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Moving Delaware Medicaid to Value: Leveraging Contracts as Policy Tools

Stephen Groff,[1] Steven Costantino[2] and Elizabeth J. Brown, MD MSHP[3]

1. Director, Division of Medicaid and Medical Assistance (DMMA), Delaware Department of Health and Social Services (DHSS)

2. Director, Health Care Reform, Office of the Secretary, DHSS

3. Medical Director, DMMA

The definition of value seems straightforward: Isn't it just quality divided by the cost? That deceptively simple equation hides a complex concept that has been widely debated in health policy. How do we measure quality? Who decides when the quality is high enough? Whose costs are counted? Can we even figure out what anything in health care costs, anyway?

Although there is a range of opinions on what constitutes value, most people agree that our current fee-for-service payment system is not designed to optimize it. Traditional payment methods treat health care services like widgets. We count the things done in an office or hospital and pay for each one. Under strict fee-for-service, providers who see the most patients and provide the most billable services end up ahead financially, without much regard for quality or outcomes. This system does not incentivize prevention, a core component of public health.

The United States spends about twice as much per person on health care than other wealthy countries, on average.[1] Despite that, our system does not provide consistently high quality care. For example, we are less likely to be able to get a same-day visit than in other comparable countries,[2] and only 8 percent of adults have received all recommended clinical preventive services.[3] Overall, our health outcomes are worse than other high-income countries, as evidenced by higher disease burden and mortality rates.

Delaware is not an exception. In 2018, Delaware ranked 31st amongst the states in health[4] despite spending nearly 30 percent of the state budget on public health care costs. To address the mismatch between health care spending and outcomes, in 2017 the Department of Health and Social Services (DHSS) launched a multipronged approach to transition from a volume-based payment system to one that rewards efficient, high quality care. Of the strategies described in *Delaware's Road to Value*[5] the statewide benchmarks for spending and quality received the most public attention. However, incorporating value-based thresholds into the contracts with the Medicaid managed care organizations (MCOs) was another important element.

Medicaid is the medical assistance program that provides insurance coverage to low-income individuals and families, and people with disabilities. In Delaware, that coverage is provided through one of two MCOs that the State selected through a competitive bid process: Highmark Health Options or AmeriHealth Caritas. After someone is determined to meet Medicaid eligibility criteria, they have the option to enroll in either MCO, or are auto-enrolled if they do not make a selection. The Division of Medicaid and Medical Assistance (DMMA) service requirements, coverage parameters, and care expectations are formalized through contracts with the MCOs. DMMA develops those contracts based on federal requirements, as well as DMMA's priorities.

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Beginning in the 2018 contracts, DMMA included value-based purchasing (VBP) as a key component in the MCO contracts. The VBP approach is dual pronged: quality performance measures (QPMs) and VBP provider contracting. DMMA set quality measure benchmarks for seven key performance measures. The contracts also establish targets for the proportions of the MCO's total spending that are part of VBP agreements with providers. In both cases, financial penalties are applied if MCOs do not meet the agreed upon targets. The explicit connection of monetary consequences to contracting and quality goals is an innovation for DMMA.

Quality Performance Measures

Performance measurement has long been an integral component of the relationship between DMMA and the MCOs. The MCOs are required to report on commonly used measure sets including the Centers for Medicare and Medicaid Services (CMS) Adult and Child Core measure set[6] and HEDIS measures.[7] Setting benchmarks and tying potential financial penalties for not meeting those benchmarks takes this a step further to ensure that we are fully incentivizing high quality care.

The seven QPMs include a mixture of structure, process, and outcome measures covering a range of chronic disease management, preventive care, and acute care (see Table 1). They were selected based on a combination of measurability, impact, historical performance, and populations affected. All except one of the QPMs are measured based on HEDIS specifications. For those measures, the minimum performance standard is set at the HEDIS 50th percentile of Medicaid plans nationally, except for the timeliness of prenatal care, where the standard is the HEDIS 66.67th percentile. For the hospital readmissions QPM, which is based on Delaware-specific specifications, 2018 was the baseline year; satisfactory performance will be any improvement over the 2018 baseline.

Table 1: Quality Performance Metrics. Benchmarks are percentiles of Medicaid managed care plans nationally. Weighting is fraction of potential maximum 1% penalty.

