Using Value-Based Purchasing Arrangements to Improve Coordination and Quality of Medicare and Medicaid Nursing Facility Benefits

Summary: A July 24, 2018 Integrated Care Resource Center (ICRC) webinar examined the role of Value-Based Purchasing (VBP) in improving coordination and quality of Medicare and Medicaid nursing facility benefits for dually eligible beneficiaries. The webinar featured presentations from two health plans, HealthPartners and Mercy Care, on their specific VBP initiatives, as well as a panel discussion on VBP experiences with representatives of these two health plans, two state Medicaid officials from Arizona and Minnesota, and one nursing facility representative from St. Anthony Park Home in Minnesota. Key takeaways include the importance of:

- Having a '**critical mass**' of health plan (or program) members in a particular facility in order to drive change through VBP;
- **State, health plan, and nursing facility collaboration** in designing VBP initiatives, including nursing facilities in the collaborative process helps to ensure nursing facility engagement and commitment to the success of the initiatives;
- Providing **on-site nurse practitioners/clinical staff** to support nursing facility staff and interact with plan members in the facility;
- **Minimizing undue burden on nursing facilities** and their staff (e.g., by utilizing quality measures already required for Medicare or other state purposes with VBP initiatives, by defining cross-cutting initiatives or measures to be used by multiple plans/payers)
- Focusing on initiatives that will **improve quality of care** for patients; and
- **Applying lessons learned** and **continuously adapting VBP initiatives** and processes to drive quality improvement.

This summary may be helpful to states, health plans, and nursing facility providers working to advance quality of care for dually eligible beneficiaries through VBP arrangements. Speakers' remarks have been condensed and edited for clarity. For webinar slides and an audio recording see: https://www.integratedcareresourcecenter.com/webinar/using-value-based-purchasing-vbp-arrangements-improve-coordination-and-quality-medicare-and.

Note that the remarks summarized in this document are those of webinar presenters and do not represent guidance from the Centers for Medicare & Medicaid Services.

Overview of Medicaid Value-Based Payment in Nursing Facilities: Erin Weir Lakhmani, ICRC

Motivations for states and health plans to implement value-based purchasing (VBP) with nursing facilities (NFs) include: (1) a desire to shift away from fee-for-service systems that promote volume of care toward systems that promote value; and (2) opportunities to improve quality of care and control costs in NFs through efforts to reduce avoidable hospitalizations and/or provide care management services for high-need residents.

States are increasingly implementing Medicaid VBP with NFs. The Medicaid and CHIP Payment and Access Commission (MACPAC) identified 23 states using VBP to provide incentives for quality in NFs in 2014. ICRC interviews with six states and five managed care plans in 2017 found that most Medicaid VBP programs focused solely on Medicaid NF services and payment, even though almost 90 percent of Medicaid NF residents are dually eligible for both Medicare and Medicaid benefits.

Cross-payer VBP can be challenging to implement, but an integrated approach can ultimately achieve more significant improvements than separate initiatives. Alignment of goals across payers reduces competing priorities/incentives for NFs, and alignment of VBP measures can reduce NF reporting burdens. Integrated VBP creates a more holistic approach to care for beneficiaries because providers have incentives to strive for care and quality improvement overall, regardless of the source of payment.

HealthPartners Partnership Homes (Minnesota)

Speakers: Tom von Sternberg, MD, Senior Medical Director of Geriatrics, Home Care, Hospice and Case Management, and Susan McGeehan, Manager of State Public Programs, HealthPartners

HealthPartners Background:

- Integrated organization: Both an insurer and a care deliverer (doctors, clinics and hospitals).
  - Care delivery: 1 million patients in 8 hospitals, > 1,700 physicians, > 50 clinics
  - Health plan coverage: > 1.4 million members
- Medicaid coverage in Minnesota since 1985: Today focusing on Minnesota Senior Health Options (MSHO) program, which started in 1997 as a CMS demonstration project and became a Dual Eligible Special Needs Plan (D-SNP)-based program in 2006 (for dually eligible beneficiaries age 65+).
- Offers a Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP) that covers medical, behavioral health, dental, pharmacy, acute and long-term care services, including community/waiver services, and NF benefits.
- Current MSHO membership: 3,100 members. Small but stable program; members have the choice to obtain services through the larger HealthPartners public programs network and are not required to seek care exclusively in the HealthPartners care system (though over 80 percent of Health Partners' MSHO members are cared for by the HealthPartners care system).
- The HealthPartners' care delivery system (of doctors, clinics and hospitals) is not a closed care system. It takes multiple payers even though it has a direct relationship with the HealthPartners health plan.

