How to Partner Effectively with Your State's Medicaid Agency

Musings from a former state Medicaid Director

February 11, 2019

bailit health

Presentation Overview

- Understanding the key priorities of Medicaid agencies and their MCOs/RAEs
  - How can associations frame safety nets needs to align with those objectives?
- A review of the continuum of value based payment/delivery system reform
  - How can different payment models work together?
- How best to engage Medicaid programs and their MCOs/RAEs
  - Hint: Build strong relationships; focus on data and not anecdotes.

Understanding the Medicaid Environment

- Some Obvious Observations:
  - Medicaid is one of biggest expenditures in every state's budget
    - Typically second only to K-12 education
    - Tremendous pressure on state Medicaid agencies to reduce cost growth
  - Average tenure of Medicaid director is between 2-3 years. Why so short?
    - As Medicaid becomes bigger part of state budget, more political and harder to stay cross parties
    - It's a hard, demanding job – everyone wants something from you, and you have very little to give

What are Key Priorities for the Medicaid Agency?

- Highest priorities for all states:
  - Stay on budget
  - Reduce cost growth
  - Keep the trains running
  - Stay out of the news
- Other key priorities:
  - Implement key priorities of the Governor and/or Secretary
    - In some states the Medicaid director will get to set the priorities – but that varies tremendously by state.
  - Implement legislative mandates
    - Required to do some things that do not otherwise align with Medicaid agency's priorities

Hot Policy Issues in State Medicaid Programs

- Addressing the opioid crisis
  - Expanding SUD treatment, including MAT
- Payment and Delivery System Reform
  - Pay for value not volume
  - Integration of Physical and Behavioral Health
- Population Health
  - Better use of data in identifying gaps in care
  - Focus on social determinants of health
- Medicaid work requirements

Hot Policy Issues in Medicaid Managed Care

- Great overlap with general priorities– most states have some form of managed care and implement policies through there MCOs
- Recent focus on states coming into compliance with Medicaid Managed Care rule
  - Network adequacy requirements
  - Quality strategy
- Purchasing behavioral health services
  - More states carving in to one plan with acute services
  - Focus can't stop there for there to be real change

How Can You Influence Managed Care Procurements

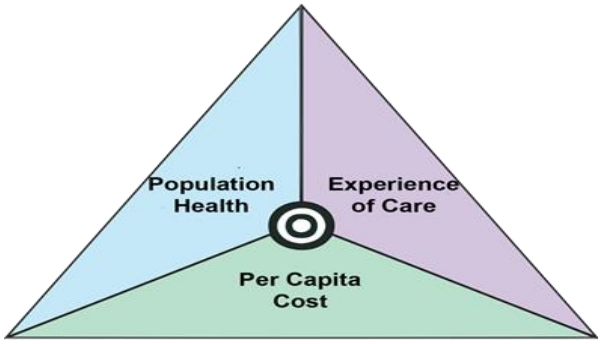
- Most states conduct significant stakeholder feedback in advance of releasing a procurement
  - Provide overview of what planning
  - Obtain feedback on priority areas
- Some states release draft procurements before final procurement is released
- Vendor selection
  - Occasionally states include provider and/or consumer representative on the review committee
  - May ask for references specifically from provider and/or consumer
  - If not asked, need to wait and see outcome; any other ways to influence may void entire process

Consider How to Frame Your Priorities to Align with State Priorities

- State Medicaid programs have little bandwidth to touch anything outside of its own priorities
  - Where is the there overlap between your priorities and the states?
    - Everyone is focused on opioid crisis.
    - Need for strong behavioral health system
    - Need for Integration of physical health and behavioral health
  - Payment and Delivery System Reform
    - States focused on moving from volume to value
    - How can FQHCs and CMHCs participate?
    - How does it impact the PPS rates?
  - Focus on Population Health/SDOH
    - FQHCs and CMHCs are well positioned to support SDOH needs

