Medicaid Learning Lab

September 7, 2022

Aurrera HealthGroup™

Mission driven. Forward thinking.

Welcome and Learning Lab Kickoff

I. Introductions

II. Purpose of the Medicaid Learning Lab

III. Medicaid 102 – *beyond basics for an accountable care audience*

IV. Medicaid APMs: A Closer Look

- Scan of Medicaid APM Trends Across the U.S.
- Highlighting State APM Programs
- Looking to the Future of APMs for Medicaid

Introductions

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Table Intros

- Name, ACO
- States where your ACO serves Medicaid members
- Years of engagement in NAACOS or similar ACO learning collaboratives
- *Share 1 thing you hope to take away from today's pre-conference*

Medicaid Learning Lab Overview

Strategic Planning 2022

Grow the number of individuals in accountable care relationships consistent with the national aim to have a substantial majority of Medicare and **Medicaid** covered lives aligned to an APM by 2030.

Help our members to be **high performing** – formalizing education over time, being intentional in **broadening the landscape of education to accountable care, and helping prepare tomorrow's accountable care leaders.**

Advocate and adapt as needed to support the accountable care landscape—influencing changes, driving innovation, communicating the value for patients in accountable care, and **supporting ACOs and accountable care in Medicaid**, Commercial, or MA.

Medicaid Learning Lab

Overall Learning Lab Project Objectives

- Understand the needs of ACOs engaging in Medicaid accountable care
- Provide a forum for further discussion on how to better serve and care for Medicaid populations, including social and behavioral needs
- Address workflows and ROI to sustain resources to meet ACO needs

Expected Outcome of Medicaid Learning Lab Sept '22-Dec '23

- Series of learning events for ACOs to participate in and learn from one another
- Follow-up meetings on topics of special interest with in-depth discussion
- Structured outcome materials, webinars and conference sessions on areas of interest concerning the Medicaid population.

In-person kick-off TODAY with virtual meetings throughout the year

Medicaid 102

Recent Medicaid Trends

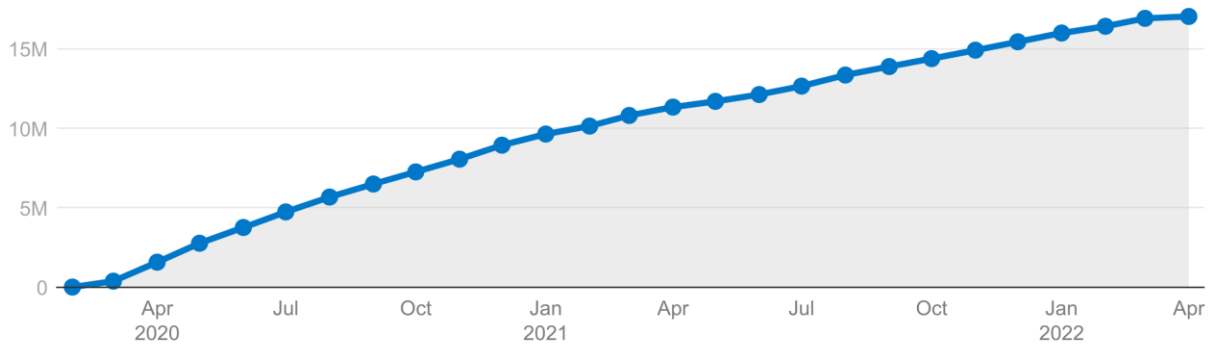
Over the recent years, several trends have emerged in Medicaid and CHIP, including:

- Enrollment Expansion
- Unwinding from the Public Health Emergency (PHE)
- Impact of Pandemic on Long-term Care Facilities
- Increased Utilization of Telehealth
- Behavioral Health Integration
- Access and Focus on Social Determinants of Health

Figure 1

Medicaid/CHIP Enrollment Has Increased Since The Start Of The Pandemic.

Cumulative Change In Medicaid/CHIP Enrollment Since February 2020



NOTE: M = Millions. April 2022 data are preliminary and subject to change; all other months are based on updated enrollment reports. These data differ from those reported in monthly "Medicaid & CHIP Enrollment Snapshots" published by CMS, which report preliminary data for all months. Medicaid/CHIP enrollment reports are submitted monthly by state Medicaid agencies, reflecting enrollment on the last day of the month. With each update, states often revise data for the previous month(s) to better align with reporting criteria, such as including retroactive enrollment or other criteria. February 2020 (baseline) enrollment was 71,239,414 in the updated enrollment report.
SOURCE: CMS, Medicaid & CHIP: Monthly Application and Eligibility Reports, last updated July 29, 2022.

