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Leveraging Medicaid to Drive Value in State Health Care Delivery

Montana Financial Modernization and Risk Analysis Committee

March 8, 2022

Agenda

- **Context Setting**
- **National Landscape: Value-Based Care**
- **Value Based Care Strategies in State Medicaid Programs**
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  - Delivery System Reforms
- **Current State of Value-Based Care in Montana**
- **Key Considerations and Opportunities**

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Context Setting

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Overview of Medicaid Program in Montana

Medicaid provides health coverage for one-in-four Montanans (279,334 individuals in 2021), with impacts on the state budget, economy, and health.

- **Federal/State Spending Overview**
  - Medicaid is jointly funded with the federal government, which reimbursed Montana for 80 cents of every dollar it spent on member care in State Fiscal Year 2021.
  - Montana leverages a lower proportion of its State General Fund (12%) to finance its Medicaid program compared to the national average (18%) and peer states with similar demographic and characteristics, including Colorado (25%), South Dakota (20%) and Wyoming (17%).
  - While Montana's average Medicaid spending per enrollee ($6,632) is in line with the national average ($6,556), Montana's per capita spending is lower than in many peer states, including, North Dakota ($10,034), Wyoming ($7,463) and Idaho ($6,823).
- **Spending During the Public Health Emergency.** While Montana's overall Medicaid spending increased from approximately $2 billion in 2019 to $2.2 billion in 2021, overall state spending decreased (from $460 million to $430 million), with the federal government picking up the difference.
- **Delivery System.** Montana is one of 10 states that does not use a managed care model in its state Medicaid program.

Sources: Forthcoming Report from the Montana Healthcare Foundation, "Medicaid in Montana."; Kaiser Family Foundation, "Medicaid Managed Care," Available here. Kaiser Family Foundation, "Medicaid Spending per Enrollee," Available here.

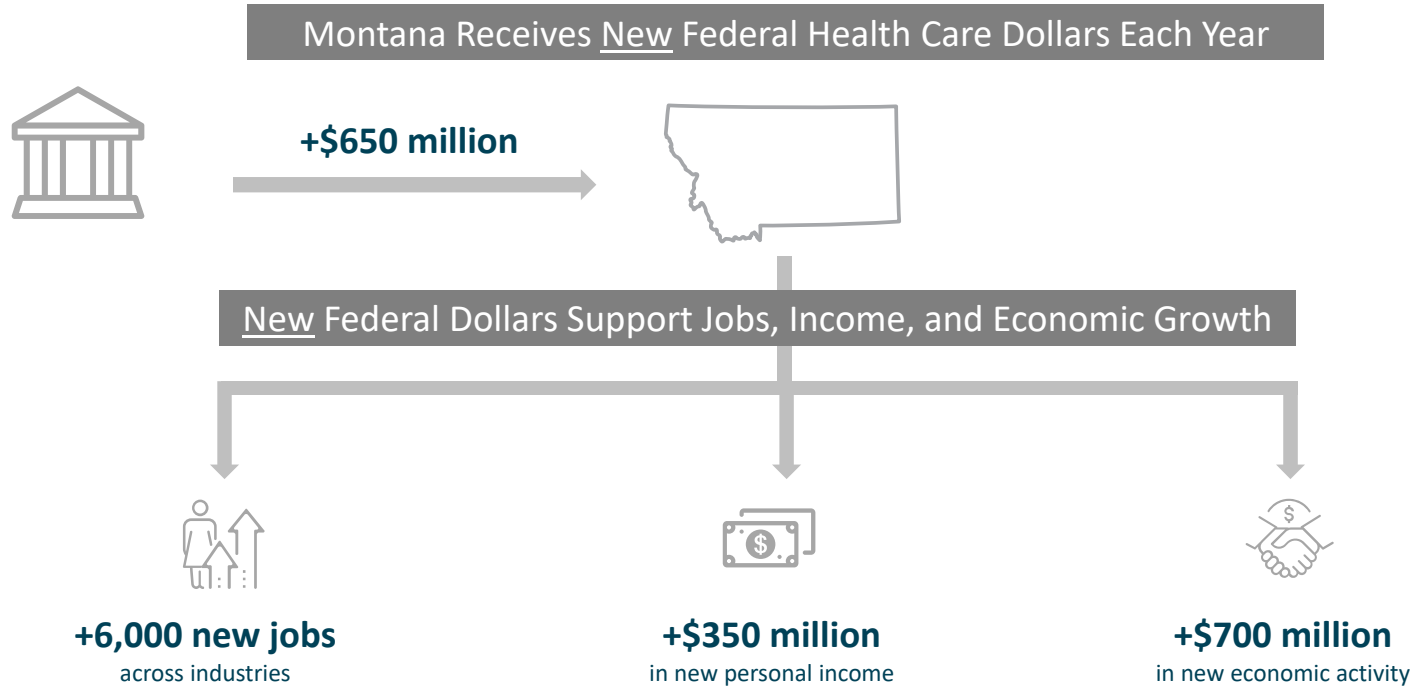
Impact of Medicaid on Access to Health Care Services in Montana

