Value Based Purchasing

RHP 9 Learning Collaborative
February 22, 2017

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Purpose

- Dialogue with RHP stakeholders on the following topics:
  - What Value Based Purchasing (VBP) is and why HHSC is promoting it
  - VBP and Models
  - High Level Overview of HHSC Value Based Purchasing and other Efforts Designed to Advance Quality/Efficiency
  - Opportunities and Barriers in VBP
  - Future VBP efforts and requirements
  - Ways that DSRIP can Help Inform VBP efforts
  - Q and A

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Value Based Purchasing Overview

- *Value Based Contracting*, *Value Based Purchasing*, *Quality Based Payments*, *Alternative Payment Models*, *Payment Reform*-all basically mean the same thing…… **moving away from volume-based payment models with no linkage to quality or value and toward payment models that link increasing portions of healthcare payments to quality or value**
- HHSC oversees numerous VBP initiatives at different levels
- It is a complex and long term endeavor, and occurs in a dynamic state and federal environment
- It is inevitable
- Maintaining administrative simplification is critical
- Coordination, communication and to the extent possible harmonization, is extremely important

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General Concepts Related to VBP

- The importance of DATA
- Maintaining open communications and transparency in processes/methods is critical
- Continuous engagement of stakeholders
- Use of effective measures to advance quality and efficiency
  - Focus on measures that improve quality (and also lower cost)
  - Must also be clearly understood
- Balance of properly scaled incentives and disincentives
- Need for a coordinated approach, harmonize where possible
- Must be cognizant of administrative burdens and overtaxing system-maintain simplicity

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Why Value Based Purchasing ?

- Has the potential to more appropriately direct clinical services in the most effective manner
- All parties better "internalize" right care in right amount
- Linking greater percentages of healthcare payments to value should result in improved outcomes and greater efficiencies over time

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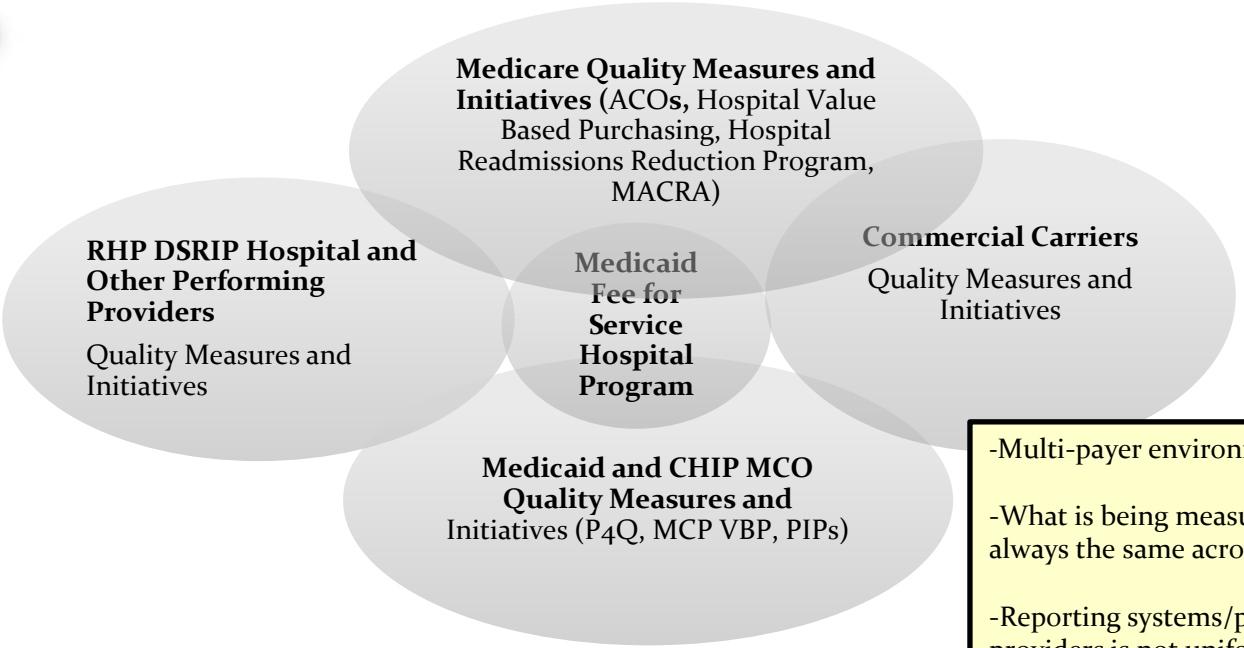
Challenge: Multiple Payers/Systems are Shaping Value Based Payment Approaches



