Alternative Payment Models in Medicaid

Payment Reform Strategy

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Putting people first, with the goal of helping all Michiganders lead healthier and more productive lives, no matter their stage in life.

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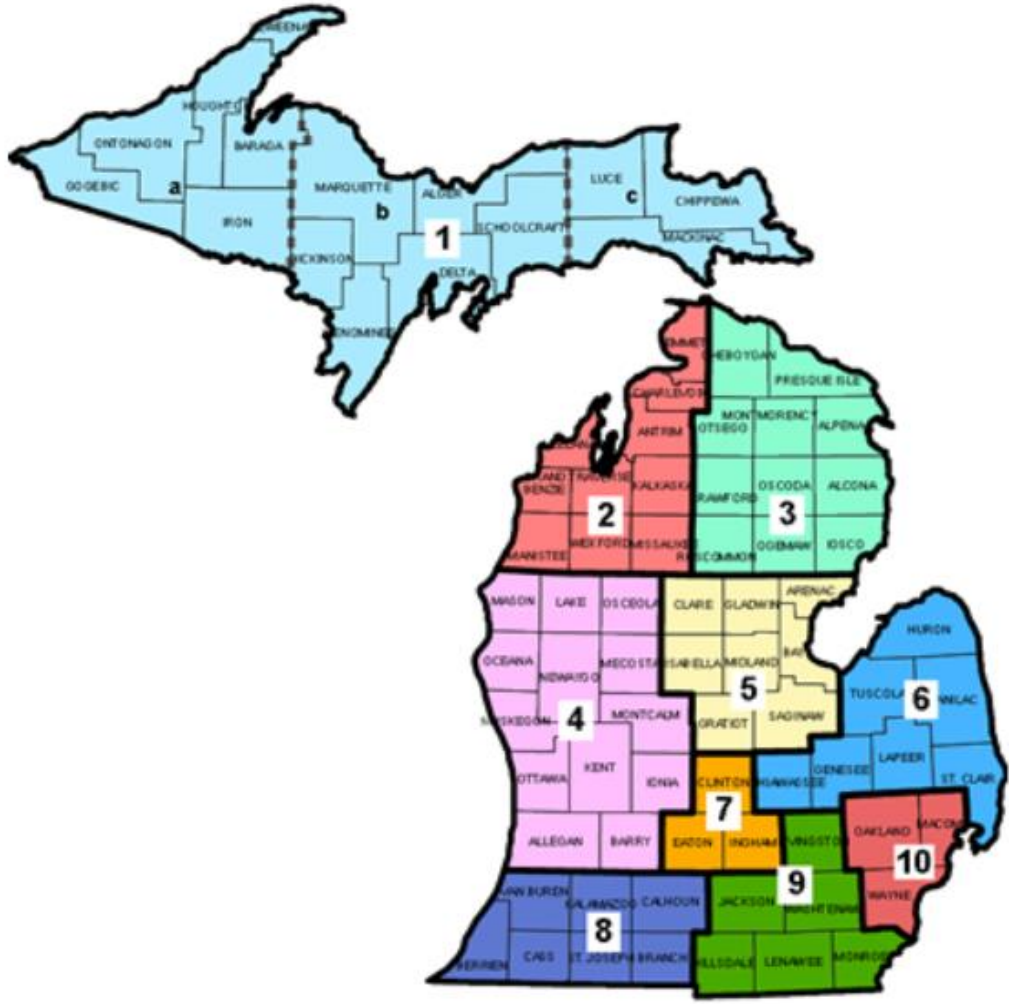
Michigan's Medicaid Landscape

