



# The University of Texas at Austin Dell Medical School

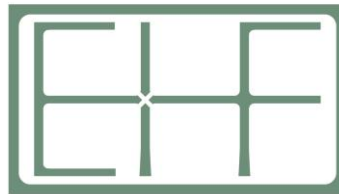
Update on Episcopal Health/Dell Med Value Based  
Payment Project with HHSC and  
Texas Medicaid's New Managed Care  
VBP Contract Targets  
May 22, 2018

# Presentation Topics

- Dell Med/EHF project with Texas Medicaid
- What Medicaid managed care VBP contract targets mean for providers
- Value Based Payment and Quality Improvement (VBPQI) Advisory Committee draft recommendations
- Next steps

# 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 by early 2018.



EPISCOPAL HEALTH  
FOUNDATION

# December 8, 2017 Symposium

- 240 in-person attendees, 90 via livestream
  - Health plans, providers, foundations, advocacy organizations, academics, other community partners
- Key questions:
  - Current areas of opportunity
  - What additional guidance and data would best support VBP
  - What to include in a VBP Toolkit
  - How HHSC can accelerate VBP
  - How to achieve greater alignment between HHSC programs, Medicaid health plans and with other payers

# Key Symposium Takeaways

- HHSC, health plans and providers have many VBP initiatives underway.
- Broad interest in VBP to enable better and less costly care and to reduce administrative burdens.
- General support for more coordinated efforts.
- Interest in more information and data sharing, including a VBP toolkit and further meetings to share best practices and identify opportunities for common approaches.

# Key Symposium Takeaways

- The Texas Healthcare Learning Collaborative portal is a valuable data resource that could be further leveraged to support VBP.
- Lack of access to data is a barrier to providers and without data, population health management is impossible.
- Plans and providers are challenged by frequently changing requirements in Medicaid (and concerned about flat/declining per capita funding).

# Key Symposium Questions

- As managed care capitation rates are set, how to encourage longer-term investments in payment and care reform models (vs. short term steps to lower prices, such as rate cuts and narrow networks)?
- How does the state balance direction with flexibility? Providers want consistency across plans, plans want flexibility to manage their members.
- How can Medicaid align with other payers (incl. ERS and TRS) so that providers are more willing/able to enter into APMs? Is HHSC/TDI convening the MCOs to discuss a viable strategy for alignment without violating anti-trust laws?
- Regional approaches - Is Texas just too big to do a statewide approach to value-based purchasing effectively?

# 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).



# HHSC Description of VBP/APMs

- Often referred to as **Alternative Payment Models (APMs)**, they are payment approaches that incentivize high-quality and cost-efficient care (i.e. link portions of healthcare payment to measure(s) of value).
- They can apply to a specific clinical condition, a care episode, or a population.
- They may incorporate financial risk and rewards or simply be rewards-based.

# What Are the MCO Targets?

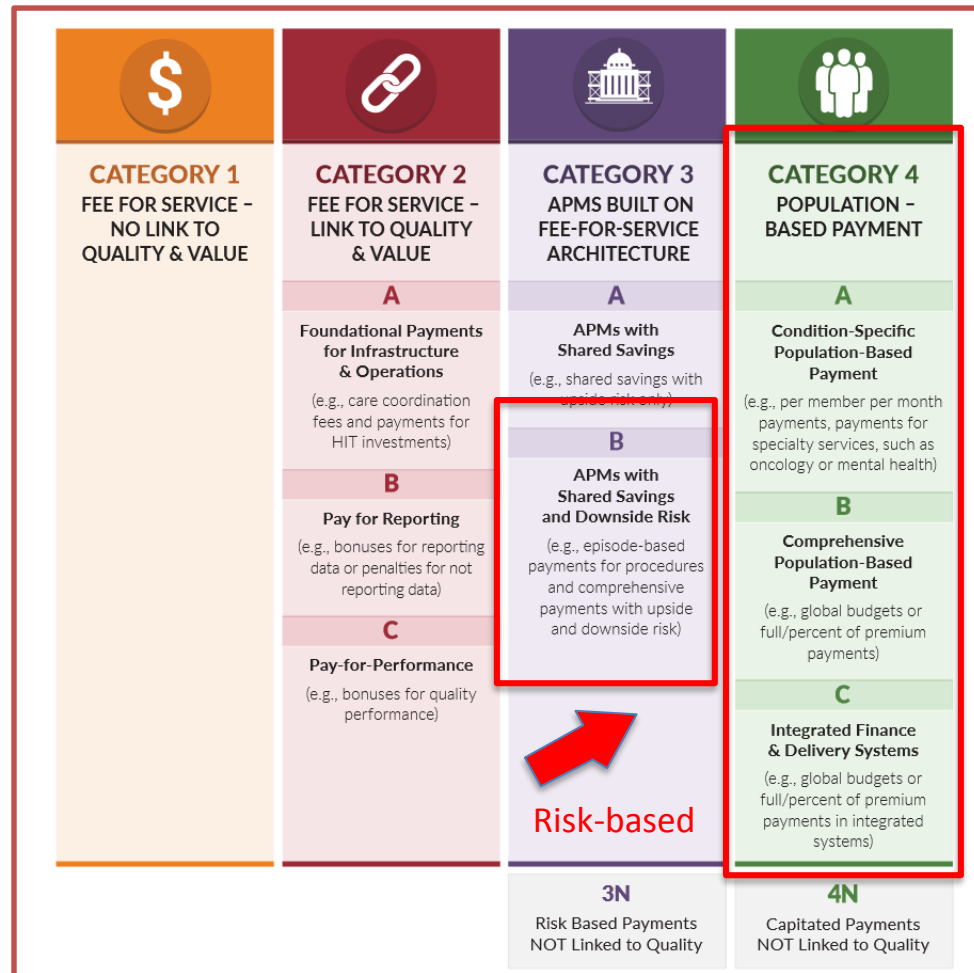
Period	Minimum Overall APM Target	Overall APM Target %	Minimum Risk-Based APM Target	Risk-Based APM Target %
Year 1 (CY 2018)	>= 25%	>=25%	>= 10%	>=10%
Year 2 (CY 2019)	Year 1 Overall APM % +25% Growth	>=31.25%	Year 1 Risk-Based APM % +25% Growth	>=12.5%
Year 3 (CY 2020)	Year 2 Overall APM % +25% Growth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



