What States and Medicaid MCOs Should Know and Do

National ACO, Bundled Payment, & MACRA Summit – 2018

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Agenda

- Disclaimers
- State perspective
  - Introduction of a framing device
  - Medicaid
  - Budget
  - Regulatory / Legislative
- Plan perspective
- Provider perspective

Disclaimers

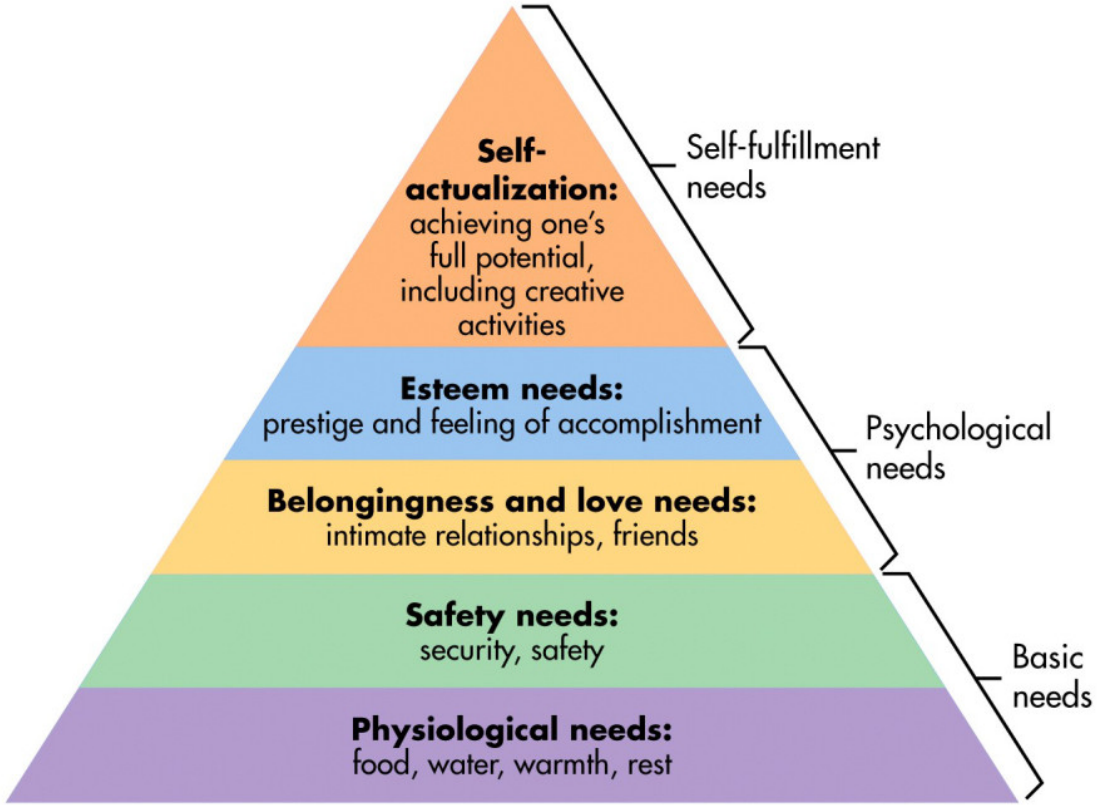
- **Disclaimers**
  - One year removed
  - Not a hotbed of Medicaid MCO innovation
  - Hardly presume to tell you what you “should know and do”

- **Replacement topics**
  - Some insight into how state officials tend to view ACOs/VBP
  - Thoughts on what plans and providers might consider in approaching states

Introduction of a framing device

With apologies to my psychology professors…

Introduction of a framing device



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The state perspective, according to *Maslow's Hierarchy of Needs*

- State officials are motivated by a hierarchy of needs
- More basic needs must be met prior to higher needs

Basic Needs: Physiological, Safety

Medicaid Directors live in the Hobbesian "state of nature"

