Background

The intergovernmental Medicaid Pathway (MP) team requested Burns & Associates (B&A) to review available data and make recommendations on an approach for paying for a new set of services and requirements under delivery system reforms discussed as part of the Medicaid Pathway project. As part of these discussions, a large amount of expenditures for services are slated to be excluded in phase one of the MP. Therefore, B&A has recommended that for phase one, the State adopt a two-pronged payment model that 1) sets a global budget target and develops a monitoring process for total spending, including those expenditures deemed excluded from phase one as well as 2) develop an Alternative Payment Model (or APM) for those services and providers identified as included in phase one. It is B&A's recommendation that expenditures under both models be subject to quality standards and that some of those metrics be linked to payments. The details on the composition of the quality framework are under development and described in the information gathering document released by the State.

B&A estimates that over 90% of funding could be included in the APM should the State lift exclusions such that more expenditures and services could be added to the APM. As more financing flows through the APM, the global budget targets would be more directly linked and come close to converging to the APM and rely less on grants, excluded funding or funding sources specific to certain programs. In doing this, the intent is to reduce the administrative burden for both the State and the providers. Implementing phase one, while more limited in scope than envisioned for the Medicaid Pathway, will improve both the validity of data and the process for monitoring performance and assessing adequacy of payments. In addition, implementing this model in phase one will allow for a phased transition for both the State and providers.

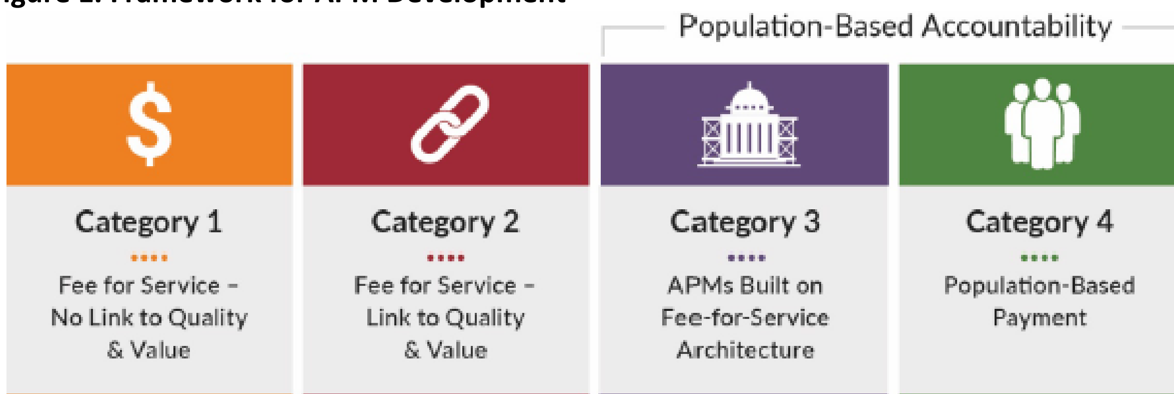
The memo below is specific to alternatives related to alternative payment options for the sub-set of services and providers currently under contemplation in phase one of the MP and described in the RFI.

Review of Alternative Payment Models (APMs)

B&A has explored the feasibility of setting a capitated payment rate or an episode-based bundled rate for the Developmental Disabilities Specialized Services Agencies (DDSSAs), the Mental Health Specialized Service Agencies (MHSSAs) and the Designated Agencies (DAs), and other Substance Abuse Preferred Providers (SAPPs) for a sub-set of covered services, programs and funding sources. There is a unique set of considerations for each of these provider types. This memo focuses only on the MHSSAs and DAs. The last section of this memo summarizes some of the unique issues specific to the DDSSAs and DD services in the DAs. This memo does not address the consideration across non-DA/SSA SAPPs, including sub-provider types like Hub and Spokes, and Recovery Centers and assumes they are not included in phase one.

The terminology of ***capitation*** and ***episode bundle*** is adopted from the federally-sponsored Heath Care Payment Learning and Action Network's (HCP LAN) recently released series of white papers on capitation and episode-based alternative payment models.[i] Figure 1 represents their framework for classifying APMs. Our federal partners and state leadership, through the All-Payer Model and Medicaid Pathway work, are examining how best to move toward category three and four alternative payment models, both described as ***population-based***.

