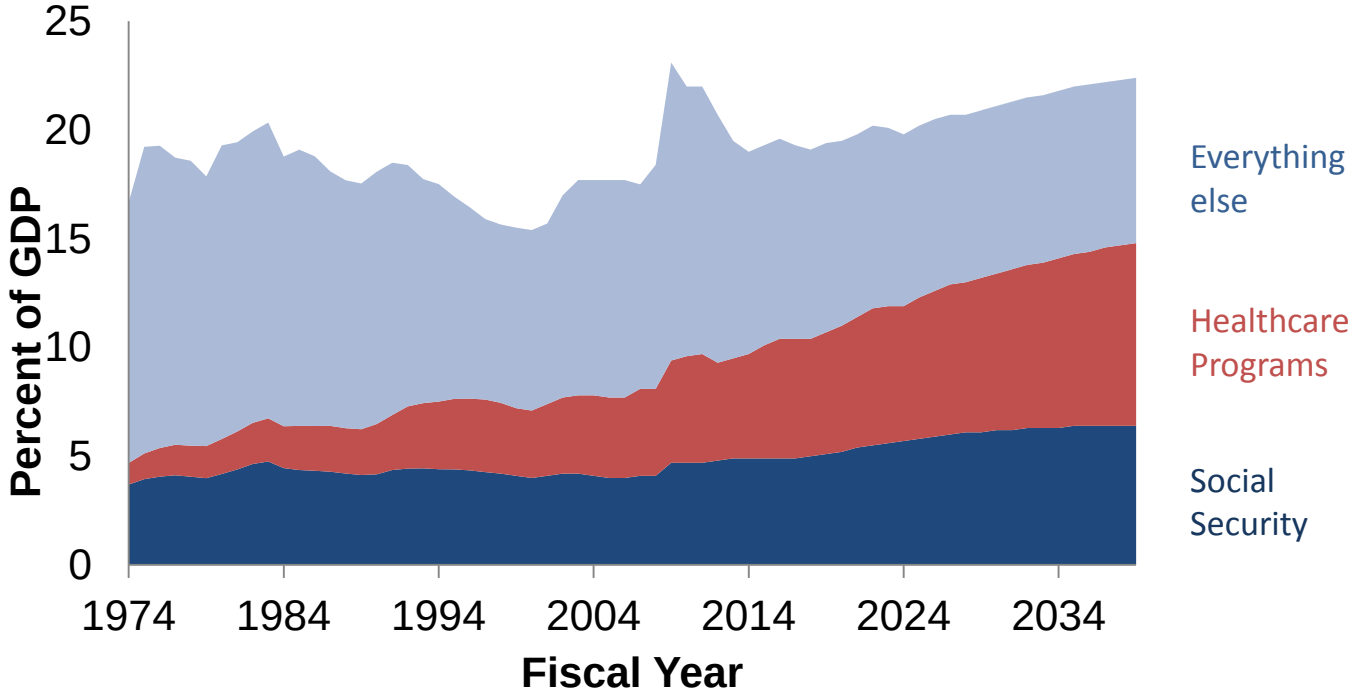
The University of Texas at Austin
Dell Medical School

Alternative Payment Models and Progress Toward Value Based Purchasing in Texas Medicaid

December 6, 2018

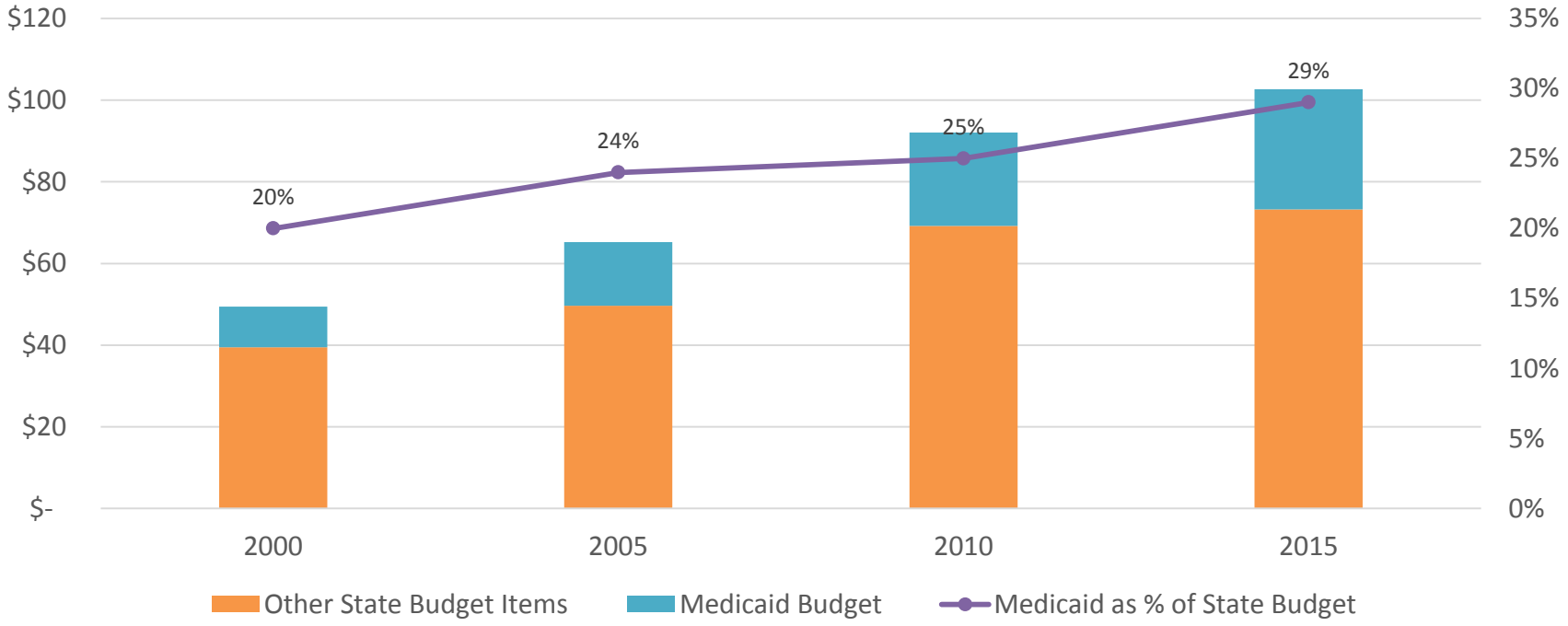
Why focus on value-based care?

Healthcare and the Federal Budget



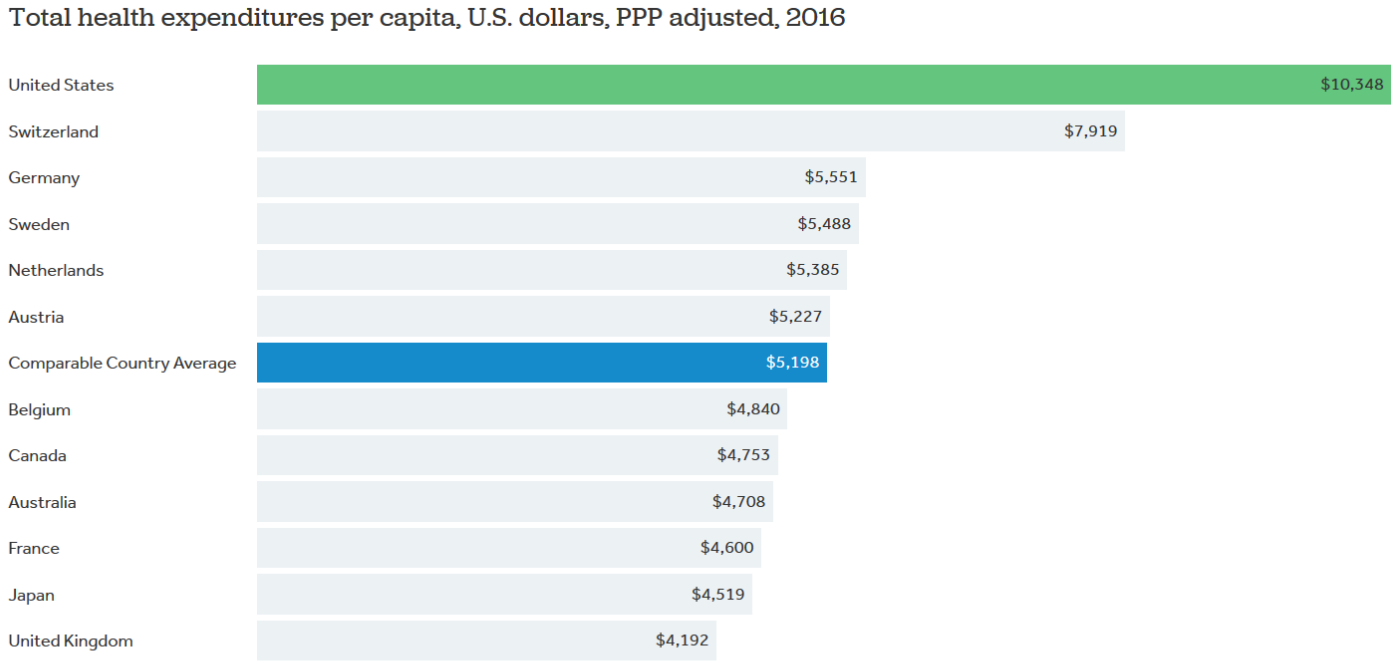
Source: Congressional Budget Office, 2017 Long-Term Budget Outlook.

