Delaware Value-Based Programs

Primary Care Collaborative Update

Delivering the Next **Generation** of Health Care

Delaware Health Care Delivery Reform

AmeriHealth Caritas Delaware

DHSS Moves Medicaid Managed Care Contracts to Value-Based Purchasing to Accelerate Health Care Delivery Reforms

Delaware's health care delivery system, Department of Health and Social Services (DHSS) Secretary Dr. Kara Odom Walker announced today that DHSS has entered into a value-based purchasing care initiative through contracts in its Medicaid Managed Care Program. This initiative applies to all managed care organizations participating in the Delaware Medicaid program.

Beyond accelerating reforms, Secretary Walker said the purpose of the agreement is to transition the system away from traditional fee-for-service, volume-based care to a system that focuses on rewarding and incentivizing improved patient outcomes, value, quality improvements and reduced expenditures. DHSS seeks to align the incentives of the managed care organizations, providers and members through innovative value-based strategies.

Delaware Health and Social Services | Office of the Governor Date Posted: Thursday, January 25, 2018

Medicaid MCO Requirements

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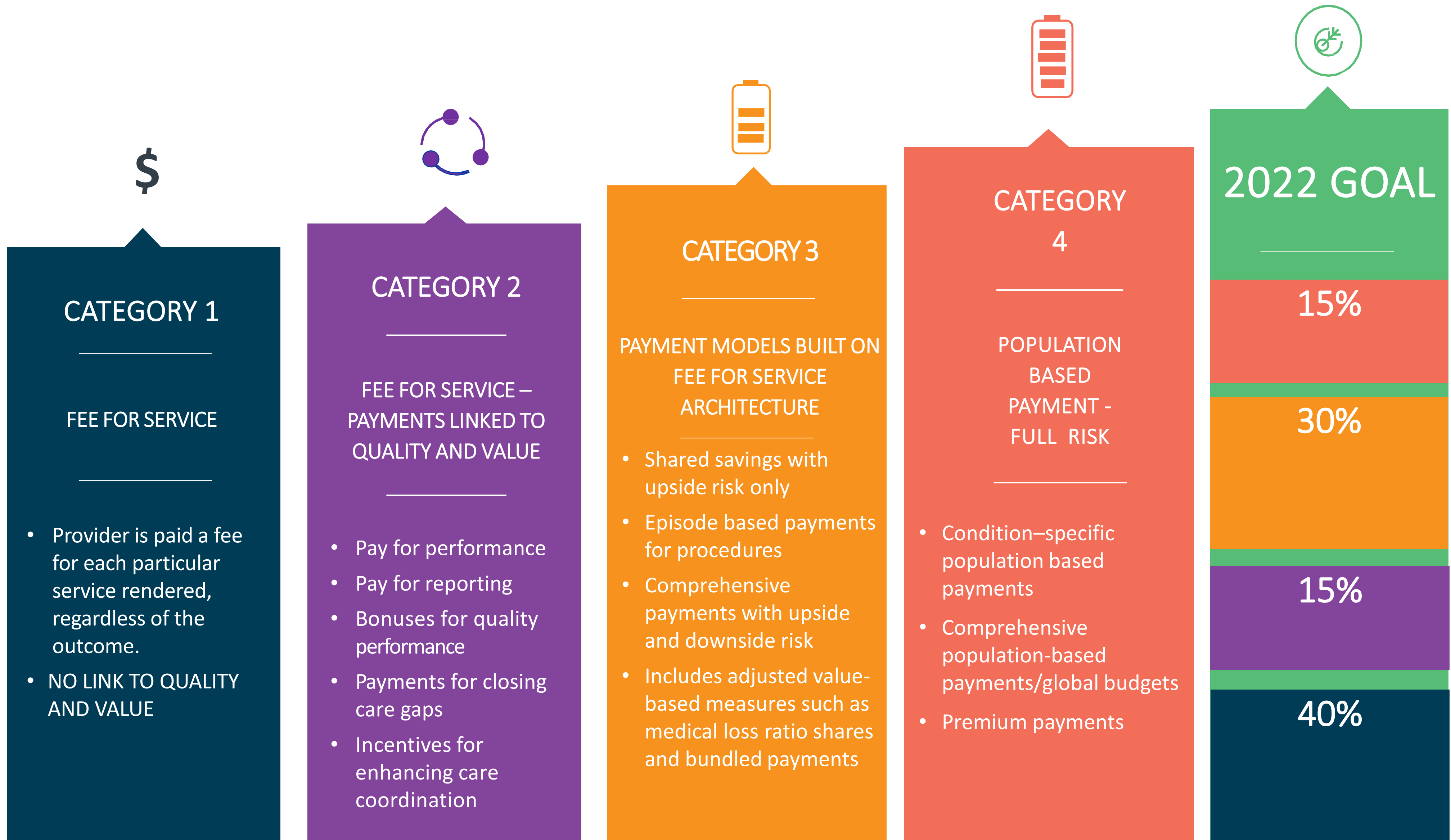
"The purpose of this initiative is to accelerate the implementation of reforms/innovation within Delaware's health care delivery system to migrate the system away from traditional fee-for-service (FFS)/volume-based care to a system that focuses on rewarding and incentivizing improved outcomes, value, quality improvement and reduced expenditures."