Name Brief Description	Type	Benchmark	2019 Weighting	2020 Weighting	Notes
Comprehensive Diabetes Care Patients ages 18-75 with diabetes with Hgb A1c <8%	HEDIS Hybrid	50th percentile	1/5	1/7	
Medication Management for People with Asthma Patients ages 5-11 and 12-18 who were identified as having persistent asthma and were dispensed appropriate asthma-control medications that they remained on for at least 75% of their treatment period.	HEDIS Administrative	50th percentile	1/5	1/7	
Cervical Cancer Screening Women age 21–64 who had cervical cytology performed every 3 years OR	HEDIS Hybrid	50th percentile	N/A	1/7	Allows 3 year lookback

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Women age 30–64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years.					
Breast Cancer Screening Women ages 50–74 who had at least one mammogram to screen for breast cancer in the past two years	HEDIS Administrative	50th percentile	N/A	1/7	Allows 2 year lookback
Adult Body Mass Index Assessment Patients age 18–74 years of age who had an outpatient visit and whose body mass index (BMI) was documented	HEDIS Hybrid	50th percentile	1/5	1/7	
Timeliness of Prenatal Care Deliveries that received a prenatal care visit as a member of the organization in the first trimester, on the enrollment start date or within 42 days of enrollment in the organization	HEDIS Hybrid	66.67th percentile	1/5	1/7	
Hospital Readmission Rate—30 day Non-elective readmission within 30 days of discharge from index inpatient admission	DE-specified Administrative	2018 baseline	1/5	1/7	

Because 2018 was the first official year of the QPMs and the reporting process was still being refined, it was considered the baseline year with no potential financial penalties. The MCOs did report estimated quarterly results and are fully engaged in the process. In future years, the financial penalty is a maximum of 1 percent of total payment, with QPMs weighted differently in 2019 and 2020. The details of how the 2021 and 2022 potential penalty will be calculated will be described in future contracts.

Challenges

There are inherent limitations in any quality measurement system. In order to keep the burden of reporting reasonable, we chose a small number of measures. That means that many well established, validated, clinically important measures could not be included. Hard to measure aspects of quality, such as patient satisfaction, could not be included. It also limited the number of population-specific measures.

Timing has been one of the major challenges. Most of the measures are based on claims data, which always have a lag time. For those measures that include both claims and chart review, that chart review can further delay accurate reporting. HEDIS Medicaid percentiles provide a valid, reliable source of benchmarking data, but final HEDIS results are generally not available until

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approximately 10 months after the end of the measurement year. If a financial penalty is ever assessed, it will be temporally distant from the performance year.

Value-based Purchasing

The second prong of DMMA's VBP approach requires the MCOs to have their own value-based arrangements with providers. Incentivizing providers to deliver high quality and efficient care requires shifting financial risk from payers to providers while measuring quality and outcomes. Along with increasing financial risk generally comes increasing flexibility for providers. Rather than being only reimbursed for services provided exactly as described under the fee-for-service framework, providers who are paid for outcomes can use innovative, non-traditional approaches to caring for patients. That could mean providing team-based care, care at home or outside the traditional office setting, telehealth or other new technologies, and proactive care coordination, to name just a few.

Making that shift generally requires an incremental approach, as providers need to develop data infrastructure, skills in population health management, and new modes of care delivery. At the same time, payers need to learn how to best share information and collaborate with providers. One of the most widely used frameworks that illustrates the steps from fee-for-service to more population-based payments is the Healthcare Learning and Action Network (LAN) framework[8] (see Figure 1). Although the MCO contracts do not explicitly refer to the LAN framework, it can be a useful graphical representation of the types of arrangements along the alternative payment model continuum.

Figure 1. Updated APM Framework[8]