Value of On-site Health Plan Practitioners: For over 40 years, HealthPartners has provided a clinical model of nurse practitioner care teams on site to deliver care to residents in NFs, which is fundamental to partnerships/relationships with long-term care providers. This is an important infrastructure element that others may want to consider.

Partnership with NFs: HealthPartners has about 400 MSHO members in NFs, and 200 in a NF with a HealthPartners Partnership Home contract. HealthPartners' partnership with NFs is logical because of the complex nature of care coordination and high risk of avoidable hospitalizations among NF residents.

The Partnership Home model focuses on long-stay NF residents and does not include post-acute/Medicare SNF care.[1]

Quality Measures: In the Partnership Homes program, HealthPartners chose to focus VBP efforts on reducing falls with injuries and pressure ulcers. It chose to focus on these two areas to align with NFs' existing priorities since it is important to not add additional burden to NF partners. HealthPartners has found that successful VBP efforts prioritize improving care in areas that are high priorities for NFs and also have the potential to improve quality of care for patients. Future measurement will be focused on hospitalization avoidance and reduction in antipsychotics. The community is more ready for the hospitalization focus now.

Mercy Care (Arizona)

Speaker: Chad Corbett, Vice President, Long Term Care, Mercy Care

Mercy Care Background:

- Part of Arizona Medicaid program since 1985. In 2000, began contract for long-term services and supports (LTSS) population in the Arizona Long Term Care System (ALTCS).
- Began looking at VBP in 2013. VBP was a cornerstone of the Arizona Health Care Cost Containment System (AHCCCS), the state's Medicaid program.

Quality Measures: Mercy Care focuses on member experience, population health, and quality. Through monthly meetings with a large PCP group, the plan saw a high volume of urinary tract infections (UTIs) that were causing unnecessary emergency department visits and hospitalizations. Therefore, it chose UTIs as measure for its VBP program.

VBP Program Structure: Mercy Care brought two NF competitors in Arizona together to work toward achieving better outcomes for the entire NF population, regardless of payer source. It wanted to develop a new way of doing business. It selected two large NF chains in Phoenix and Tucson and set a common VBP goal (the goal would only be considered 'met' if both NFs achieved it). Through this single approach, the organizations were working together instead of competing.

Program Goal and Progress: Mercy Care used calendar year 2013 claims data for membership at 11 facilities in these two chains to get per member per month (PMPM) medical costs as a baseline. The initial goal was set as six percent reduction in associated medical costs in the first year. Mercy Care gave the two companies up-front investment dollars to use how they saw fit. One hired a medical trainer and purchased educational materials on UTIs, cranberry tablets, and water pitchers. The two companies shared their strategies and could copy each other's best practices. They held meetings at 3, 6, and 9 months into the project and shared their progress toward the goal.

[1] In a subsequent email to ICRC, Dr. von Sternberg noted, "We actually do have a well-developed strategy for post-acute care and have a limited number of preferred SNFs that we describe as our 'preferred network' for post-hospital care, but we don't have financial upside or downside arrangements with them at this time – we are working toward that. Note, though, that it is even more difficult to achieve a 'critical mass' of plan members in SNFs than in NFs."

The two organizations did not meet the six percent reduction goal in the first year, but did see a one and a half percent reduction. Because it took six months to disperse the initial investment dollars, Mercy Care decided to add a second year with a goal of a three percent reduction in total PMPM. Both groups exceeded the target in year two with a five percent reduction in PMPM across two years.

Program Future: The next phase of Mercy Care's VBP program is focused on reducing unnecessary antibiotics and avoidable hospitalizations.

Moderator Questions for HealthPartners (Tom von Sternberg and Susan McGeehan)

Moderator: In your VBP initiative(s), how are participating NF providers selected, and how do you encourage provider participation?

One challenge is defining what constitutes a high-quality NF. HealthPartners looks at NF leadership and staff turnover and also listens to "on the ground intel" from HealthPartners' on-site nurse practitioner teams (to gain clinician perspective on facilities' attention to what's important).

The volume of MSHO numbers in the facility is another important consideration. It is not a good use of resources if they only have a few members in a facility. Health Partners is looking at possibly requiring a minimum number of members in each NF.

Moderator: What have you done to support providers along the way?