Delaware Health and Social Services | Medicaid Managed Care Master Services Agreement

1. MCO contract requirements were implemented effective 1/1/2018 requiring MCOs to meet or exceed seven specific quality thresholds and to achieve value-based contracting threshold targets.
2. The value-based contracting thresholds increase each year to reach a minimum 60% of all medical/service expenditures for all populations by 2022. 3/4 of the 60% must be from combination of: shared savings; bundled/episodic payments; risk/capitation/total cost of care; or other innovative payment arrangements approved by the state.
3. Significant penalties will be assessed for each year of non-compliance; no additional funding was added to MCO rates for these new requirements.

Alternative Payment Model Continuum



Source: Adapted from AmeriHealth Caritas

AmeriHealth Caritas Delaware Implementation Plan

2018 ACDE Year 1
Meet or Exceed
10% threshold level

- **Health Plan Go Live 1/1/18!!!**
- Convert all LOAs to fully executed contracts
- Complete credentialing of provider network
- Outreach to members and providers to create PCP assignments for all transitioned members
- Implement targeted Value-Based Programs based on shared savings
- Meet state VBP contract requirements
- Establish quality baselines
- 499 Primary Care Physicians
- 236 Specialists

2019 ACDE Year 2
Meet or Exceed
20% threshold level

- Evaluate 2018 results and adjust programs as needed
- Begin automation of data exchanges (i.e., DHIN, i2i, Carelink)
- Incorporate partial risk arrangements into new or existing contracts
- Launch Specialty Value-Based Programs (i.e., FQHC, Home Health, BH)
- Identify additional internal quality interventions to support provider initiatives and close care gaps
- Identify opportunities for additional provider/payer collaboration in support of 2022 targets
- 555 Primary Care Physicians
- 300 Specialists

2020 ACDE Year 3
Meet or Exceed
40% threshold level

- Evaluate 2019 results and adjust programs as needed
- Ongoing analysis to validate member auto-assignment vs. utilization
- Identify additional internal quality interventions to support provider initiatives and close care gaps
- Continue automation of data exchanges
- Launch PerformPlus Quality Enhancement Program (QEP) for PCPs not enrolled in an existing VBP
- Continue to transition Shared Savings Contracts to Partial/Full Risk Arrangements as appropriate
- Identify opportunities for additional provider/payer collaboration in support of 2022 targets

Source: Adapted from AmeriHealth Caritas

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2020 PerformPlus Quality Enhancement Program

- The PerformPlus Quality Enhancement Program is designed by AmeriHealth Caritas to link the fee-for-service payment model to quality and value.
- The Quality Enhancement Program model is built on the idea that receiving the right care at the right time in the right setting can improve health outcomes. It is a foundational alternative payment model and is intended to be an introduction in the evolution toward pay-for-performance reimbursement structures.
- The program measures are tailored to align with the state's Medicaid quality and aim to increase the use of preventive services.
- All primary care physician groups with greater than or equal to at least 50 ACDE member panels not already participating in an ACDE value-based program are eligible to participate and may receive financial rewards for accurate data reporting and exemplary quality performance.

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Lessons Learned

- Many adjustments to our criteria needed to be made along the way due to immature data as a new health plan.
- Data extractions and interfaces greatly reduce administrative burden for providers and payers.
- Payers and providers need to better leverage DHIN capabilities.
- Increased reimbursement without improved quality does not reduce total cost of care.
- Payment transformation is a journey which requires ongoing provider/payer collaboration to achieve better outcomes.
- The quality of provider/payer collaboration is a critical success factor.

More than

35 YEARS

of making

care the **heart**

of our **work.**