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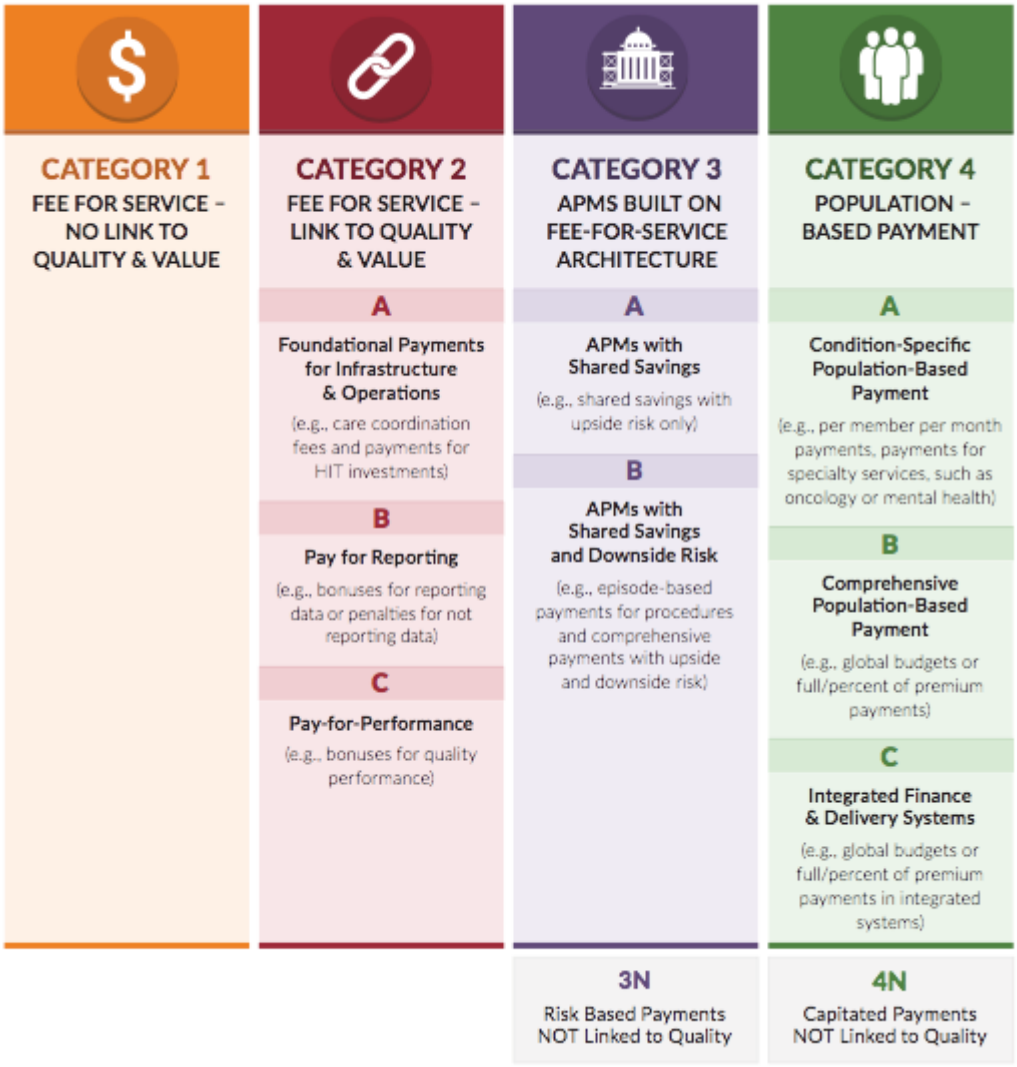

The first steps generally include ways in which providers can receive payments above and beyond what they could get in fee-for-service, such as care coordination fees that are not tied to quality or outcomes, to pay-for-performance bonus payments, to shared-savings arrangements with "upside risk," or the potential for increased payment only. More advanced payment models put providers at true financial risk, including potential losses for poor performance, so-called "downside risk. " Advanced payment models range from "bundles" or a single payment surrounding an episode of care such as a surgery, to shared savings with upside and downside risk, to full capitation. In these more advanced arrangements, the increasing level of financial risk creates stronger provider incentives to maximize prevention and provide high quality care in the right place at the right time.

Shifting to risk means that often a common language is important. Of particular importance to the Department is potential confusion regarding the difference between "value" and "risk." These two terms often are used interchangeably, but are significantly different in the MCO contracts. In an April 2018 issue brief from the American Hospital Association (AHA),[9] the AHA noted that value is a term that means different things to different people:

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> "For some, value is simply finding the right mix of health care services that meet their needs. Some only want the best there is to offer, regardless of price or convenience. For others, value means friction-free, convenient access to health care services. Yet others focus solely on price, typically the price of front-end premiums, to determine whether the health care services offered will match their budgets … it's a concept of relative worth."

The AHA concluded that value is the relationship between outcomes and patient experience to cost.

To balance encouraging behavior change with the time needed to implement new systems and processes, DMMA's MCO contracts expect that increasing percentages of provider contracts will be in VBP arrangements over time. The MCO-to-provider arrangements are measured as the percentage of all medical and service payments to providers that are under alternative payment arrangements. To ensure that we are encouraging value, those payment arrangements must include more advanced payment models over time, with true shared financial risk as the program matures. We want to move toward Category 4 alternative payment models to promote the transition of our health care system to be more dominated by innovative, value-based alternative payment arrangements.