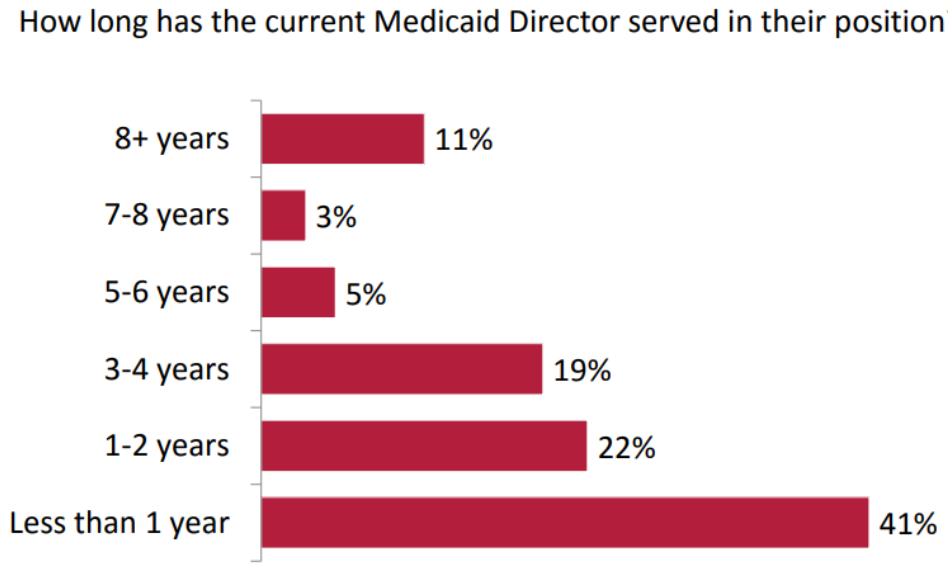
- Life is "solitary, poor, nasty, brutish, and short"

<u>Daily crises and distractions</u>

- Litigation, legislative hearings, federal oversight
- Budget problems
- Press and communications
- Technology failures
- Complaints, demands for more services from aggrieved parties – advocates, plans, providers