-Multi-payer environment

-What is being measured/incentivized is not always the same across payers

-Reporting systems/processes by payers to providers is not uniform across payers

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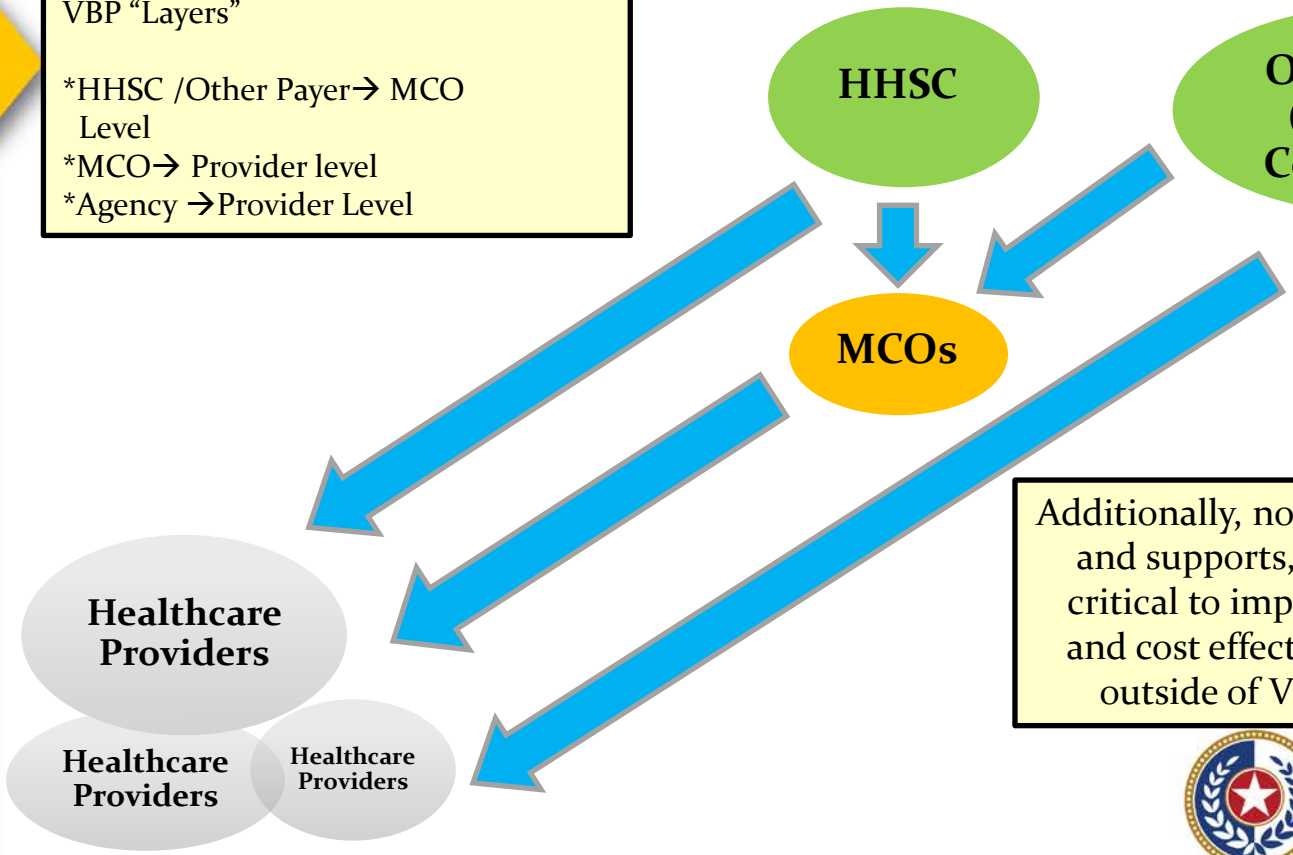
Challenge: Value Based Payment Efforts in Medicaid/CHIP Are Occurring at Multiple Levels

VBP "Layers"

*HHSC /Other Payer→ MCO Level
*MCO→ Provider level
*Agency →Provider Level



Additionally, non-medical services and supports, which are often critical to improving outcomes and cost effectiveness are often outside of VBP approaches