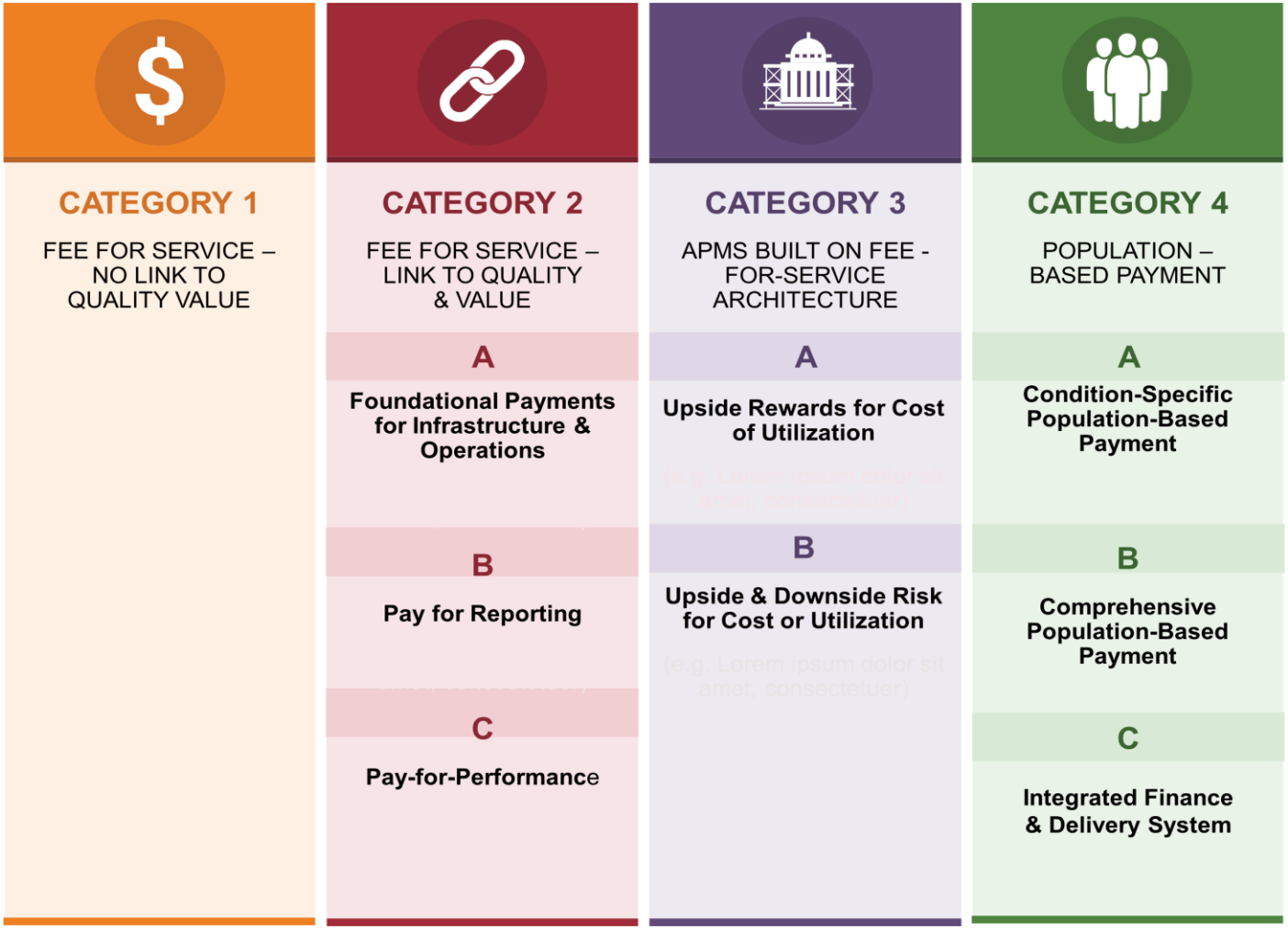
Understanding Value Based Payment and Delivery System Reform

- Most states have one or more initiative focused on payment reform.
  - Payment reform should not be for sake of payment reform only.
  - To be effective needs to be coupled with delivery system reform
  - Incentivize value over volume
    - States looking to meet triple aim – improved quality and outcomes; reduced costs.



