

OFFICE OF THE
LEGISLATIVE
FISCAL
ANALYST

JONATHAN C. BALL
DIRECTOR

MEMORANDUM FOR EXECUTIVE APPROPRIATIONS COMMITTEE

FROM: Russell Frandsen, Product Manager
DATE: May 9, 2017
SUBJECT: Medicaid ACO Report on Current Efforts and Future Plans to Convert to Value-based Payment Arrangements

The 2017 Legislature passed the intent language below in H.B. 3, *Current Fiscal Year Supplemental Appropriations*, in item 86.

The Legislature intends that the Medicaid accountable care organizations report to the Executive Appropriations Committee in May 2017 on their current efforts and future plans to convert their payments to direct-care providers to value-based payment arrangements. The Legislature also intends that the Department of Health work with the Medicaid accountable care organizations to prepare a proposal for modifying the Utah Medicaid accountable care organization structure effective January 1, 2019 to qualify as an "Other Payer Advanced Alternative Payment Model" under federal Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) standards.

There are four reports included, one from each of Medicaid's accountable care organizations.

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SelectHealth Community Care
Value Based Payment Initiatives
May, 2017

Overview

SelectHealth Community Care launched in January, 2013, and is the largest Medicaid Accountable Care Organization (ACO) in Utah with over 96,000 enrollees. In 2016, the Community Care plan underwent Accreditation through the National Committee for Quality Assurance (NCQA) and was awarded Commendable status, receiving 87.8 points out of 100 (90 points represents Excellent status, the highest rating, which we expect to reach in 2018). The NCQA also rates health plans annually on a scale of 1 to 5 based on clinical quality, member satisfaction, and accreditation survey results. We received a 3.5 rating in 2016, and with weighting for Accreditation, we expect our score to increase to a 4 this year. In 2016, our Medicaid and CHIP products were also reviewed by Medicaid's External Quality Review Organization and received a score of 100% and 99%, respectively. With the implementation of feedback, we expect to reach the 100% level with our CHIP product.



Value Based Payment Initiatives

Aligning financial incentives has been a priority for SelectHealth and Intermountain Healthcare. We have a long history of providing performance based rewards to providers through our Medical Home and Quality Improvement programs, and are committed to improving the health of the communities we serve.

In 2011, Intermountain Healthcare and SelectHealth launched Shared Accountability, an organization-wide strategy to consistently deliver evidence based care, engage patients in their health and care choices, and align financial incentives. As part of this strategy we have launched several Alternative Payment Models (APM).

- In 2013, we implemented a shared risk APM between organizations to align incentives, and improve quality and service.
- In 2014, we piloted a physician APM with commercial enrollees, which was fully implemented and expanded to Medicaid and Medicare enrollees on January 1, 2016.
- In 2016, we launched a shared risk APM with Intermountain Primary Children's Hospital for commercial and Medicaid enrollees. The Pediatric Specialty Services APM includes physicians from the University of Utah Medical Group who practice at Primary Children's Hospital. Together they take financial risk for the unique pediatric services provided to children in the community. An early win has been the design of a program to discharge children from the Neonatal Intensive Care Unit to their homes for assisted feeding, rather than keeping them at the hospital. Beyond the cost savings, this program opens space for more critical patients, there is reduced infection risk, and the children are with their parents.
- Care coordination payments are also made to physicians to support the infrastructure needed to coordinate care for complex enrollees. Most are made through our patient centered medical home model, and some are also made to specialty care. For example, primary care physicians receive a

payment for providing care for Restricted enrollees (i.e., super-utilizers). There are also payments made to specialists who care for medically needy patients, such as trach-dependent children.

We also participate nationally in the Health Care Payment Learning and Action Network (LAN), and support its mission to accelerate APMs. The LAN’s mission aligns with our Shared Accountability model, and we are committed to having 60% of all insured member enrollment in a shared-risk APM by 2020.