- **Preventive Services.** Medicaid provides access to preventive services to help Montanans of all ages maintain their health, particularly among low-income adults enrolled as a result of Medicaid expansion. In 2021, more than 55,000 expansion enrollees received preventive services.
- **Behavioral Health.** Medicaid expansion has opened new federal and state funds to support substance use prevention and treatment. Over 31,000 expansion enrollees received mental health treatments, and over 5,000 received substance use disorder treatments in 2021.
- **Telehealth.** Prior to and during the COVID-19 pandemic, telehealth services have played a critical role in supporting Montanans with behavioral health needs, particularly in rural areas.
- **Emergency Department Utilization.** Forthcoming research, presented by the Montana Healthcare Foundation in its *Medicaid in Montana* 2022 annual report (produced in partnership with DPHHS), will share encouraging findings on emergency department use for Medicaid expansion enrollees.

Source: Forthcoming Report from the Montana Healthcare Foundation, "Medicaid in Montana."

Impact of Medicaid Expansion on Montana's Economy

Medicaid expansion brings over $650 million into Montana annually, creating jobs and supporting new economic activity.



Source: Forthcoming Report from the Montana Healthcare Foundation, "Medicaid in Montana."

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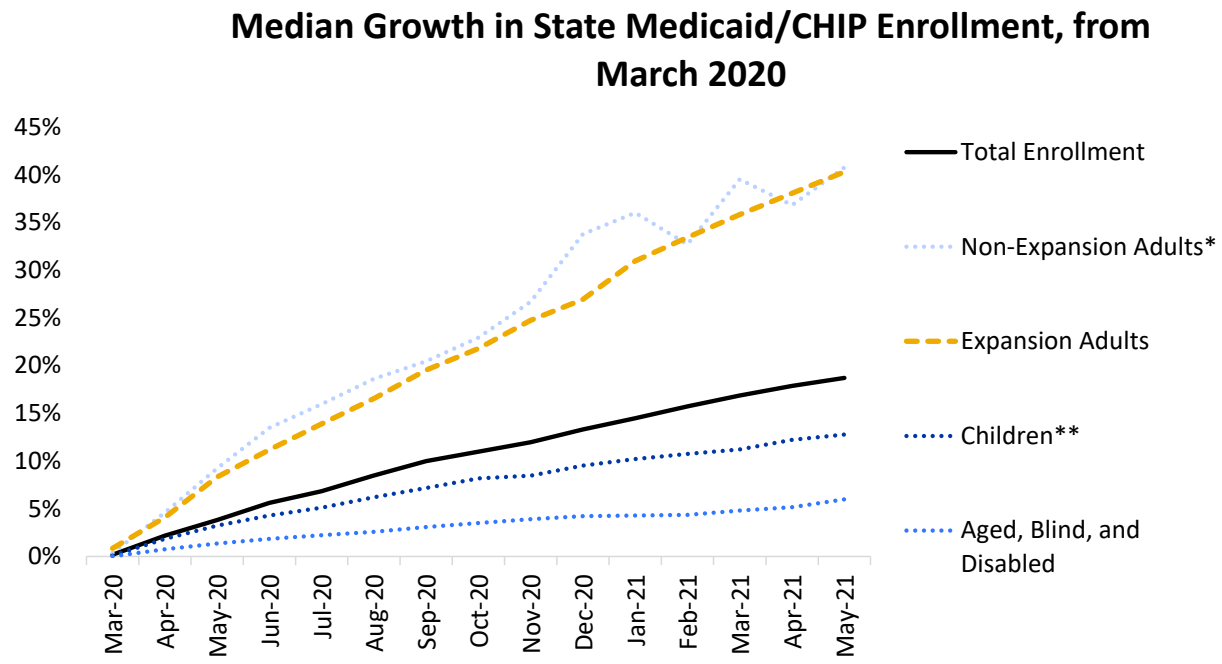
Medicaid Growth During the COVID-19 Public Health Emergency