Basic Needs: Physiological, Safety

Majority of Medicaid Directors are new to position



Average tenure of a state Medicaid Director: 19 months

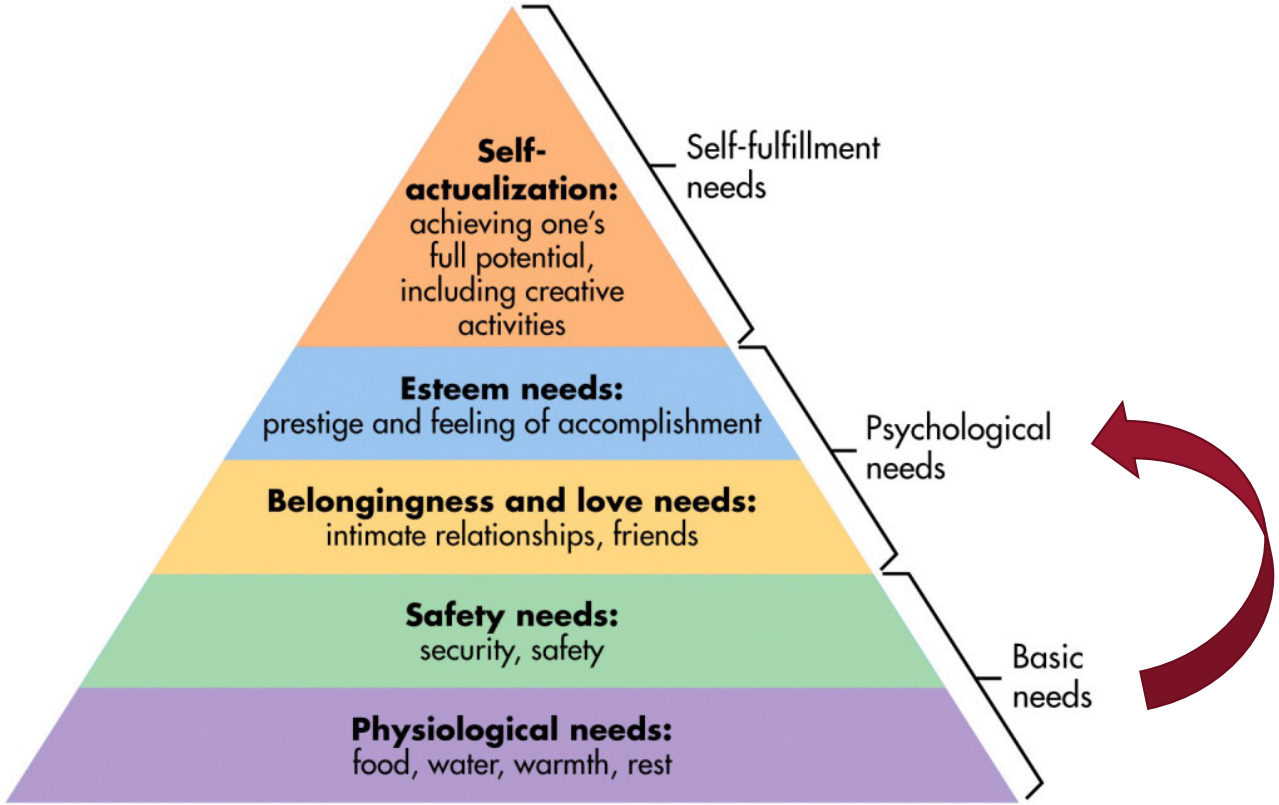
Source

Andy Allison, “Navigating the Choppy Waters of Medicaid Leadership”: November 2015

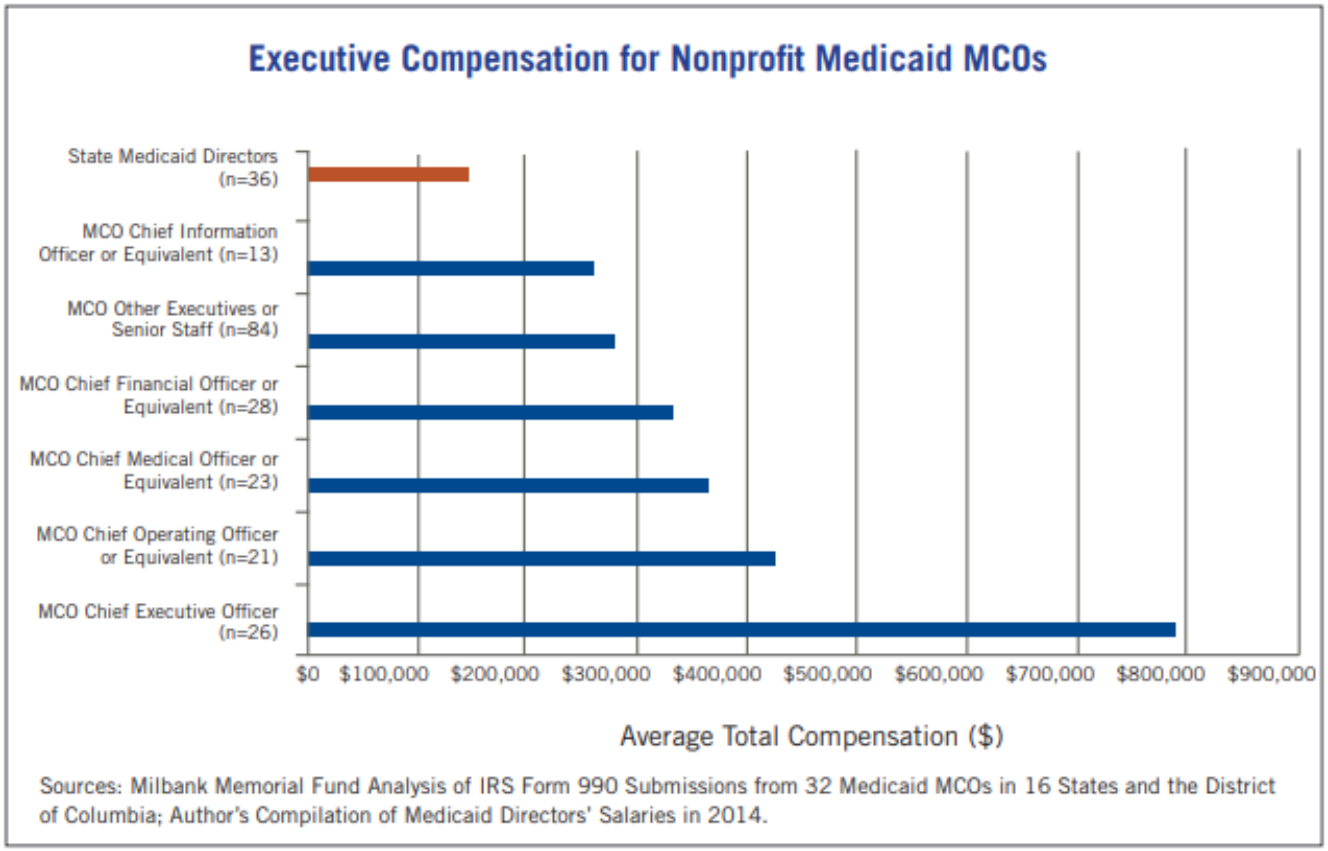
NAMD
National Association of Medicaid Directors