HealthPartners meets with Partnership Homes bi-annually to support engagement, problem solve, discuss process improvements, and share quality performance data. The leadership from NFs, nurse practitioner on-site teams, and the health plan all attend since it is helpful to have all three areas together. The relationship-building/partnership is just as important as metrics. In addition to VBP, it is important to have a forum for discussion to support NFs more effectively.

The program is relatively small, so it is difficult to have significant numbers of members in any given facility, and it is not necessarily possible to have exclusivity of members in a NF. Balancing having a "critical mass" against NFs having to deal with multiple payers is an important consideration.

HealthPartners has also delegated care coordination of the members in these NFs to the nurse practitioner on-site teams, which offers NFs on-site care coordination, another element in HealthPartners' success.

Moderator: What specific NF behavior(s) have you aimed to change with the VBP program(s) you described today and why? What outcomes have you seen?

HealthPartners is not trying to change behavior so much as reinforce what facilities attempt to do as they attend to regulatory requirements and quality metrics. The role is to support their mission in providing high quality care. The plan chose pressure ulcer reduction and falls with injury prevention because facilities want to have a comprehensive intervention approach. They offer PMPM payment (Minnesota Senior Health Options [MSHO] census-driven) to incentivize focusing on quality initiatives and annual quality bonus payments as benchmarked are reached. The outcome was favorable, with 70 percent of NFs achieving quality bonus in 2015 and 80 percent in 2016.

HealthPartners is moving now to start focusing on avoidable hospitalization and antipsychotic use. NFs have increased interest in reducing avoidable hospitalizations. Facilities are often responding to

clinicians who choose to hospitalize. They are emphasizing use of the INTERACT[2] approach, and ways facilities can utilize their own clinical staff to improve quality of care.

Moderator: When did planning/implementation begin for the VBP program(s) you described today? How have the programs evolved over time?

HealthPartners' contract with the state of Minnesota requires integrated care system partnerships; this requirement was added approximately five years ago. The state pushed pursuit of creative partnerships with less traditional providers such as long-term services and supports (LTSS) and home- and community-based services (HCBS), as well as with traditional (acute care) providers. Each MSHO health plan chose partnerships to pursue, and HealthPartners was already working on Partnership Homes, so it was a perfect fit. The state organized a collaborative health plan clinical leadership group that created a list of quality measures that could be used in these partnership arrangements. This collaborative was a great experience, where HealthPartners shared best practices and upcoming innovations.

HealthPartners has been partnering with NFs for over 20 years. It has been waiving the Medicare SNF three-day hospital stay requirement and giving direct access to Medicare SNF coverage, which is now seen as fundamental, although 20 years ago it was innovative. Now, HealthPartners is looking beyond NFs to partner with assisted living facilities and adult day centers.

It is important to focus on measure consistency (for the state and CMS) to avoid undue administrative burden for NFs. HealthPartners talks to NFs about future measurement change and what would make the most impact.

Health plans need to maintain a member threshold/"critical mass" for programs to continue. Facility success is dependent on staff consistency/staff turnover and ability to hire; awareness of these challenges is important. What works regarding VBP incentives continues to evolve. Right now, it is all about up-side risk. It is important to know what facilities are capable of and what they have an appetite for when thinking about ways to partner.

Moderator Questions for Mercy Care (Chad Corbett with Paul Fawson, Director of Value Based Programs and Charlton Wilson, MD, Chief Medical Officer, Mercy Care)

Moderator: How have state VBP initiatives influenced/affected your plan-based initiatives? How does (or how could) your state support you in developing Medicare-Medicaid VBP initiatives?

AHCCCS is a public-private partnership. AHCCCS takes a collaborative approach to implementing VBP, and the approach has evolved over time. The state started by adding a requirement in its health plan contracts for a VBP pilot program with a deliverable and a narrative report. In the next year, the state used some promising practices from that pilot to set policy objectives and targets that it sees as valuable and added those into the contract to raise the bar. That is how the VBP initiative in Arizona started (around 2010). First, there is a requirement to pilot a VBP initiative, then specific targets to achieve for spend and VBP for each managed care organization, starting with one to two percent, then 10 or 20 percent, and eventually 70 percent or more.

[2] Interventions to Reduce Acute Care Transfer (INTERACT) is a quality improvement program to improve care and reduce avoidable hospitalizations. For more information about INTERACT for NFs, see: http://www.pathway-interact.com/interact-tools/interact-tools-library/interact-version-4-0-tools-for-nursing-homes/

It is important to establish a common vocabulary and common ways to describe activities. Currently, Mercy Care is using the Learning and Action Network Alternative Payment Model framework to describe VBP activities in Arizona.