During the public health emergency, Medicaid has been a foundational support for individuals impacted by job loss and COVID-19-related illness.



*E.g., parents and pregnant women
**Includes children enrolled in Medicaid and CHIP
Note: The number of states reporting data varies by month.
Source: Manatt analysis of state Medicaid enrollment databases.

- Nationally, Medicaid enrollment from March 2020 to July 2021 has **increased in every state**.
- Medicaid and CHIP have **added more than 12 million enrollees** since the beginning of the pandemic.
- In Montana, **Medicaid enrollment increased by approximately 24,000** enrollees (8.8%) from 2020 to 2021.
- Some states have seen overall growth **in excess of 30%.**
- Enrollment growth has been the **fastest among non-elderly, non-disabled adults** in nearly all states, with a median growth of 40.3%.

Emerging from the Public Health Emergency

As the nation emerges from the pandemic, states are looking to ensure that Medicaid programs, even with higher enrollment, can continue to deliver high-quality care at contained costs.

- States have been federally required to maintain continuous Medicaid coverage during the federal public health emergency as a condition of receiving a temporary FMAP increase under the Families First Coronavirus Response Act.
- When continuous coverage requirements end, Montana will need to conduct a full redetermination for all enrollees who would have otherwise been subject to redetermination.
  - History has shown that redeterminations can cause coverage losses, even among eligible individuals.
  - As Montana emerges from the pandemic, it will be critical to ensure that eligible individuals remain enrolled in coverage, while maintaining high quality care.

States face an opportunity to establish new care models that ensure high-quality care is delivered to increasingly high numbers of enrollees, while containing state costs.

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National Landscape: Value-Based Care

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Value-Based Care Objectives & Strategies

The goal of value-based care is to improve the quality of care while containing costs. Healthcare payers are designing new ways to pay for and deliver care that move away from "volume" and towards "value". State Medicaid programs, which cover approximately 20% of the population nationally, can be leaders in driving systemwide movement towards value-based models.

Example Value-Based Care Strategies

Focus on high-risk and high-utilizing patients.

Use care coordination processes.

Establish common goals for quality, cost, and patient experience.

Monitor and report on provider performance.

Link to services addressing the social drivers of health.

Note: Not all value-based models will address each of these areas.