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States Have Growing Interest in APMs and Accountable Care

- Medicaid covers nearly 1 in 4 Americans; there is a level of urgency for providing value-based care because Medicaid enrollees are a vulnerable population
- State Medicaid programs are interested in payment reform models to better outcomes and lower costs
- States have also been focused on incentivize quality using APMs to drive:
  - Payment and delivery reform efforts
  - Managed care contract requirements

Figure 5

States Requirements for MCO Provider APMs and VBP Initiatives as of July 1, 2021

n = 37 MCO states

Require MCOs to:	# of States	States
Meet a target % for provider APMs	20	AZ*, DC, FL*, HI*, IA, LA*, MA, MI*, NC, NE, NH, OH*, OR*, PA*, SC*, TN, TX*,VA, WA*, WV
Participate in a state-directed VBP initiative	11	CA, DC, FL, HI, MA, MD, OH, OR, SC, TN, WI
Develop a VBP strategy within state-specified guidelines	16	AZ, DC, FL, IA, KS, KY, LA, MA, MD, MI, NC, NY, OH, PA, TN, VA,

NOTE: DE, MN, NM, and RI did not respond to the 2021 survey.
States with an * reported MCO contracts include incentives or penalties for meeting or failing to meet APM targets

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States Don’t Grow APMs Overnight

States have broad discretion to design and implement their Medicaid programs to address the unique needs of their populations

- **State Plan Amendment (SPA) and Waivers**
  - Most common waivers are managed care waivers, home and community-based services waivers, and 1115 demonstration waivers
- **Managed Care Organization (MCO) Partnership**
  - States are partnering with MCOs to drive the transition to value-based care
  - Key objectives of Medicaid managed care are improvement in these areas:
    - ✓ Health plan performance
    - ✓ Health care quality
    - ✓ Outcomes

Table 1. Overview of State Plan Amendments and Waivers

	State Plan Amendments (SPAs)	Waivers
Description	A proposed change to an existing state Medicaid program.	A request made by a state to waive existing federal Medicaid requirements. Can be broadly classified as program waivers and research and demonstration waivers.
Enrollment Populations	All state plan populations except Medicare enrollees, certain children with special needs, and American Indians.	Program waivers include all state plan populations; research and demonstration waivers require all state plan populations as well as individuals not otherwise eligible for Medicaid.
Budget Requirements	No budget requirements or cost analysis.	Depending on type of waiver, must demonstrate cost- effectiveness and efficiency of program or budget neutrality.
Time Frame	Indefinite approval period, approved within 90 days of CMS receipt, no renewal needed.	Program waivers are initially approved for two years, approved within 90 days of CMS receipt, customarily renewed up to two years or up to five years if covering dually eligible enrollees. Research and demonstration waivers are initially approved for three to five years. There is not a required time frame for CMS approval, but there is a minimum waiting period of 45 days after submission, customarily renewed up to three years or up to five years if covering dually eligible enrollees.
Monitoring and Evaluation	CMS monitors implementation to ensure requirements are met; separate evaluation of managed care entities conducted by state.	CMS monitors implementation to ensure requirements are met; depending on type of waiver, either state conducts evaluation or requires periodic evaluation of the project.

Source: Medicaid and CHIP Payment and Access Commission. (2016). Characteristics of key Medicaid managed care SPAs and waivers. Retrieved from https://www.macpac.gov/characteristics-of-key-medicaid-managed-care-spas-and-waivers/

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APM Resources*

Question(s)	Where to Start
What is my state doing?	Visit your state's Department of Health and Medicaid program websites to see what APM(s) your state is implementing; Review current and past RFPs for APMs or Medicaid managed care
What are other states doing? *What kind of APMs are out there?*	**IMI Current Medicaid Programs by State:** https://www.medicaidinnovation.org/current-initiatives/state-facts **Medicaid Resources for States**: https://www.medicaid.gov/resources-for-states/index.html **National Association of Medicaid Directors (NAMD):** https://medicaiddirectors.org **Medicaid SPAs**: https://www.medicaid.gov/medicaid/medicaid-state-plan-amendments/index.html **Medicaid State Waiver Tracker**: https://www.kff.org/medicaid/issue-brief/medicaid-waiver-tracker-approved-and-pending-section-1115-waivers-by-state/ **Health Care Payment Learning & Action Network – APM Framework White Paper**: https://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf **For more information on innovative models piloted by states**: https://innovation.cms.gov/ **State Delivery System and Payment Strategies Aimed at Improving Outcomes and Lowering Costs in Medicaid:** https://www.kff.org/medicaid/issue-brief/state-delivery-system-and-payment-strategies-aimed-at-improving-outcomes-and-lowering-costs-in-medicaid/ **Additional resources can be found at the end of slide deck*