SCHA

From Basic to Psychological Needs



Psychological Needs: Belongingness, Esteem



Andy Allison, "The Role of State Medicaid Directors: A Leadership Imperative," Milbank Memorial Fund

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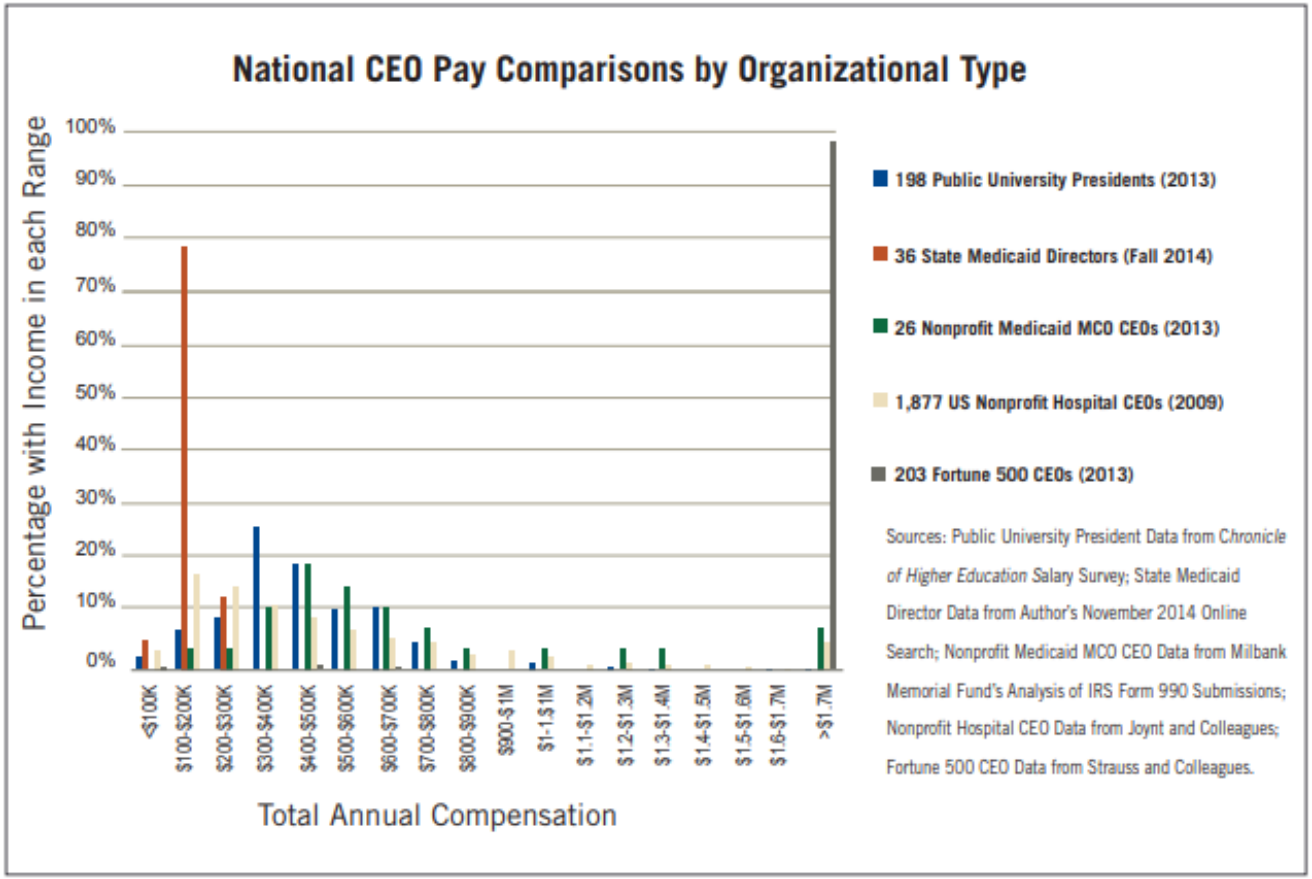

