North Dakota Medicaid VBP

Interim Health Care Committee
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Medicaid VBP
Presentation Agenda

- Evolution of Centers for Medicare and Medicaid Services (CMS) Value Based Care
- Traditional Fee For Service “Volume” to ”Value” payment comparison
- What are the demographics of the traditional Medicaid population?
- North Dakota Medicaid Quality Strategy
- VBP Collaborative Considerations
Evolution of CMS Value Based Care Initiative

2010

The Patient Protection and Affordable Care Act (ACA) established CMS Innovation Center
- Make affordable health insurance available to more people
- Expand the Medicaid Program
- Support Innovative care delivery models

Medicare Shared Savings Program (MSSP) began
- Accountable Care Organizations (ACOs) established to provide high quality coordinated care to improve outcomes and reduce cost to a defined population

2012

2015

Medicare Access and Reauthorization Act of 2015 (MACRA) was signed into law
- Established Quality Payment Program that emphasized Value-Based Payment Models
- Medicare and other payers increasingly implementing Value Based Programs

CMS continues to implement additional and different iterations of Medicare and Medicaid Innovation models, with most of them having a Value component

2016 To Date
What are Volume and Value Based Provider Payments

Traditional “Volume” Based Payment:
- Fee For Service payment (FFS)
  - Providers bill and are reimbursed for services provided
  - Payment typically based on an agreed Fee For Service Contract or Fee Schedule seldom tied to quality outcomes
- Prospective Payment System (PPS) for hospitals, Federally Qualified Health Centers (FQHC)s, Home Health, SNF, etc.
- Cost Based Reimbursement for providers such as Critical Access Hospitals (CAHs) Rural Health Clinics (RHCs), etc.

Value Based Payment:
- Value-based programs reward health care providers with incentive payments for quality
  - Often includes traditional Fee for Service payments tied to quality outcomes
  - Pay for Performance, Shared Savings, Total Cost of Care, etc.
- Improve Patient Outcomes (Better health)
- Enhance healthcare delivery with a greater focus on Wellness, Prevention and Care Coordination
- Achieving results will lower cost growth/lower cost
- A great payer/provider partnership is imperative to success
Where Does The Medicaid Member Live

- Over 87,000 members
- Majority of members between the ages of 0-20 (64%)
- Male: 44%, Female: 56%
Total Members – Traditional Medicaid Population

Enrollment by Cohort (October 2021)

Aged - Non-Dual: 165
Aged - Dual: 3,772
Children: 47,860
Disabled - Non-Dual: 3,888
Disabled - Dual: 4,517
Foster Care: 3,652
Pregnant Woman: 1,919
TANF Adult: 11,925
Institutional - Non-Dual: 604
Institutional - Dual: 3,727
Waiver - Non-Dual: 3,380
Waiver - Dual: 1,712

Total: 87,121
Total Member Months – Traditional Medicaid Population by Age

Median age is 14
North Dakota Medicaid’s Quality Strategy

Focus Populations
- Healthy Children and Adults
- Women and Infant Health
- Behavioral Health
- Chronic Conditions
- Oral Health
- Special Initiatives

Design for Improved Outcomes
- Data and Analytics
- Social Determinants of Health
- Community Engagement
- High Value Services from Vendors
- Smart System Design with Providers

Improve Outcomes
- Preventive Health Services
- Prenatal Care to Well Mothers and Babies
- Comprehensive and Coordinated Behavioral Health Services
- Well Managed Asthma, Diabetes, and Hypertension
- Preventive Dental Services

Special Initiatives
- 1915i Health Homes
- Health Tracks SUD Voucher
- DOH Initiatives

NORTH Dakota Be Legendary
Human Services
VBP Collaborative Considerations:
Still in Discussion...

- Financial Component
  - Withhold, Payback, Quality Payment add on, other

- Quality Measures
  - Opportunities for improving member health status

- Quality Metrics – Benchmarks, Data, Targets, etc.
  - How will benchmarks be established, data gathered and targets for quality incentives be determined

- Member Attribution Methodology
  - How will member and provider relationships be determined

- VBP Rollout
  - What is the timeline?
  - Providers – Systems, independent providers, CAHs, FQHCs, RHCs, etc.