Medicaid APMs: A Closer Look

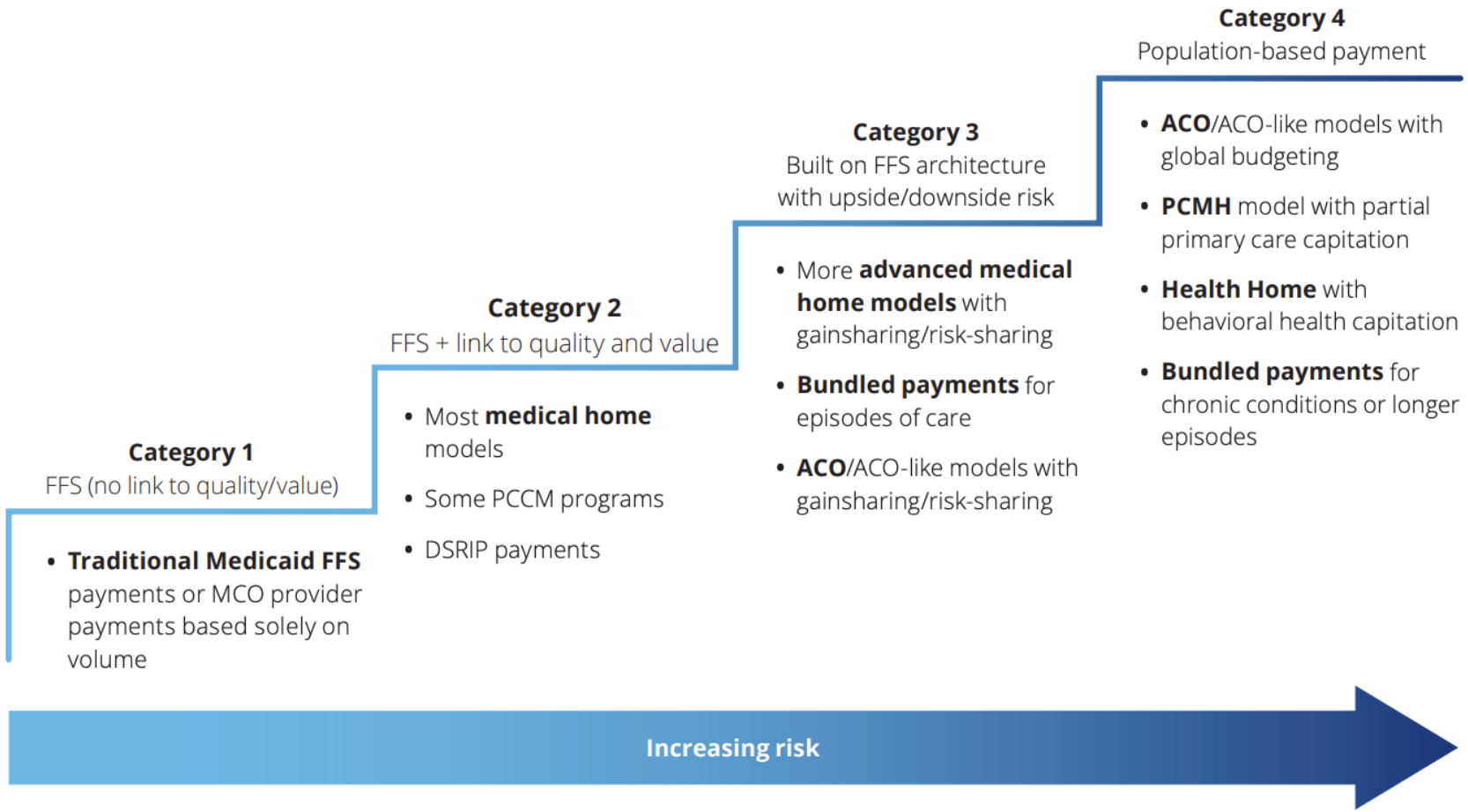
Let’s get to know you!

Scan of Medicaid APM Trends Across the U.S.

Common State APM Models

Patient-Centered Medical Homes (PCMH)	Health Homes	Accountable Care Organizations (ACOs)	Episode of Care (EOC) / Bundled Payments
PCMHs improve primary care quality, cost, and patient/provider experience through patient-centered, comprehensive, coordinated, accessible care focusing on quality and safety.	**Health Homes integrate physical and mental health** care for beneficiaries with **chronic conditions or a serious mental illness**. Health homes build on the PCMH model.	**ACOs** are groups of providers that **manage care** and are evaluated on quality of care and cost.	**EOCs** (also known as Bundled payments) are **lump sum payments for all health services** for a patient with a specific condition or illness used as a financial incentive to improve care coordination among providers.