- Managed Care Program
- 11 Medicaid Health Plans
- Prosperity Regions



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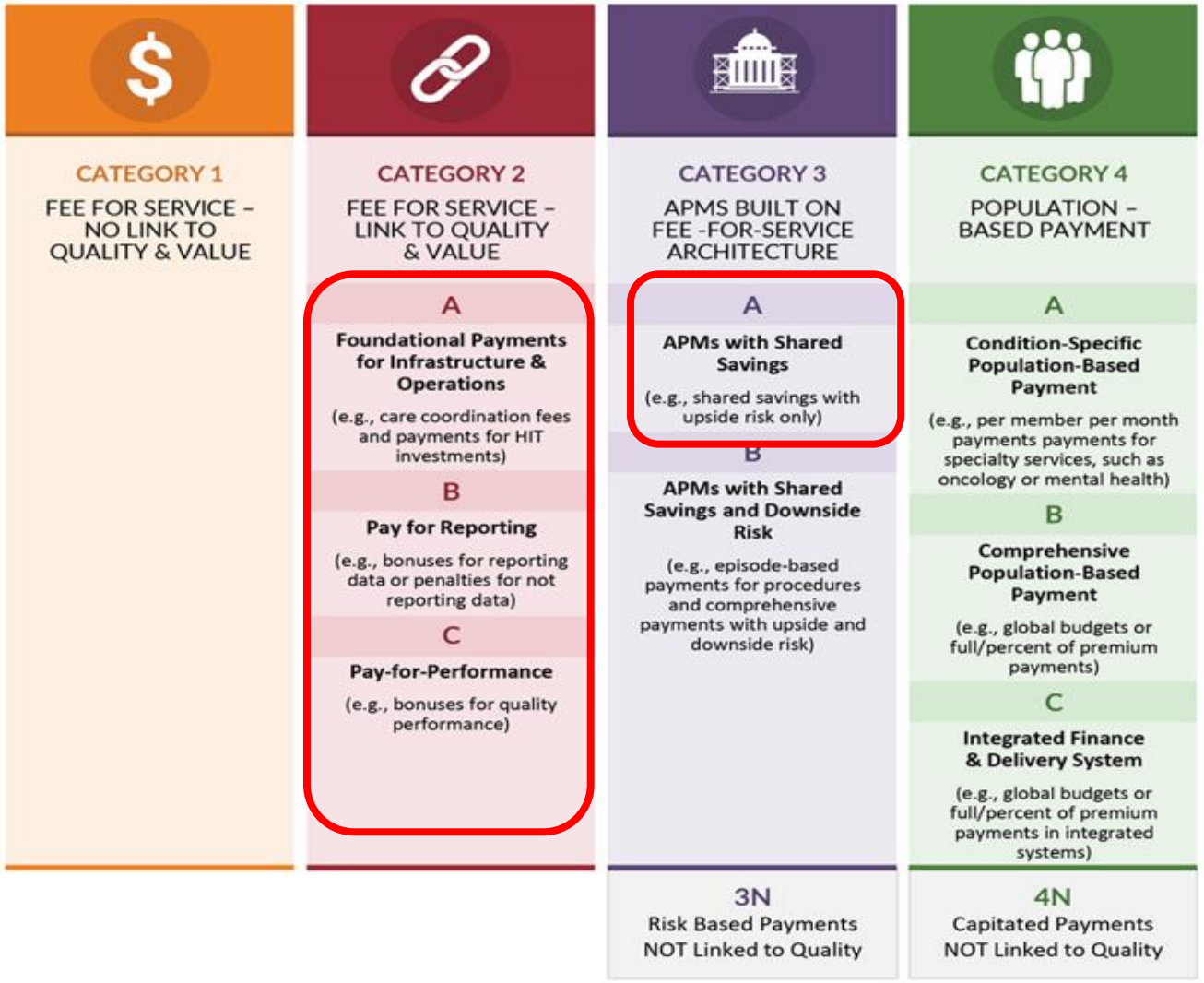
MDHHS Michigan Department of Health & Human Services

Michigan Blueprint for Health Innovation: Payment Reform Vision in 2012

The *Blueprint's* Conceptual Payment Framework:

Model Element	Payment Options
Patient Centered Medical Home	• Care management payments (risk-adjusted) • Practice transformation payments • Pay-for-performance incentives
Accountable Systems of Care	• Same as above • Shared savings upside only • Shared savings upside/downside • Partial capitation for defined services • Global payment for high cost conditions

