Value Based Purchasing (VBP)

Long Term Supports and Services Stakeholder Finance Work Group

Indiana Family and Social Services Administration
Office of Medicaid Policy and Planning
February 25, 2021

Why Reform Indiana's LTSS System?

From 2010 to 2030 the proportion of Hoosiers over 65 will grow from 13% to 20%. Indiana's disjointed system must be reformed to meet growing demand and to ensure Choice, drive Quality and manage Cost.

Choice: Hoosiers Want to Age at Home

- 75% of people over 50 prefer to age in their own home – but only 45% of Hoosiers who qualify for Medicaid are aging at home
- The risk of contracting COVID and impact of potential isolation drives an even increased desire to avoid institutional settings

Cost: Developing Long-term Sustainability

- Indiana has about 2% of the U.S. population, but over 3% of nursing facilities
- LTSS members are 4% of Medicaid enrollment, yet 28% of spend - only ~ 19% of LTSS spend goes to home and community-based services (HCBS)
- For next ten years, population projections show 28% increase in Hoosiers age 65+ and 45% increase in Hoosiers age 75+

Quality: Hoosiers Deserve the Best Care

- AARP's LTSS Scorecard ranked Indiana 44th in the nation
- LTSS is uncoordinated and lacks cultural competency
- Payment for LTSS services is poorly linked to quality measures and not linked to outcomes

Indiana's Path to LTSS Reform

Our Objective

1) 75% of new LTSS members will live and receive services in a home and community-based setting
2) 50% of LTSS spend will be on home and community-based services

Key Results (KR*) to Reform LTSS

1. Ensure Hoosiers have access to HCBS within 72 hours
2. Move LTSS into an mLTSS model
3. Link provider payments to member outcomes (value-based purchasing)
4. Create an integrated LTSS data system linking individuals, providers, facilities, and the State

*All KR work will be coordinated with Medicaid supplemental payment reform and depends upon finalization of federal guidelines

Deliberative and Confidential

Rate Methodology Goals and Objectives

To develop rate methodologies that comply with Centers for Medicare and Medicaid Services (CMS) rules and achieve the following:

1. **Alignment and Transparency** - bring continuity and alignment across the rate methodologies and rates for all programs, providing a consistent framework
2. **Sustainability** - facilitate adequate participant access to services and be sustainable under the FSSA budget and operations
3. **Promotion of Person-Centeredness and Value-Based Purchasing** - striving to align provider and participant incentives to achieve access to person-centered services, encourage appropriate utilization, and drive healthy outcomes for all Hoosiers that we serve

Agenda

- Background - Healthcare Purchasing Models
- Definition of Value Based Purchasing (VBP)
- Value Based Reimbursement Continuum
- Existing Nursing Facility VBP Program
- Update in Nursing Facility VBP Metrics
- Next Steps for Long Term Supports and Services

*** Audience Participation Opportunities***

Fee For Service Model

- A traditional volume-based model that generally pays a provider fee for each visit, service, procedure or admission regardless of its value
- Providers have a financial incentive to provide more services or higher cost services
- Traditional Fee for Service Model has limited controls over utilization, inflationary pressures

Capitated Risk Transfer Model
Example from 1933

Pre-Paid Medical Plan - Cost 5 cents per person per day

Colorado River Aquaduct Project

Pre-Payments

Contractors General Hospital - Mojave Desert

- A provider (or Health Plan) is paid a fixed monthly fee for each covered member and is then responsible for providing all necessary care for that member
- Providers have a financial incentive to <u>provide services at the lowest cost</u>

Healthcare Purchasing Question #1

Which US President signed legislation that enabled broad expansion of the **Capitated Risk Transfer Payment** Model?

1. Lyndon Johnson
2. Richard Nixon
3. Ronald Reagan
4. George Bush
5. Barack Obama

Healthcare Purchasing Answer #1

Which US President signed legislation that enabled broad expansion of the Capitated Risk Transfer Payment Model?