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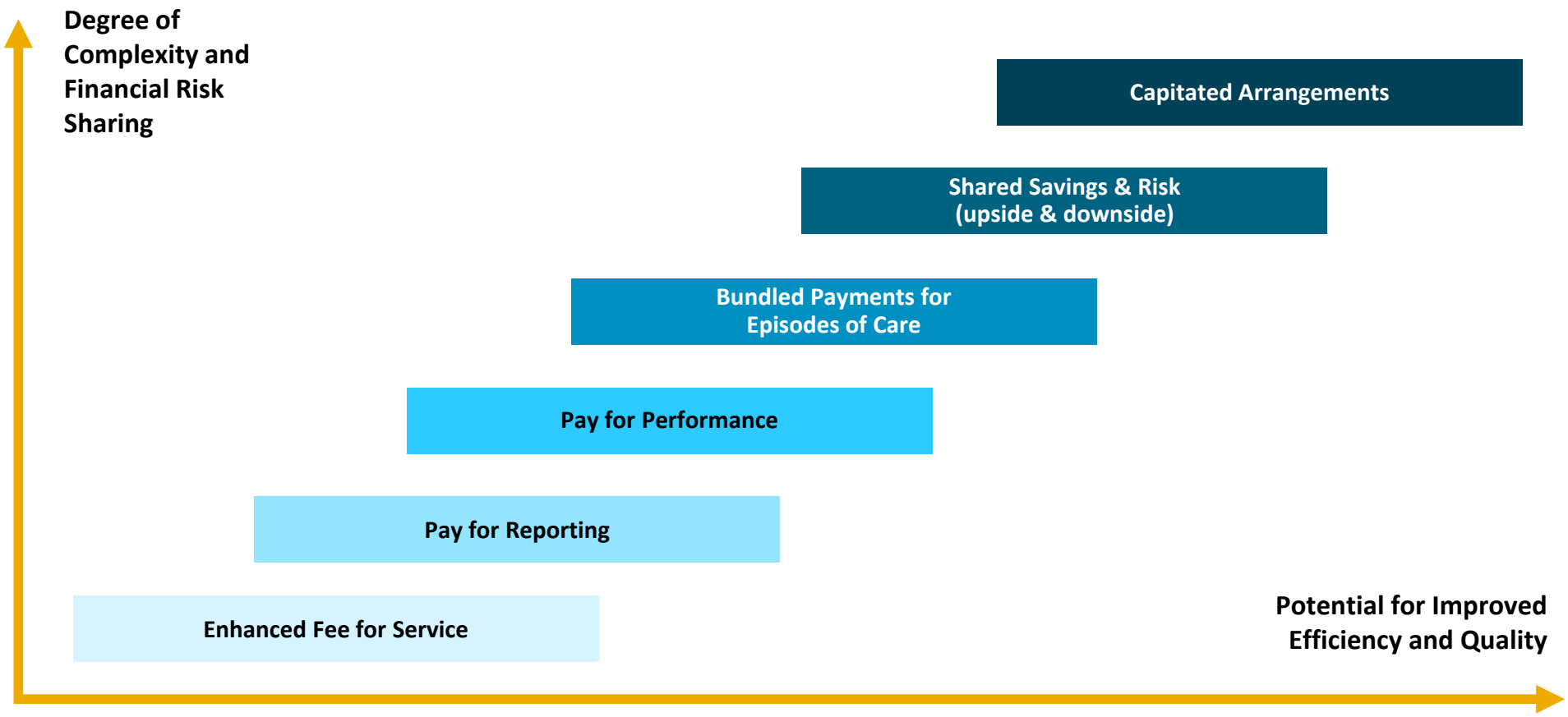
Spectrum of Value-Based Payment Models



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Value-Based Payment Models

Value-based payment models realign provider incentives and can incorporate risk to encourage improved performance, discourage unnecessary care, and control costs.

Value-based payment models are often combined with or linked to delivery system reforms, including programs that enhance care coordination and connect enrollees with wraparound services and supports.

Pay-for-Performance:

Provides incentives to providers to improve performance in specific areas, such as quality (process & outcomes measures), patient experience, and cost.

Bundled Payments:

Reimburse providers based on expected costs for clinically-defined episodes of care. Payments aim to discourage unnecessary care, encourage coordination, and improve quality.

Shared Savings:

Providers typically are assigned a patient population and a cost benchmark to manage under. Providers are offered a percentage of net savings realized as a result of their efforts. Providers may eventually assume downside risk as well as shared savings.

Capitated Arrangements:

Providers or provider groups are paid a fixed amount for each enrolled patient. Payment is typically based on the average expected health care utilization of that patient and may be adjusted for patient risk factors, demographic information, and location.

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Episode-Based ("Bundled") Payments

Episode-based payments, sometimes called "bundled payment" programs, reimburse providers on the basis of expected costs for clinically-defined episodes of care.