Figure 1. Framework for APM Development



Source: Alternative Payment Model (APM) Framework and Progress Tracking Work Group

A key distinction between a ***capitated model*** as contemplated by the HCP LAN working groups under their framework compared to an ***episode bundled model*** relates to the scope of the benefit of covered service and the population covered. Each model also comes with unique considerations and incentives.[ii] For example, there are different approaches to setting financial benchmarks (i.e., rates) as well as measuring quality and performance.

The HCP LAN describes the difference in the models as follows:

- The ***capitation model*** accepts full accountability for an entire population across all services (i.e. both users and non-users).
- The ***episode model*** focuses on provider accountability for those individuals within a population affected by a particular condition, health event or treatment intervention (i.e. users only).

The HCP LAN also importantly points out that both ***capitated*** and ***episode bundled*** APMs in categories three or four are considered ***population-based***. Said another way, the State can achieve its goal of implementing a population-based APM for these providers using either a ***capitation model*** or an ***episode model*** as long as these models fall under category three or four of the framework.[iii]

It is important to note that neither model contemplated by the HCP LAN perfectly fits the services and provider types contemplated in phase one of the Medicaid Pathway and, therefore, there is a need to adapt these models for this purpose. There are a number of

reasons why an ***episode-based*** model in categories three or four would be more appropriate to implement than a ***capitated*** model for those providers and services currently contemplated for phase one of the Medicaid Pathway. Key reasons to support an ***episode bundle*** over a ***capitated*** APM for phase one of the Medicaid Pathway include:

1) Given that a ***capitated*** model is meant to cover all services for all beneficiaries, the initial set of services and providers targeted for the APM do not represent all services received for a given population. In fact, they do not represent all mental health and substance abuse services that may be received.
    a. The ***capitated model*** in the ACO APM by contrast, covers the entire eligible Medicaid population for the entire medical benefit across many different types of providers, with some limited exclusions that are unique to Medicaid.
    b. The ***episode bundle*** contemplated by the HCP LAN includes providers across settings of care. In this adaptation for phase one of Medicaid Pathway, it would be limited to the DDSSAs, MHSSAs, and DAs.
    c. Future adaptations could expand the ***episode bundle*** to cover additional providers and services for a defined population.

2) Attribution, or assigning accountability for a beneficiary to one provider for a full year, is a component of a capitation model.

    a. B&A found that there was a small percentage of the historic population served by DAs who did seek services across the DDSSAs, MHSSAs, and DAs in a given year. In order to address these cases, a reconciliation process would need to be developed. Moreover, attribution through the ACO APM and Blueprint are based on a patient's relationship with their primary care doctors and thus would be a different approach than an attribution of the population to a DDSSA, MHSSA or DA. Alignment around attribution is helpful as models mature and integration is fostered. Additionally, the ACO APM is researching whether a switch in attribution methodology should occur in the early years of that model, which would impact any attribution in other Medicaid-only models.

    b. The ***episode bundle*** model avoids the need to develop an attribution methodology since it is triggered by receipt of services and therefore does not require attribution to a provider. The model would need to assign provider accountability to the DASSA, MHSSA, or DA within a given month or have a process to discount multiple claims across providers in the same month.

3) Traditional risk adjustment--retrospective and prospective--uses underlying health status information like diagnosis and service utilization to predict future medical benefit spending. ***Capitation models*** use risk adjustment to account for the differences in underlying health status in predicted versus actual populations and to account for differences between a managed care or accountable care organization's population compared to the total population.

a. The most widely-used risk scores are Medicare's CMS-HCC software and the University of California, San Diego's Chronic Illness and Disability Payment System (CDPS).
b. The risk scores produced are meant to predict total medical benefit spending not the specific sub-set of costs and providers contemplated for phase one of the Medicaid Pathway.[ivv] In fact, because some of the costs excluded from the Medicaid Pathway are those that are more expensive (such as institutional or acute settings of care), those with higher severity scores are less expensive to MHSSAs, DDSSAs, and DAs given those other costs are excluded from phase one.
c. The Medicaid ACO APM, by contrast, is using the CDPS to adjust for differences in health status.
d. Therefore, adjusting using a traditional risk adjustment score would produce large deviations from current payments and would not strongly correlate the actual costs of providing services and are not appropriate for phase one of the Medicaid Pathway because there is too much potential variability in the resulting payments.