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- The HMO Act of 1973 enabled expansion of HMOs throughout the US
- The objective of the Act was to combat cost increases being seen for the Medicare population (which was being paid on FFS basis)
- Introduced the name “Health Maintenance Organization”
- Allowed provider bonuses for lower utilization

Healthcare Purchasing Question #2

Which US President signed legislation that enabled expansion of the **Value Based Purchasing** Model?

1. Lyndon Johnson
2. Richard Nixon
3. Ronald Reagan
4. George Bush
5. Barack Obama

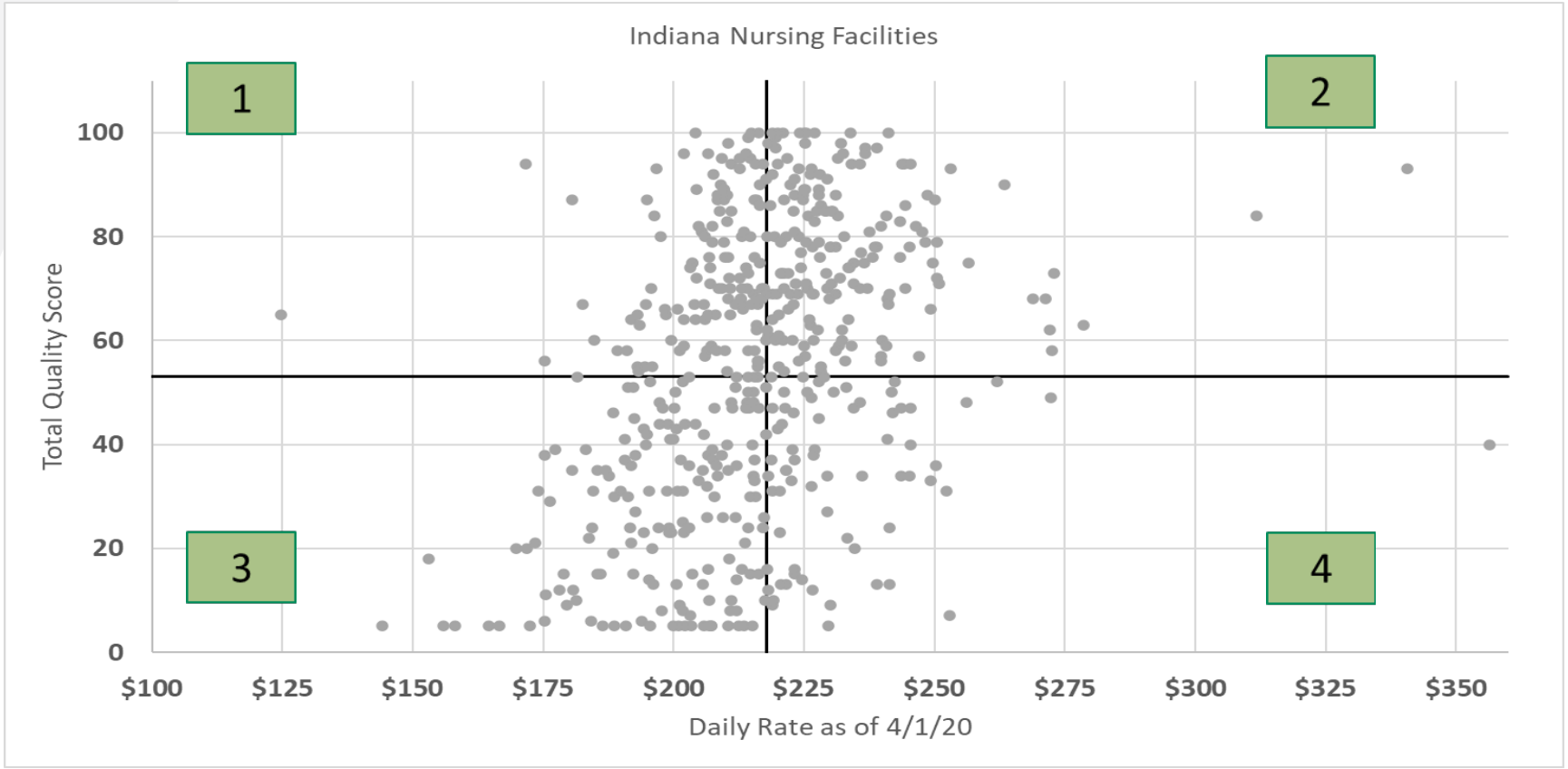
Healthcare Purchasing Answer #2

Which US President signed legislation that enabled expansion of the **Value Based Purchasing** Model?

1. Lyndon Johnson
2. Richard Nixon
3. Ronald Reagan
4. George Bush
5. Barack Obama

- The Patient Protection and Affordable Care Act was signed in 2010
- One objective of the Act was to reduce healthcare spending and improve quality of care
- The Act Introduced VBP approaches including Pay for Performance, Accountable Care Organizations and Bundled Payments
- VBP payments hold providers accountable for both cost and quality of care

Question 3 : What is Value?
Nursing Facility Rates vs. Quality Scores



Which Quadrant represents the best Value?

What is Value-Based purchasing?

- Value-Based Purchasing (VBP) is a set of performance-based payment models that link providers' performance to financial incentives:
  - Value based payment reduces inappropriate care and rewards providers who achieve desired performance outcomes
  - VBP drives **improvements in quality** and **slows the growth in health care spending**

- Value based incentives should:
  - **Reach the providers that deliver care**
  - Be significant enough to motivate providers to invest in infrastructure and adopt new approaches to care delivery
  - Be based on meaningful quality performance measures
  - Be timely

Healthcare Payment Learning & Action Network

Value-Based Payment Models

1. **Rewards:** Providers receive a bonus payment for measureable performance in quality, patient satisfaction, resource use, and/or cost.