- Bundled payments aim to:
  - Discourage unnecessary care
  - Encourage coordination across providers
  - Improve quality without penalizing providers for caring for sicker patients
- Bundles may include services provided by all providers, including nurses.
- Bundled payments are being tested in Medicare and Medicaid and can be accomplished in either fee-for-service (FFS) or managed care delivery system.

State Example: Arkansas Payment Improvement Initiative

- Arkansas Medicaid, which delivers the vast majority of Medicaid services through a FFS delivery model, established 12 episodes of care.
- Providers are reimbursed on FFS basis. At the end of the year, individual provider spending per episode is compared to average spending per episode. Provider shares in savings or losses if spending is far above or below average.
- Providers must meet quality benchmarks to share in savings

Global Budget

Global budgets are a form of capitation in which providers—typically hospitals—are paid a prospectively-set, fixed amount for the total number of services they provide during a given period of time.

- Global budgets aim to:
  - Contain overall spending growth
  - Identify lower-cost ways of delivering hospital care
  - Increase investments in primary care
- Providers are responsible for expenditures in excess of the set amount in addition to quality outcomes, creating an incentive to reduce unnecessary utilization and invest in prevention.
- States including Maryland, Pennsylvania and Vermont are testing the utility of the model in different settings.

State Example: Maryland's Global Hospital Budget

- In 2014, Maryland initiated an all-payer global budget program for all acute-care hospitals in the state.
- The program limits growth in per-person total spending on hospital care, across all payers in Maryland, to a predetermined percent each year.
- Maryland's global budget program has reduced total expenditures and total hospital expenditures without shifting costs to other parts of the health care system outside of global budgets.

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Patient-Centered Medical Homes

The Patient-Centered Medical Home (PCMH) is a care delivery model in which a patient's treatment is coordinated through their primary care physician to ensure they receive the necessary care when and where they need it, in a manner they can understand.

- PCMH programs promote patient-centered care through:
  - Care management teams
  - Focus on patient-centered access and continuity of care
  - Setting performance goals
- PCMHs are often paid a per member per month fee in addition to FFS payments for Medicaid patients, which may be risk-adjusted to pay for patients with complex needs.
- PCMH programs can save money by reducing hospital and emergency department visits, mitigating health disparities, and improving patient outcomes.

State Example: Community Care of North Carolina (CCNC)

- CCNC is a public-private partnership that creates regional networks of primary care clinicians, hospitals, and community organizations to provide care using the PCMH model.
- Enrollees are linked to a primary care provider that performs primary care services and provides care coordination and 24/7 on-call assistance.
- CCNC providers have outperformed other providers in management of chronic disease and lowering costs.

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Accountable Care Organizations

Accountable care organizations (ACOs) refer to a group of health care providers that share responsibility for health care delivery and outcomes for a defined population.

- ACOs are designed to improve care coordination and delivery by holding providers financially accountable for the health of a specified patient population by:
  - Implementing a value-based payment structure
  - Measuring quality improvement
  - Collecting and analyzing data
- ACOs can be provider-driven (Colorado), health-plan driven (Oregon), or a hybrid of both models (Massachusetts, Minnesota).
- ACOs that meet quality standards can share savings.
- In SFY 2019, 14 states reported having Medicaid ACOs.

State Example: Colorado Medicaid Accountable Care Collaborative (ACC)

- Primary care providers contract with regional care collaborative organizations (RCCOs) to provide services to Medicaid enrollees.
- Colorado's seven RCCOs are responsible for providing medical management and care coordination and are accountable for quality and cost through utilization-based incentive payments and a shared savings program.
- ACC has demonstrated reductions in costs and utilization as well as growth in enrollment.

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Health Homes

The Medicaid Health Home optional benefit allows states to access enhanced federal reimbursement for coordinating care for individuals with chronic conditions.

- Medicaid Health Homes are designed to promote access to and coordination of physical and behavioral health services and long-term services and supports for individuals with complex needs.
  - States may establish Health Homes for individuals who have two or more chronic conditions, have one chronic condition and are at risk for a second, or have one serious mental health condition.
  - States have flexibility to design their own payment models for Health Homes to maximize efficiency.
- Five states have implemented a SUD Health Home program focused on opioid use disorder.

