North Dakota Legislative Council

Prepared for the Health Care Committee
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MEDICAID PROVIDER REIMBURSEMENT ARRANGEMENTS STUDY - BACKGROUND MEMORANDUM

INTRODUCTION

Section 53 of Senate Bill No. 2012 (2023) (Appendix A) directs the Legislative Management to study the benefits of basing provider reimbursement rates for the Medicaid program in accordance with a provider's performance under established and accepted value-based care metrics.

BACKGROUND

Value-based payment (VBP) is an incentive-based health care reimbursement structure that prioritizes outcomes rather than services delivered. Traditionally, the health care system has operated under a fee-for-service (FFS) model, in which health care providers and hospitals are paid for each service they provide. Value-based care ties the amount health care providers earn for their services to the results they deliver for patients, rather than rewarding based on the volume of service provided.[1] The goal of value-based care is to lower costs, improve the quality of care, and incentivize patient-centered practices, three goals known as the triple aim. In response to the ever-changing needs of the health care system, the triple aim has expanded to include clinician well-being and health equity.

The Centers for Medicare and Medicaid Services (CMS), spurred by the federal Affordable Care Act, has taken a leading role in implementing value-based care payment models, including pay-for-performance (PFP) systems. The Centers for Medicare and Medicaid Services has implemented more than 50 unique, value-based care models that have been used in all 50 states, largely designed for Medicare. The Centers for Medicare and Medicaid Services has directed that by 2030, all Medicaid health care facilities move towards value-based reimbursement systems for all health insurers. Many commercial payers and state Medicaid agencies have followed CMS's blueprints when implementing their own value-based models. Value-based models designed by CMS currently impact more than 41 million beneficiaries, aimed at addressing disparities and giving regulatory agency authority to establish rates and manage hospital budgets.

The Centers for Medicare and Medicaid Services has used a number of strategies to promote value-based care.[2] Incentives and mechanisms used by CMS to encourage health care providers and organizations to deliver higher-quality, cost-effective care include:

- **Financial incentives** - Payments that link clinician, hospital, or health system compensation to performance on specific cost, quality, and equity metrics. These models can be applied with upside or downside risk and prospective or retrospective payments. Providers are more likely to respond to incentives that are direct, clearly linked to specific outcomes, and large enough to be meaningful.
- **Nonfinancial incentives** - Opportunity for greater flexibility to deliver care can positively impact a provider's purpose and mission and elevate the provider's reputation.
- **Measurement** - Tying payment to performance on specific measurements of quality, safety, equity, and cost also helps to gauge a provider's performance.

