# Nevada
# State Innovation Model (SIM)

## Delivery System and Payment Alignment Work Group

July 27, 2015

Nevada Department of Health and Human Services
Division of Health Care Financing and Policy

# Meeting Purpose

- To review the aim and drivers of change for Nevada SIM plan
- To discuss key components for successful delivery system reform and how to address those components
- To discuss and recommend a Nevadan PCMH model
- To discuss and recommend Nevadan Value-Based Purchasing (VBP) model
  - PCMH
  - MCO
  - CMO

## CMS Triple Aim

- Improved Health Outcomes
- Lower Cost
- Improved Patient Experience

## Nevada Aim

- Improve Nevada's Health Status Ranking From 39th to 34th by 2019 While Maintaining Expenditures <= 2% of GSP

## Target Areas

- Obesity
- Smoking Cessation
- Diabetes
- Behavioral and Mental Health
- Heart Disease/ Stroke

**DRIVER DIAGRAM CONNECTS AIMS TO TARGET AREAS**

# Primary Drivers

Improve Health Ranking From 39th to 34th While Controlling Costs

- **Improve Access to Care**
- **Redesign Delivery System**
- **Foster and Develop Health Information Technology and Data Infrastructure Development and Adoption**
- **Improve Patient Experience**

# SIM Payer Alignment

- ✓ Medicaid/CHIP
- ✓ Public Employees Health Benefit Program
- ✓ Indian Health Services
- ✓ Culinary Health Fund
- ✓ Other Payers (Phase In Over Time)

| Payer | Nevada | US |
|---|---|---|
| **Uninsured** | **20.5%** | **14.5%** |
| **Employer/Military** | **52.0%** | **51.0%** |
| **Individual** | **4.0%** | **5.4%** |
| **Medicaid/CHIP** | **8.7%** | **13.4%** |
| **Medicare** | **14.9%** | **15.8%** |

*Source: Data from 2013, SHADAC analysis of American Community Survey (ACS), Nevada State Profile (revised April 2015), page 10*

# Population Health Measurement Strategy

- Start with nationally recognized quality stewards
  - Customize where necessary
- Develop Value Based Purchasing (VBP) Approach
  - May have to consider phased-in approach using process measures, reporting measures, and ultimately outcome measures
- Utilize a strong Health Information Technology and Data Strategy to support population health improvement
- Next steps
  - Define strategies to improve population health in these areas
  - Identify specific performance and outcome measures
  - Work with HIT & Data Taskforce on analytic needs

# Keys to Successful Delivery System Reform

**What?**

- ✓ Enable Planning and Stakeholder Engagement
- ✓ Enable Effective Coordination and Support of Goals
- ✓ Develop Strong Data Infrastructure and Quality Measurement
- ✓ Develop Financing and Payment Methods that Incentivize the Goals

**Who?**

- ✓ Governmental entities (federal, state and local)
- ✓ Community agencies (social services, housing)
- ✓ Payer (commercial, Indiana Health Services)
- ✓ Provider (primary care, hospitals)

**When?**

- ✓ Identify implementation timelines
- ✓ Short term, mid term, long term goals

# Keys to Successful Delivery System Reform

| Component | State | Community | Payer | Provider |
|---|---|---|---|---|
| **Enable Coordination and Support** | ✓ Multi-payer Collaborative | ✓ Regional Health Improvement Offices | ✓ Provider and patient education | ✓ Integration with Behavioral Health and Community Support Services |
| **Enhance Data Infrastructure and Quality Measurement** | ✓ Integrated warehouse and analytic tools | ✓ HIE and EHR system support | ✓ Pool quality data<br>✓ Measure alignment | ✓ PCMH adoption<br>✓ Medicaid Health Home |
| **Develop Financing and Payment Incentives** | ✓ Identify state and federal funding<br>✓ Participate in P4P | ✓ Identify local funding | ✓ Identify private funding<br>✓ Participate in P4P | ✓ Participate in P4P |

# Enabling Coordination

- Convene a Multi-payer Collaborative (MPC)
  - Brings together payers and employers in the state invested in reaching consensus to develop goals, measures and a provider payment model to meet the Nevada aim.
  - Goals of the MPC would be:
    1. Provide support on approach to provider practice transformation.
    2. Create a PCMH PMPM payment framework.
    3. Develop a standard, but flexible, Value-based purchasing (VBP) approach and support adoption.
    4. Establish pay-for-performance (P4P) improvement goals.
    5. Establish timelines for adoption of PCMH framework.
    6. Agree to established performance measurement parameters for simplified reporting and accountability.

