Medicaid 2.0
Issue Brief: Value-Based Purchasing

NEW JERSEY HEALTH CARE QUALITY INSTITUTE
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Background

Our initial market scan indicates NJ Medicaid has several small value based purchasing (VBP) demonstrations - See Table 1. At the payer level, the state MCO contract currently includes a performance bonus for quality but to date none have achieved the results to qualify. At the payer/provider level, there are a variety of initiatives aimed at segments of the Medicaid population, such pregnant women and high utilizers. Of these early efforts, Patient Centered Medical Homes (PCMH) and Behavioral Health Homes have shown positive results. The ACO and Delivery System Reform Incentive Payments (DSRIP) initiatives are still in progress and have not been formally evaluated to date. The MCOs have multiple proprietary value based initiatives underway but progress and/or results are not publicly available.

Despite these targeted initiatives, beneficiaries continue to experience hospital readmission, pre-term birth and low birth weight rates far above the national average. Additionally, over use of the emergency room and the cost and management of end of life care remain major challenges. Nationally Medicare and state Medicaid programs are moving aggressively towards alternative payment models (APM). Medicare has set a target of having 50% of all its payments linked to APMs by 2018. Other state Medicaid programs are seizing on a select group of models like CPC+ and bundled payments and requiring their MCOs and providers to adopt them statewide.

States that have DSRIP programs are using them to finance and support the conversion to APMs and share risk with their hospitals. Going forward, CMS has indicated that states must structure their DSRIP programs to facilitate improvements in the quality and cost of care by requiring hospitals to share downside risk. In other states, a portion of DSRIP funds are being directed towards services that address the social needs of beneficiaries including housing and employment services.

For those with dual Medicare/Medicaid eligibility the State's waiver renewal calls for increasing the number of beneficiaries enrolled in Medicare Advantage Special Needs Plan (SNPs). Currently only one on ten dual-eligible is enrolled in a DSNP. That means the majority of services they receive --hospital, physician and pharmacy – are reimbursed through Medicare fee-for-service and largely unmanaged. More over Medicaid MCOs serving duals that are in need of long-term care services have no financial incentive to manage patients care beyond the services for which they are at risk. Coordinating care for the duals has been a long standing challenge nationally and is attributable to federal policy which prohibits mandatory managed care enrollment for Medicare beneficiaries.

Problem Statement

- There is no defined Medicaid VBP strategy. Current efforts are complicated by overlapping care coordination efforts and the use of risk sharing APM models is very limited.

- CMS will require DSRIP participants to share risk. NJ will need to have a strategy that begins to redirect these funds to VBP models. The current DSRIP approach is disparate and does not provide a statewide strategy for quality improvement and managing the total cost of care (TCOC).
- Care for dually eligible beneficiaries remains largely unmanaged and perpetuates misaligned incentives between payers and MCOs.

Goal(s)

- Develop a statewide VBP strategy that transitions a substantial portion of overall payments from fee-for-service to performance based risk sharing models
- Streamline care coordination among various VBP initiatives and adopt a core set of quality measures
- Develop a DRSIP strategy that promotes the conversion to VBP and provides the flexibility to use these funds to address the social needs of at risk beneficiaries
- Identify strategies to manage care for duals that do not enroll in SNP

Strategy Options

- Require all Primary Care practices to obtain PCMH status
- Require MCOs to adopt CPC Plus model
- Use Adult Day Centers as Medical home for duals
- Expand the use of PACE
- Use DSRIP to move to risk by using funds to pay for care management, specialists, palliative care and housing
- Require MCO to reimburse hospitals with bundled payments for episodes of care
- Provide an at-risk option for hospitals willing to provide the full continuum of services i.e. hospital based insurer
- Require MCOs to use core quality measures for value-based initiatives developed through SIM grant
- Require MCOs to engage community based organizations to manage high need patients' social services, including housing and employment
- Request a waiver that allows Medicare to make bonus payments to NJ MCOs that achieve Medicare quality metrics for dually eligible individuals

Research Links

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* The NJHCQI website is being updated. Documents saved on the NJHCQI website may have different links once the new site launches.

Table 1 NJ Medicaid Market Scan and Assessment

NJ Medicaid Market Scan and Assessment
May 2016

State Sponsored Reform Initiatives	Effective Date	Funding Source	Scope	Counties	Authority	Providers	Status	Results
Medicaid MCO Performance Bonuses	2015	Medicaid - 50% Federal	5 Key HEDIS Measures	statewide	HMO Contract	All	In Progress	No MCOs have earned the bonus
Managed Long Term Supports and Services (MLTSS)	2014	Medicaid - 50% Federal	All Medicaid Long-Term Care Services	statewide	Comprehensive Waiver	Nursing Homes, Assisted Living, Home Health, Home Care, Adult Day Care and Behavioral Health providers	More than half of all MLTSS patients receive their services under HMOs. Full coversion to HMO coverage is expected by 2018	In Progress - Pending CSHP Interim Evaluation
Accountable Care Organizations (ACO)	2015	Medicaid	Coordinated care for complex patients	Camden, Mercer, Essex	Demonstration Statute and Comprehensive Waiver	Hospitals, clinics, physicians, behavioral health and social services providers	In Progress	Project initiated in 2015 - results will not be available until 2018
ACO Lookalikes	2015	None	Coordinated care for complex patients	Cumberland, Middlesex, Passaic and Union	None	Hospitals, clinics, physicians, behavioral health and social services providers	In Progress	Not being evaluated
Patient Centered Medical Home (PCMH)	2011	MCOs provide incentive payments for value based care	Frail, Elderly and those with Chronic Conditions	Camden,Cumberland,Essex, Hudson and Ocean	Demonstration Statute and Comprehensive Waiver	Physicians and Primary Care Clinics	The 3 largest MCOs have established medical home programs and plan to continue and expand the program. A fourth program was discontinued when the MCO was sold to a new market entry.	Preliminary results are showing decreases in ED visits and readmission rates; however, several screening rates are lagging behind the baseline targets. Also, early feedback indicated improved patient satisfaction. One MCO reported modest cost savings.
Behavioral Health Homes	2015	Medicaid -90% Federal - Providers paid thru enhanced encounter rates	Integrated Primary Care and Behavioral Health Services for Seriously Mentally Ill	Atlantic, Bergen, Cape May, Mercer , Monmouth	State Plan Amendment and Comprehensive Waiver		In Progress	Results from the SAMHSA Bergen pilot include: Normal Blood pressure achieved for 92% of population; 82% reduction in ER use; 100% participation in wellness program; and 90% overall patient satisfaction
DSRIP	2012	Medicaid - 50% Federal		statewide	Medicaid Comprehensive Waiver	48 of 72 Acute Care Hospitals	Currently in Year 4 of the 5 year program	No Results published to date
Strong Start for Mothers Newborns	2010	$1.7M CMMI Grant	Prenatal Care	Central NJ	Federal Grant	4 Hospitals and 3 FQHCs	In progress	Central Jersey Family Health Consortia reports 7% reduction in pre term birth rate. Results from a study of the South Carolina pilot indicated that participation in the program reduced premature birth risk by 36%, low birth weight by 44% and 28% lower risk of being admitted to a NICU
NJ State Innovation Model (SIM)	2015	CMS - $3M	Improving birth outcomes through smoking cessation efforts, particularly among pregnant women; advancing behavioral and physical health integration strategies; and addressing Medicaid cost/value, especially for high-cost patients.	statewide	Federal Grant	All	In Progress	