The state's policy objectives and targets include alignment of Medicare and Medicaid when the health plan controls the Medicare side as well. There are natural reasons for health plans to do this anyway, but by setting targets, state can push this objective.

The use of VBP creates an environment for innovation, which leads to variation. One MCO working with a provider is different than another MCO in a different area with a different provider. This creates a lot of learning and sharing of ideas. The new ideas are brought to market earlier than otherwise possible. The "down" side of so much innovation is attempting to identify sources of progress with so many different activities. However, since Arizona has created a learning environment, there has been a lot of discussion and sharing among organizations and providers. There is a natural process – once someone learns something, others adopt quickly. Arizona has implemented special funding for a targeted assessment program and sets overarching objectives around integration of behavioral and physical health. This allows managed care organizations to adopt and follow certain measures and creates some commonality among VBP activities to prevent provider fatigue while promoting innovation.

Moderator: What resources are required to implement a VBP program? From what source(s) have you been able to draw the resources to implement these programs?

It is important to have a multi-stakeholder approach. Analytics help identify and quantify VBP opportunities (e.g., the number of members included, potential impact on quality measures, finance, etc.). MercyCare brings in subject matter experts from a variety of areas to ensure the program is sustainable and doesn't just look good on paper. There is provider engagement, finance, operations, contracting/monitoring, as well as post-execution follow up. The meetings are important to see how things are going and to consistently touch base with providers. It is important to have buy-in from executive leadership to drive initiatives forward since if you invest up-front cost, hopefully there will be savings later.

Moderator: Are there opportunities to use savings from reducing avoidable hospitalizations or other quality initiatives to fund VBP programs like yours?

Almost all of Arizona's programs are fully aligned, with managed care organizations overseeing all benefits (and the Dual Eligible Special Needs Plan [D-SNP]/MLTSS program in Arizona offers voluntary alignment for dually eligible enrollees). This aligns incentives, and helps health plans focus on total cost of care, and the ultimate goals to achieve. There are opportunities to reduce hospitalizations and emergency department visits through steps taken in institutional settings, home- and community-based and primary care settings. By using a total cost of care view, health plans can increase costs in certain areas to achieve a reduction in other areas, such as hospitalizations and emergency department visits. State infrastructure in Arizona supports this – health plans are able to submit information about VBP incentives/rewards to the state and earn credit from the state for avoided costs. It allows the state to prevent premium slide and other perverse incentives that do not drive clinical outcomes.

Moderator Questions for State Medicaid Officials (Tom Heiser, Operations Compliance Officer for Medicare, Arizona Health Care Cost Containment System (AHCCCS) Division of Health Care Management, Gretchen Ulbee, Manager, Special Needs Purchasing, and Valerie Cooke, Manager, Quality and Research, Minnesota Department of Human Services)

Moderator: How do Medicare-Medicaid NF VBP initiatives fit within your state's broader VBP initiatives and/or integrated care initiatives for dually eligible beneficiaries? How (if at all) do Medicare-Medicaid NF VBP initiatives fit within the vision your state has for the future of integrated care?

Arizona: VBP supports many initiatives within the broader context of AHCCCS' strategic goals, which include establishing a system of integrated health plans that support provider integration activities to improve member health outcomes, particularly directed at dually eligible beneficiaries and those with chronic conditions. It also supports increased use of alternative payment models in all programs, so Arizona can work on appropriate alignments and incentives to drive quality improvement forward across all provider types, including NFs. In the Arizona health plan contracts, VBP is contractually required for all Medicaid MCOs. Since Medicaid MCOs serving dually eligible beneficiaries are required to have a companion Medicare D-SNP, VBP initiatives can extend across Medicaid and Medicare services, taking into account both Medicaid-paid NF services and Medicare-paid hospital and other services.

Minnesota: The state's D-SNPs are an integral part of its purchasing strategy for seniors in particular. MSHO provides a broad array of services (e.g., acute and NF care) all paid for by one entity that contracts with CMS as a Medicare D-SNP and with the state as a Medicaid managed care plan. The state feels strongly that having one entity caring for members across the care continuum is important.