# Enhancing Data Infrastructure Exchange and Quality Measurement

## Patient-centered Medical Home (PCMH)
## Medicaid Health Home

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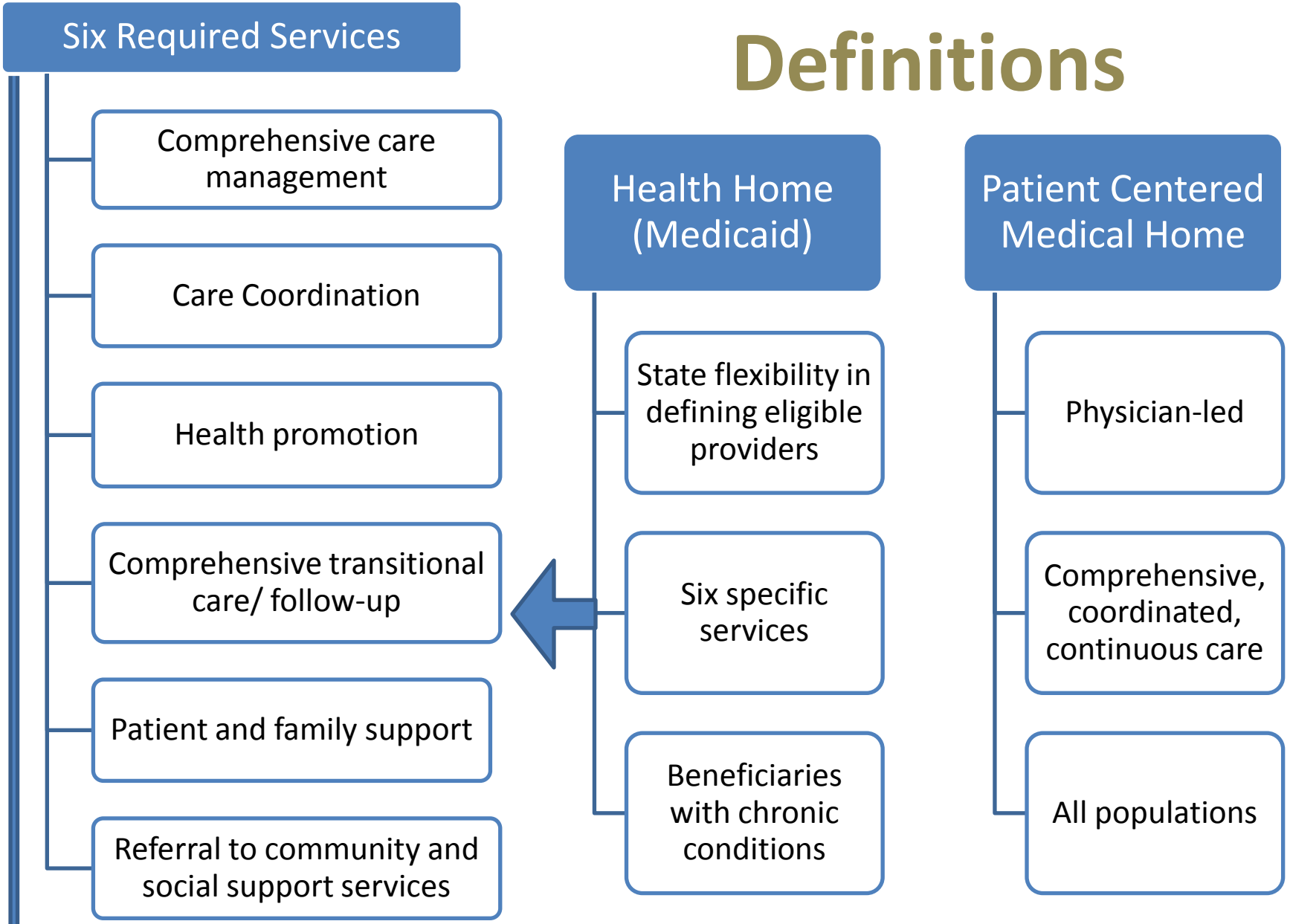
# Definitions