Health Care Payment Learning & Action Network Framework



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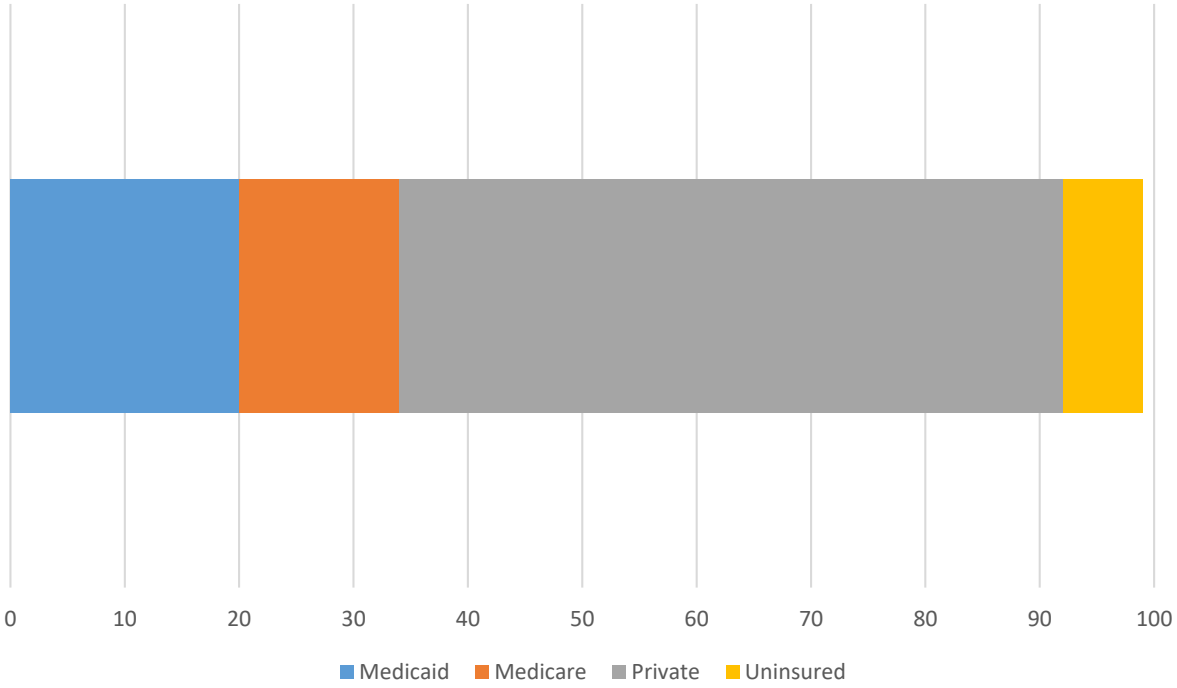
Multi-Payer Partnership Is Key

- Michigan's Overall Payer Mix
  - Private- Employer: 52%
  - Private- Non-Group: 6%
  - Medicaid: 20%
  - Medicare: 14%
  - Uninsured: 7%
- Each of Michigan's payer mix categories (with the exception of the uninsured) is comprised of multiple health insurance providers