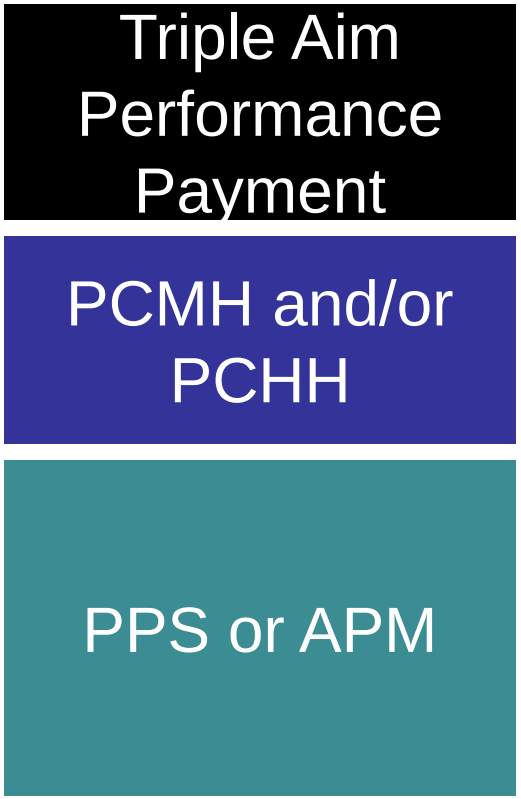
IHI Triple Aim

LAN APM Framework



VBP for Primary Care: Multi-layered

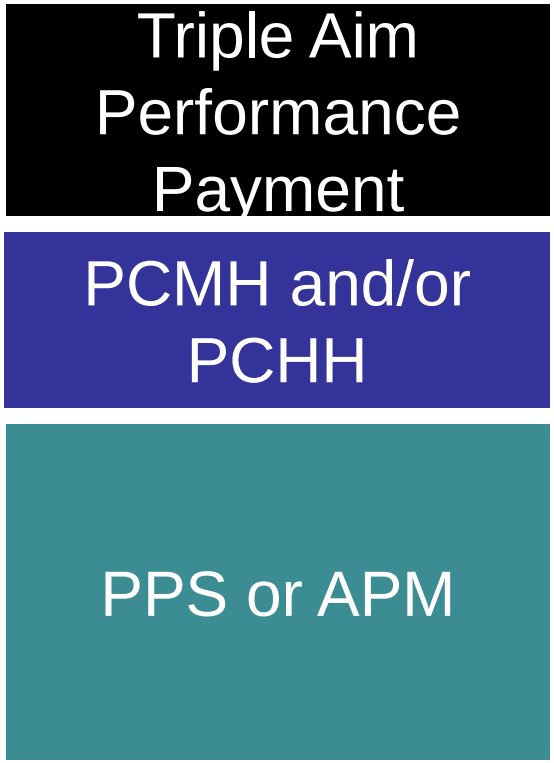
Multiple payment reforms can work together and is a common model proposed for primary care



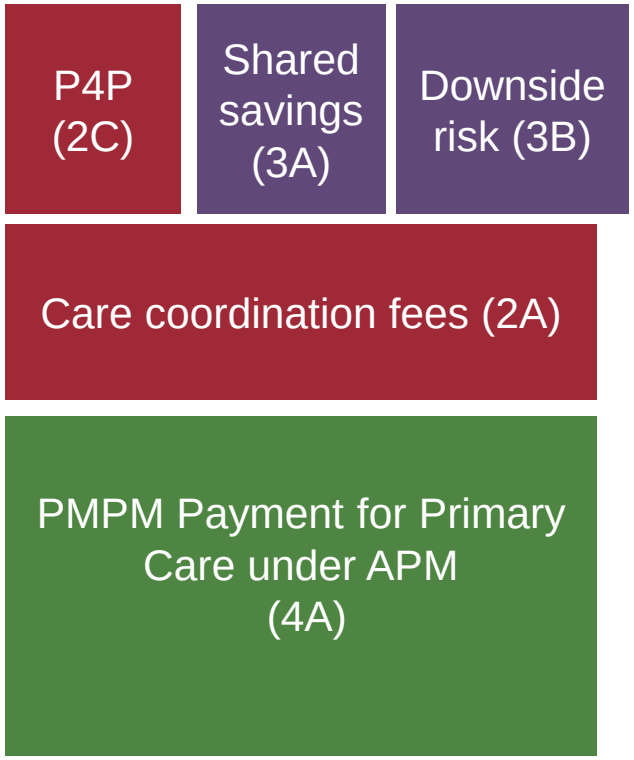
- **Incentivize** quality and cost outcomes (upside incentives and/or downside risk/penalties)
- **Invest** in new services/capabilities
- Provide funding for most services
- **Flexibility** to deliver care differently

VBP for Primary Care: Multi-layered

NACHC/JSI Model (2014)



Viewed through HCP-LAN Lens



Payment Reform: Multi-layered

A potential BH model…….