2. **Penalties:** Providers receive lower or no payment for events and procedures that are harmful and were avoidable.

3. **Bundled Payments:** Providers receive an inclusive payment for a specific scope of services to treat an "episode of care" with a defined start and end point.

4. **Shared Savings/Risk:** Providers have an annual, risk-adjusted, predicted total-cost-of-care target for an attributed set of patients. Providers that succeed in keeping actual costs below projected costs can keep part of the savings.

5. **Global or Capitated Payment:** Providers receive a per-member-per-month payment to cover a wide range of services and bear the financial risk for their patients for the specified services.

Healthcare Purchasing Question #4

Indiana Medicaid Managed Care programs currently cover 1.5M Hoosiers. Which payment model(s) are featured in these programs?

1. Fee for Service
2. Capitated Risk Transfer
3. Pay for Performance Quality Payments
4. Value Based Purchasing
5. All of the above models

Healthcare Purchasing Answer #4

Capitated Risk Transfer – Risk is transferred from the State to the MCEs

Fee for Service – MCEs pay the vast majority of claims on a fee for service basis

Pay for Performance – A portion of MCE capitation rates (~2%) are subject to Pay for Performance Quality requirements

Very Limited Value Based Payments to Direct Care Providers

State and Provider VBP for LTC

States are increasingly looking to implement VBP in long term care provider settings for reimbursement

- Payment may be made as a rate add-on as part of the per-diem rate for providers meeting the quality thresholds or measurements.
- Data is typically used from Nursing Home Compare, Report Card Scores, Staffing data, and Person-Centered Care measures.
- A few states using or developing VBP for LTC:
  - Idaho
  - Kansas
  - Indiana
  - Minnesota
  - Oklahoma
  - Maryland
  - Texas
  - Missouri

VBP Program Considerations

What are our program objectives / measures of success?

- Quality Improvement?
- Cost Containment?
- Both?

How do we define Quality?

- Existing Industry Metrics? (CMS Stars , HEDIS)?
- State specific metrics? (Tied to Strategic Plan, Governor's Pillars)
- Long term measurements?

Where will our program fall on the VBP continuum?