Medicaid is a Growing Share of the Texas State Budget (in Billions)



Texas Medicaid and CHIP in Perspective, HHSC, February 2017

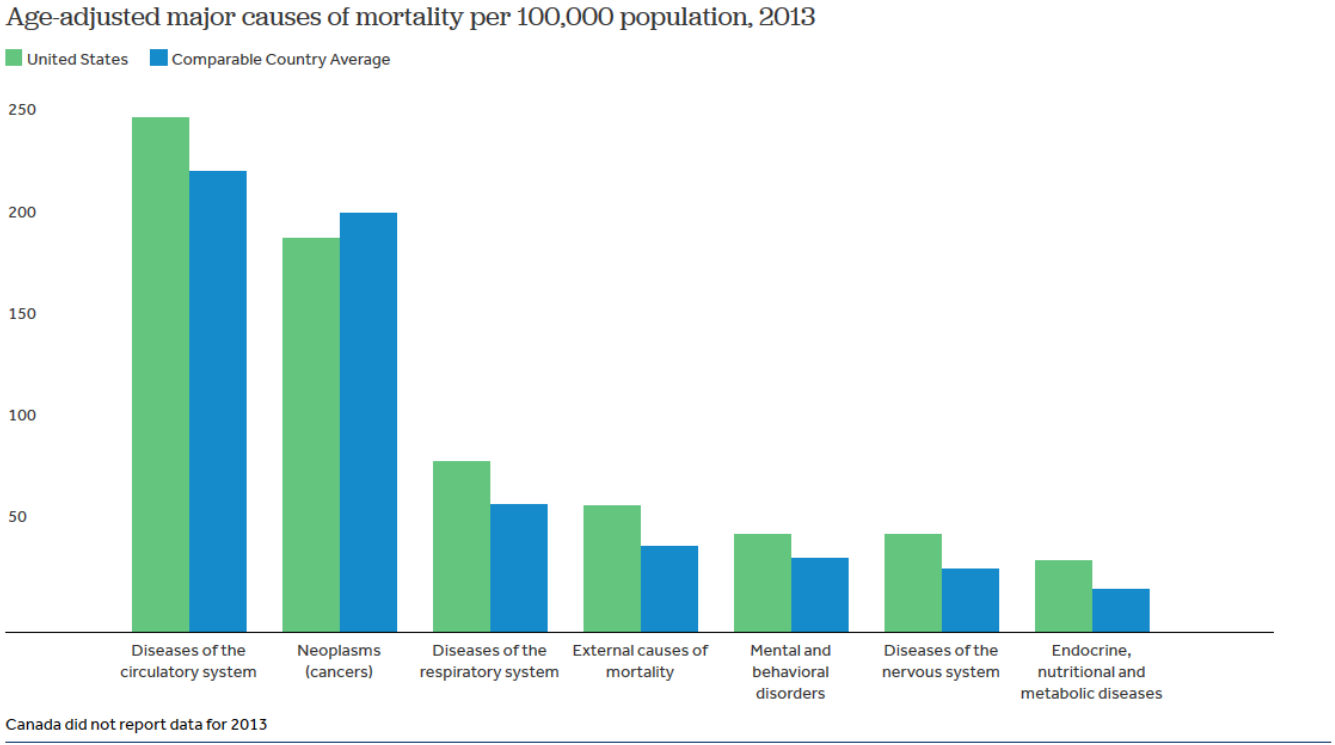
On average, other wealthy countries spend half as much per person on healthcare than the U.S.



Source: Source: U.S. data are from the 2016 National Health Expenditures Account. Comparable country data are from OECD (2017), "OECD Health Data: Health expenditure and financing: Health expenditure indicators", OECD Health Statistics (database). DOI: 10.1787/health-data-en (Accessed on March 19, 2017) • Get the data • PNG

Peterson-Kaiser
Health System Tracker

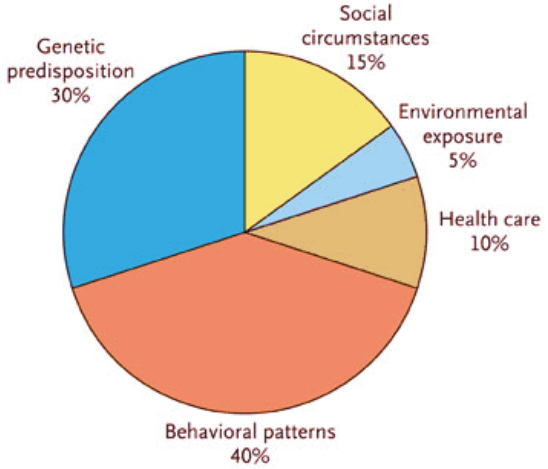
For most of the leading causes of death, mortality rates are higher in the U.S. than in comparable countries



Source: Kaiser Family Foundation analysis of data from OECD (2017), "OECD Health Data: Health status: Health status indicators", OECD Health Statistics (database). (Accessed on March 17, 2017). • Get the data • PNG

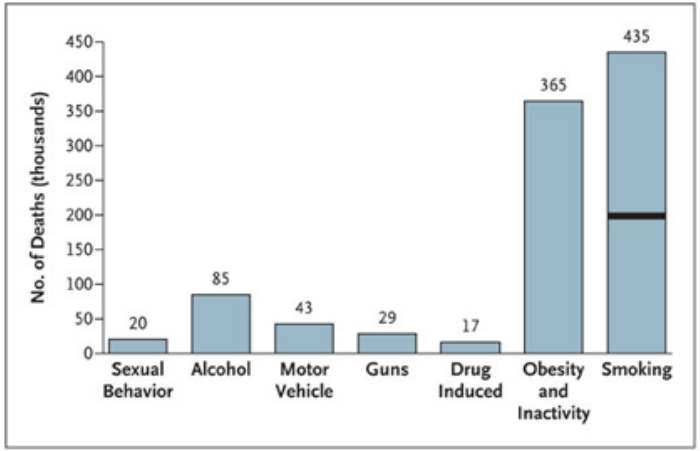
Peterson-Kaiser Health System Tracker

Determinants of Health Outcomes



Determinants of Health and Their Contribution to Premature Death

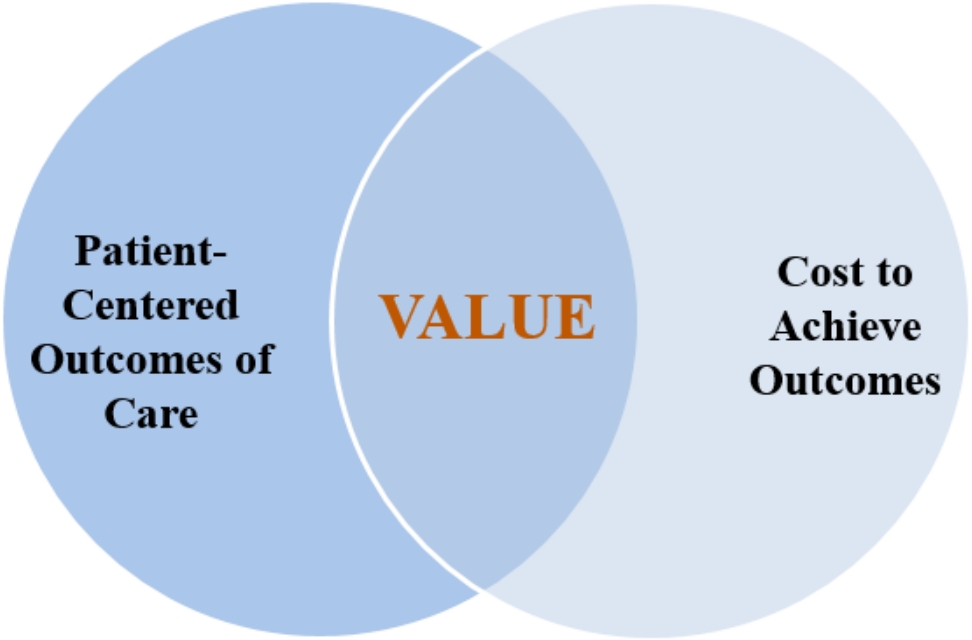
McGinnis, Social Determinants of Health, 2002

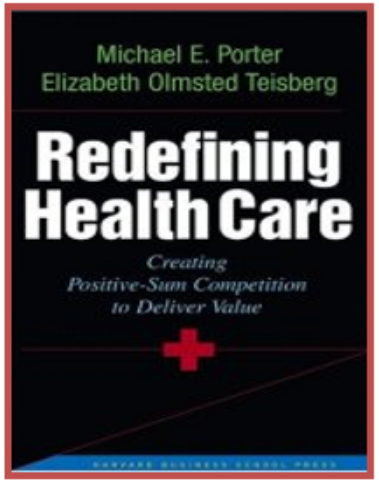


Numbers of U.S. Deaths from Behavioral Causes, 2000.