The state has contractual requirements for VBP. It wants this to be utilized for behavioral health, long-term care, and acute care, including NF care. In addition to managed care work, all this is resting on strong foundation of quality work across the board in NFs. No one health plan will have a majority of residents in any given NF, so the state sees a strong need for a foundation on which health plan efforts can rest. One of the key goals of managed care VBP is to support efforts already underway.

There is a robust NF quality measurement system in Minnesota. The state's measures are aligned with federal measures as much as possible, based on the Minimum Data Set (MDS) NF assessment, to prevent extra data collection for providers. The pay-for-performance initiative is agnostic to the payer source. The state does use quality measures to influence Medicaid fee-for-service rates. Minnesota is a rate equalization state, so those quality performance measures also influence private pay rates.

Some NF quality initiatives in Minnesota provide financial incentives for quality improvement over a baseline, and others reward high performers. VBP efforts like those described by HealthPartners help support state's overall NF quality improvement goals.

Moderator: What steps has your state taken to encourage health plan development of NF VBP initiatives involving dually eligible beneficiaries and/or provider participation in those initiatives? What support(s) does your state offer to health plans like those on the call today in developing NF VBP initiatives? To providers participating in VBP initiatives?

Arizona: A foundational element for Arizona VBP programs, including nursing facilities, is that the state sets a framework for how health plans can design and implement VBP for different populations. The

health plans can include different elements for different populations – an acute care and physical health VBP is going to look different than one for elderly and disabled MLTSS, so there is design flexibility, and there is also design flexibility for different health plans. All initiatives are targeted toward achieving overarching goals that AHCCCS puts forward every year, but the state does not require health plans to follow exact same requirements.

Collaboration among health plans, providers, and the state helps to develop what is possible and look at best practices that come out of the process of trying something new. The process has evolved over the years and measures change over time. Arizona evaluates to see what works best and then to apply best practices.

Minnesota: The state made it a contractual requirement that health plans work on long-term care VBP initiatives. The state brought clinicians together to look at measures and see what works in order to minimize the number of measures being used in these arrangements.

Minnesota also offers technical assistance for providers. It has a quality improvement nurse who does on-site consulting and phone support and helps develop quality improvement projects. The states hold a "boot camp" annually for providers to develop pay-for-performance quality improvement projects and participate in a competitive process.

Moderator: What challenges has your state faced in developing NF VBP initiatives like those described today and/or supporting health plan development of these initiatives?

Arizona: The state sees challenges as opportunities. As new processes evolve, opportunities always present themselves. How a state attempts to discuss and address these opportunities is important. VBP implementation is a learning process, and the state is sharing what it learns over time to benefit all stakeholders, always keeping the member as the primary focus to help drive quality improvement.

It is important to have constant communication and start early with stakeholders, and do it often to keep engaging them since it is an ongoing process. Arizona looks for best practices and solutions, and then evaluates them for performance, and identify opportunities for improvement – that is one big objective of VBP. Driving quality improvement drives cost improvement as well. Stakeholder buy-in is important, both from the health plans and among providers. Everyone needs to understand the reasons why they are attempting to implement particular features, and get that buy-in to it early. Also, it is necessary to listen as processes are implemented and incorporate received feedback. There needs to be reinforcement and taking what was learned, and modifying /refining components through an evaluation process.

It is important to offer flexibility in how health plans design VBP with NFs. What may be appropriate for one health plan may not be appropriate for another and there is a need to factor in geographic location, acuity of the population, etc. These characteristics reflect the health plan's populations, and what measures may be appropriate.

Minnesota: One primary challenge is really to capture results and what is actually happening. There are a lot of initiatives underway in Minnesota. The state knows that senior dually eligible beneficiaries do better in integrated products than in the Medicaid-only products. The state has a longitudinal study that shows people in Minnesota's integrated products are half as likely to have an emergency department visit. However, the multitude of initiatives in the state makes it challenging to do VBP. It needs to make

sure providers are not overburdened, especially with Medicare and CMS in the mix as well as the state. Minnesota is trying to find a place for these initiatives in a crowded field, and also to tease out results. It becomes iterative, and little things add up. A big piece is creating relationships with NFs, and changing expectations, and some of that is difficult to measure.

At the provider level, one of Minnesota's quality programs is simple to participate in, so Minnesota gets 100 percent participation in that program, but the financial rewards are not as strong. A second program involves much more of an administrative process – an application, design, etc. – and often free-standing NFs do not feel they have the resources or skills to put that together. Minnesota is working to bring more NFs into that program.