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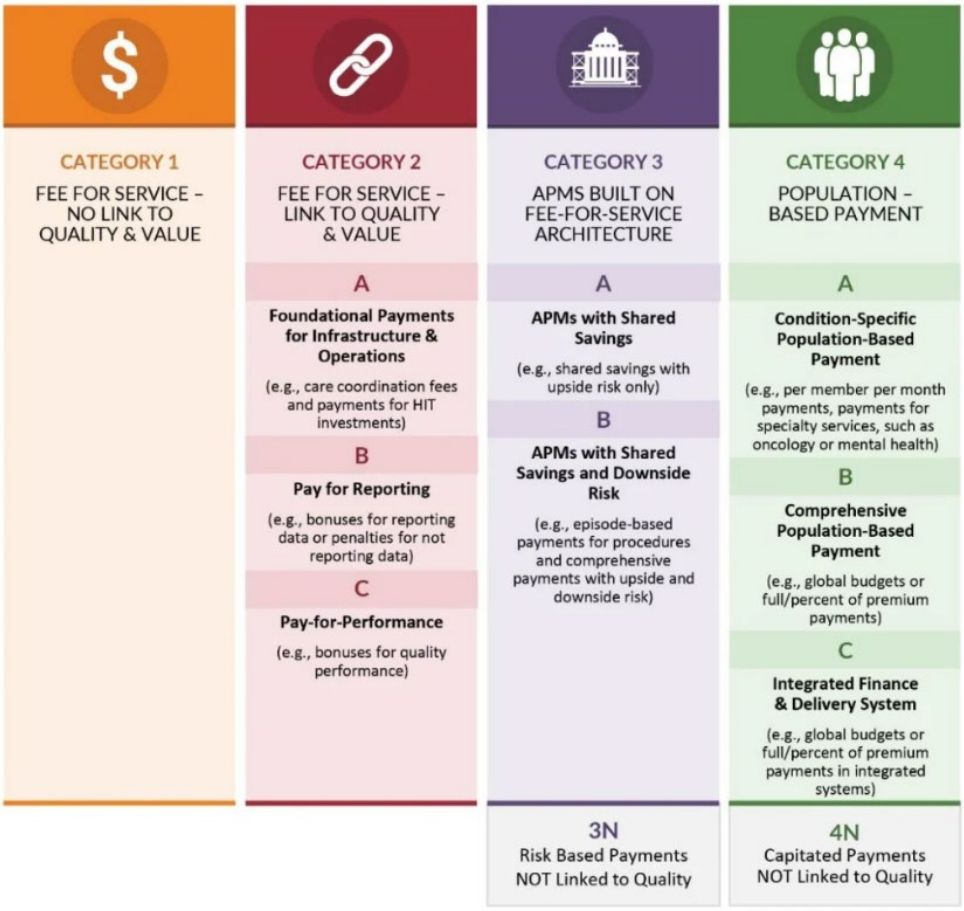
[1] *Value-Based Care: What Is It, and Why It's Needed*, Corinne Lewis, Celli Hortsman, David Blumenthal, and Melinda K. Abrams, February 7, 2023. (https://www.commonwealthfund.org/publications/explainer/2023/feb/value-based-care-what-it-is-why-its-needed#:~:text=Through%20financial%20incentives%20and%20other,care%20at%20the%20right%20time.)

[2] *The CMS Innovation Center's Strategy to Support Person-centered, Value-based Specialty Care*, Liz Fowler, JD, PhD; Purva Rawal, PhD; Sarah Fogler, PhD; Brian Waldersen, MD, MPH; Meghan O'Connell, MPH; Jacob Quinton, MD, MSHS, Centers for Medicare & Medicaid Services, November 7, 2022. https://www.cms.gov/blog/cms-innovation-centers-strategy-support-person-centered-value-based-specialty-care.

- **Accreditation** - A government entity may require a provider in the entity's network to adhere to certain standards set by third parties to participate in Medicare or Medicaid programs to receive reimbursement or remain a provider.
- **Regulation** - A government agency may create rules that require providers to meet specific standards of care in order to expand quality, equity, and value.
- **Public reporting** - Publishing provider outcomes on specific measures can help drive improvement by providing patients better access to information to make health care-based decisions.

The Health Care Payment Learning and Action Network (HCPLAN) developed four broad categories for VBP models. The categories are based on the level of financial risk assumed by the health care provider for quality and outcomes, whether payments are tied to value and quality, and the duration for which the provider assumes the risk. The higher the category, the greater the innovation and movement away from traditional FFS models. As of 2021, FFS payments from Category 1, with no link to quality and value, comprised 40.5 percent of all health care payments. The vast majority of reform efforts fall under Category 2, with movement growing towards Categories 3 and 4.

The following table from the Health Care Payment Learning and Action Network's 2022 publication, *Progress of Alternative Payment Models - 2022 Methodology and Results Report*, outlines the four categories for alternative payment models.



PAY-FOR-PERFORMANCE MODEL

The PFP model has emerged as a common VBP subtype through which providers are rewarded or penalized according to predetermined quality targets.[3] This model subtype falls under Category 2C on the HCPLAN chart. The PFP model aligns payment with value and quality of care by tying reimbursement to metric-driven outcomes, proven best practices, and patient satisfaction. The PFP model commonly is implemented in tandem with an

[3]*What is Pay for Performance in Healthcare?*, NEJM Catalyst, March 1, 2018. https://catalyst.nejm.org/doi/full/10.1056/CAT.18.0245.