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Psychological Needs: Belongingness, Esteem

FORTUNE 500		
21	Fannie Mae	$112,394
22	Alphabet	$110,855
23	Home Depot	$100,904
24	Bank of America Corp.	$100,264
25	Express Scripts Holding	$100,064.6

Medi-Cal
FY 2018-19 May Revision
$103.9B

Psychological Needs: Belongingness, Esteem

FORTUNE 500		
491	Peabody Energy	$5,578.8
492	ON Semiconductor	$5,543.1
493	Simon Property Group	$5,538.6
494	Western Union	$5,524.3
495	NetApp	$5,519
496	Polaris Industries	$5,504.8
497	Pioneer Natural Resources	$5,455
498	ABM Industries	$5,453.6
499	Vistra Energy	$5,430
500	Cintas	$5,428.9

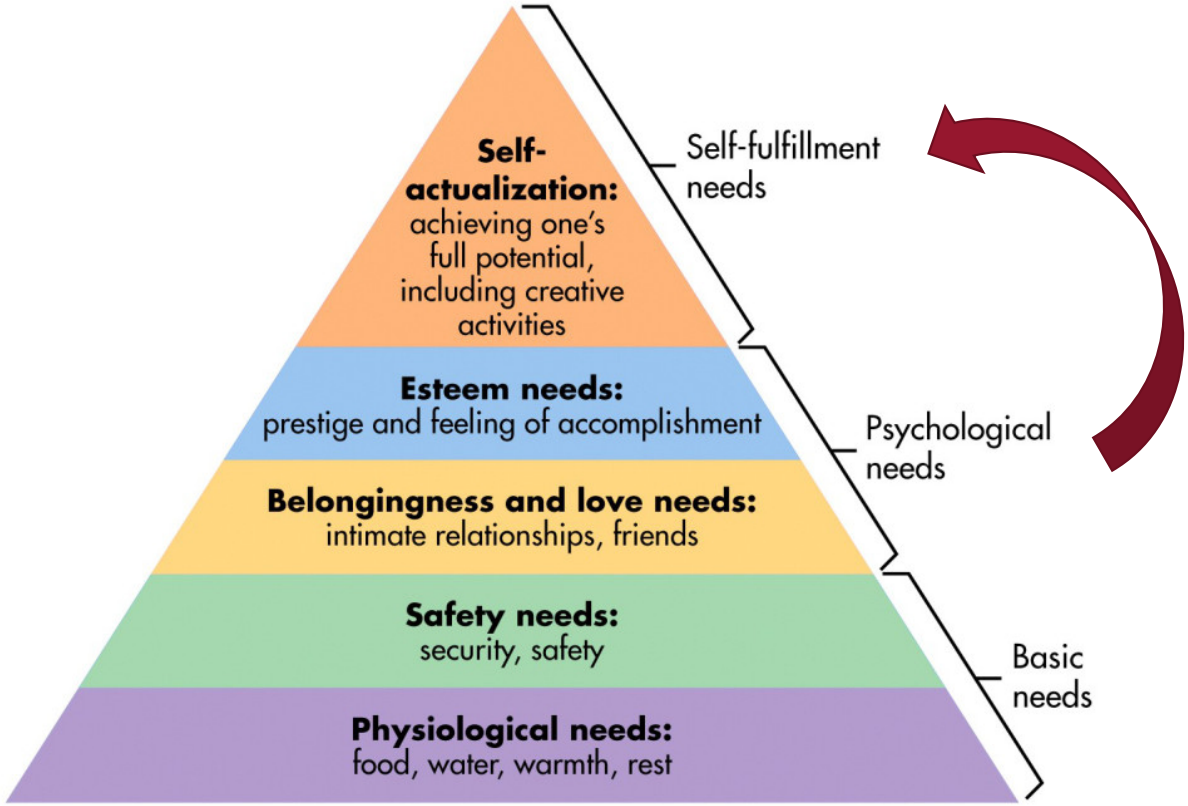
New Mexico
FY 2015-16 Spending
$5.537B

31 Medicaid programs would be above #500

Psychological Needs: Belongingness, Esteem

- Not just making a point about Medicaid Director compensation…
- State agencies face serious capacity constraints (quantity)
  - Salary and FTE limits
  - Cumbersome and unpredictable procurement rules
- The work environment drives away top-tier candidates (quality)
  - Glacial pace of change in the public sector
  - Political factors – partisanship, risk of job loss, 24/7 position
  - Years of litigation to follow, potential exposure in individual capacity