Triple Aim Performance Payment

PCHH for BH

FFS or PMPM under CCBHC

Viewed through HCP LAN Lens

P4P (2C)

Shared savings (3A)

Downside risk (3B)

Care coordination fees (2A)

PMPM Payment for BH under CCBHC (4A)

Progress Towards VBP: FQHCs

- Most of FQHCs are PCMHs and also have some experience with P4P.
  - Some experience with shared savings
  - Limited experience with shared risk
    - OR/WA both have primary care capitation payment to FQHC but potential for reconciliation
  - FQHCs as backbone of ACOs
    - MA – Two models include FQHCs
      - Merrimack Valley ACO includes health center as key partner in ACO/MCO partnership
      - direct ACO with the state through the Community Care Cooperative (C3)
    - RI – 3 out of 5 RI certified ACOs are based in one or more FQHC
    - MN - FUHN (Minneapolis/St. Paul)

Implementing VBP in FQHCs

- Strong understanding of impact of SDOH and impact on care
- Varying levels of capability with using data to help manage care
- Varying levels of financial capacity to take on new payment models
- Varying levels of willingness to take on risk
- Challenges with attribution
  - Some beneficiaries assigned that FQHCs have never seen

Progress Towards VBP: BH Providers

- BH providers have less experience with any VBP
  - Have not been focus of infrastructure payments
  - Some P4P, but not many standardize quality measures
  - Some experience with case rates, but not experience with risk
    - Colorado – case rates to PIHPs; also serving as RAEs and receiving CM funds on PMPM basis
    - MI – current work with MCOs to consider payment reform under 298 Pilot (which integrates acute and BH care within managed care)
    - NH – CMHCs agreed to capitated payments with risk

Implementing VBP in CMHCs

- Strong understanding of impact of SDOH and impact on care
- Treating BH conditions is key to reducing total cost of care
- Challenges with real/perceived data sharing issues
- Varying levels of capability with using data to help manage care
- Varying levels of financial capacity to take on new payment models
- Varying levels of willingness to take on risk

How Best to Engage Medicaid Agencies

- Associations should work to build **long term relationships** with Medicaid agencies.
  - See Medicaid agency as a partner
    - Similar missions: to serve the underserved
  - Focus on them always, not just when you need/want something
  - Get to know not just the Medicaid director but key program leadership
  - Participate in state working groups to show dedicated to the Medicaid program and its population
  - Work collaboratively across providers (this is a good start!)

Partnership Principles (From Joe Parks)

DO

- Ask about their needs first
- Give something
- Assist wherever you can
- Make it about the next 10
- Pursue common interest
- Reveal anything helpful
- Take one for the team

DON'T

- Talk about your needs first
- Expect to get something
- Limit assistance to a project
- Make it about this deal
- Push a specific position
- Withhold information
- Let them take their lumps

When Have a Specific Ask of Medicaid Agency

- Keep request simple and reasonable
  - Understand where state agency has flexibility and where it doesn't
  - Rates are always an issue – and very hard to solve.
  - Don't just come in with a problem; propose a solution
    - Use data to illustrate what the problem is that you are trying to solve
      - Are there other organizations in state willing to identify and call out the problem? (e.g., Foundation?)
    - Describe how problem is issue for beneficiaries – not just for providers
    - Use data and evidence-based practice examples to show why your proposed solution works
      - Consider impact of solution on other providers/stakeholders
      - If negative, how do you mitigate?
      - If positive, can you engage them to work with you?

Challenge: IA – Attribution

- Challenge: beneficiaries are attributed to FQHC but have never been seen at Center
- Approach to Problem Solving:
  - Data: Present state with monthly list of attributed members who have never been seen at center.
    - Ask state to share data on those members to determine if/where they have been seen
  - Beneficiary Impact: Not clear.
    - If being seen by other provider, no impact;
    - if not being seen at all, unengaged beneficiary
  - Proposed Solution:
    - Where getting care elsewhere, move attribution to different provider
    - Where not getting care; remain with FQHC to make effort to engage patient

Challenge: MA – Tangle of Requirements

- Challenge:
  - As providers work to integrate primary care and behavioral health have come up against regulatory requirements that create barriers to implementation
- Approach to Problem Solving:
  - Provide state with specific examples of regulatory requirements and how they do not work
    - Example: may only bill for one visit per day
    - Data: keep specific log of barriers so can show trend of where impacting integration
    - Beneficiary Impact: keep specific log of where beneficiary couldn't get service on same day, and if/when they came back for service
    - Solution: provide draft regulations that remove limit; where possible, do data analysis to show budget impact

Questions? Comments? Discussion?

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