Adapted from Mokdad et al.

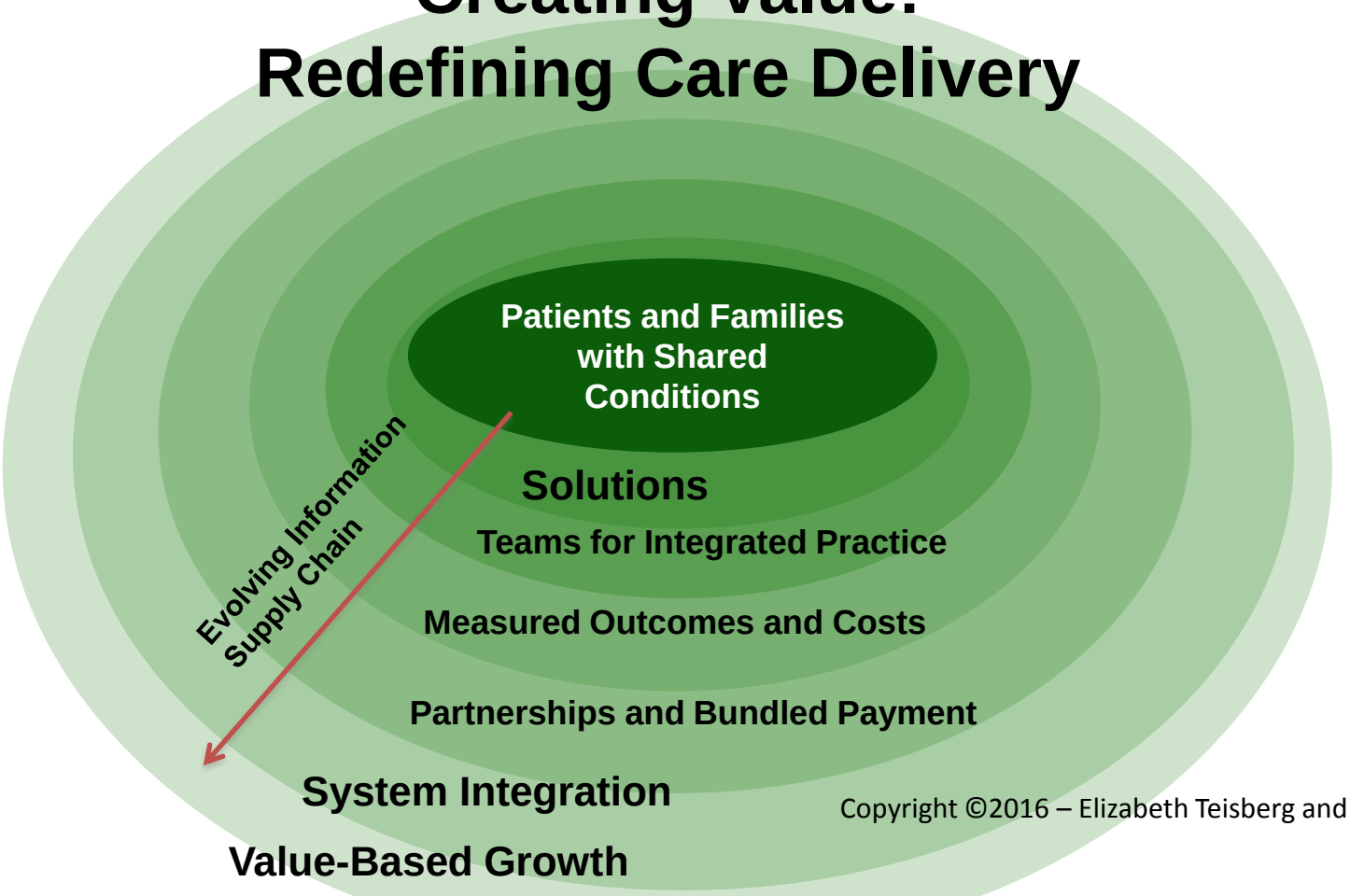
Value Based Care





$$\text{Value} = \frac{\text{patient centered health } \underline{\textit{outcomes}}}{\text{health dollar expended}}$$

Creating Value: Redefining Care Delivery



Alternative Payment Models

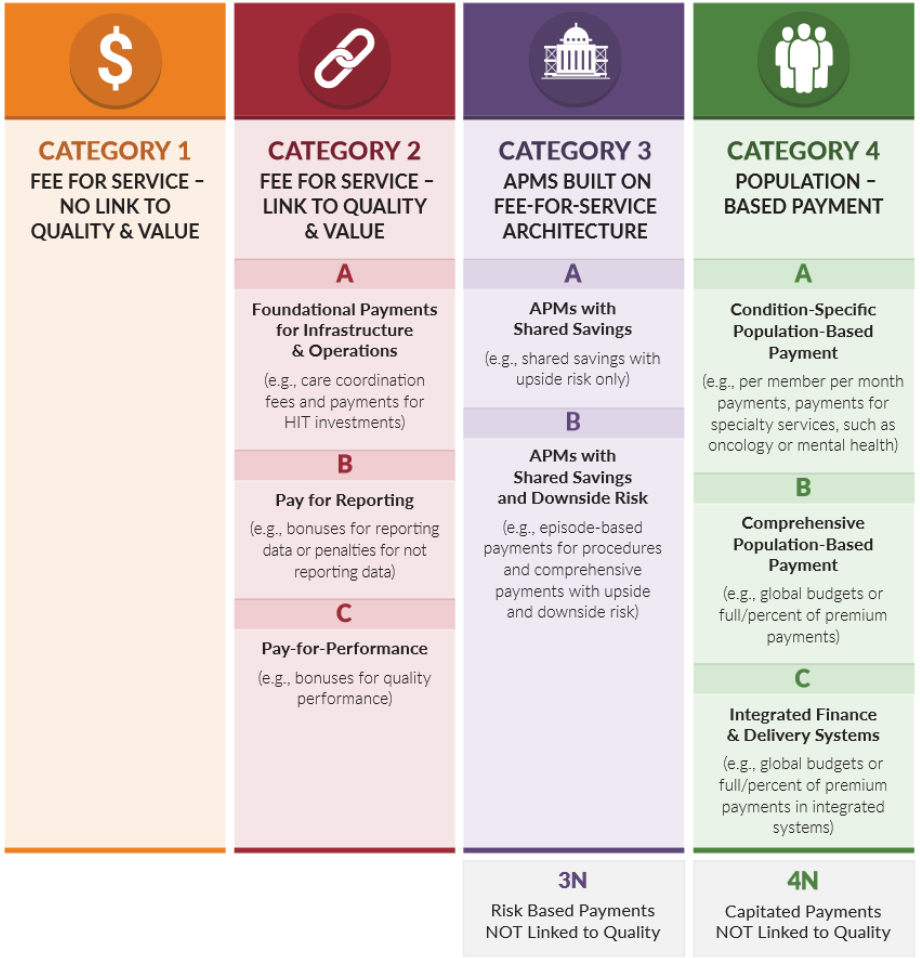
Medicare, commercial payers, and Medicaid all are moving to alternative payment models (APMs) to provide higher-value care

- The Center for Medicare and Medicaid Innovation (CMMI) at the Centers for Medicare & Medicaid Services (CMS)
- The Health Care Payment and Learning Action Network

HCP LAN
Health Care Payment Learning & Action Network

The Alternative Payment Model framework is a step toward the goal of better care, smarter spending, and healthier people…

- For payment reform capable of supporting the delivery of person-centered care
- For generating evidence about what works and lessons learned



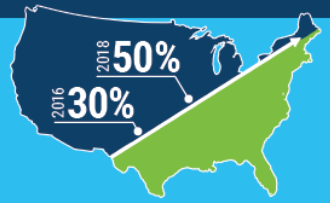
Select Principles of the HCP-LAN APM Framework

- To be an APM, a model must take into account quality of care.
- It is essential to empower patients to be partners in health care transformation. Changing financial incentives providers receive is not sufficient to achieve patient-centered care.
- Delivery systems must be capable of supporting new payment mechanisms.