Because AmeriHealth Caritas was new to the market beginning in 2018, their thresholds were set lower for 2018 and 2019 than the thresholds for Highmark Health Options (see Figure 2). By 2022, both plans are expected to have at least 60 percent of their spending in VBP arrangements, and at least 75 percent of that must be in advanced payment models. If the plans fail to meet the thresholds, they could be subject to a penalty of up to one percent of the payment they receive from DMMA. In the first year of reporting, both plans met the threshold, so no penalties will be assessed for 2018.

Figure 2. Value Based Purchasing Benchmarks

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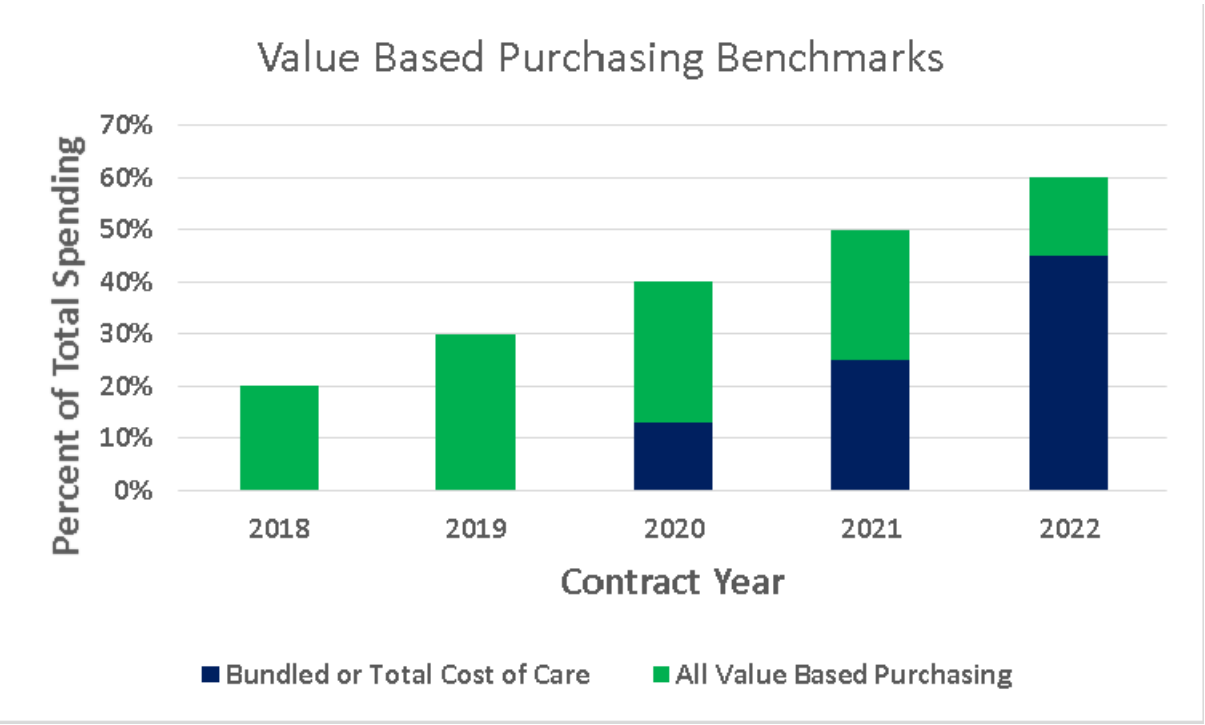

Challenges

Even though the contract specifications described the types of arrangements that would be considered acceptable, it was impossible to anticipate all of the details of potential arrangements. Over the reporting year, DMMA and the MCOs needed to discuss the details of the arrangements and do some interpretation of whether they truly met DMMA's expectations. The contract also requires that the arrangements be in place, but does not assess the outcomes of the VBP contracts. The MCOs are ultimately responsible for interpreting the success of their VBP arrangements and modifying them if they are not encouraging the high quality, efficient care they are designed to produce.

In summary, including a VBP program in the contracts that DMMA has with our MCOs is an important step toward a Medicaid program that rewards value over volume. It has reshaped the relationship between the State as a payer and the entities that we contract with to ultimately deliver services. In 2018, we demonstrated that such a program was possible and learned important lessons in how to implement it. As we enter future contract years with more ambitious thresholds, we look forward to continually assessing our progress toward a system that provides the best value to our Medicaid population and our state.

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