State Example: Vermont Opioid Use Disorder Health Home

- System of regional hubs focused on providing medication assisted therapy (MAT) and related services for individuals with opioid dependence.
- **Hub**: Registered nurse and master's level licensed clinician case manager, and program director paid monthly bundled rate per patient.
- **Spoke**: Registered nurse and clinician case manager employed by Blueprint Community Health Team.

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Current State of Value-Based Care in Montana

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Current State of Value-Based Care in Montana

DPHHS operates three provider-based care coordination programs that range in the supports they provide for Medicaid beneficiaries depending on their acuity. Passport to Health acts as the "gatekeeper" and directs members to more intensive supports.

Passport to Health: Provides primary care, preventive care, health maintenance, treatment of illness and injury, and coordination of member's access to medically necessary specialty care by providing referrals and follow-up. Includes care management for behavioral health conditions.

Comprehensive Primary Care Plus (CPC+): A multi-payer pilot program sponsored by CMS. Track 1 and Track 2 providers offer all Passport to Health services and enhanced functions including risk stratified care management, parent and caregiver education, and population health programs. Beginning January 2022, CPC+ practices will also be able to participate in Primary Care First (PCF).

Patient Centered Medical Homes (PCMH): Offer all Passport to Health services, team-based ongoing patient care, and care coordination services. Care management teams usually consist of the primary care provider, a nurse, a social worker and in some cases a behavioral health specialist.

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Montana's Integrated Behavioral Health Model

Across Montana, primary care clinics are increasingly equipped to screen patients for behavioral health – mental health and substance use disorder (SUD) – concerns and facilitate connections to needed treatment and support.

- Over half of adult Medicaid patients (59%) are assigned to primary care clinics that also provide behavioral health services.
- By integrating behavioral health services into primary care, providers work together to identify and treat behavioral health conditions.
- The delivery of basic behavioral health services in primary care clinics helps keep the state's more limited, specialty behavioral health services for the people who need them most.

Adoption of the Integrated Behavioral Health Model Across Montana

- ✓ 9 of the 11 large hospitals
- ✓ 32 of 48 critical access hospitals
- ✓ 4 of 5 urban Indian health centers
- ✓ All 14 federally qualified health centers

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Montana's 1115 HEART Waiver

DPHHS is requesting a Section 1115 Demonstration to build upon the state's work to establish a comprehensive continuum of behavioral health services for its Medicaid members.

- The demonstration, known as the HEART Waiver, is a critical component of the state's commitment to expand coverage and access to prevention, crisis intervention, treatment and recovery services through Governor Gianforte's HEART Initiative.
- DPHHS is seeking federal authority to authorize:
  - Evidence-based stimulant use disorder treatment models, including contingency management
  - Tenancy supports
  - Services for justice-involved population 30-days pre-release
  - Reimbursement for short-term residential and inpatient stays in institutions of mental disease (IMDs)
- DPHHS also intends to add other services for Medicaid members with behavioral health needs to its Medicaid State Plan and expand allowable provider types to deliver SUD services.

Looking Ahead

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Looking Ahead

As the state emerges from the COVID-19 pandemic, Montana has an opportunity to continue strengthening ongoing programs and build new value-based models for Medicaid enrollees.

- **Cost Growth.** Due in large part to the response to COVID-19, US health care spending increased 9.7 percent to reach $4.1 trillion in 2020, a much faster rate than the 4.3 percent increase seen in 2019. At the same time, gross domestic product declined, and the share of the economy devoted to health care spending spiked.
- **Opportunity for State Medicaid Programs.** States have an opportunity to use Medicaid programs to mitigate continued cost growth by driving new value-based payment and delivery system models.
- **Considerations for Montana Medicaid.** As Montana emerges from the pandemic, the state may look to a number of strategies that include, but are not limited to, strengthening behavioral health care services; expanding care coordination models; and exploring other opportunities to generate value in a fee-for-service environment.

Source: Health Affairs, "National Health Care Spending in 2020: Growth Driven by Federal Spending in Response to the COVID-19 Pandemic," December 2021. Available here.