- Do we start with Pay for Performance?
- Are IN providers ready for risk sharing programs?

Indiana Nursing Facility VBP Program Current Quality Measurements

Existing Industry Metrics

- CMS STAR Ratings - Long Stay Quality Metrics
- Indiana State Department of Health Survey Scores

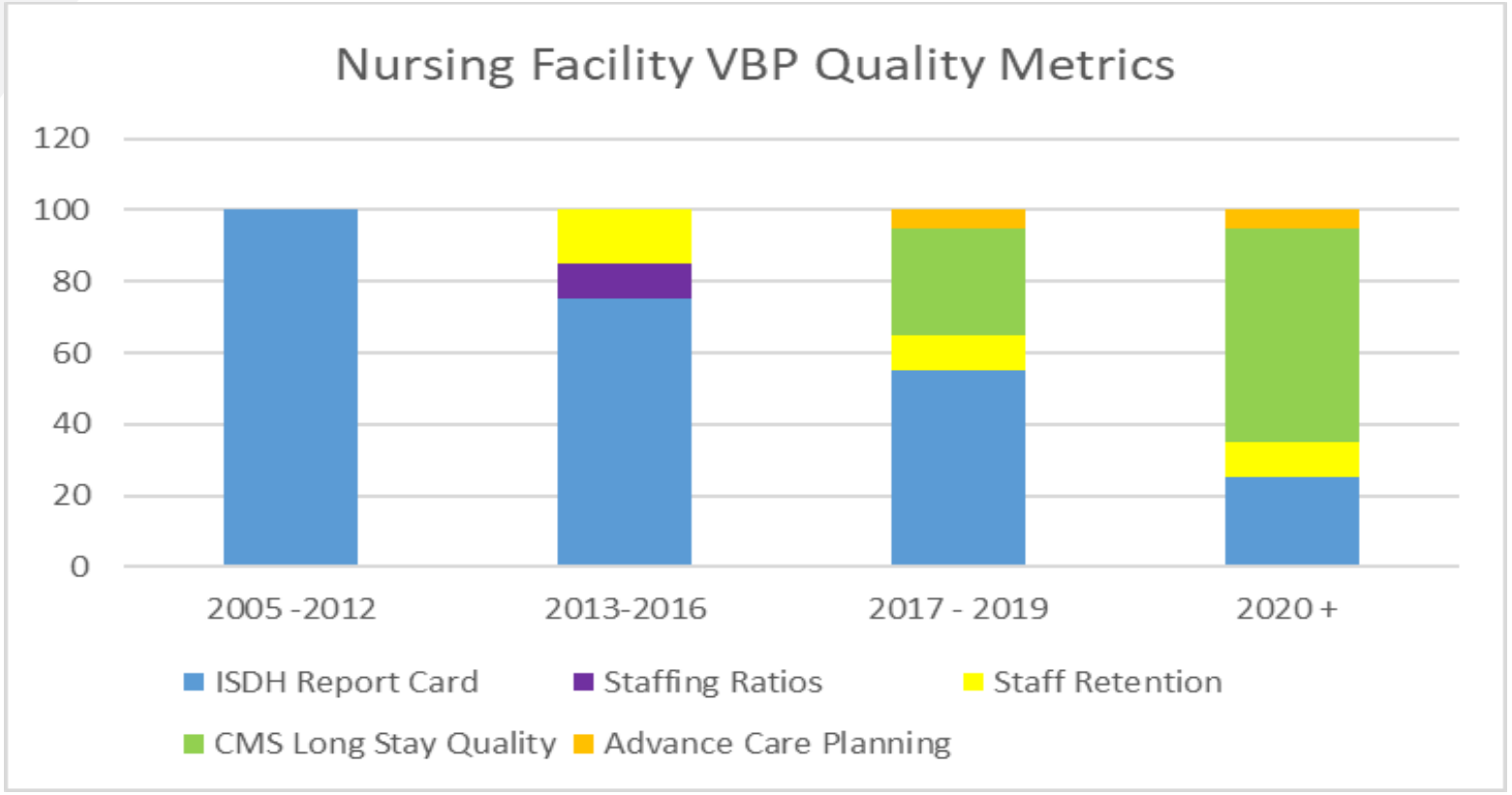
State Specific Metrics

- Nursing Facility Employee Retention
- Advanced Care Directive Training

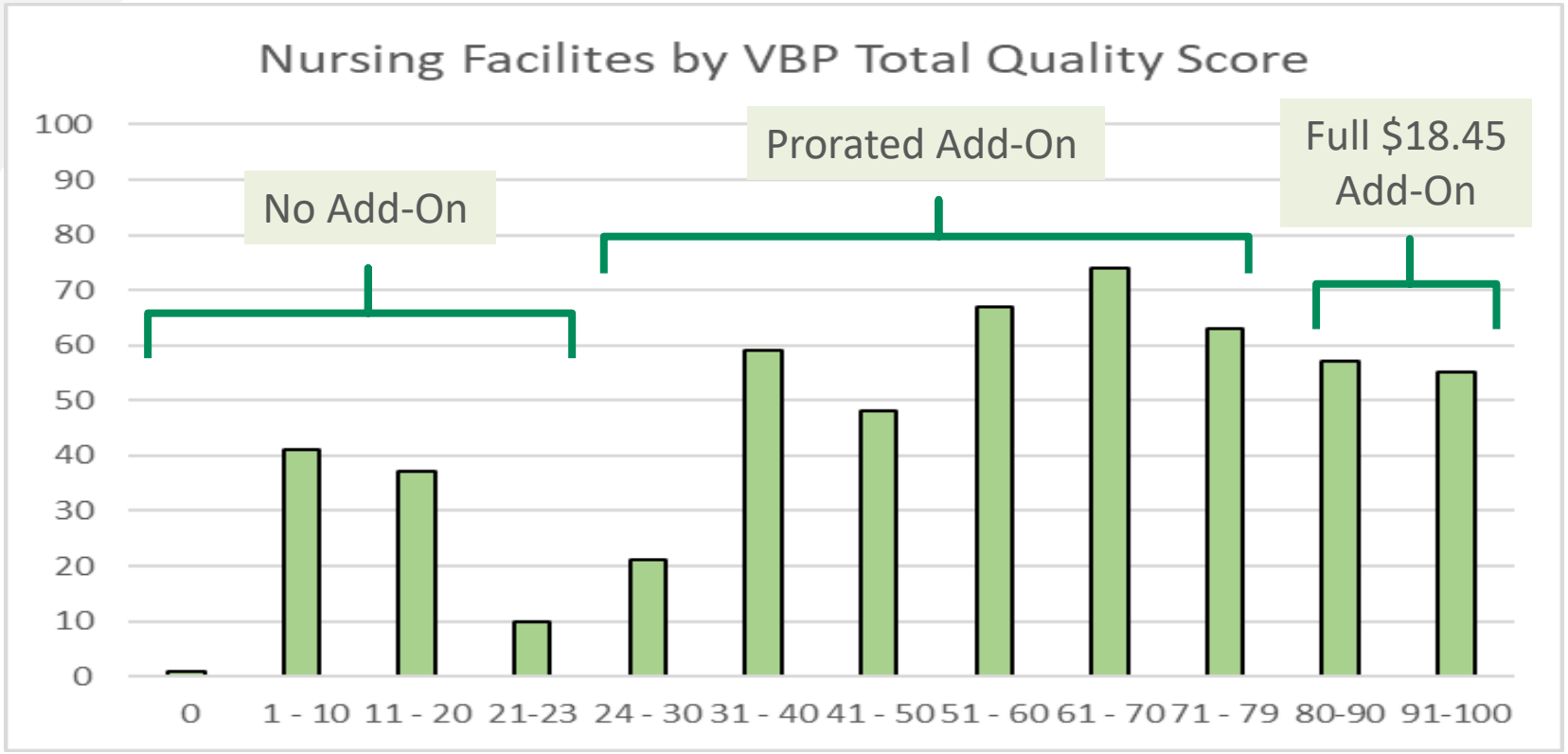
Indiana Nursing Facility VBP Program Current Quality Measurements