Moving Toward Self-Actualization



Moving Toward Self-Actualization

- Self-actualization is about engaging in creative activities and achieving your full potential
  - Moving to new payment/delivery models may be imperative to you…
  - …unfortunately, state officials tend to see ACOs at this more aspirational level

- A real pivot toward ACOs/bundles:
  - Likely cannot occur during one Medicaid Director's tenure
  - Won't produce state savings in his/her term (but adds lots of work)
  - Cannibalizes resources that could be devoted to other crises/priorities
  - Is still tinged blue, in the eyes of many GOP officials

What does any of this have to do with ACOs?

Medicaid Director's Perspective

Pro

- Long-term savings
- Improved outcomes
- Interesting/creative opportunity
- Prestigious/rewarding
- Use emerging state flexibility?

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- He/she takes the risk, but the successor reaps the benefits
- No immediate savings
- Provider vs. provider
- Provider vs. plans
- Additional workload
- Shifting federal landscape

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- Long-term savings
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- **No cost?**

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- **Cost?**

Medicaid vs. Budget Director

Medicaid

- Focus is “state share”
- General Fund and maybe others
  - Cigarette taxes, tobacco MSA
  - Provider assessments
  - Intergovernmental transfers
  - County and other contributions

Budget

- Focus is the General Fund
- Are “other” funds off-budget?
- Executive authorizations vs. appropriated lines?
- What are the limits on using federal funds and does anyone pay attention to that amount?

Financing Payment Reform

Positive Sum

•General Fund: Competing against all other programs

•Tax Vote: Provider assessment, cigarette taxes, etc. IGT?

Zero Sum

•Backalley Fight: Go after Medicaid match residing in other agencies? Tobacco MSA?

•Self-financing: Pay for with rate cuts or a spend-neutral plan that takes from the “losers”

Regulatory / Legislative

- What impact does the plan have on the overall state budget?
- Which constituencies feel like “winners” vs. “losers”?
- How might the program affect the competitive landscape?
  - In particular – will providers continue to negotiate in good faith with MCOs, if they have their own ACOs/PLEs?
  - If not, will state action be required and what would it look like?
- State actors do not want to have to mediate between MCOs and the providers who are backing PLEs

PLEs and the Prime Directive

“The Prime Directive is not just a set of rules.

It is a philosophy, and a very correct one.

History has proved again and again that whenever mankind interferes with a less developed civilization, no matter how well intentioned that interference may be, the results are invariably disastrous.”