APM Payment Arrangements



Source: Deloitte Center for Health Solutions analysis of 2016 HCP-LAN APM framework

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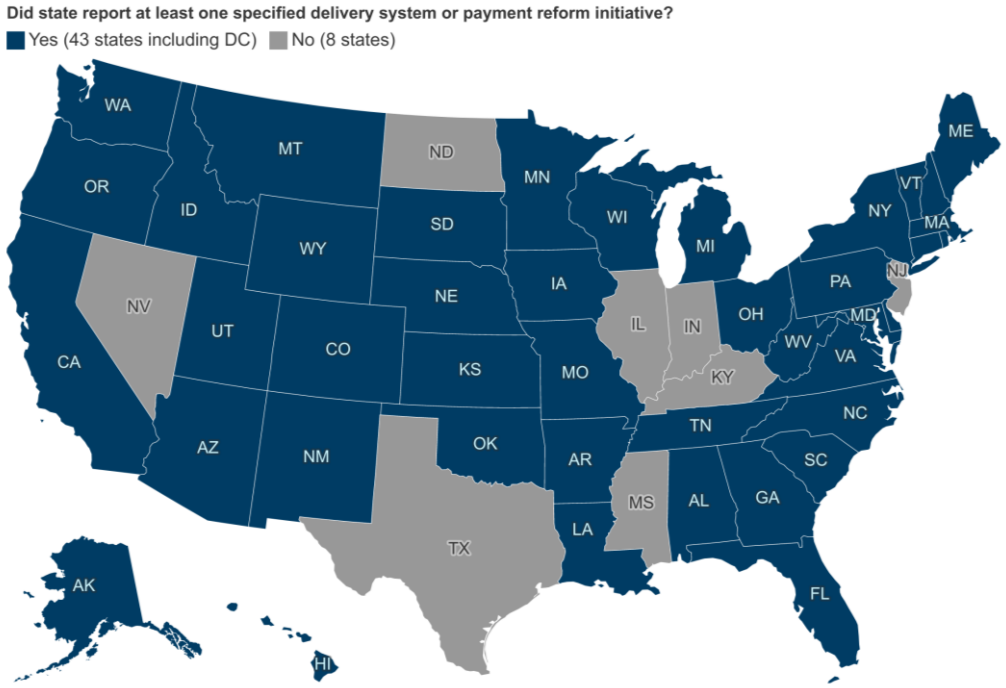
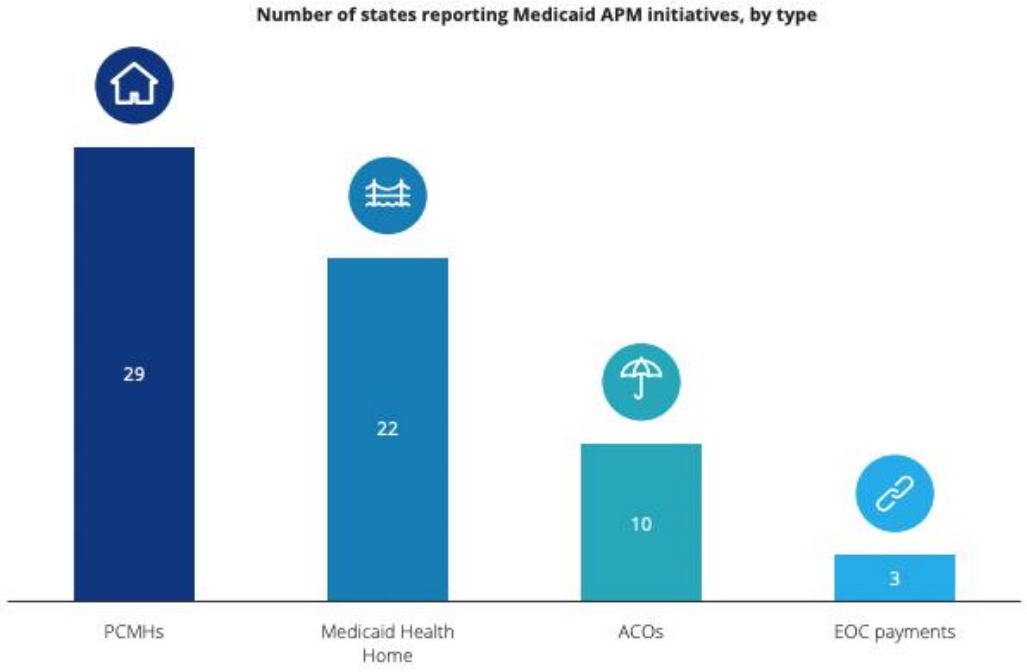
APMs Across the States



NOTE: DE, MN, NM, and RI did not respond to the 2021 survey; 2019 survey data and publicly available data used to identify initiatives in place for these states.
SOURCE: KFF survey of Medicaid officials in 50 states and DC conducted by HMA, October 2021.