## 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

- The targets are statewide targets for each MCO by managed care program (STAR, STAR+PLUS, etc.)
  - e.g. If a plan provides STAR in multiple service delivery areas, it may use APMs in one or more service areas to meet the STAR 25%/10% targets in 2018. (It does not need to meet the target in each individual area.)
  - e.g. If a plan is participating in both STAR and STAR+PLUS, a separate target applies to STAR+PLUS
- MCOs self report on their APMs to HHSC once a year, and HHSC will use this information to calculate whether the MCO met the target percentages.
- If an MCO does not meet the targets or certain allowed exceptions, the MCO will be required to submit a corrective action plan and HHSC may impose contractual remedies, including liquidated damages.

# 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	

# 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) <ul style="list-style-type: none"><li>• Timeliness of prenatal care</li><li>• Postpartum care</li></ul>	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)

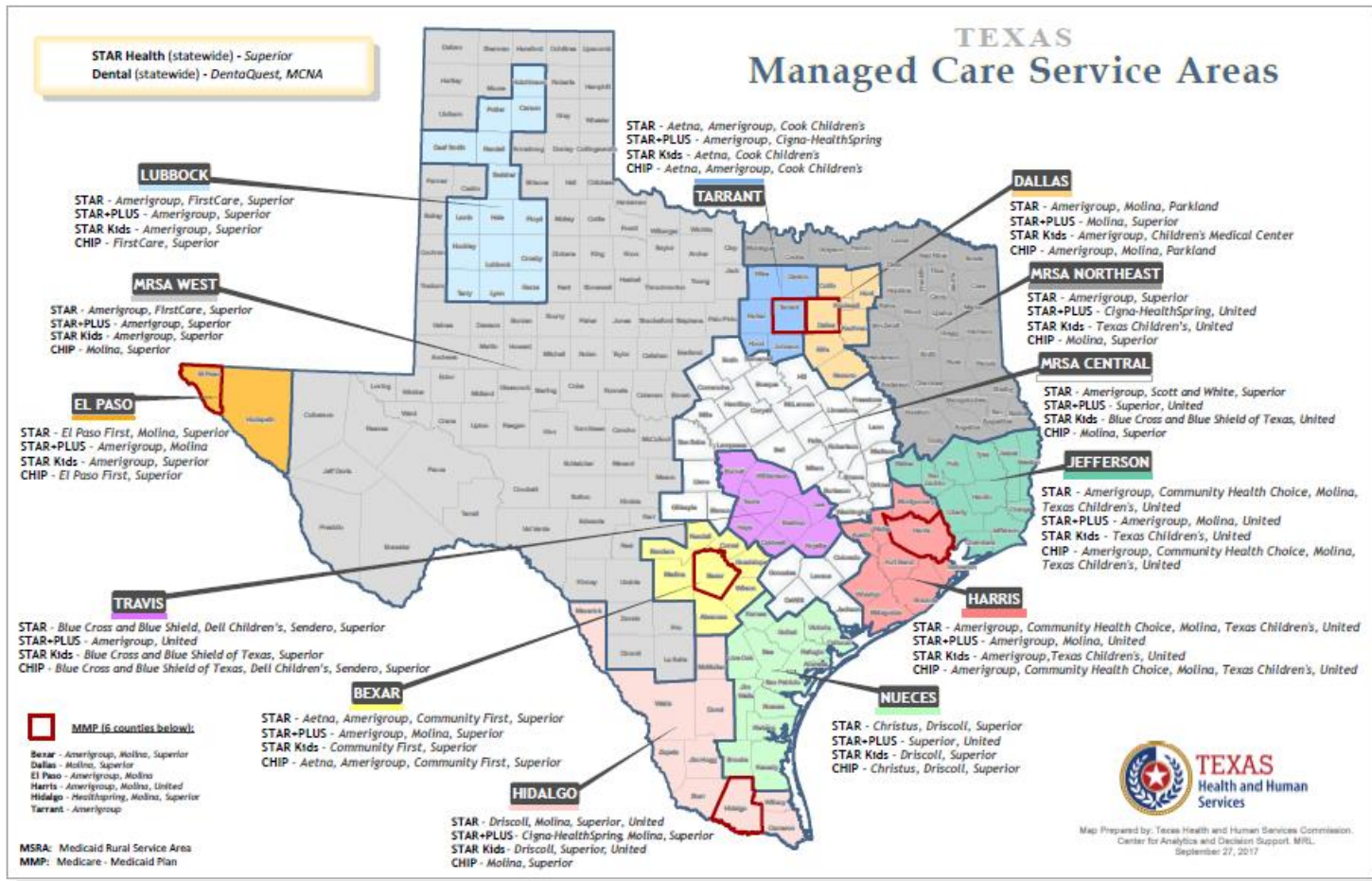
# STAR+PLUS Pay for Quality Measures

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

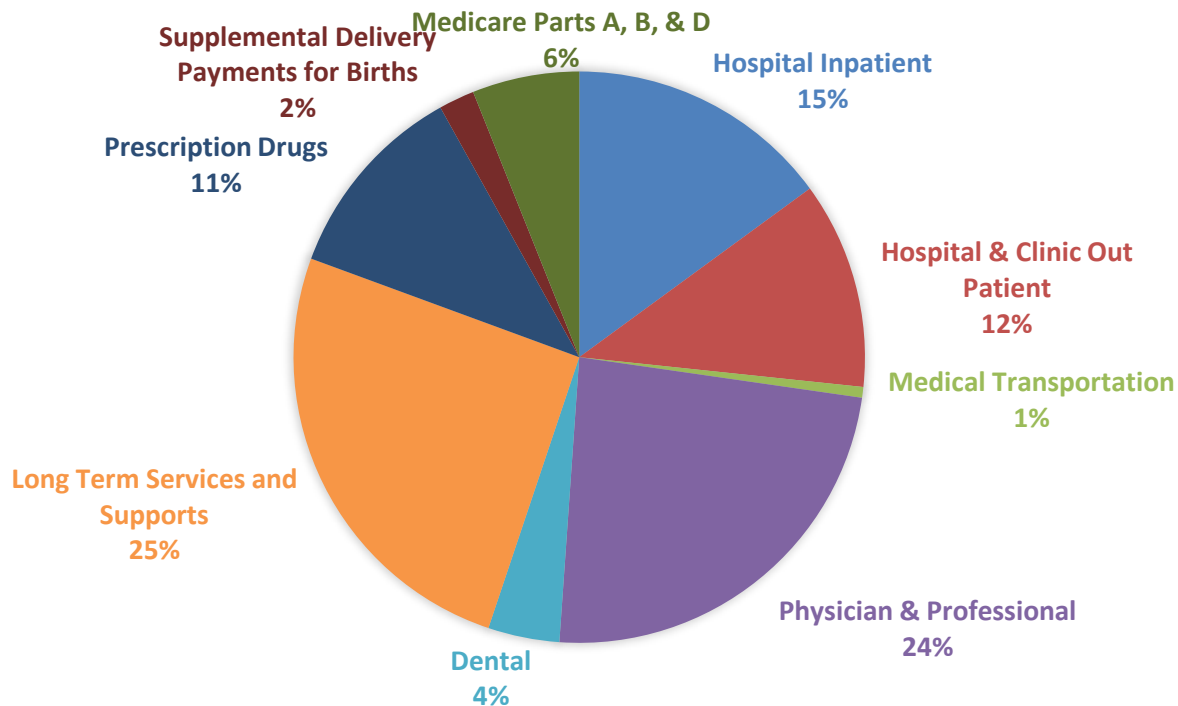
The targets do not mean that a portion of each APM provider's payment will be reduced and need to be earned back by doing more

- 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)



## TEXAS MEDICAID SERVICES SPENDING (IN BILLIONS), FY2014

### TOTAL MEDICAID SERVICES SPENDING: \$24.8 BILLION\*



\*Excludes supplemental payments such as DSH, UC, and DSRIP.