-- *Captain Jean-Luc Picard*

Dealing with the State

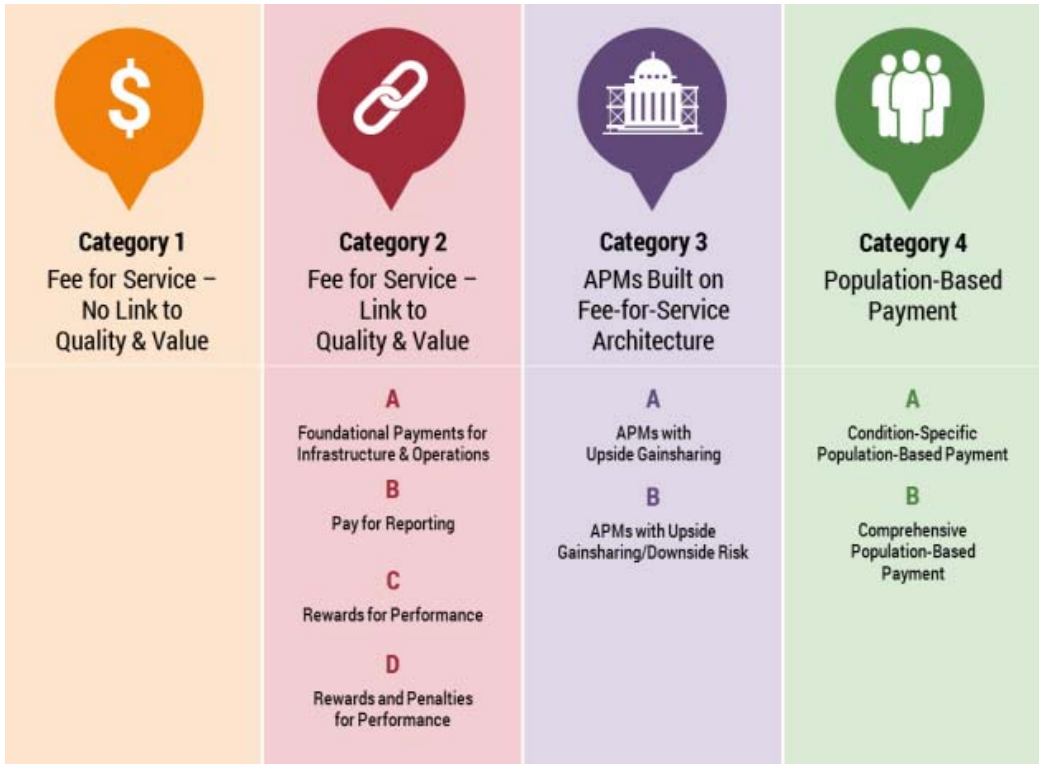
- Understand their capacity constraints
  - ACOs are important to you; officials may have no idea what you're talking about
  - Make it as easy as possible for them to give you what you want
  - May mean consultants – move from abstract to concrete ASAP

- Think about your financing options
  - Have to ultimately satisfy Medicaid, the budget chief, and the appropriators

- Build the right coalition
  - How will all potentially affected constituencies view your proposal?
  - Believe in the power of enlightened self-interest

- Embrace incrementalism

Climbing the APM Ladder in Medicaid



- Add-on modifiers
- PCMH incentives
- Bonus/withhold (HEDIS)
- Bundles/episodes
- Directed payments (438.6)
- DSRIP-style waivers
- Global payments
- CMMI exotics?

- *Which Medicaid members?*

Thumbnails

- **Bonus / Withholds**
  - Relatively easy to implement, HEDIS is a national standard
  - Many HEDIS measures are more about outputs than outcomes
  - States may use as a *de facto* rate cut
  - Value proposition for providers may not be clear/existent
  - If not risk-adjusted, may really just promote selection of healthy members

- **Bundles / Episodes**
  - Requires significantly more capacity, system-wide collaboration
  - Better opportunity to prioritize (condition-specific) clinical outcomes
  - Tends to more clearly define the value proposition for providers
  - Tension between condition-specific and whole-person pathways?

Thumbnails

- **Directed Payments**
  - 2016 managed care rule opens up directed payment pathways, now with a preprint available as well
  - Approvable plans must be grounded in the state's Quality Strategy and the opportunity to earn payments must be open to whole classes of providers
  - CMS keeps moving to sunset supplemental payments
  - Limited in the aggregate to 5% of the actuarially sound rate

- **Waiver-based**
  - Greatest opportunity to flex rules and create federal funding
  - Transitory opportunity, heavily subject to 5-year renegotiations
  - Glory days of early DSRIPs are over

Plan Perspective

- Get the state as close to 105% as possible [42 CFR 438.6(b)(2)]
- Identify state matching sources that are the most politically palatable
- Enlist the support of key provider constituencies
  - Emphasize impact on quality, outcomes
  - Generation of state match is an important consideration
- Potentially leverage as an argument for further carve-ins

Provider Perspective

- Get the state as close to 105% as possible [42 CFR 438.6(b)(2)]
- Identify state matching sources that are the most politically palatable
- Enlist the support of key constituencies
  - Emphasize impact on quality, outcomes
  - Generation of state match is an important consideration
- Potentially leverage as an argument against MCOs
  - If the state is directly involved in designing bundles, devising directed payments, etc., then how are the MCOs earning their admin fees?
- Consider Medicaid initiatives as a test-bed to earn MACRA AAPM bonuses

Closing Thoughts

- Treat state officials like the patient – “Meet them where they are”
- Be prepared to explain things starting at a very basic level
- Be ready to submit reaction drafts and models
- Build coalitions by being thoughtful about who pays, who stands to benefit, and reducing implementation and administrative effort
- Have a long-term vision with lots of short-term targets along the way

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