KFF

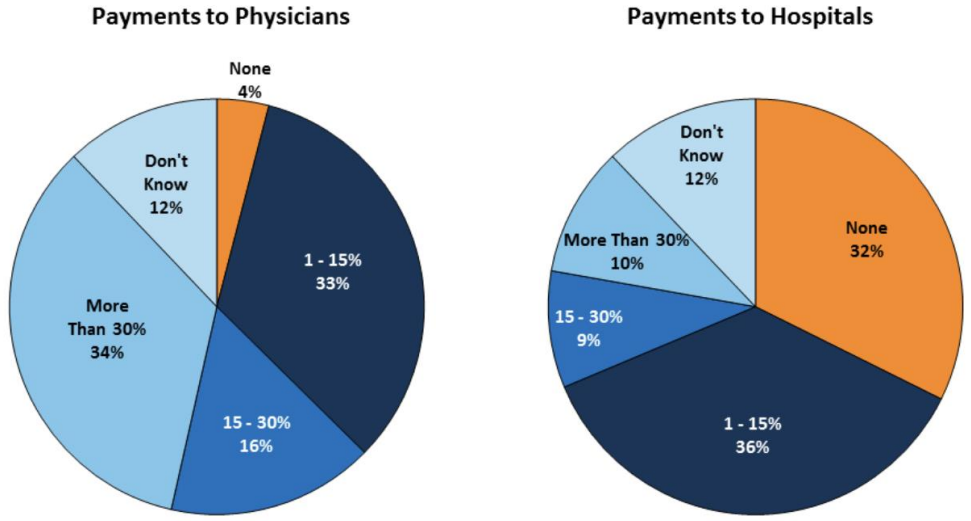


Sources: KFF 50-state Medicaid Budget Survey for FY16 and FY17; CMS list of approved Medicaid Health Home SPAs (May 2017); CHCS Medicaid ACO Fact Sheet (June 2017)

Most Medicaid Enrollees Receive Care Through MCOs

- Managed care organizations (MCOs) manage payment to providers
- As of 2019, nearly 70% of Medicaid beneficiaries received care through MCOs.
- Payments to MCOs make up about half of national Medicaid spending

Share of Medicaid MCO Payments Made Through Alternative Payment Models (APMs)



NOTES: Totals may not sum to 100% due to rounding.
SOURCE: Kaiser Family Foundation Survey of Medicaid Managed Care Plans, 2017.

How Do States Measure Quality?

Quality Measures	
Core Sets	The core sets are a list of standardized quality performance indicators that can be compared across states in attempt to drive quality improvement.
Consumer Assessment of Healthcare Providers and Systems (CAHPS)	CAHPS surveys are given to beneficiaries to measure their care experience. Questions include themes around access to services, ability to schedule appointments, and communication with providers.

Challenges				
Data	Standardization	Accuracy	Unintended consequences	A focus on conditions easy to measure

Highlighting State APM Programs

Delivery System Reform Incentive Payment (DSRIP) Program Overview

Authorized under the Section 1115 waiver, DSRIPs are provider-led efforts **to change the delivery of care, improve the quality of care, and promote population health**. Program structure varies across states due to their state's unique goals and structure**.** Funds are tied to meeting metrics in four major categories:

Infrastructure Development

Focused on investments in technology, tools, and human resources

System Redesign

May include redesigning primary care models, establishing patient navigation programs

Process

Clinical Outcome Improvements

Population Focused Improvements

Tied to measurable outcomes and metrics to address patient care and safety, and improvements in population health.