Select Principles of the HCP-LAN APM Framework

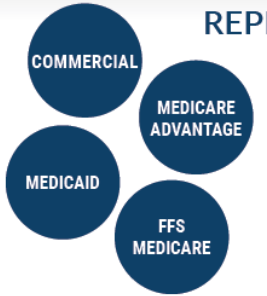
- The goal is to move most national spending to Categories 3 and 4.
- Incentives should be considerable enough to motivate providers to invest in and adopt new approaches to care delivery without subjecting them to unmanageable financial and clinical risk.
- Incentives should reach the teams that deliver care.

APM MEASUREMENT EFFORT



Public and private health plans, managed FFS Medicaid states, and FFS Medicare voluntarily participated in a national effort to measure the use of alternative payment models (APMs) as well as progress towards the LAN's goals of tying 30% of U.S. health care payments to APMs by 2016 and 50% by 2018.

PARTICIPANTS



REPRESENTING OVER **245 MILLION** AMERICANS AND...

...APPROXIMATELY **84%** OF THE COVERED POPULATION IN FOUR MARKET SEGMENTS

2016 PAYMENTS*

LEGACY PAYMENTS IN CATEGORY 1

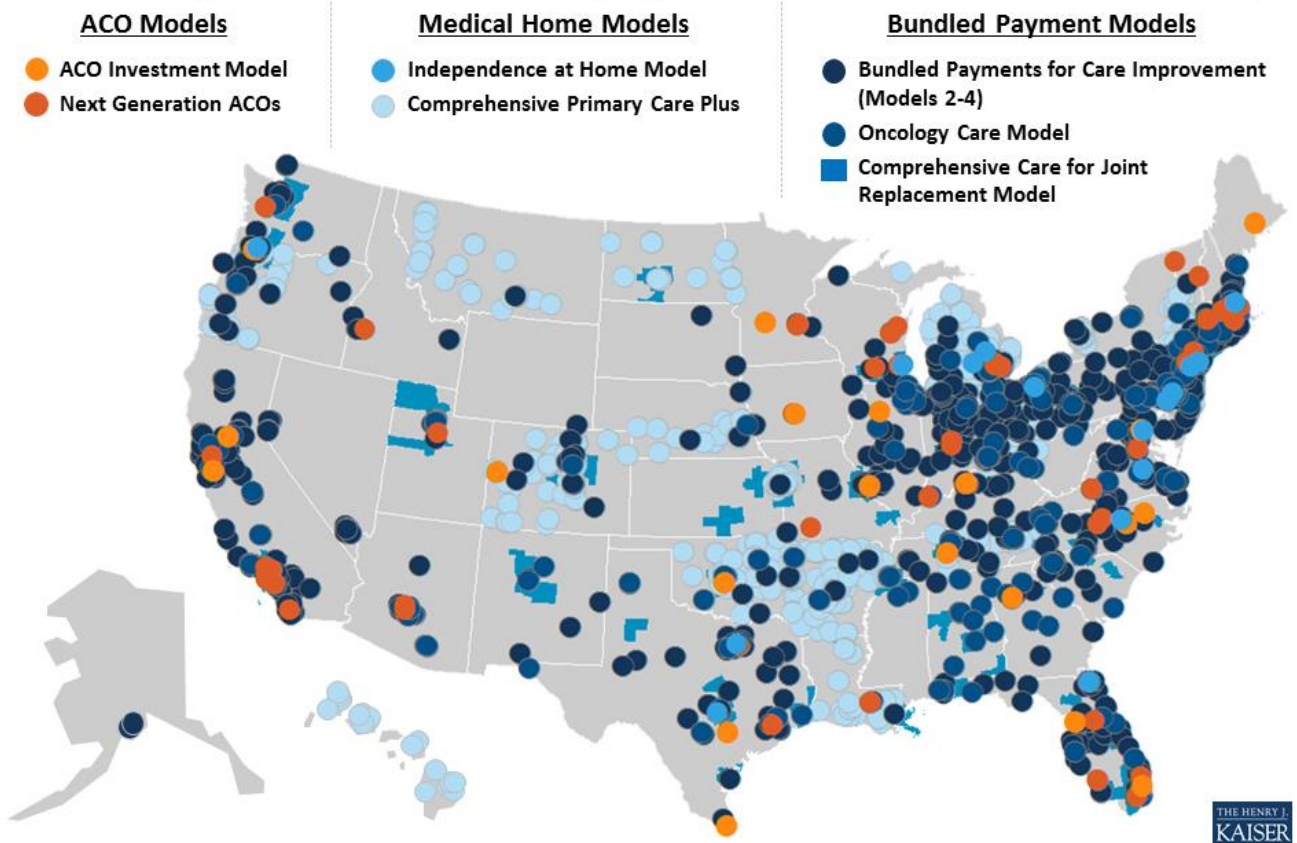
LINK TO QUALITY IN CATEGORY 2

PAYMENTS IN APM CATEGORIES 3 & 4

*Participants categorized payments made to providers in 2016 according to the original LAN Framework and the LAN aggregated results.

Figure 1

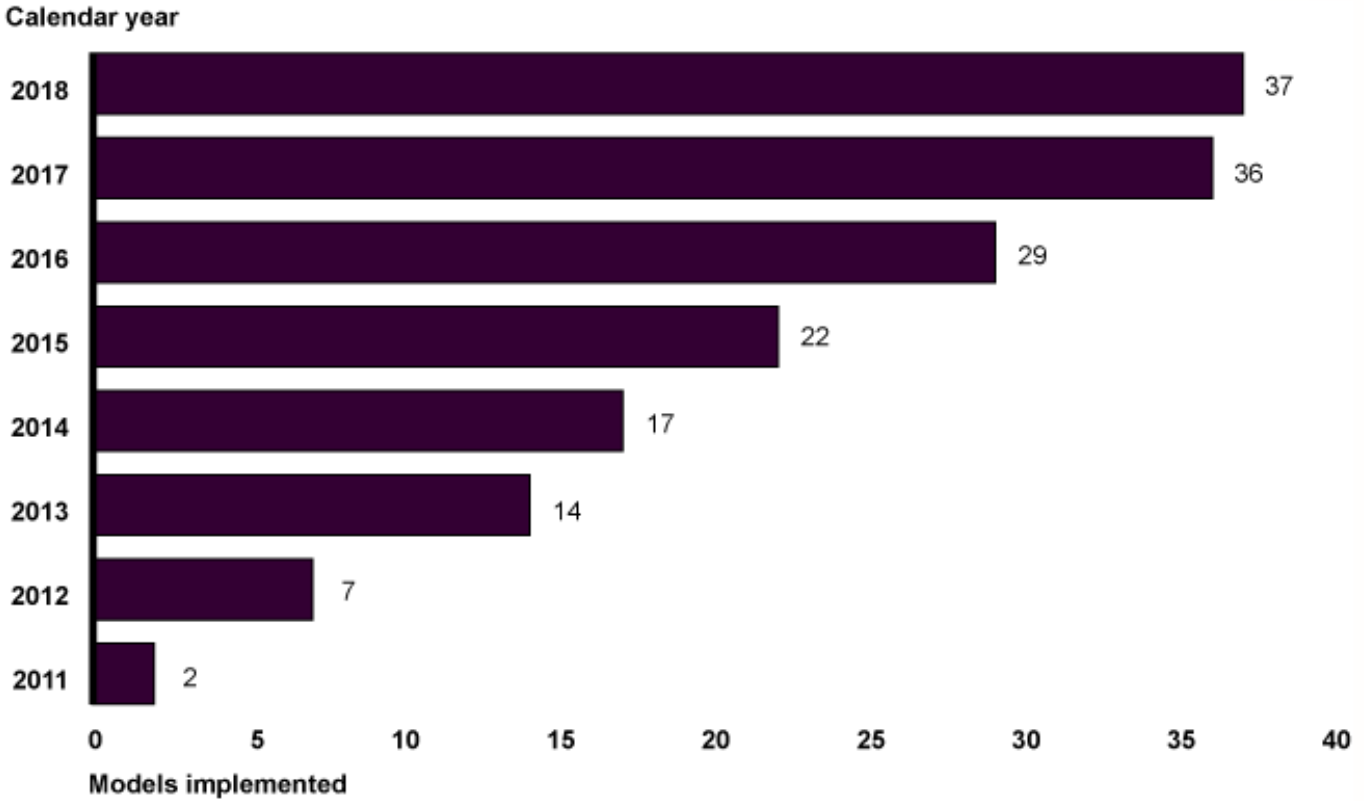
CMMI Payment and Delivery System Reform Models (2018)



Source: Map data downloaded February 8, 2018 from CMS, "Where Innovation is Happening."