FFS model in which payers make baseline payments for services and then use an incentive and penalty approach to increase or decrease a provider's income. For example, foundational payments to a provider may be supplemented by bonuses if a provider reports certain data and delivers high-quality care. Penalties may be assessed to a provider for not reporting data or consistently failing to meet performance benchmarks. A state may implement PFP models that target concerns and priorities specific to the state's population.

Pay-for-Performance Models Used by Medicare

The Centers for Medicare and Medicaid Services has implemented programs that impact hospital reimbursement utilizing PFP models through Medicare, including:

- The Hospital Value-Based Purchasing Program, which aims to improve quality and patient experience as determined by the Hospital Consumer Assessment of Healthcare Providers and Systems Survey.
- The Hospital Readmissions Reduction Program (HRRP), which penalizes hospitals with higher rates of readmission relative to all other acute care hospitals in the hospital's peer group, based upon the socioeconomic status of patients, for specific episodes of care.
- The Hospital-Acquired Condition Reduction Program (HACRP), which reduces payments by 1 percent to hospitals in the bottom quartile of performance based on risk-adjusted measures of hospital-acquired conditions and patient safety.

Benefits and Detriments of the Pay-for-Performance Model

Various benefits and detriments have been identified for the PFP reimbursement model. Benefits of the model include the model stressing quality over quantity, redirecting funds to encourage clinical best practices and positive health outcomes, increasing transparency through publicly reported metrics, encouraging accountability and competition through consumer informed choice, and reducing costs. Detriments of the model include harm and reduced access for socioeconomically disadvantaged populations, punishment for providers that treat a greater share of low-income patients, and reduced job satisfaction and intrinsic motivation for clinicians.[4]

VALUE-BASED CARE IN NORTH DAKOTA

Comprehensive Primary Care Plus

According to CMS, North Dakota is 1 of 18 states that participated in Comprehensive Primary Care Plus (CPC+), a 5-year multi-payer model through CMS which began in January 2017. Comprehensive Primary Care Plus was an advanced primary care medical home model that rewarded value and quality by offering an innovative payment structure to support delivery of comprehensive primary care. Participating providers followed one of two "track" models. Track 1 was the pathway for practices to build their capabilities to deliver comprehensive primary care. Track 2 was for more established primary care facilities to increase their comprehensiveness of care. The key payment elements of the CPC+ model included:[5]

- **A care management fee** - A care management fee was a non-visit-based fee paid per beneficiary, per month. Care management fees were paid on a quarterly basis and were risk adjusted for each practice to account for the intensity of care management services required for the practice's specific population.
- **A performance-based incentive payment** - The Comprehensive Primary Care Plus model prospectively paid and retrospectively reconciled a performance-based incentive based on how well a practice performed on patient experience measures, clinical quality measures, and utilization measures that drove total cost of care.
- **Payment under the Medicare physician fee schedule** - Track 1 billed and received payment from Medicare FFS as usual. Track 2 practices also continued to bill as usual, but the FFS payment was reduced to account for CMS shifting a portion of Medicare FFS payments to Comprehensive Primary Care Payments (CPCP), which were paid in a lump sum on a quarterly basis absent a claim. Track 2 practices were expected to increase the comprehensiveness of care delivered, and thus, the CPCP amounts would have been larger than the FFS payment amounts the CPCP amounts were intended to replace.

Primary Care First

Beginning in 2021, many Sanford providers moved to an alternative 5-year model offering an innovative pay structure based on the underlying principles of CPC+. The Primary Care First (PCF) model prioritizes the

[4]*APM Measurement, Progress of Alternative Payment Models*, Health Care Payment Learning & Action Network, 2022.
[5]*Comprehensive Primary Case Plus*, Centers for Medicare & Medicaid Services, August 5, 2022. https://innovation.cms.gov/innovation-models/comprehensive-primary-care-plus#:~:text=There%20were%202%2C610%20primary%20care,Capital%20Region%20of%20New%20York%2C.

clinician-patient relationship, enhances care for patients with complex chronic needs, and focuses financial incentives on improved health outcomes for Medicare enrollees. The model tests whether delivery of advanced primary care can reduce the total cost of care, accommodating practices at multiple stages of readiness to assume accountability for patient outcomes. The PCF model focuses on advanced primary care practices ready to assume financial risk and receive performance-based payments. The PCF model aims to be transparent, simple, and hold practitioners accountable by:

- Providing model payments to practices through a simple payment structure, including:

  A flat payment that encourages patient-centered care, and compensates practices for in-person treatment;

  A population-based payment to provide more flexibility in the provision of patient care along with a flat primary care visit fee; and

  A performance-based adjustment providing an upside of up to 50 percent of model payments as well as a small downside (negative 10 percent of model payments) incentive to reduce costs and improve quality, assessed and paid to practices on a quarterly basis.