Findings from Payment Reform Stakeholder Engagement: February 2015 to April 2016

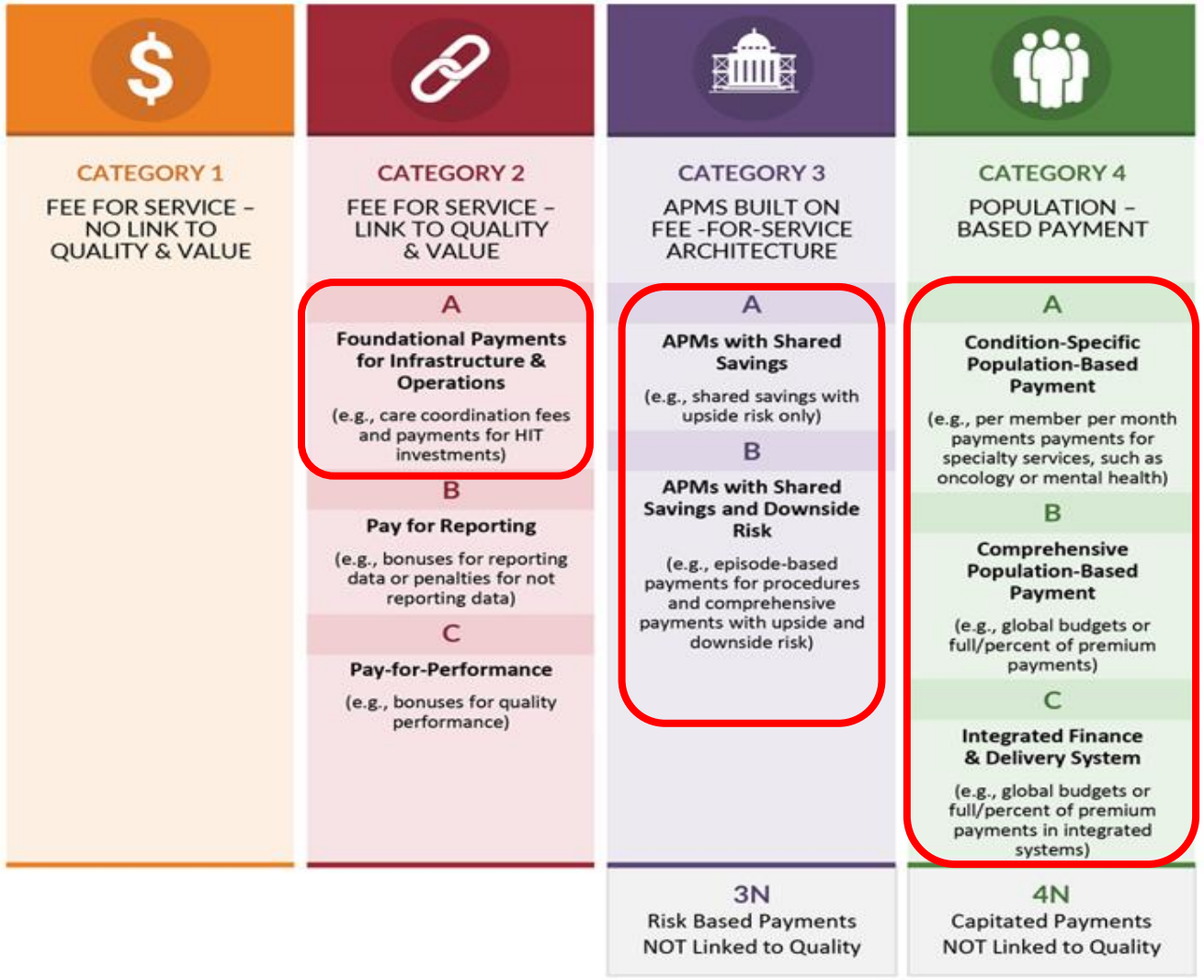
- Strong MDHHS commitment to sustain and expand PCMH, including support for and coordination between MCO care managers and practice-based care managers
- Strong MDHHS commitment to begin defining and encouraging the development and adoption of payment that moves away from fee-for-service
- ASC would be resource-intensive to develop and regulate responsibly on behalf of our health plan partners managing financial risk.
- Payer / provider marketplace already developing innovative approaches to move away from fee-for-service
- Prescriptive approach not conducive to supporting and enhancing the market-driven payment innovations already underway

Broad Advanced Alternative Payment Model (APM) Approach

	Baseline Year 2016 & 2017	Initiative Year 1 2018	Initiative Year 2 2019	Initiative Year 3 2020
Broad APMs	Collect Michigan's APM baseline	Implement strategy and establish goals Progressively increase percentage of payment in APMs		

- Broad adoption of APMs will be allowable statewide
- APM adoption in Medicaid will be administered through the Medicaid managed care organization contract
- APM adoption by other payers will be encouraged through collaborative discussion and partnership