THE HENRY J. KAISER FAMILY FOUNDATION

Cumulative Number of Models Implemented by the Center for Medicare and Medicaid Innovation, January 2011-February 2018



Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-18-302

April 2018 GAO Study on CMMI Models

Four of the models implemented by CMMI as of Sept. 30, 2016, either produced healthcare cost savings while maintaining or enhancing care quality, or improved care quality while maintaining or decreasing healthcare costs.

- **Pioneer Accountable Care Organization (ACO) initiative (CMMI recommends expanding)**
- **Diabetes Prevention Program (CMMI recommends expanding)**
- Initiative to Prevent Avoidable Hospitalizations among Nursing Facilities Residents Phase I
- Lower-extremity joint replacement bundles under the Bundled Payments for Care Improvement (BPCI) initiative

U.S. Gov't Accountability Office, *CMS Innovation Center: Model Implementation and Center Performance*, GAO-18-302. Published: 3/26/2018. Publicly Released: 4/25/2018

Provider Competencies to Succeed in APMs

- Governance & Culture
- Financial Readiness
- Health IT – data is critical
- Patient Risk Assessment
- Care Coordination
- Quality
- Patient Centeredness

https://www.accountablecarelc.org/

Roadmap for Driving High Performance in APMs

HCP-LAN is working to release later this year operational guidance for implementing successful Category 3 and 4 APMs. It will include:

- criteria that can be used to evaluate the success of APMs
- best practices from APMs that drive high performance

Dell Med/Episcopal Health Foundation Project with HHSC

To provide information and support on options for advancing value-based payment in Medicaid to Texas decision makers, HHSC, and the HHSC Value-Based Payment and Quality Improvement Advisory Committee.

EPISCOPAL HEALTH FOUNDATION

Value-Based Payment and HHSC

From HHSC's Draft Value-Based Purchasing Roadmap (8/2017):

VBP = Linking health care payments to measures of quality and/or efficiency (outcomes/cost = value)

Through its managed care contracting model, HHSC is making progress on a multiyear transformation of provider reimbursement models that have been historically volume based (i.e., fee-for-service) toward models that are structured to reward patient access, care coordination and/or integration, and improved healthcare outcomes and efficiency.

New Managed Care Contract Requirements

- Starting in 2018, to incentivize higher quality, value-based care, HHSC is requiring that a certain portion of Medicaid health plan (MCO) and dental plan (DMO) payments to providers be value-based.
- HHSC is using the terms alternative payment model (APM) and value-based payment (VBP) interchangeably.
- APM/VBP is a shift from payment for volume (fee for service) to payment tied to quality and/or value (where value = quality/cost).

What Are the MCO Targets?

Period	Minimum Overall APM Target	Overall APM Target %*	Minimum Risk-Based APM Target	Risk-Based APM Target %*
Year 1 (CY 2018)	>= 25%	**>=25%**	>= 10%	**>=10%**
Year 2 (CY 2019)	Year 1 Overall APM % +25% Growth	**>=31.25%**	Year 1 Risk-Based APM % +25% Growth	**>=12.5%**
Year 3 (CY 2020)	Year 2 Overall APM % +25% Growth	**>=39.0625%**	Year 2 Risk-Based APM % +25% Growth	**>=15.625%**
Year 4 (CY 2021)	>= 50%	**>=50%**	>= 25%	**>=25%**

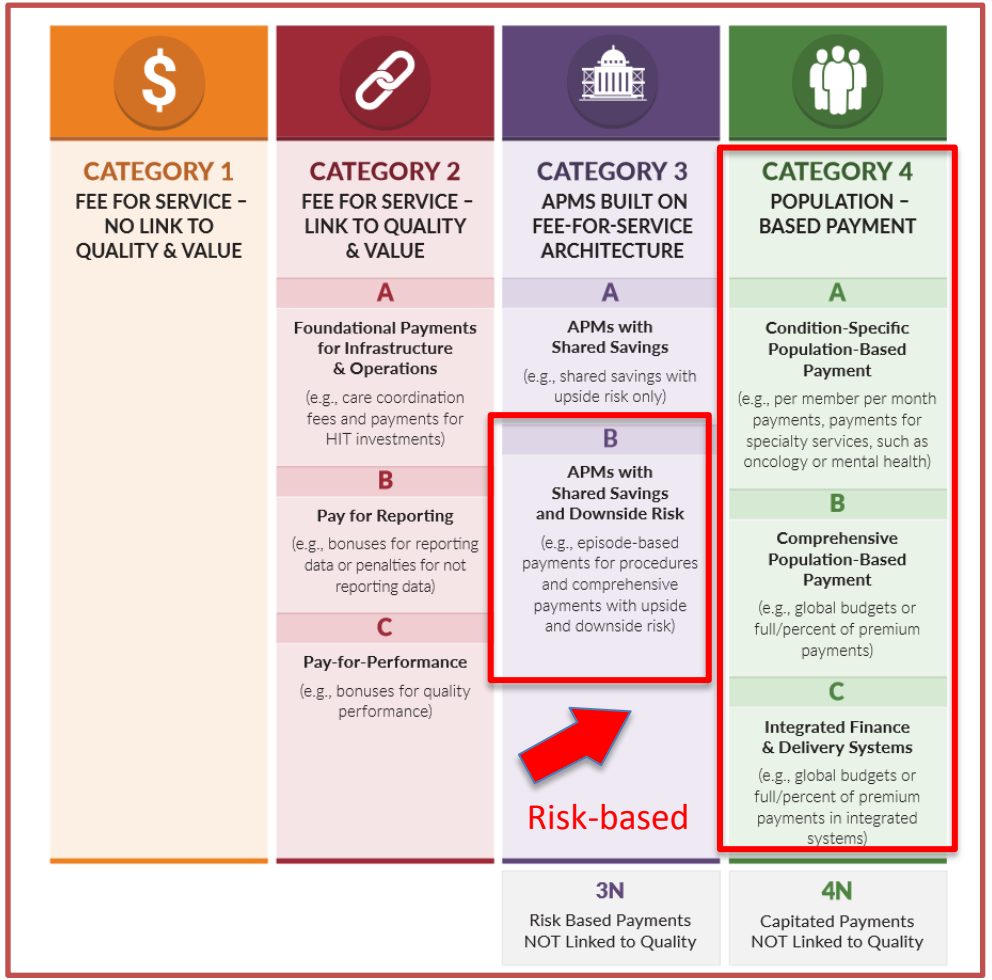
*The % targets could be lower for an MCO based on exceptions, such as achieving a higher than expected level of performance on both potentially preventable hospital admissions and emergency department visits (PPAs and PPVs) as defined in the contract.

HCP LAN
Health Care Payment Learning & Action Network

Alternative Payment Model Framework

The framework is a step toward the goal of better care, smarter spending, and healthier people…

- For payment reform capable of supporting the delivery of person-centered care
- For generating evidence about what works and lessons learned



Details from the MCO Contracts

MCOs are required to:

- share data and performance reports with APM providers on a regular basis. MCOs are to provide outreach and negotiation, assistance with data and/or report interpretation, and other activities to support provider's improvement
- dedicate resources to evaluate the impact of APMs on utilization, quality and cost, as well as return on investment

Details from the MCO Contracts

The target APM ratios (e.g. 25% and 10% in 2018) are expressions of APM-based provider payments relative to total provider payments.