# Patient Centered Medical Home

- Goal: 80% of Nevadans connected with PCMH by December 31, 2019
- Covers all populations across a life span
- Multi-payer model
- Physician-led primary care practices, but may include some mid-level practitioners
- Team-based coordinated care
- Reimbursement is for care coordination, typically through a per member per month payment and may include additional payments through VBP model

# PCMH Model Examples

| Examples | Payment Features | General Criteria |
|---|---|---|
| **Common** | • Fee-for-service<br>• Fixed supplemental per-member-per-month<br>• Pay-for-performance (P4P) | |
| **Arkansas** | • Risk-adjusted care coordination payment (ranging from $1 - $30 per attributed beneficiary per month; avg. $4 Medicaid<br>• Shared savings; upside-only based on 1) improvement from one year to another, 2) being a high performer in a state | • Statewide<br>• Multi-payer<br>• 5,000 patients |
| **Colorado** | • Colorado Comprehensive Primary Care Initiative (CPCi) is a nationwide, multi-payer CMMI project for Medicare<br>• Risk-adjusted PMPM care management fee ranging from $8 to $40, avg. $20;<br>• Separate estimates for practice sites of 1-2 physicians, 3-5 or more physicians; Pay ranges established for each level of NCQA recognition | • Statewide<br>• Multi-payer |
| **Washington** | • Washington State Multi-Payer Medical Home Reimbursement Pilot<br>• Care management fee of $2.50 PMPM in the first 8 months of the pilot, and $2.00 for the remaining 2 years<br>• 50% shared savings above the amount paid PMPM, if clinical quality maintained; potential for penalty if shortfall up to a maximum of 50% of PMPM | • Multi-payer |

Resource: Patient-Centered Primary Care Collaborative and CHCS

# Nevada PCMH Approach

| Component | Feature | Phase 1/ Year 1 | Phase 2/ Year 2 |
|---|---|---|---|
| **Recognition** | Achieve NCQA Accreditation | ✓ | ✓ |
| **Population** | | Age 20 years and under | 65 and over, disabled, Medicaid expansion |
| **Payers** | Multi-payer | ✓ | ✓ |
| **Payment Mechanism** | Fee-for-service | • Care Coordination PMPM<br>• VBP Incentive Payment<br>• Adjust for PCMH recognition levels<br>• Establish minimum patient threshold for VBP eligibility<br>*- Consider lump sum payment for recognition level achievement* | • Medicare-specific payment<br>• Care Coordination PMPM<br>• VBP Incentive Payment<br>• Adjust for PCMH recognition levels<br>• Establish minimum patient threshold for VBP eligibility<br>*- Consider lump sum payment for recognition level achievement* |
| **P4P Outcomes** | SIM conditions | ✓<br>Youth focused | ✓<br>Super-utilizers through risk-stratification |

# Health Home Models

| Examples | General Criteria<br>Payment Features |
|---|---|
| **ACA** | **2703 Health Home State Plan Amendment for low income adults with two or more chronic diseases or individuals with one chronic condition and at-risk for a second**<br>• Medicaid Only<br>• Comprehensive care management<br>• Care coordination and health promotion<br>• Comprehensive transitional care from inpatient to other settings; including appropriate follow-up<br>• Referral to community and social support services<br>• Use of HIT to link services<br>• Fee-for-service payments |
| **Washington** | • Risk-adjusted PMPM<br>• 3 Tiered Care Coordination payment |
| **Iowa** | • Tier 1 (1-3 conditions) $12.80<br>• Tier 2 (4-6) $25.60<br>• Tier 3 (7-9) $51.21<br>• Tier 4 (10 or more) $76.81<br>• Eligible for P4P bonus of up to 20% of the total PMPM annually |

Resource: Patient-Centered Primary Care Collaborative and CHCS

# Value-Based Payment and Service Delivery Model

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# Value-Based Payment Model

- Objective

  Align payment for health care services such that at least 80% of health care reimbursement is based on quality and outcomes by December 31, 2019.

- VBP has been discussed by the workgroups as being part of:
  - Patient Centered Medical Home reimbursement
  - Health Home/Superutilizer model
  - Episode-based bundled payments
  - Provider population health management performance
  - Introduction of VBP and P4P concepts in public payer contracts

# Value-Based Payment Model

- Standard VBP approach for all payers, with some flexibility.
- Each payer responsible for payments related to their patients.
  - Commercial payers may be negotiate payments with hospitals within range.
- Common set of performance measures that have standard criteria.
  - Clinical and Quality Workgroup will make recommendations for clinical performance measures.