<https://hhs.texas.gov/sites/default/files/040616-hhsc-costgrowth-quality.pdf>

# Example of How an MCO Can Meet Overall APM Requirement

Providers	Dollar Value of Expenditures	Percentage of Total MCO Payments	Year 1 Goal: >=25% with APM	Year 2 Goal: Y1 Overall APM % +25% Growth	Year 3 Goal: Y2 Overall APM % +25% Growth	Year 4 Goal: Overall APM % >=50%
Hospital - A	\$1,500,000	15%	7.5%	7.5%	7.5%	7.5%
Hospital - B	\$1,500,000	15%	7.5%	7.5%	7.5%	7.5%
Physician Practice – A	\$1,000,000	10%	5%	10%	10%	10%
Physician Practice – B	\$1,000,000	10%	5%	5%	7%	7%
Physician Practice – C	\$500,000	5%	-	-	-	
LTSS	\$2,500,000	25%		2%	5%	10%
Pharmacy	\$1,000,000	10%				3%
All Other Providers (incl BH)	\$1,000,000	10%	-	-	2.5%	5%
<b>Total</b>	<b>\$10,000,000</b>	<b>Total VBP/APM %</b>	<b>25%</b>	<b>32%</b>	<b>39.5%</b>	<b>50%</b>
		<b>Required %</b>	<b>25%</b>	<b>31.3%</b>	<b>39.1%</b>	<b>50%</b>

# Example of How an MCO Can Meet Risk-Based APM Requirement

Providers	MCO Provider Payments	Percentage of Total MCO Payments	Year 1 Goal: >=10% with Risk-based APM	Year 2 Goal: Y1 Risk-based APM % +25%	Year 3 Goal: Y2 Risk-based APM % +25%	Year 4 Goal: Risk-based APM % >=25%
Hospital - A	\$1,500,000	15%	7.5%	7.5%	7.5%	7.5%
Hospital - B	\$1,500,000	15%	7.5%	7.5%	7.5%	7.5%
Physician Practice – A	\$1,000,000	10%			2%	5%
Physician Practice – B	\$1,000,000	10%	-			2%
Physician Practice – C	\$500,000	5%	-	-	-	
LTSS	\$2,500,000	25%				3%
Pharmacy	\$1,000,000	10%				
Other (incl BH)	\$1,000,000	10%	-	-		2%
<b>Total</b>	<b>\$10,000,000</b>	<b>Total VBP/APM %</b>	<b>15%</b>	<b>15%</b>	<b>17%</b>	<b>27%</b>
		<b>Required %</b>	<b>10%</b>	<b>12.5%</b>	<b>15.6%</b>	<b>25%</b>

# 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/>



# 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. CCBHC
- STAR Kids Health Homes
  - Relatively new model, but some MCOs are beginning to enter into quality and care coordination payment arrangements for health home providers
- Pharmacy

# VBPQI Advisory Committee Draft Recommendations May 8, 2018

1. *Improve HHS system data resources, including by building capacity to incorporate clinical and other data available through electronic health records (EHR) systems*
2. *Work with stakeholders to better leverage the Texas Healthcare Learning Collaborative portal (and other tools as appropriate) to increase data available to health plans and providers to support VBP*
3. *Develop guidance for Medicaid health plans and providers on how to leverage the Quality Improvement (QI) cost strategy available in managed care to provide patient navigation services to patients with high needs and high utilization patterns*

# VBPQI Advisory Committee Draft Recommendations May 8, 2018

- 4. Work with stakeholders to develop a maternity/newborn episode of care payment bundle (and/or other maternity/newborn VBP approaches) to present to Texas leadership for endorsement.*
- 5. Develop value-based purchasing strategies to sustain strong behavioral health-related DSRIP work such as integrated behavioral health/primary care. The current development of Certified Community Behavioral Health Clinics [CCBHC] could be included as a sustainability strategy.*
- 6. Develop VBP strategies to improve the identification and treatment of substance use disorders.*
- 7. Clarify that MCO APMs with providers may include models that reduce administrative burden for high performing providers as a non-financial incentive.*



## Next Steps – VBPQI Committee

- Release draft committee report with recommendations for stakeholder comment this summer
- Next committee meeting - August 7, 2018
- Goal is to release the final report by September 2018

# Next Steps – Dell Med/EHF Project

- Meetings with stakeholder associations to:
  - Discuss the draft VBPQI Committee recommendations
  - Get input on data sharing options to support VBP
  - Get input on what additional information would be most valuable to include in the Medicaid VBP Toolkit
- Develop and discuss with HHSC use cases for what health plans may include as QI 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

# 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:
  - List of MCO provider contacts for VBP
  - Summary information on each MCO's existing 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

# Thank You!

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