Health Care Payment Learning & Action Network Framework



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Objectives

1. Increase APMs
2. Improve Quality
3. Reduce Provider Burden

APM Initiative Process

Objective 1: Increase APMs	Objective 2: Improve Quality	Objective 3: Reduce Provider Burden
APM Reporting: • Data Collection		
	Quality Strategy: • Regional Measures • Plan-Specific	
Oversight: • APM Strategic Plan • APM Implementation Plan		
		State Preferred Model: • PCMH

Reporting: Data Collection Tool

- MDHHS developed a data collection tool to monitor progress of MHPs in implementing alternative payment methodologies (APMs)
- Data collection tool builds off of the LAN
  - LAN whitepaper. https://hcp-lan.org/groups/apm-framework-refresh-white-paper/
  - definitions in the APM Reporting Tool are almost all identical to LAN APM Data Collection Tool. *http://hcp-lan.org/workproducts/apm-measurement-final.pdf*
- Unlike the LAN, the MDHHS APM Reporting tool:
  - Focuses only on Medicaid line of business
  - Adds a "small numerator"
  - Includes "pay per click" as part of Category 2B
  - Defines dominant APM to be that in which most funding can be earned/lost by a provider (note: this only applies to the big numerator)

Reporting: Data Collection Tool

- The report measures MHP implementation of APMs in two ways:

  Big Numerator

  - Follows LAN Framework
  - Measures all provider payments that are part of a contract that includes an APM

  Small Numerator

  - MDHHS developed
  - Measures only those provider payments within a contract that are actually part of an APM (e.g., the incentive payment)

- MHPs reported 2 years worth of data to create a baseline
- MDHHS provided extensive TA to ensure data was valid & reliable

Other Elements in the Report

- Potential Provider Incentive $
  - The full amount of funding that a provider in an APM arrangement may earn during the payment period if the provider meets all applicable quality and cost-effectiveness benchmarks for APMs that include Category 2B, 2C and/or 3A
- Beneficiary Count & Provider Counts
  - Captures individual count of beneficiaries and providers that participate in APMs
- Subcategory
  - Provides opportunity for MHPs to describe the different models and include narrative of where models overlap
- Definitions
  - Includes clarification on what words mean for the purposes of the APM reporting

Quality Strategy

- Regional Measures
  - Data analysis & methodology
  - MHPs were required to include a region-specific HEDIS measures in any APM in all regions they operates in
- Medicaid Health Plan-Specific Measures
  - MHPs included at least one additional measure in their APM model, specific to their own performance improvement assessment and goals

APM Strategic Plans

- MHP contracts required submission of APM strategic plans
  - Detailed how MHPs will increase use of APMs across LAN categories for a 3-year period
  - APM goals set by MHPs were based on baseline data
  - Included quality measures required by MDHHS
- MHPs submitted implementation plans for executing strategies
- MDHHS performed site visits to receive updates on progress by MHPs towards implementation of APM strategies consistent with implementation plans

State-Preferred PCMH Model

- Sustaining Care Management & Care Coordination services for Medicaid beneficiaries (SIM)
- MHP PCMH Discovery Process
- PCMH Proposed Model & Feedback

Health Plan PCMH Discovery Process

- All 11 MHPs submitted detailed information on their PCMH programs, including:
  - Current PCMH Program (narrative)
  - PCMH Designation Approach
  - Provider Eligibility and Participation
  - Care Management and Coordination Services
  - Link to Quality
  - Payment Methodology
  - Social Determinants of Health
  - Health Information Exchange Use Cases

State-Preferred PCMH Model

- MDHHS has developed a set of statewide PCMH program parameters that will be linked to future bonus payments

- PCMH Model Components:
  - Recognizing Providers based on accreditation and performance
  - Payment Parameters for PCMH practices/providers
  - Quality Reporting
  - Monitoring

Key Takeaways

- Validity and reliability of data collection process to accurately evaluate and monitor increases in APMs
- Quality improvement should be at the heart of adopting APMs
- Collaborative process and evidence based, rather than prescription and mandated methods to design a standard approach