# Value-Based Payment Model

Goal: Develop a PCMH Value-based Reimbursement Model – Phased Approach

1. Phase I: Process/Participation measures
2. Phase II: Quality Reporting Capacity and Compliance – Pay for Reporting
3. Phase III: Outcomes and Performance – Pay for Performance
4. Phase IV: Shared Savings – throughout the implementation process, historical and current cost and utilization analysis is conducted to determine the average PMPM cost for the PCMH patients. If the anticipated costs are maintained at no more than a specified level below the forecasted cost trend, the PCMH will receive a bonus. Or the PCMH begins to be paid on a PMPM versus fee for service that takes into the consideration the shared savings approach.
5. Phase V: Shared Loss – If the anticipated cost trend is higher than a threshold of the forecasted trend, the PCMH incentive payments will be reduced by agreed upon allocation factors. Or the PCMH continues to be paid on a PMPM versus fee for service basis and the payment model transitions to a risk-model that is decreased based on the loss.

# Value-Based Payment Model

**Phased- in Approach For Example Purposes Only:**

- January 1, 2017:
  - 10 process and compliance measures begin to be reported, monitored and measured. Provider is reimbursed an incentive payment based on a pay for reporting/participating structure annually.

- January 1, 2018:
  - In addition to the 10 process and compliance measures collected, the provider now is required to report on 10 outcome measures on a semi-annual, or annual basis.
  - Pay for reporting for the new measures.
  - Pay for improved performance begins for measures reported and measured in 2017.

- January 1, 2019:
  - Pay for reporting is discontinued.
  - Pay for performance continues.
  - Shared Savings bonus begins or up-side shared savings approach.

- January 1, 2020:
  - Pay for performance continues.
  - Shared Savings incentive reduction applies, or down-side risk approach.

# Delivery System and Payment Alignment Goals

## Baseline State and Future Expectation:

| | CURRENT STATE | | | |
|---|---|---|---|---|
| **Delivery System and Payment Model** | **PCMH** | **Medicaid Health Home** | **CMO -** *Health Care Guidance Program* | **MCO** |
| PROVIDER/ ENTITY # | 293 NCQA Recognized | | 1 CMO Vendor | 2 MCOs |
| MEMBER LINKAGE # | | | 41.5k - Medicaid | 320k - Medicaid |
| PAYMENT MECHANISM | FFS | | FFS, Vendor Contract | Full Capitation |
| GEOGRAPHIC COVERAGE | Statewide | | Statewide | Clark, Washoe |
| PAYER MIX | Limited | | Medicaid | Medicaid |
| | **FUTURE STATE** | | | |
| PROVIDER/ ENTITY # | | | 1 CMO Vendor | 2 MCOs |
| MEMBER LINKAGE # | 2.3 Million[1] | | | |
| PAYMENT MECHANISM | FFS, PMPM, VBP | FFS, PMPM, VBP | FFS, Vendor Contract | Full Capitation, VBP |
| GEOGRAPHIC COVERAGE | Statewide | Statewide | Statewide | |
| PAYER MIX | All | Medicaid | Medicaid | Medicaid |

[1] Based on 80% of 2014 Census population estimate of 2,839,099 residents; http://quickfacts.census.gov/qfd/states/32000.html; Accessed July 17, 2015

# Questions to be addressed by the MPC

- Set common expectations for the following:
  - Minimum threshold for patient panel
  - Patient/payer assignment logic
  - Patient/provider attribution model
  - Incentive payment amounts
  - Whether providers can pool practices for VBP
  - Performance improvement goals

# Health Information Technology Plan

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# HIT Plan

- State Health System Innovation Plan (SHSIP) must contain an HIT Plan
- HIT considered a fundamental infrastructure support transformation
- Health care delivery and payment system redesign must be accompanied by the appropriate HIT strategy

# HIT Plan

- **Needs Identified to Date:**
  - Ability to electronically capture health care and related data for Nevadans
  - An analytics tool that can measure population health and related outcomes for Nevadans
  - More than just claims data – more than HIE data
  - Enterprise Master Patient Index
  - Strong privacy considerations

- **Areas to be addressed regarding the solution:**
  - Ownership
  - Authority
  - Governance
  - Policy/legal agreements
  - Technical architecture
  - Business and technical operations
  - Financing
  - Sustainability

# Discussion

Next Meeting Objective – Determine Timeframes and VBP for State Contracts