Moderator Questions for Nursing Facilities (John Barker, Administrator, St. Anthony Park Home, Minnesota and Chad Corbett, Mercy Care[3])

Moderator: From your perspective, what are the benefits to participating in Medicare-Medicaid VBP initiatives like those described in today's call?

St. Anthony Park Home: The NF perspective is a different perspective than many of the other speakers. NFs have patients in the facility and have to take care of them every day. The patients say, "I don't like your food," but nobody says "I don't like your food, but your VBP program is great." It is important to have context of what really works, and the NF's focus is on what is going to really improve patient care.

The physician team from HealthPartners is huge. They see 75 percent of the St. Anthony Park Home's patients. They come to the facility, and people see the practitioner as an employee of the facility, which is the biggest "plus" right now. The physician team is critical. The NF needs relationships with the patients to know what they want; no two patients want the same thing. When the physician team is there, they get that information and input from the family members who want different things, and push that information up to Health Partners. The physician teams have a better chance to communicate with patients than we do.

The NF gets paid the same, no matter who pays. There are financial benefits to St. Anthony to reduce pressure ulcers and falls through the VBP program with HealthPartners, as well as other administrative/management things. Those are great, but they do not change a lot, since the facility should be doing those things because it is right for the patient, not because it costs less or more. The NF should be reducing falls because it's better for patients and therefore it's better for business.

Moderator: What are the biggest challenges that NFs face in participating in Medicare-Medicaid VBP initiatives?

St. Anthony Park Home: Access to medical records is the biggest barrier. The NF should have access to those, but they do not always get them. Health Partners offered St. Anthony's the opportunity to access electronic medical records from one regional hospital, which has worked well to get quick information to patients and families and to be able to look up patient records, test results, etc. The NF is fighting for basic information for patients. If a doctor does not prescribe a medication right away, the patient gets mad at the NF, not at the doctor. The NF is the one who gets blamed and is held responsible, and it is.

[3] The NF representative from Arizona (a partner in Mercy Care's VBP initiative) scheduled to speak during this forum was unable to attend the call, so Chad Corbett shared some of the feedback that Mercy Care had received from that provider and its other NF partners regarding the VBP initiative.

They need all other providers to step up, and that does not always happen, so access to information is critical.

Chad Corbett: Some of the challenges in Arizona, from the NF perspective, include having to work with multiple health plans, each with their own direction and design for VBP. This is time-consuming for NF staff to track and monitor all different elements from different health plans. It can be helpful for the NF to take the initiative and sit down with all plans together and decide on one VBP initiative or one set of VBP measures.

The number of plan members in a facility is another challenge, already mentioned earlier.

Rewards for effort are important as well. Looking back, in the first year, Mercy Care had 11 facilities working for a common goal but did not meet the six percent reduction, so there was no reward for all of that effort. There should have had some type of a reward to encourage facilities to do it again in year two.

And finally, in designing VBP initiatives, states and health plans need to consider regional differences and characteristics. What works in rural areas may not work in urban communities. There needs to be an understanding of the facility and the communities when designing a program.

Moderator: How can states and health plans best support NF participation in Medicare-Medicaid VBP initiatives?

St. Anthony Park Home: There are a couple of initiatives in Minnesota that are accessible to all facilities. They are nice and helpful, but not the reason why to attempt to make something better.

There are difficulties with plan re-assignments when someone has been on a particular managed care plan for years. Locking patients into a particular plan until they choose elsewhere would be helpful.

There needs to be a clear way to exchange information and clarity on what each provider is allowed to get (regarding patient information).

Moderator Question for All Participants

Moderator: Any lessons learned speakers would share with other states or health plans new to this area?

Mercy Care: It is important for health plans to go out and meet with NFs and encourage their suggestions and feedback on VBP programs. There needs to be discussion and buy-in into the design.

Arizona: It is important to encourage collaboration from the grassroots – health plans and providers – in designing VBP. That addresses some of the characteristics, like the differences between rural and urban settings. There needs to be collaboration that brings ideas together and see what will work best.

HealthPartners: Health plans should ask about the various kinds of facilities and their distinct populations, especially with dually eligible populations. Many NFs limit Medicaid and/or dual membership. Some facilities have a high concentration of duals with behavioral health, mental illness, or dementia. Those facilities are critical to the long-term care infrastructure, and they will struggle with star measures and quality outcomes for a variety of reasons. It could be useful to partner with and incentivize certain facilities because of their role in your plan or care system continuum.

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