Outcomes

DSRIP Program Highlights: Texas & California

Texas

- Initial demonstration: 2011 – 2017
- Second demonstration 2017 - 2021
- 335 providers organized into 20 regional health care partnerships (RHPs) $26.12 billion made available to hospitals and other providers (both demonstrations)
- Providers implemented a total of 1,450 projects
- Resulted in increased access to primary and preventive care, ED diversion, and enhanced attention to individuals with behavioral health needs

California

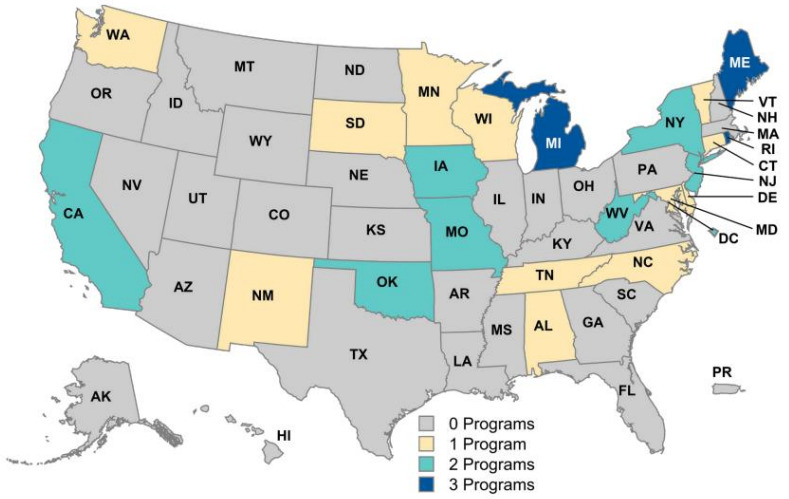
- 2010 – 2015
- 17 designated public hospital systems (DPHs) participated
- $6.67 billion in federal and non-federal funding
- DPHs implemented 221 projects
- Moved providers towards achieving Triple Aim goals
- Improved data infrastructure and quality measurement
- Led to additional efforts such as Public Hospital Redesign & Incentives In Medi-Cal (PRIME) and Quality Incentive Pool (QIP) Program

Medicaid Health Homes Overview

Medicaid health home programs aim to improve health outcomes for beneficiaries with chronic conditions through **coordinated care provided by an interdisciplinary team linking primary, behavioral health, and long-term services and supports**.

- Started in 2011
- Targets high-cost, high-need populations
- Core services include:
  - Comprehensive care management
  - Care coordination
  - Health promotion
  - Comprehensive transitional care and follow up
  - Individual and family support
  - Referral to community and social services
  - Use of health information technology to link services

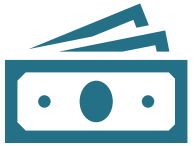
Geographic Variation in Health Home Programs Expected* to Report Health Home Core Set Measures, FFY 2020



Medicaid Health Homes Overview

Health Home Design

- States are required to submit Medicaid SPAs to implement a health home
  - Some states have multiple SPAs to target different populations or phase-in regional implementation
  - States are given considerable flexibility in the design and implementation of their health homes benefit



Payment & Reporting

- States have flexibility in designing payment methodologies
  - States receive a 90% match, first two years
- As a condition of payment, providers are required to report quality measures to the state
  - These measures make up the Health Home Core Set, used specifically to monitor and improve the quality of health care provided to health home enrollees

Health Home Highlight: Maine

Program structure varies across states due to their state's unique goals and structure**.** Funds are tied to meeting metrics in four major categories.

Chronic Care Health Homes

- Community care teams partner with primary care practices and community providers to support members with certain chronic conditions and who are at risk of poor health outcomes and/or utilization or services

Behavioral Health Homes

- Partnership between licensed community mental health provider and one or more health home practices to manage needs
- Utilizes a pay-for-performance structure

Opioid Health Homes

- Team-based treatment of opioid use disorder including medication, counseling and comprehensive care management

Community care teams reported reductions in ED visits and hospital stays as well as better self-management and treatment adherence for their complex-need patients

Minnesota Integrated Health Partnerships (IHP)