- Providing practice participants with performance transparency, through identifiable information on the practice participant's performance and the performance of other practice participants to enable and motivate continuous improvement.

Medicaid

For many states, a critical component of the Medicaid delivery system reform is payment reform, or more specifically, implementing VBP approaches.[6] In July 2014, CMS launched a concerted effort between the Center for Medicaid and Children's Health Insurance Program Services and the Center for Medicare and Medicaid Innovation called the Medicaid Innovation Accelerator Program (IAP). The Medicaid IAP seeks to improve health and health care for Medicaid beneficiaries and to reduce associated costs by providing targeted and technical support to states for payment and delivery system reforms. In October 2015, the Medicaid IAP began providing technical support to states seeking to integrate Medicare and Medicaid data. In 2017, the Medicaid IAP began offering general data analytics technical support to states. The Medicaid IAP also is working with states on health care delivery system reform efforts in VBP and program areas such as reducing substance use disorders, improving care for Medicaid beneficiaries with complex care needs and high costs, promoting community integration via long-term services and supports, and supporting physical and mental health integration.

The Medicaid IAP provided data analytics technical assistance to North Dakota from April 2017 to April 2018. During this period, the Medicaid IAP developed data analytic strategies, used data to drive programmatic decisionmaking, integrated various non-Medicare data sets with Medicaid data, and designed data visualizations to enhance understanding of trends. The Medicaid IAP's report (Appendix B) indicated North Dakota's data analytics goals included identifying the top five focus areas for data management and visualization and developing user persona templates to elicit stakeholder requirements under each focus area. Input from the user personas informed the design of a series of dashboards to enhance visualization and reporting efficiency. Using North Dakota's chosen data analytics platform, the Medicaid IAP team provided demonstrations and developed sample dashboard screenshots relevant to each user persona and delivered a user guide for developing department and role-based dashboards in a production environment. The state also sought to develop a strategy for merging claim and encounter data from Indian Health Service facilities. Although this goal ultimately was postponed in favor of consideration of a federal solution to facilitate discussions with Indian Health Service facilities regarding data sharing, the Medicaid IAP team provided North Dakota with talking points on care coordination, merging claim and encounter data, and a high-level strategy to accomplish a potential data merge.

Testimony provided by the North Dakota Department of Health and Human Services during the 2023 legislative session indicated the department is working towards implementing value-based care in the state's traditional Medicaid programming. The department seeks to move from an FFS model to a pay-for-reporting model by 2026, and thereafter, to a PFP model. The proposed prospective payment system would base certain inpatient and outpatient hospital payments on quality measures. Targets would be set for hospitals based upon hospital's peers, and up to 4 percent of Medicaid revenue for the specified subset of services would be returned to the state if the measures are not met. Additionally, if certain performance metrics are satisfied, providers would have the opportunity to earn funds back. These models will begin to be implemented in 2023, with a pay-for-reporting baseline anticipated by 2024.

[6]Resources for States, Innovation Accelerator Program, Data Analytics, https://www.medicaid.gov/resources-for-states/innovation-accelerator-program/functional-areas/data-analytics/index.html.

STUDY APPROACH

In conducting this study, the committee may wish to receive testimony from representatives of:

- North Dakota hospitals, health care facilities, and providers regarding concerns associated with outcomes, reimbursement rates, and value-based care;
- Health insurers operating in the state, including information on pay rates, reimbursement structures, and regulatory practices; and
- The Centers for Medicare and Medicaid Services, and other interested parties, regarding what other states have done to implement value-based care and the corresponding outcomes.

ATTACH:2