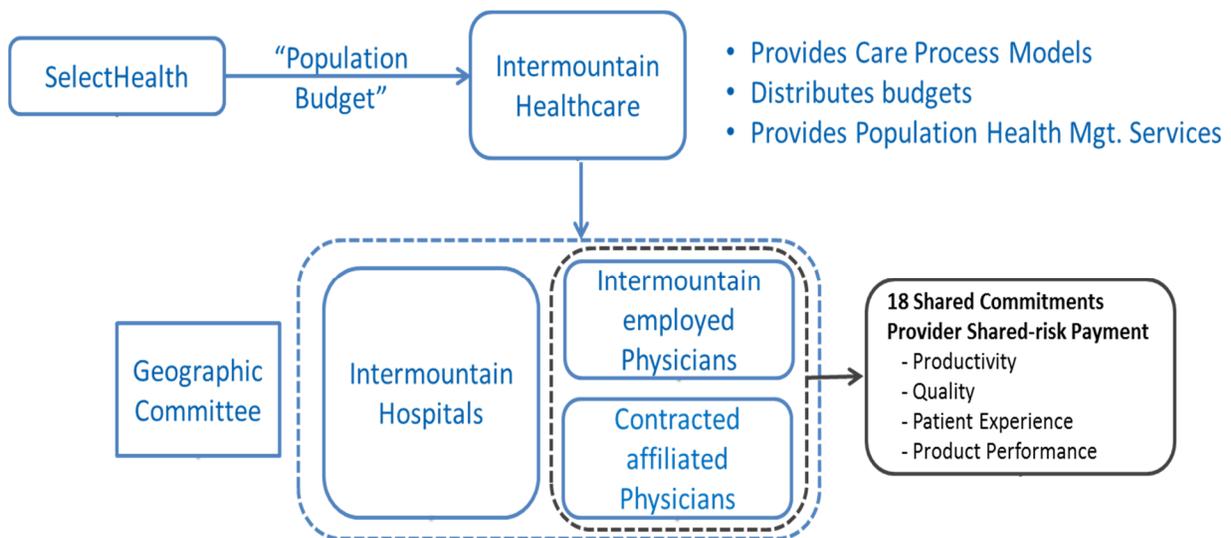
Shared Accountability – Shared Risk APM Framework

Shared Accountability has three goals:

1. Align financial incentives.
2. Engage patients in their health care.
3. Provide evidence based care.

The description and graphic below provides an overview of the Shared Accountability framework.

- The medical expense portion of the health care dollar becomes a population health budget.
- Intermountain provides evidence-based care process models, population health services such as analytics, and distributes budgets to regions.
- Regions oversee the budget, which has upside and downside risk.
- Regions are responsible for managing the health care for individuals who live in their service areas.
- A Geographic Committee made up of intermountain and affiliate network physicians creates improvement goals for the region, and engages physicians.
- Within regions there is a physician APM that was launched in January 2016.
 - Under this model, employed and affiliate network physicians commit to clinical excellence, equal access for all patients, and use of certified health record technology, among 18 shared commitments.
 - Payment is based upon a fee schedule, with performance payments for improvements in quality, patient experience, and the performance of the product. Intermountain regions hold the downside risk, and share upside performance payments with physicians.



Executive Appropriations Committee Report

Health Choice Utah

May 16, 2017

About Health Choice Utah

Health Choice Utah was established in 2011 by IASIS Healthcare and commenced business in April of 2012. Health Choice Utah exists to improve the health and well-being of the individuals we serve through our health plans, integrated delivery systems, and managed care solutions. We currently provide services to 18,472 members in 18 counties, which represents 7.6% of enrolled ACO membership.

Currently, 27% of our members receive care from a provider who participates in a Health Choice value-based reimbursement contract that rewards providing appropriate care in the right setting, and improving quality and patient satisfaction. We expect that more than 50% of our providers will be participating in value-based contracts by the end of CY17.