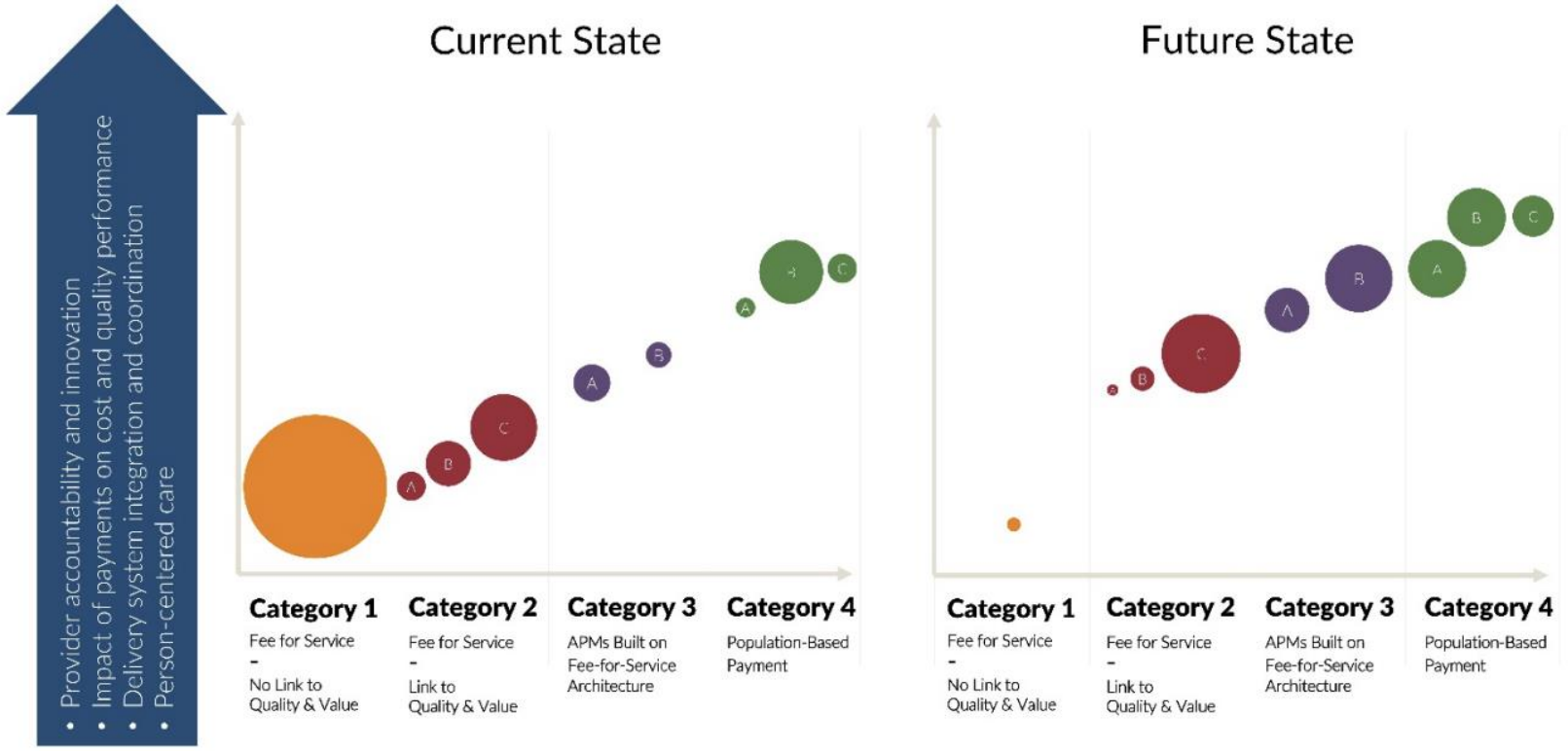
First launched in 2013 to test health care delivery systems, including ACOs, and value-based payment arrangements for Minnesota's Medicaid program. The goal of the program is to **improve the quality and value of care** provided to citizens served by public health care programs

- Major component of SIM grant
- IHP 2.0 began in 2018
  - **Track 1:** Non-risk bearing contract for smaller organizations
  - **Track 2:** Providers are held financially accountable for costs and quality of care
- Participants receive a **population-based payment** for care coordination and must design an intervention to address specific health disparities

Combined, the 27 providers participating in IHP 2.0 deliver better health care at a lower cost to more than 445,000 Minnesotans!

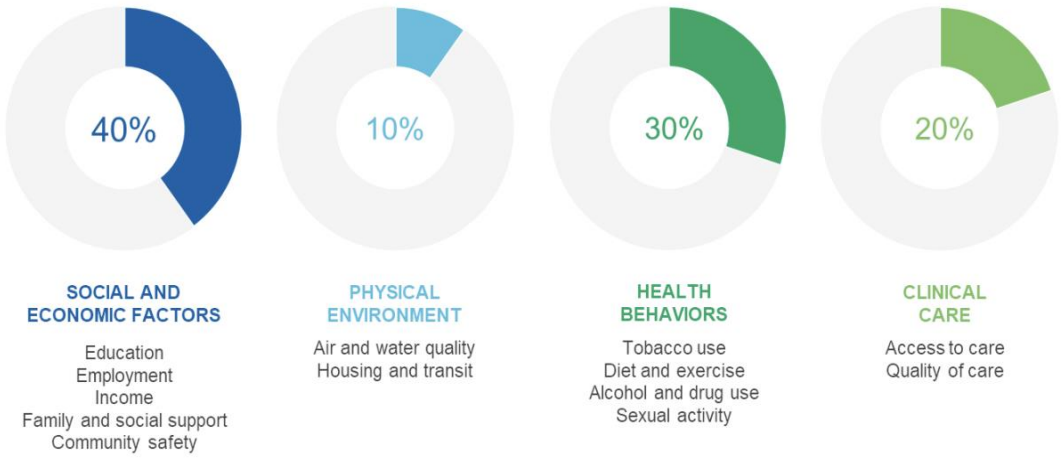
Looking to the Future of APMs

Shifting Away From Fee-For-Service



Models Focusing On Efficient, Coordinated Care

Emerging care models include the following components:



Social Determinants of Health (SDOH)	Trauma-informed care
Person-Centered Care	Medical/behavioral integration
Community-based care	Safety-Net Providers

For More Information…

Aurrera Health Group: https://www.aurrerahealth.com/

Pathways to Resilience: https://pathways-us.org/

Questions?

References

AHRQ - Defining the PCMH

AHRQ - Expanding the Toolbox: Methods to Study and Refute Patient-Centered Medical Home Models

AHRQ - The Collaborative Care Model: An Approach for Integrating Physical and Mental Health Care in Medicaid Health Homes

CAPH - California's Delivery System Reform Incentive Program

CBO - Issues and Challenges in Measuring and Improving the Quality of Health Care

CMS - Addressing & Improving Behavioral Health

CMS - Behavioral Health Strategy

CMS - CMS Issues New Roadmap for States to Address the Social Determinants of Health to Improve Outcomes, Lower Costs, Support State Value-Based Care Strategies

CMS - Conditions Targeted by Medicaid Health Homes

CMS - Framework for Health Equity 2022-2032

CMS - Glossary

CMS - Medicaid Health Homes: SPA Overview

CMS - Quality Measures

CMS - Quality of Care for Children and Adults Enrolled in Medicaid Health Homes: Findings from the 2020 Health Home Core Set

Deloitte - Health Policy Brief: Alternative payment models in Medicaid - Could MACRA be a catalyst for states' value-based care efforts?

DHCS - UCLA Final Evaluation Report of California's Delivery System Reform Incentive Payments (DSRIP) Program

HCP LAN - APM Framework

Health Affairs - CMS Innovation Center Launches New Initiative to Advance Health Equity

Health Affairs - Finding the Sweet Spot: When It Comes To Medicaid MCOs And Payment Reform, One Size Does Not Fit All

Health Affairs - Strengthening Behavioral Healthcare To Meet The Needs Of Our Nation

HMA - Minnesota Releases Integrated Health Partnerships Program RFP

Institute for Medicaid Innovation - Medicaid 101 - An Overview of State Plan Amendments & Waivers

KFF - 10 Things to Know About Managed Care

KFF - An Overview of Delivery System Reform Incentive Payment (DSRIP) Waivers

KFF - Analysis of Recent National Trends in Medicaid and CHIP Enrollment

KFF - Medicaid Managed Care Plans and Access to Care: Results from the Kaiser Family Foundation 2017 Survey of Medicaid Managed Care Plans

KFF - Over 200,000 Residents and Staff in Long-Term Care Facilities Have Died from COVID-19

KFF - State Delivery System and Payment Strategies Aimed at Improving Outcomes and Lowering Costs in Medicaid

KFF - States Respond to COVID-19 Challenges but Also Take Advantage of New Opportunities to Address Long-Standing Issues: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2021 and 2022

MACPAC - Delivery System Reform Incentive Payment (DSRIP) Programs

MACPAC - Quality Measures Used in Medicaid and CHIP

MACPAC - Using Medicaid Supplemental Payments to Drive Delivery System Reform

Maine DHHS - Behavioral Health Homes and Opioid Health Homes

Mathematica - Delivery System Reform Incentive Payments: Interim Evaluation Report

Mathematica - Medicaid Section 1115 Demonstrations Summative Evaluation Report

Medicaid.gov - Unwinding and Returning to Regular Operations after COVID-19

Milliman - Care Management for Medicaid: Optimizing New Models of Care for Better Population Health and Lower Costs

Minnesota DHS - Integrated Health Partnerships (IHP)

primary care collaborative - Integrated Health Partnerships Initiative

primary care collaborative - MaineCare's Health Homes Imitative

Texas HHS - Texas DSRIP Outcomes

The Commonwealth Fund - The Next Generation Paying for Value in Medicaid

U.S. Government Accountability Office - CMS Should Assess Effect of Increased Telehealth Use on Beneficiaries' Quality of Care

Urban Institute - Health Homes in Medicaid: The Promise and the Challenge