How Targets are Calculated

	VBP Model	Numerator	Denominator
	FFS with upside bonus for achievement of quality metric or other identified measure (i.e. after hours)	Total base FFS payments based on provider claims processed by MCO plus bonuses earned by provider for period of measurement	Total medical expenses by MCO (medical and pharmacy) for period of measurement
2	FFS with bonus and downside risk	Total base FFS payments based on provider claims processed by MCO plus net bonuses earned by provider for period of measurement	
3	Partial Capitation	Total capitated payments made by MCO to provider plus net bonuses earned by provider for period of measurement	
4	Bundled Payment	Total bundled payments made by MCO to provider plus net bonuses earned by provider for period of measurement	
5	Episode of Care Payment	Total episode based payments made by MCO to provider plus net bonuses earned by provider for period of measurement	
6	VBP models 1-5 that have a provider risk/reward component based on total cost of care of enrollee	Total paid claims for enrollees served under VBP model for period of measurement plus bonuses/recoupments based on total cost of care targets established between MCO and provider	
	Hospital Quality Based Payment Program for PPR/PPC	Total inpatient claims paid to network hospitals plus safety net hospital incentives paid to hospitals for period of measurement	
8	Full Capitation	Capitated payments made by MCO to provider plus net bonuses earned by provider for period of measurement	

From HHSC 4/5/18 Webinar

Clearing up Misperceptions

The targets do not mean that MCOs need to have APMs with all their providers

- Given the administrative work required for an MCO and provider to participate in an APM, it makes sense that the MCOs are starting with providers that represent a larger share of their business and who are most ready to engage in APMs.
  - For example, to participate in an APM, a health plan might require that a provider care for at least 100 or 500 or of that plan's enrolled members.
  - Many of the Medicaid MCO APMs, and especially the risk-based models, are in the larger urban areas.
- MCOs will focus APM efforts on providers that can help them:
  - avoid unnecessary costs through appropriate primary, preventive and specialty care and care coordination, and
  - succeed with the Pay for Quality measures for which 3% of the MCO payments are at risk.

STAR Pay for Quality Measures

STAR At-Risk Measures	STAR Bonus Pool
Potentially Preventable Emergency Room Visits (PPVs)	Potentially Preventable Admissions (PPAs)
Appropriate Treatment for Children with Upper Respiratory Infection (URI)	Low Birth Weight (LBW)
Prenatal and Postpartum Care (PPC) • Timeliness of prenatal care • Postpartum care	CAHPS Children with good access to urgent care (child)
Six or more Well Child Visits in the First 15 months of Life (W15)	CAHPS Adults rating their health plan a 9 or 10 (adult)

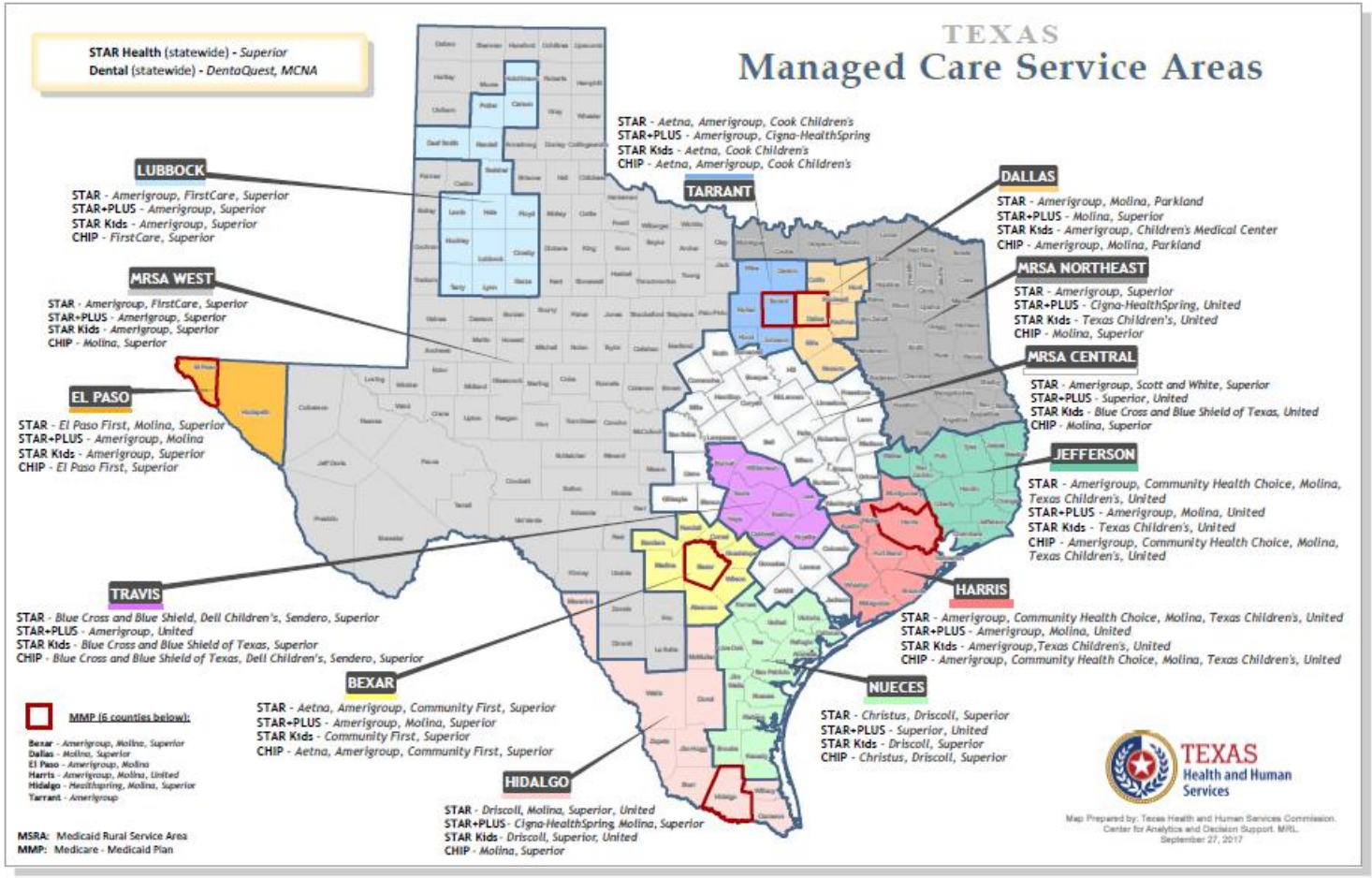
STAR+PLUS Pay for Quality Measures

STAR+PLUS At-Risk Measures	STAR+PLUS Bonus Pool
Potentially Preventable Emergency Room Visits (PPVs)	Potentially Preventable Readmissions (PPRs)
Diabetes Control - HbA1c < 8% (CDC)	Potentially Preventable Complications (PPCs)
High blood pressure controlled (CBP)	Prevention Quality Indicators (PQI) Composite
Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are using antipsychotics (SSD)	CAHPS Adults with good access to urgent care
Cervical cancer screening (CCS)	CAHPS Adults rating their health plan a 9 or 10

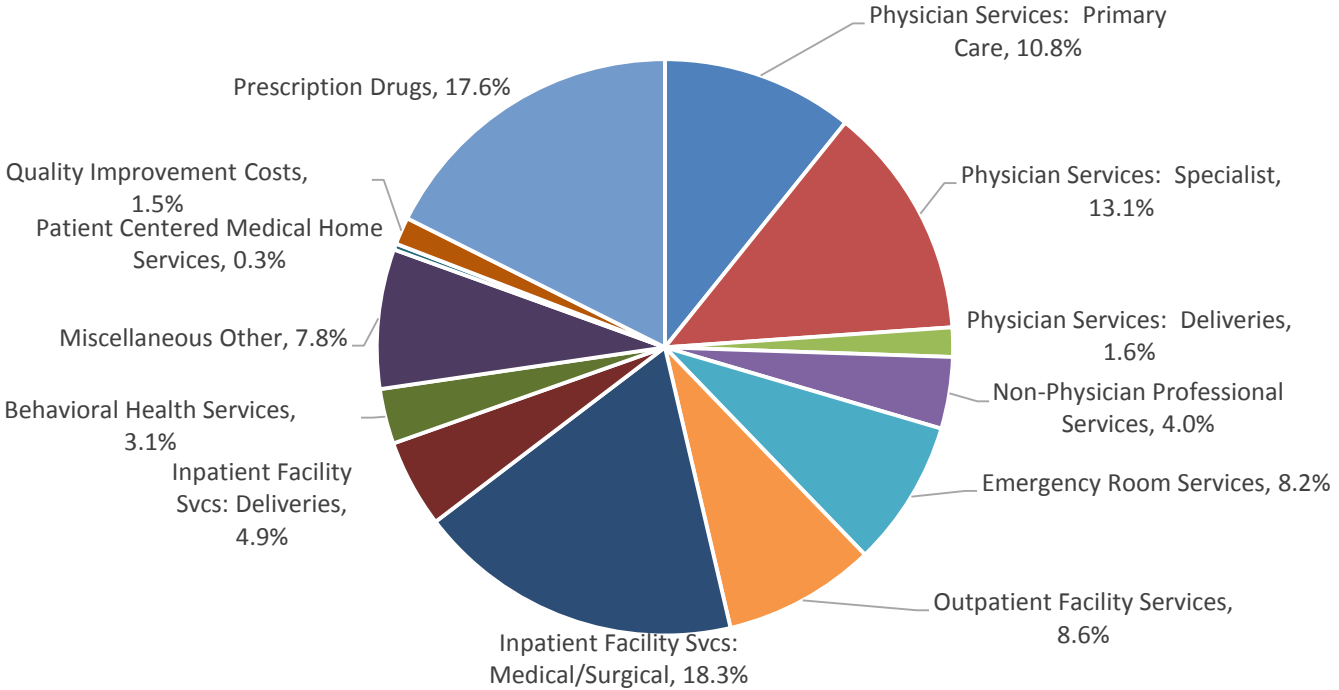
Clearing up Misperceptions

The targets do not mean that a portion of each APM provider's payment will be reduced and need to be earned back by doing more