The Power of Provider Partnerships & Value Based Reimbursement

Financial incentives drive behavior - *"The best way to herd cats is to move their food"*. Dr. Arlen Jarrett, IASIS Utah Market - Chief Medical Officer

- Engaging PCPs in moving from fee-for-service episodic visits to intelligent risk management and care avoidance episodes, creating focus on preventative best practices, evidence-based protocols, and the total cost of care for a given patient
- Providing accountability for peer-to-peer performance measures (quality, cost, satisfaction) and measurement of variance; validated to support transparency efforts
- Encouraging providers-patient engagement efforts that impact non-value added waste in the system: transitions for high acuity members, readmission risk factors, effective management of chronic disease, socialization, addiction and behavioral health
- Developing data feeds that contribute to continuous improvement circles, empowering more effective processes and more impactful patient interaction
- Focusing on patient and *caregiver* engagement through technology and transparency, designed to provide options based on preference and appropriate care

Aligning the Interests of PCPs, Specialists, and Hospitals

- Aligning economic interests of individual providers and hospitals in order to facilitate a positive net impact to Utahans, and provider stakeholders
- Acting on policy and State statutes that supports an aligned and united vision (end of life care and advanced directives)
- Improving risk pools that reward PCPs, specialists, and hospital partners, rewarding volume only after value is demonstrated

Provider Assumption of Financial Risk & Supporting a "Glide Path to Risk"

- Accommodating different appetites for down side risk assumption based on panel size, operating infrastructure, provider specialty, analytics capability, and current staffing: Strategies are defined to accommodate large multi-specialty providers and smaller practices with 10 or less providers
- Ensuring success factors defined in contracts support steps on glide path continuum
- Aligning methodologies for the management of Medicaid, Medicare, and Commercial risk

Our Commitment

Health Choice Utah affirms our commitment to improve the value of care provided to residents in Utah by transitioning to value-based reimbursement contracts and by supporting the Utah Department of Health in qualifying the ACO Medicaid program as an Advanced Alternative Payment Model under MACRA standards.

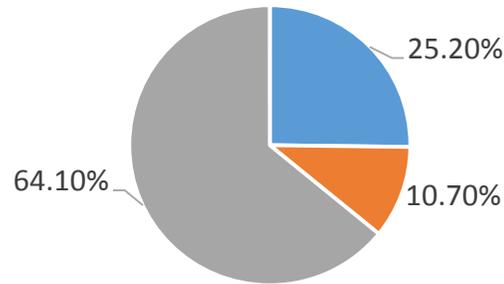
Executive Appropriations Committee

- Established in 1998, Healthy U currently covers over 46,000 Medicaid lives throughout the state of Utah.
- Healthy U partners with providers of all health systems, multispecialty clinics, and independent practices.
- Healthy U is committed to working with providers to transition to population health management with aligned quality outcomes and financial measures.
- Healthy U established our first value-based payment model in 2013 as a foundation for advanced alternative payment models.

Healthy U's Risk Maturity

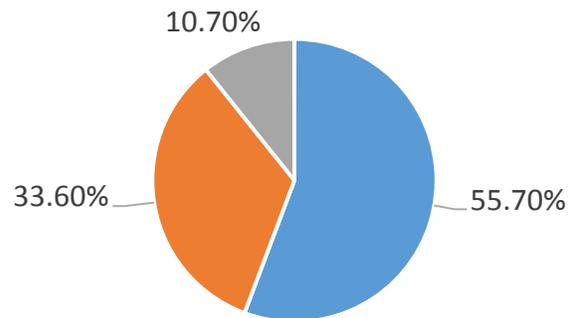
Percentage of Membership & Dollars under Alternative Payment Models

