

SoonerCare Choice Value Based Purchasing Options

The Pacific Health Policy Group – July 2015

Introduction

As health care costs continue to rise, payers seek payment approaches that recognize quality care and positive outcomes, thereby reducing cost growth. Payers recognize that traditional, fee-for-service payment methodologies reward providers based on volume rather than the quality of care provided.

Private insurance companies, Medicare and state Medicaid programs all have developed approaches that tie provider payments to value and outcomes rather than volume. Value Based Purchasing (VBP) approaches can be implemented under contracts with managed care organizations, groups of providers and/or individual providers.

Numerous VBP models have been developed and studied over the last several years. Broadly defined, each model is a “demand side strategy to measure, report and reward excellence in health care delivery” (National Business Coalition on Health).

While the design of each model varies, VBP approaches generally include the following components:

- Defined criteria for the measurement and reporting of access, quality/outcomes and/or cost.
- Funding approaches that range from incentive payments to shared risk arrangements, such as:
 - Predetermined division of profits/losses between the state and contractor;
 - Partial withholds of payments to be earned back as incentives;
 - Global budgets whereby the contractor is given a lump sum (possibly distributed monthly or quarterly) and required to manage services for all eligible persons within the budgeted amount; or
 - Traditional per member per month capitation.
- Rewarding of demonstrated value through defined and reported criteria.

Value Based Purchasing



“Demand side strategy to measure, report and reward excellence in health care delivery”

- National Business Coalition on Health

- Defined populations for measurement and reporting; can include entire aid categories or high risk groups, such as persons with complex/chronic conditions.
- Defined providers (or groups of providers) that may include primary care providers, specialists, hospitals and/or health systems.

Currently, most VBP approaches at the provider level include strategies that tie payment to measurable outcomes for physicians and hospitals. VBP approaches for physicians may include incentive payments for meeting patient centered medical home (PCMH) criteria, achieving certain childhood immunization rates or improving rates for routine, preventive office visits.

At the hospital system level, one example is the Medicare Quality Incentive Program. The program subjects hospitals to rewards and penalties based on outcomes for Medicare patients (e.g., readmission rates and death rates).

Another example is the Accountable Care Organization (ACO) model, under which systems can enter into shared-risk contracts and achieve financial rewards. ACOs began in the Medicare and commercial sectors, but have since expanded to Medicaid. In some states, the ACO concept has been further broadened into models under which community-based health systems accept greater risk.

VBP Initiatives in State Medicaid Programs

State Medicaid programs also have incorporated VBP approaches into contracts with managed care organizations. Examples include incentive payments (or payment withholds) based on reported compliance with quality measures (HEDIS, accreditation standards), achieving certain timeliness targets (appointment accessibility, call center responsiveness, completion of care plans) and/or demonstrating targeted outcomes (reducing preventable inpatient admissions).

PHPG reviewed VBP initiatives around the country, focusing on states undertaking VBP outside of MCO contracts. PHPG identified four states with promising initiatives of potential interest to Oklahoma. They are:

- Arkansas – Episode Based Care Model
- Colorado – Regional Care Collaborative Organizations
- Minnesota – Integrated Health Partnerships
- Oregon – Coordinated Care Organizations

Arkansas – Episode-Based Care Model

The Arkansas Payment Improvement Initiative was launched in 2012 and combines PCMH and Health Home delivery models with **episode-based payments** for treatment of certain conditions. (Arkansas received a \$42 million State Innovations Model (SIM) grant in 2013.)

Under the model, a “Principal Accountable Provider” (PAP) agrees to be responsible for coordinating all care – this can be a physician, hospital or other provider, depending on the type of care. Examples of episode-based care services include treatment of upper respiratory infection, ADHD, perinatal care, CHF and hip and knee replacements.

Participating providers submit claims and are paid fee-for-service for episode-base care, just as they did prior to the program. PAP performance is measured over time (typically 12 months) against quality metrics and in terms of the cost of care. PAPs that meet specified quality metrics can earn “shared savings” payments.

In addition, a PAP’s average cost for an episode of care is compared to all PAPs and rated “commendable”, “acceptable” or “not acceptable”. The rating determines whether the PAP earns shared savings (apart from quality shared savings), must contribute toward covering the additional costs or simply receives its fee-for-service payment with no subsequent adjustment.

The exhibit below provides a summary of quality measures and cost targets for perinatal episodes of care.