- The most common type of MCO-initiated APM in Texas Medicaid is FFS payment with upside bonuses for primary care practices for achievement of quality metrics or other measures (also common for OB/Gyn and other specialty practices)

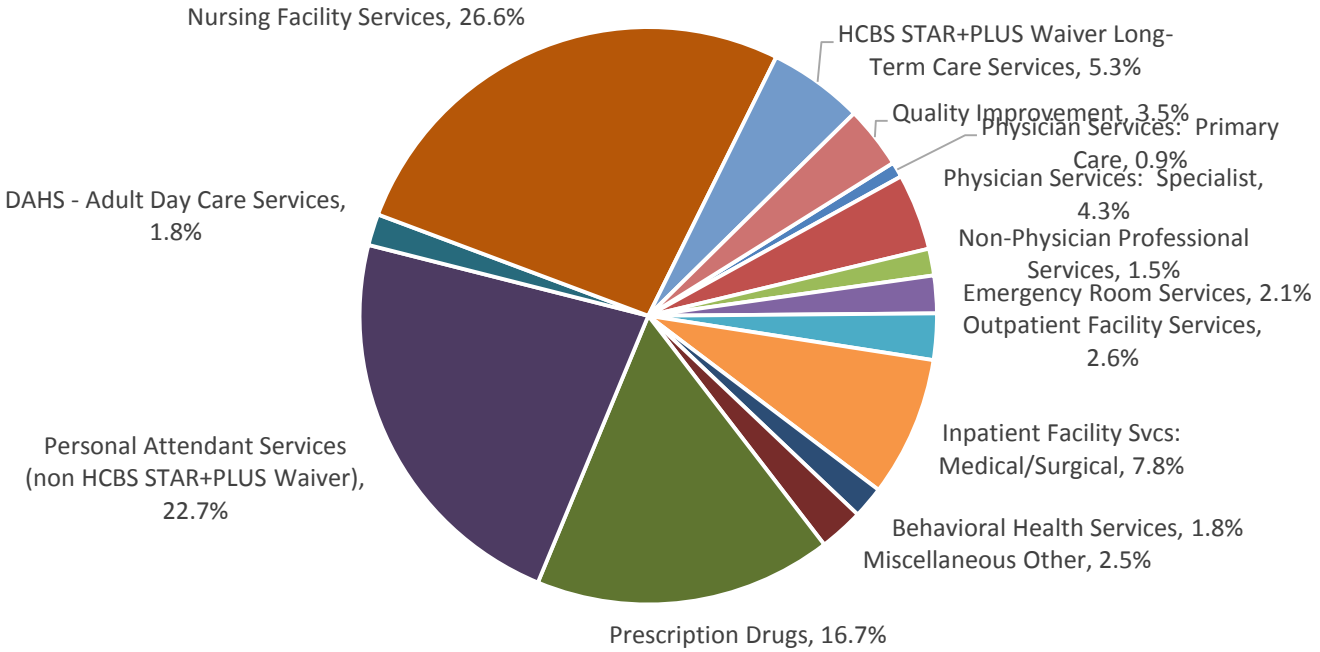

STAR Health (statewide) - Superior
Dental (statewide) - DentaQuest, MCNA
TEXAS
Managed Care Service Areas
STAR - Aetna, Amerigroup, Cook Children's
STAR+PLUS - Amerigroup, Cigna-HealthSpring
STAR Kids - Aetna, Cook Children's
CHIP - Aetna, Amerigroup, Cook Children's
LUBBOCK
STAR - Amerigroup, FirstCare, Superior
STAR+PLUS - Amerigroup, Superior
STAR Kids - Amerigroup, Superior
CHIP - FirstCare, Superior
TARRANT
DALLAS
STAR - Amerigroup, Molina, Parkland
STAR+PLUS - Molina, Superior
STAR Kids - Amerigroup, Children's Medical Center
CHIP - Amerigroup, Molina, Parkland
MRSA WEST
STAR - Amerigroup, FirstCare, Superior
STAR+PLUS - Amerigroup, Superior
STAR Kids - Amerigroup, Superior
CHIP - Molina, Superior
MRSA NORTHEAST
STAR - Amerigroup, Superior
STAR+PLUS - Cigna-HealthSpring, United
STAR Kids - Texas Children's, United
CHIP - Molina, Superior
MRSA CENTRAL
STAR - Amerigroup, Scott and White, Superior
STAR+PLUS - Superior, United
STAR Kids - Blue Cross and Blue Shield of Texas, United
CHIP - Molina, Superior
EL PASO
STAR - El Paso First, Molina, Superior
STAR+PLUS - Amerigroup, Molina
STAR Kids - Amerigroup, Superior
CHIP - El Paso First, Superior
JEFFERSON
STAR - Amerigroup, Community Health Choice, Molina, Texas Children's, United
STAR+PLUS - Amerigroup, Molina, United
STAR Kids - Texas Children's, United
CHIP - Amerigroup, Community Health Choice, Molina, Texas Children's, United
TRAVIS
STAR - Blue Cross and Blue Shield, Dell Children's, Sendero, Superior
STAR+PLUS - Amerigroup, United
STAR Kids - Blue Cross and Blue Shield of Texas, Superior
CHIP - Blue Cross and Blue Shield of Texas, Dell Children's, Sendero, Superior
HARRIS
STAR - Amerigroup, Community Health Choice, Molina, Texas Children's, United
STAR+PLUS - Amerigroup, Molina, United
STAR Kids - Amerigroup,Texas Children's, United
CHIP - Amerigroup, Community Health Choice, Molina, Texas Children's, United
BEXAR
STAR - Aetna, Amerigroup, Community First, Superior
STAR+PLUS - Amerigroup, Molina, Superior
STAR Kids - Community First, Superior
CHIP - Aetna, Amerigroup, Community First, Superior
NUECES
STAR - Christus, Driscoll, Superior
STAR+PLUS - Superior, United
STAR Kids - Driscoll, Superior
CHIP - Christus, Driscoll, Superior
MMP (6 counties below):
Bexar - Amerigroup, Molina, Superior
Dallas - Molina, Superior
El Paso - Amerigroup, Molina
Harris - Amerigroup, Molina, United
Hidalgo - Healthspring, Molina, Superior
Tarrant - Amerigroup
MSRA: Medicaid Rural Service Area
MMP: Medicare - Medicaid Plan
HIDALGO
STAR - Driscoll, Molina, Superior, United
STAR+PLUS - Cigna-HealthSpring, Molina, Superior
STAR Kids - Driscoll, Superior, United
CHIP - Molina, Superior
TEXAS
Health and Human Services
Map Prepared by: Texas Health and Human Services Commission,
Center for Analytics and Decision Support, MRL
September 27, 2017