Membership



■ Fee for service ■ Value based payment ■ Capitation

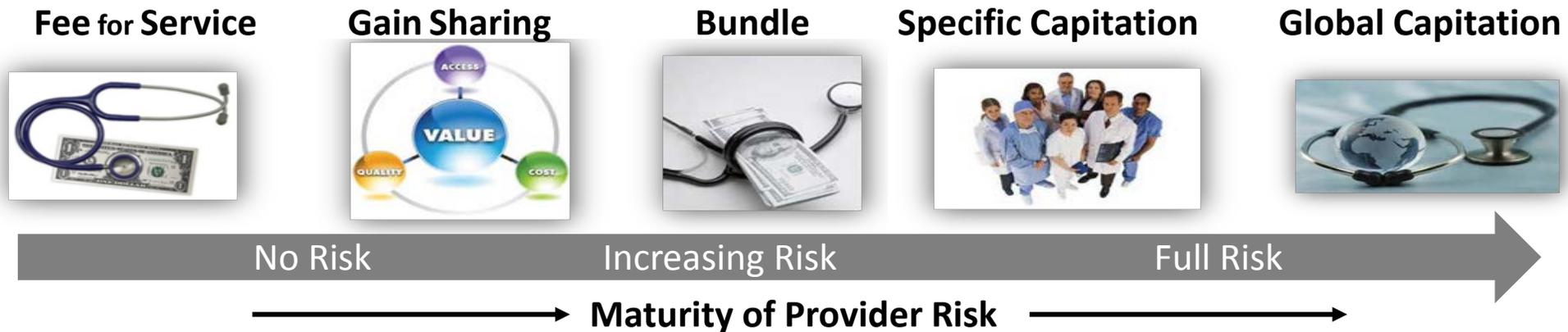
Paid Dollars



■ Fee for service ■ Value based payment ■ Capitation

- Over 74% of Healthy U members are attributed to a provider in an alternative payment model, representing over 40% of total Healthy U medical expenditures.
- Healthy U's value based payment model, started in 2013, includes both financial and quality based measures.
- Healthy U actively utilizes risk stratification models in identifying the appropriate population health management techniques in partnership with providers.
- Healthy U continues to work with primary care physicians and specialists to develop additional APMs, data infrastructure, meaningful outcomes, and patient/member engagement.

Continuum of Payment Models





Molina Healthcare of Utah
Value Based Reimbursement
W. David Patton, Plan President, PhD

May 16, 2017

Our mission – to provide quality healthcare to people receiving government assistance.

What makes us unique – we are a multi-state healthcare organization with **broad capabilities** focused exclusively on **government sponsored healthcare programs** for low income individuals and families.

Health Plans



Risk based health plan for Medicaid, Medicare, and the Marketplace programs

Medicaid Health Information Management



Medicaid non-risk, fee based fiscal agent services, business process outsourcing, and care and utilization management