4) Case-mix adjusting, or creating clinically similar resource-driven groups, is needed in order to ensure that providers who vary with regard to the mix of services provided can be compared. Case-mix adjusting payments across a class of providers is an important building block towards ensuring the underlying data used to set capitation rates are sound.
    a. As highlighted in the HCP LAN's financial benchmark paper, methods of setting financial ***capitation*** benchmarks assume the data being used is case-mix adjusted. Examples of case-mix adjustments used for other provider classes include diagnostic related groups (DRGs) in hospitals, Ambulatory Payment Classifications (APCs) in outpatient hospitals, Home Health Resource Groups (HHRGs) in home health.
    b. The initial set of services and providers contemplated under phase one are not systematically case-mix adjusted in the same way. Using an ***episode bundled*** model and revising existing billing guidelines will help collect improved and more standardized data on which to improve future case-mix adjustment and ultimately improve data that would be used in a broader ***capitation*** rate.

5) The level of risk in a ***capitation model*** is greater than in ***an episode bundled*** model. Moreover, the incentives for steering patients to other settings or minimizing care are also stronger. If the State pursues a capitation model, the performance monitoring, including any incentives or penalties based on outcomes, will be even more important than in the episode-model in which these incentives are mitigated by decreasing the length of time the payment covers and triggering payment based on services received instead of prospective, annual attribution.

Options for Phase One: Episode Bundled Model

B&A initially explored creating a category three model and it is currently described in the public solicitation of feedback on the Medicaid Pathway (MP). In response to initial feedback on the model, B&A explored a category four model to try to address make case-mix groups reflect groupings of population cohorts instead of those based on previous programmatic groups or service categories. The primary difference in the models is in how costs are grouped and paid across providers.

Instead of five categories as described in the original approach (DS, MH-Adult, MH-Child, Emergency/Crisis, SA), the categories would be instead based on population definitions such as:

- DS
- MH-Adult, without SA
- MH-Adult, with SA
- MH-Child, without SA
- MH-Child, with SA

Both models resemble what is known as the prospective payment system (PPS) version two (PPS-2) of the federal Certified Community Behavioral Health Center (CCBHC) model. One of the goals of the Medicaid Pathway is to not divert too far from this model. Both models produce stable categories on which to set rates based on our initial financial analysis. Therefore, B&A would recommend either approach, category three or category four, to an ***episode bundled*** model.

Options for Phase Two

Assuming the State adopts a category three or category four ***episode bundled*** APM as phase one of the Medicaid Pathway, there would be two options to consider to move this ***episode bundle*** under a ***capitated*** model. In either scenario, the State could choose to add more services or providers to ***episode bundled*** APM as exclusions were lifted, which would be captured in either option 1 or 2 described below.

1) The current Medicaid ACO APM could be expanded to include providers and services under the Medicaid Pathway continuum. Data from the post-implementation of phase one of the Medicaid Pathway would be incorporated into the ACO ***capitated*** rates and, for those beneficiaries not attributed, the State would continue to pay the prospective ***episode bundled*** rates.

2) The State would define an enhanced benefit that would extend beyond the defined medical benefit currently included in the Medicaid ACO APM. In this model, an organization--could be an ACO, a a DA, a SSA or other--would take accountability across a comprehensive set of services and providers for a defined population. The benefit would include a wider array of providers than those considered under phase one of the

Medicaid Pathway—for a defined population. Having implemented the ***episode bundled*** rates, would ensure that the data used to set future ***capitation*** rate for the enhanced benefit would be case-mix adjusted for the these services and providers.

Special Considerations

1) If the DSSSAs and DS services provided by DAs are to be included in the episode bundle APM, the first year would largely be based on historic spending due to a lack of data with the specificity and charge data necessary to case-mix across these providers. The APM assumes that after collection of data that a re-base would then adjust rates to set them based on the costs of providing services and not on the individual budget process as currently included in the treatment of care plans. A key decision point for the State is whether the APM prospective approach will either replace or be done in concert with the individual budget process and how providers may need to update their reporting of encounter data for this purpose.

---

[i] The Health Care Payment and Learning & Action Network (HCP LAN). Accelerating and Aligning Population-based Payment Models: Financial Benchmarking. 2016. https://hcp-lan.org/groups/pbp/fb-final-whitepaper/.
[ii] The Health Care Payment and Learning & Action Network (HCP LAN). Accelerating and Aligning Population-based Payment Models: Financial Benchmarking. 2016. https://hcp-lan.org/groups/pbp/fb-final-whitepaper/
[iii] The Health Care Payment and Learning & Action Network (HCP LAN). Accelerating and Aligning Population-based Payment Models: Financial Benchmarking. 2016. https://hcp-lan.org/groups/pbp/fb-final-whitepaper/
[iv] https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Risk-Adjustors.html
[v] http://cdps.ucsd.edu/