizations (APCO): Primary care clinic(s) enrolled as Healthy Connections providers serving at least 1,000 qualifying Medicaid participants assigned to the participating VCO's primary care clinic(s).
- Accountable Hospital Care Organizations (AHCO): An integrated network of primary care clinic(s), enrolled as Healthy Connections providers serving at least 10,000 qualifying Medicaid participants assigned to the participating VCO's primary care clinic(s), and at least one participating acute care hospital.

Idaho Medicaid will set an annual risk-adjusted cost target for each participating VCO. VCOs that successfully reduce costs during the annual performance period compared to their Per Member Per Month (PMPM) cost targets (i.e., what Medicaid would have spent without the HCVC program), while maintaining or improving quality outcomes, will be eligible to receive a portion of the savings through an incentive payment. Any VCOs that exceed their PMPM cost targets will be subject to repay the Department a portion of the additional costs. More information available at: [www.healthyconnections.idaho.gov](http://www.healthyconnections.idaho.gov).

### **F. Risk-Based Payments Not Linked to Quality (LAN category 3N)**

These arrangements pay providers a set amount but do not have any tie to quality or efficiency. Many existing provider payments fall into this category.

### **G. Condition-Specific Population-Based Payments (LAN category 4A)**

This value-based payment approach includes bundled payments for the comprehensive treatment of specific conditions as well as prospective, population-based payments covering all care delivered by a type of provider, such as primary care providers or obstetricians/gynecologists.

### **H. Comprehensive Population-Based Payments (LAN category 4B)**

This value-based payment strategy involves prospective, population-based provider payments covering all of a person's health care needs. This approach is similar to at-risk managed care approaches that pay managed care organizations a global payment for all covered participants in exchange for coordinating, delivering, and monitoring covered health care benefits, but directly pays providers rather than managed care organizations. While these arrangements have been in place for many years, many states currently using Medicaid managed care have established only a loose connection between the payments and the value and quality of the services being delivered. Numerous states have established value-based payment targets for their managed care plans or are actively working on initiatives that will improve that linkage.

Idaho Medicaid Plus<sup>1</sup> is a managed care program for Medicaid participants eligible for both Medicare and Medicaid. Both plans participating in Idaho Medicaid Plus are committed to value-based payment and will be expanding their efforts in future years. One of the plans already pays out a significant percentage of its provider payments through value-based arrangements that reward providers for achieving quality goals and managing the total cost of care for their members.

**I. Integrated Finance and Delivery System (LAN category 4C)**

Under this strategy finance and healthcare delivery are managed through a single organization to control costs and quality. Sometimes these integrated arrangements consist of insurance companies that own provider networks, while in other cases they involve delivery systems that offer their own insurance products.

**J. Capitated Payments Not Linked to Quality (LAN category 4N)**

The Idaho Behavioral Health Plan, the Idaho Smiles dental benefits plan, and the Idaho non-emergency medical transportation brokerage are all provided under capitated arrangements with managed care or brokerage organizations. Idaho Medicaid pays these organizations a set amount per participant every month. In return, they are responsible for paying for services delivered by providers for those participants under their contract terms. While payment varies based on defined quality measures for all these programs, the LAN framework is specific to payments to providers, not to managed care organizations.

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<sup>1</sup> Including the Medicare Medicaid Coordinated Plan or MMCP

## V. Information Requested from Respondents

Idaho Medicaid recognizes the importance of stakeholder engagement as we identify, build, and test new models for VBP. To meet this goal, Idaho is seeking input from a wide variety of stakeholders and partners familiar with the health care delivery system in Idaho including individuals who use Medicaid services, health care providers, health insurance providers, advocates, vendors and potential vendors, policy makers, and other interested parties.

Respondents are encouraged to provide complete but concise responses to the questions outlined below. Respondents are also encouraged to identify the specific questions they are responding to in their submission. Please note that a response to every question is not necessary for consideration of the responses. Additionally, respondents may identify and comment on other issues that they believe are important for Idaho Medicaid to consider in designing these models.

### A. RFI Response 1 – Guiding Principles

1. Do the Guiding Principles provide appropriate and sufficient guidance for VBP decision-making and prioritization?
2. Are there any Guiding Principles that should be adjusted, added, or deleted? *Please provide explanation and rationale for any recommended edits.*

### B. RFI Response 2 – VBP Models

1. Is the Alternative Payment Models (APM) Framework from the Health Care Payment Learning and Action Network (HCP-LAN or LAN) a helpful way to think about value-based payment?
2. Should Idaho Medicaid use the Alternative Payment Models (APM) Framework to guide its transformation to Value-Based Purchasing?
3. Are there alternative frameworks or models that would be helpful for Idaho to consider as guides for its movement to Value-Based Purchasing?
4. Many states and national organizations have set goals to increase the percentage of value-based purchasing arrangements. For example, the Health Care Payment Learning and Action Network has suggested that Medicaid and commercial plans should tie at least 25% of payments by 2022 and 50% of payments by 2025 to quality and value. Oregon has adopted the goal of increasing value-based payments by requiring that by 2024, no less than 70% of their Medicaid Coordinated Care Organization payments to providers must be value-based, and Washington has set a goal that 90% of their Medicaid health care payments will be value-based by 2021.