Example: Perinatal Episode ¹
Quality Metrics Triggering Shared Savings
<ul style="list-style-type: none">• HIV screening rate of 80%• Group B Strep screening rate of 80%• Chlamydia screening rate of 80%
Average Cost per Episode Thresholds
<ul style="list-style-type: none">• Under \$3,400 – “Commendable” - Qualifies for shared savings• \$3,400 to \$3,900 – “Acceptable” – No additional payment or penalty• Over \$3,900 – “Not Acceptable” – PAP shares in additional cost

Colorado – Regional Care Collaborative Organization

Colorado has enrolled Medicaid beneficiaries in managed care for two decades, including through MCOs in the Denver area and Primary Care Case Management (PCCM) throughout the state. Colorado’s **Regional Care Collaborative Organization (RCCO)** model was implemented in 2011 as a next-generation PCCM model.

Colorado contracts with seven regionally-based RCCOs that include primary care networks responsible for coordinating physical and behavioral health services for 700,000 members.

¹ Source: “Payment for Value in Medicaid: A Synthesis of Advanced Payment Models in Four States”, State Health Access Data Assistance Center (SHADAC) (February 2014).

Payment began with monthly case management fees but has since been expanded to include performance-based incentives tied to quality and outcomes, as well as risk-based payments.

A 2013 study² of the impact of RCCOs found:

- A 12 percent reduction in net cost of care for members post-enrollment.
- Smaller increase in ER utilization for RCCO members than non-members (1.9 percent versus 2.8 percent), though still an increase.
- Reductions in hospital admission rates:
 - 9 percent for persons with diabetes;
 - 5 percent for persons with hypertension; and
 - 22 percent for members with COPD.
- 15 percent reduction in hospital readmissions.
- 25 percent reduction in high-cost imaging services.

Minnesota – Integrated Health Partnerships

Minnesota has enrolled Medicaid beneficiaries in managed care for two decades, including private and public MCOs. Minnesota’s **Integrated Health Partnership** (IHP) model began development in 2011 and is in the process of being fully implemented. The IHP program currently serves 175,000 members (the pre-existing MCO program also continues to operate).

The IHP program aligns primary care providers with community-based organizations and social service agencies for the purpose of improving quality and reducing costs. Early IHP participants included a consortium of children’s hospitals and the Mayo Clinic. Providers not affiliated with a hospital/health system can participate in “virtual” IHPs; larger systems with 2,000+ members participate as formal IHPs.

IHP providers receive monthly patient-level data concerning ER utilization, hospital admissions and other indicators of the potential need for care management. Providers also receive aggregate quarterly cost and utilization data. IHP performance is to be measured against risk-adjusted target care costs and quality/outcome measures. IHPs will share in risk and savings based on measured performance

Oregon - Coordinated Care Organizations

Oregon’s Coordinated Care Organization (CCO) model was implemented in 2012 to replace the state’s previous MCO program. The CCOs are locally governed provider networks responsible for all physical and behavioral health services. The state contracts with 16 geographically-based CCOs serving over 900,000 members.

² Source: Colorado Department of Health Care Policy and Financing (2013).

CCOs are funded through global budgets that are increased annually at a fixed rate. CCOs also have the opportunity to earn back withholds by meeting quality/outcome targets.

Since implementation in 2012, the following findings have been reported³:

- The CCOs have increased primary/preventive care spending by 20 percent.
- ER visits have decreased by 22 percent (2014 rate was 47.3 per 1,000 member months, versus 69.9 for SoonerCare Choice).
- Hospital admission rates have fallen:
 - 44 percent reduction for members with asthma
 - 40 percent reduction for members with CHF
 - 60 percent reduction for members with COPD
- Hospital readmissions have fallen by 12 percent.

In 2014, CCOs received over \$125 million in incentive payments for meeting performance/quality targets in areas such as diabetes and depression management.

VBP in SoonerCare

VBP already is incorporated into the demand side of SoonerCare Choice at the patient-centered medical home level through higher payments to PCMH providers in higher tiers and SoonerExcel incentive payments to reward specific PCMH activities and outcomes. VBP also is employed for other components of SoonerCare, such as through Focus-on-Excellence payment structure for nursing facilities.

The OHCA can look to initiatives in other states, such as the above four, for possible application to the SoonerCare program. The SoonerCare Choice Health Access Network model also offers a possible platform for launching a VBP initiative. As discussed in chapter three, the HANs have shown early promise in improving member utilization and health outcomes.

The OHCA is in the process of strengthening HAN performance requirements as part of new contracts slated for SFY 2016. The contracting process offers the opportunity to incorporate VBP principles, e.g., through outcomes-based incentive payments (possibly funded through withholds). The OHCA also could explore introduction of limited risk sharing arrangements for larger HANs able to accept financial risk.

³ Source: Oregon Health Authority.