Direct Delivery Primary Care



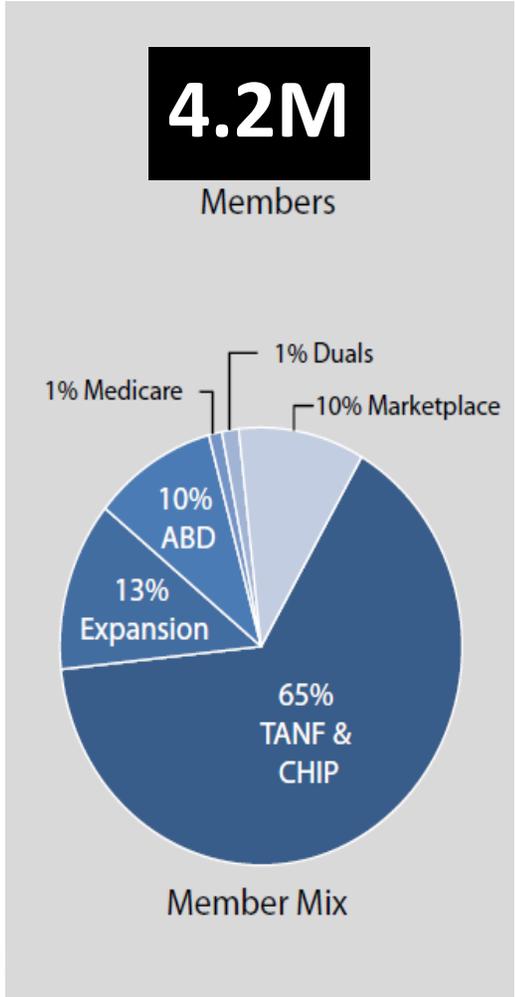
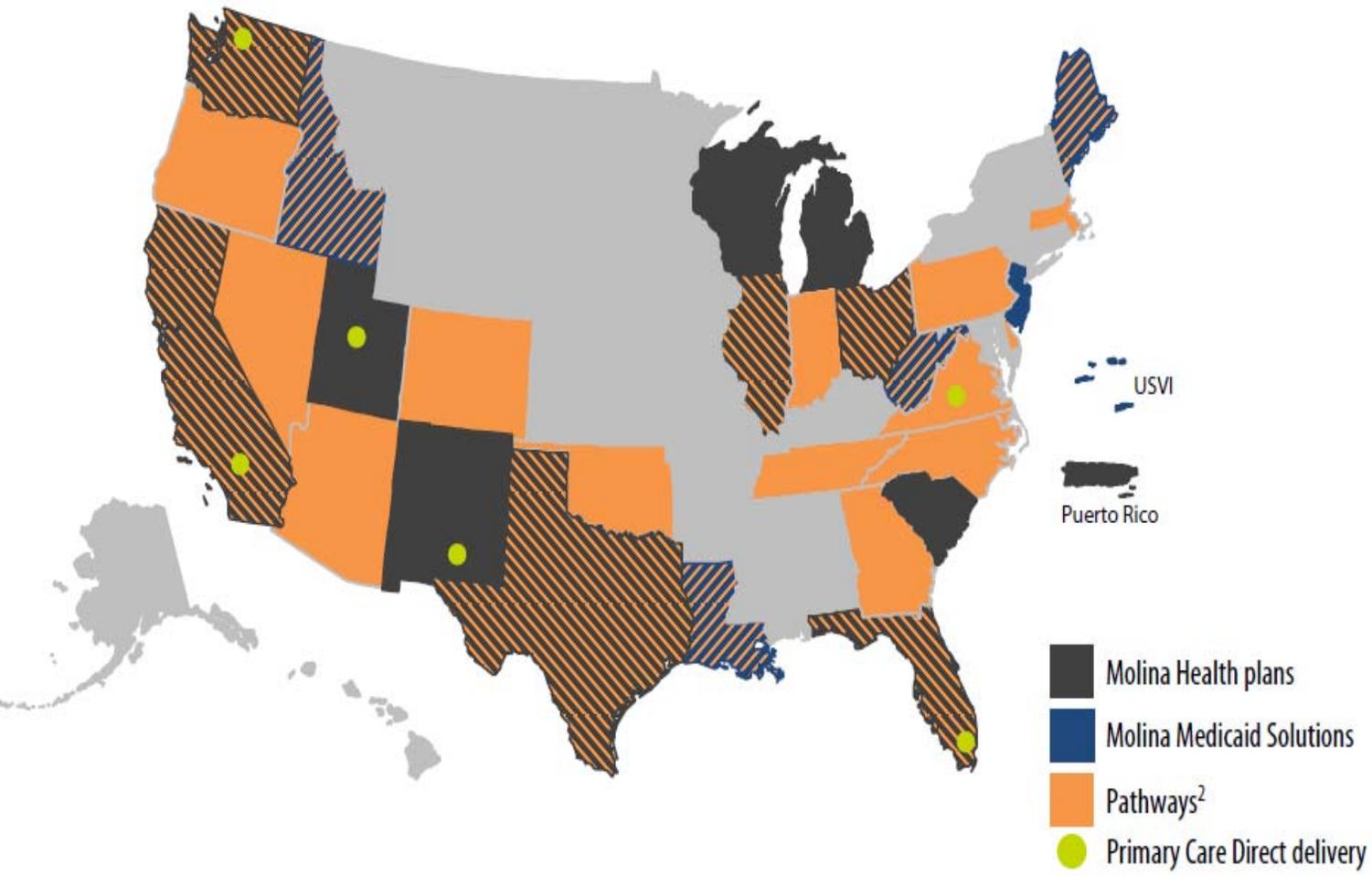
Company owned Molina operated primary care and community clinics

Medical Services Behavioral Health



Provider network of outcomes based behavioral/mental health and social services.

Footprint today includes the five largest Medicaid markets, the three largest Marketplace markets, and the largest D-SNP and MMP enrollments in the country



- The Legislature intends that the Medicaid accountable care organizations report to the Executive Appropriations Committee in May 2017 on their current efforts and future plans to convert their payments to direct-care providers to value-based payment arrangements.

- All direct-care providers have been encouraged to participate in value-based payment plans.
- This leads to:
 - Greater focus on the quality and cost of care
 - Earlier transition from fee-for-service to value-based care
 - Incentives to providers that meet agreed upon standards of quality outcomes
- Successes to date:
 - Six large Primary Care groups participating in a Medicaid shared savings and quality agreement covering nearly 50% of Medicaid members