The Healthcare Transformation Coalition of Idaho (HTCI), a group of leadership from payers, providers, and healthcare-oriented organizations has established the goal of moving Idaho's healthcare payments as a whole to 50% value-based payment under the LAN model by 2023.

What is your feedback on HTCI's goal and its relationship with Medicaid payments?

Should Idaho Medicaid pursue the same goal or a more or less aggressive goal for its value-based payments? Or do you feel a different approach is appropriate?

5. For the VBP models planned or currently in place under Idaho Medicaid as outlined in Section IV above:
  - a. Are there successes or challenges that you have experienced with these models? Please detail.
  - b. Do you have suggestions for improvement or opportunities to evolve these approaches to continue to transform Idaho's Medicaid program?
  - c. Are there other existing programs in Idaho Medicaid that you think should be highlighted or improved?
  
6. For the VBP models not currently operating under Idaho Medicaid as outlined in Section IV above:
  - a. Should Idaho Medicaid further explore these models as part of the transformation to VBP? Why or why not?
  - b. Are there other VBP models in operation in Idaho, outside the Medicaid program, that Idaho Medicaid should use in its transition to VBP?
  - c. Are there other VBP models not yet in operation in Idaho that Idaho Medicaid should use or consider for its transition to VBP?
  - d. Which LAN framework category do these models fall into?
  - e. Is there a framework category you feel offers the most promise for Idaho?

**C. RFI Response 3 – Other.**

Provide any other VBP information for consideration that has not been requested in RFI Responses 1-2.

## VI. Terms and Conditions

- A.** All material submitted in response to this RFI becomes the property of the IDHW and shall not be returned to the responding vendor.
- B.** At the sole discretion of IDHW, the information provided may be used for the following purposes:
1. Identify options and refine requirements for future VBP opportunities including potential RFP(s) which may be released later.
  2. Design health system program improvements.
  3. Assist in projecting budget and/or savings for implementing new VBP options.
  4. Identify potential providers and vendors who may be interested in participating in new or existing VBP models and/or submitting a future competitive proposal.
- C.** The Idaho Public Records Law, Idaho Code Section 74, allows the open inspection and copying of public records. Public records include any writing containing information relating to the conduct or administration of the public's business prepared, owned, used, or retained by a state or local agency regardless of the physical form or character. All, or most, of the information contained in your response will be a public record and as such will be subject to disclosure under the public records law. Certain exemptions from disclosure can apply, one of which may be for "trade secrets" as defined in the Idaho Public Records Act, Idaho Code Sections 74-101 through 74-126, a copy of which is available for viewing on-line at:  
<https://legislature.idaho.gov/statutesrules/idstat/Title74/T74CH1/>
1. Trade secrets include a formula, pattern, compilation, program, computer program, device, method, technique or process that derives economic value, actual or potential, from not being generally known to, and not being readily ascertainable by proper means by, other persons and is subject to the efforts that are reasonable under the circumstances to maintain its secrecy.
  2. If you consider any element of your response to be a trade secret, or otherwise protected from disclosure, you must so indicate by marking each page of the pertinent document. Include the specific basis for your position that it be treated as exempt from disclosure.
  3. Marking your entire response as exempt is not acceptable or in accordance with the Public Records Act and will not be honored. In addition, a legend or statement on one (1) page that all or substantially all of the response is exempt from disclosure is not acceptable or in accordance with the Public Records Act and will not be honored. Prices quoted in your response are not a trade secret.

The IDHW, to the extent allowed by law and in accordance with these terms and conditions will honor a designation of nondisclosure. You will be required to defend any claim of trade secret or other basis for nondisclosure in the event of an administrative or judicial challenge to the IDHW nondisclosure. Any questions regarding the applicability of the Public Records Law should be addressed to the IDHW or should be presented to your own legal counsel - prior to submission.

- D.** THIS IS NOT A BID; NO AWARD WILL BE MADE.

## VII. Addresses for Responses

If you are interested in providing any of the information requested in this RFI, please submit your written response by close of business **January 3<sup>rd</sup>, 2020** to:

***\* Responses will only be accepted by e-mail or hard copy. \****  
***\*\* Do Not Submit Your Response Through IPRO. \*\****

Email: [MedicaidVBP@dhw.idaho.gov](mailto:MedicaidVBP@dhw.idaho.gov)

Hard Copy Responses:

Value Based Payment Request for Information

Idaho Dept of Health & Welfare

Division of Medicaid

P.O. Box 83720

Boise, ID 83720-0009

Telephone: (208) 364-1804