STAR Medical Expenditures
Fiscal Year 2017



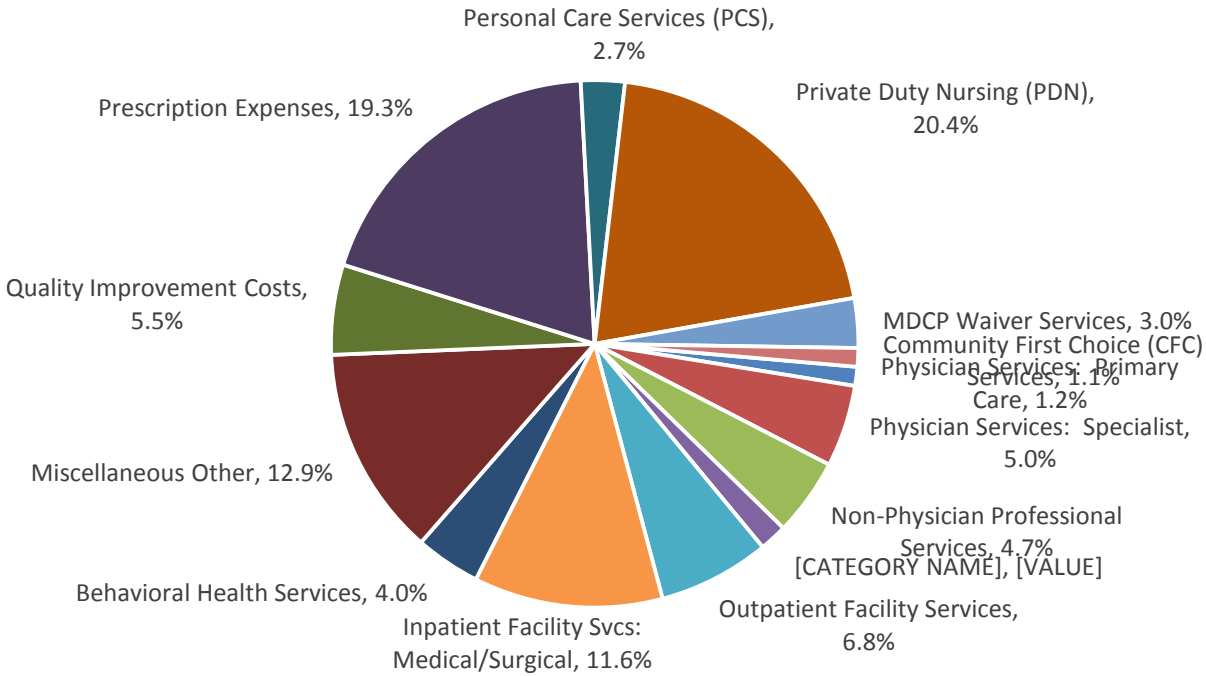
*From Financial Statistical Report data. Excludes supplemental payments such as DSH, UC, and DSRIP.

STAR+PLUS Medical Expenditures
Fiscal Year 2017



*From Financial Statistical Report data. Excludes supplemental payments such as DSH, UC, and DSRIP.

STAR Kids Medical Expenditures
FY 2017



*From Financial Statistical Report data. Excludes supplemental payments such as DSH, UC, and DSRIP.

List of 2016 Texas Medicaid APMs

HHSC recently posted to its Value-Based Contracting webpage an Excel file showing each health plan's APMs implemented in 2016:

https://hhs.texas.gov/about-hhs/process-improvement/medicaid-chip-quality-efficiency-improvement/value-based-contracting (2016 (Excel))

For each model, the file shows where it's implemented (managed care programs and service areas); performance metrics, and the health plan representative to contact for additional information.

Examples of Current Texas Medicaid APMs

- FFS Payment with bonuses for strong performance
  - MCO shares information on key measures with provider periodically (quarterly or monthly)
  - Common measures: well-child visits, PPVs (potentially preventable ED visits), prenatal/postpartum care, diabetes care, total cost of care

Examples of Current Texas Medicaid APMs

- Bonus for providing after hours care
- Physician recognition programs (e.g. Bridges to Excellence for diabetes, asthma care)
- Gold card programs with reduced prior authorization requirements for high performing providers

Examples of Current Texas Medicaid APMs

- Maternity/newborn care bundle with two large volume providers
- Full or partial capitation to clinics or other providers, including Accountable Care Organizations (ACOs)
- Patient Centered Medical Home/Health Home per member per month care coordination payment
- Bundled, fixed case rates to a hospital for certain procedures

Examples of Current Texas Medicaid APMs

- The HHSC-required hospital Potentially Preventable Readmissions (PPR) and Potentially Preventable Complications (PPC) programs are risk-based APMs that all MCOs are required to pass through to their hospital providers
  - Penalties for low performers and incentives for safety net hospitals that perform in the top tier

Examples of Medicaid Managed Care Efforts around Social Drivers of Health

- Pilots using community health workers (CHWs) with high cost, high needs patients
- Peer support specialists to help BH/SUD enrollees with community transition after inpatient care
- Coordination with housing entities to locate and provide supportive housing for high needs homeless members
- Green and Healthy Homes initiative to address environmental factors that exacerbate asthma

What to Look for in Medicaid APMs in the Near Future

- Additional episodes of care (bundled payment)
- LTSS, DME
  - E.g. incentives to home health agencies (and their attendants) if STAR+PLUS members go for an annual checkup
- Behavioral Health
  - Build on DSRIP work around intensive care coordination for high cost, high needs patients with serious mental illness/SUD and physical comorbidities
  - Comprehensive health home and care integration for those with serious mental illness, e.g. Certified Community Behavioral Health Clinics (CCBHC) model
- STAR Kids Health Homes
  - Relatively new managed care program (began November 2016), but some MCOs are beginning to enter into quality and care coordination payment arrangements for health home providers
- Pharmacy

VBPQI Advisory Committee

- HHS established the Value-Based Payment and Quality Improvement (VBPQI) Advisory Committee in Fall 2016
  - Provides a forum for ongoing public-private, multi-stakeholder collaboration for VBP and quality improvement, with a focus on Medicaid/CHIP
  - Comprised of a broad range of interdisciplinary health industry leaders from across the state
  - Goal: to help Texas achieve the highest value for healthcare in the nation
  - First deliverable: Report to the 86th Texas Legislature (due 12/2018)

VBPQI Advisory Committee Recommendations

1) The Legislature should direct HHS to develop a comprehensive initiative to leverage enhanced federal matching funds to maximize the usability of HHS system data resources, including by building capacity to integrate clinical and health risk data available through electronic health records (EHRs) with Medicaid claims, pharmacy, and other administrative data sets.
2) HHSC should work with stakeholders to better leverage the Texas Healthcare Learning Collaborative portal (and other tools as appropriate) to increase and improve the data available to health plans, providers, and policy makers for core metrics, analytics, and care coordination to support value-based purchasing and quality improvement.

VBPQI Advisory Committee Recommendations

3) HHSC should provide guidance for MCOs and providers on how to leverage the Quality Improvement cost strategy available in managed care to provide patient navigation services to patients with high needs and high utilization patterns. The guidance should clarify what latitude the plans have to use this cost category and reflect consensus from relevant areas within HHSC and the HHS Office of Inspector General (OIG).
4) HHSC should work with stakeholders on value-based payment approaches to improve maternal and newborn care.
   - Develop a maternity/newborn episode of care payment bundle (and/or other maternity/newborn VBP approaches)
   - Study the cost effectiveness and feasibility of a Medicaid waiver proposal to extend postpartum care beyond the current 60-day Medicaid benefit within a value-based model

VBPQI Advisory Committee Recommendations

5) HHSC should develop value-based purchasing (VBP) strategies to sustain strong behavioral health (BH)-related DSRIP work, which has enhanced BH services and filled many gaps in BH care over the past several years.
6) HHSC should study and present a proposal to State leadership on VBP approaches to improve the identification and treatment of opioid and other substance use disorders (SUD).
7) To promote provider participation in alternative payment models (APMs), HHSC should work to reduce associated administrative burdens.
    - Support for implementing consistent models across health plans, well-understood definitions (e.g. regarding attribution and outcome measures), and regular review and updating of service bundles
    - Clarify that MCO APMs with providers may include approaches that reduce administrative burden for high performing providers as a non-financial incentive

Next Steps – Dell Med/EHF Project

Toolkit

- Reorganize existing VBP content on HHSC website to make more user-friendly
  - Highlight how to access the Texas Healthcare Learning Collaborative data portal and what data is available there
- Add information to the website, such as:
  - Summary information on each MCO's 2017 VBP arrangements in each service area (type of payment arrangement, type of provider, measures used)
  - Information from the Dell Med/EHF project, including the symposium summary and information from VBP-related webinars, including this one

Next Steps – Dell Med/EHF Project

- Develop and discuss with HHSC use cases for what health plans may include as Quality Improvement costs, including for navigation services for patients with high needs and high utilization patterns
- DSRIP sustainability strategies including potential input into the CMS required transition plan
- Possible strategic assistance with 1115 Waiver required HIT Strategic Plan
  - From STC #39 - *The state will use Health IT to link services and core providers across the continuum of care to the greatest extent possible.*

Feedback from Providers and Health Plans

- Many providers that the health plans have not yet engaged in APMs are interested, including smaller physician practices, pharmacy, home health, etc. How best can they participate?
- How does HHSC know which APMs are most successful? (Concern that some APMs may be more focused on cost than quality, and may not adhere to all the guiding principles in the VBP roadmap)
- Need to share best practices
- Desire for additional guidance from HHSC, including on consistent measures, measure definitions, attribution methodologies

Thank You!

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