ISDH Health Survey - 25% (0 -25 points)	CMS Long Stay Quality - 60% (0-60 points)
CMS publishes health inspection ratings Categories surveyed include Administration, Care and Services, Resident Rights, Dietary and Environment; recnt focus on Infection Control	CMS assigns point for measures such as: Loss of mobility, increased need for help with daily activities, fall with injury, pressure ulcers, use of physical restraints, psychotic medicine, urinary tract infections
Staff Retention - 10% (0 - 10 points)	**Advance Care Planning - 5% (0 or 5 points)**
What % of staff employed January 1st are still employed on December 31st? 72% or higher = 10 points 53% or lower = 0 points Points prorated between 53% and 72%	Facilities must have one staff member go through Advance Care Planning training module each year Training completed = 5 points No training = 0 points

Nursing Facility VBP Program Historical Quality Metrics



Nursing Facility VBP Program Quality Add-On to Daily Rate (4/1/20)



Average Daily Rate Before Quality Add-on is **$209.52**

Full Add-On of $18.45 is paid to 21% of facilities; represents **8.3% increase**

Prorated Add-On is paid to 62% of facilities; represents **4.7% increase**

Remaining 17% of facilities receive no Add-On

Updated Quality Metrics and Add-On Rate For Rates Effective 7/1/2020

VBP Metrics	SCORES			VBP Points (Old Weights)		VBP Points (New Weights)		VBP Daily Rate Add-On	
	Range	CY 2018	CY 2019	CY 2018	CY 2019	CY 2018	CY 2019	CY 2018	CY 2019
CMS Long Stay Quality	320-840 (Higher is Better)	615.0	638.5	14.6	17.8	29.1	35.6	N/A	N/A
ISDH Health Survey	0-340 (Lower is Better)	62.0	65.1	28.6	26.8	13.0	12.2	N/A	N/A
Staff Retention	25% - 100% (Higher is Better)	61.9%	61.0%	5.2	5.0	5.2	5.0	N/A	N/A
Advance Care Planning	0% -100% (Higher is Better)	96.6%	95.6%	4.8	4.8	4.8	4.8	N/A	N/A
Total		N/A	N/A	53.2	54.4	52.2	57.6	$9.82	$10.85

- Scores improved for CMS Long Stay Measure and worsened for other metrics
- Formula for weighting metrics changed to increase Long Stay Measures from 30% to 60% of Total Score
- **Net result is increase of $1.03 to Average Daily Add-On Rate**

Nursing Facility VBP - Next Steps

Defining Program Success

- Are current quality metrics showing improvement relative to historical quality metrics?
- Have some facilities achieved an acceptable level of quality? Do the average results meet expectations?
- How do quality metrics for Indiana compare to other states?

Metrics / VBP Payments for the Future

- Should metrics be revised to reflect new needs identified during COVID pandemic?
- Would current metrics be appropriate for use with the Nursing Facility Supplemental (UPL) Program?
- Should we have one VBP Program structure or allow each Managed Care Plan the flexibility to innovate?
- What portion of reimbursement should be quality based / at risk?

VBP Objectives for mLTSS

Two Key Results have been identified:

- 50% of provider payments will be tied to outcomes
- 25% of the outcome-based payments will have downside risk/shared savings

Considerations for the mLTSS Team

- How do we build a VBP system that will improve quality and outcomes?
- How do we align priorities across all LTSS services?

Areas of focus could include:

- Caregiver support
- Case management/care coordination/care transitions
- Collaborative, multi-disciplinary financial / clinical goals

Next Steps

- *Stakeholder Feedback on VBP Concepts / Quality Metrics*
- *Focused Smaller Group meetings to be Scheduled for more detailed discussions*