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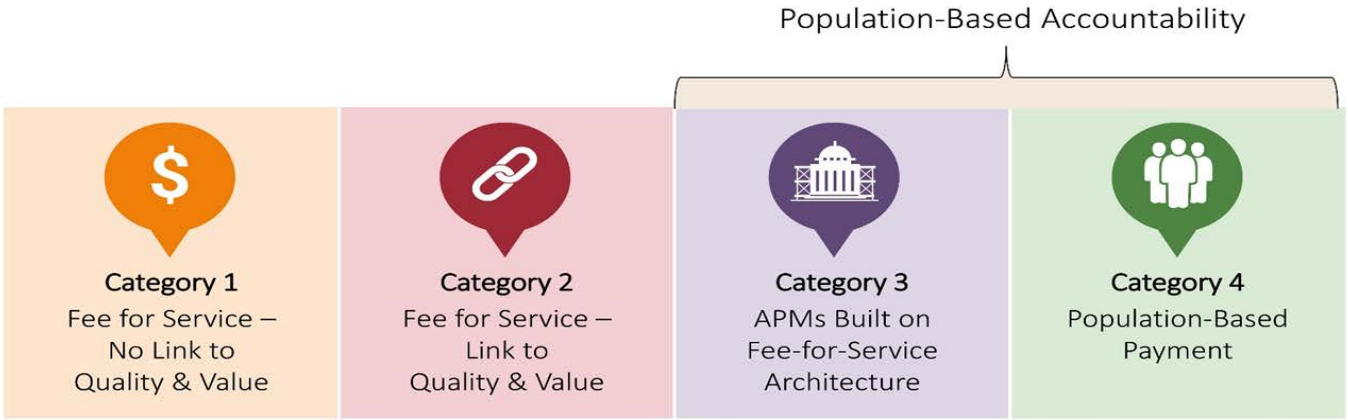
Challenge: Continued movement thru the VBP "Continuum"



Notes:

Source: Alternative Payment Model (APM) Framework and Progress Tracking Work Group https://hcp-lan.org/
More detailed white paper: https://hcp-lan.org/workproducts/apm-whitepaper.pdf

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VBP at HHSC-MCO Level: MCO/DMO Pay for Quality

- Percentage of MCO capitation is placed at-risk, contingent on performance on targeted measures---risk/reward
- Program has evolved over time:
  - Percentage of capitation at–risk
  - Selection of measures
  - Overarching structure of program
- Ideally, MCO value-based contracting with providers and Performance Improvement Projects (PIPs) goals should align with P4Q metrics
- Program challenges:
  - Design and risk/reward scaled to the measures of focus
  - Expansions of managed care
  - Measures selection
  - Data sources/data collection
  - Knowledge transfer
- Program is being re-tooled for 2018

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VBP at HHSC-MCO/Provider Level: Hospital Pay-for-Quality

- Potentially Preventable Re-admissions (PPR)
- Potentially Preventable Complications (PPC)
- FFS reimbursement adjustments (reductions) to hospitals based on PPR and PPC rates in excess of established threshold
  - PPR: 1% to 2 % reduction of inpatient claims (based on high rates)
  - PPC: 2% to 2.5 % reduction of inpatient claims (based on high rates)
  - Re-calculated annually
- Hospital adjustments are also made in each MCO's experience data and adjustments are then made to MCO capitation rates
- Recently introduced an incentive component (leveraging PPR and PPC analysis and metrics)
- Technical assistance and "customer service" function at HHSC
- Challenges:
  - Data lags vs Real time
  - Knowledge transfer

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VBP at MCO-Provider Level: MCO Value-Based Contracting with Providers

- Operates under the premise (supported by literature) that FFS payment models tend to reward based on volume and not necessarily quality
- Recent provision in the MCO/DMO contract has strengthened the requirements for MCO/DMO-provider payment structures to focus on quality, not volume
- Requires MCOs/DMOs to submit to HHSC their plans for alternative payment structures (value-based purchasing) with providers
  - Describes types of models, metrics used, volume (approximate dollar amount and enrollees impacted), and process for evaluation
  - Regular Quality Improvement meetings with MCOs to discuss progress and barriers
  - Data collection tools and interaction with MCOs/DMOs will enable HHSC to better assess MCO/DMO progress in this area
- FY18: VBP Targets and Other Requirements

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VBP at MCO-Provider Level: MCO Value-Based Contracting with Providers (cont.)

Challenges:

- Medicaid is not the only book of business for providers
- The science and methods behind this are not fully evolved
- Measurement of progress is challenging
- Complexity and readiness at State, MCO and provider levels
- MCO and provider willingness (although many now see this process as inevitable)
- Need to maintain administrative simplification in Medicaid while undertaking this endeavor
- Wide range of sophistication and administrative infrastructure among provider types
- VBP tends to work more effectively with providers with large patient panels-Texas has many providers with small patient panels

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VBP at MCO-Provider Level: MCO Value-Based Contracting with Providers (cont.)

Challenges:

- Texas has a large number of MCOs, and has separated managed care into different programs. This makes VBP more difficult for some MCOs
- Appropriately crediting MCO costs for quality improvement as medical expense (although HHSC efforts in this area are progressing)
- MCO rate setting methods may need to become less linked to FFS fee schedules
- Ensuring encounter data integrity and completeness
- Investment may be needed
- It is a challenge to develop effective VBP models when multiple providers are involved in a patient‘s care.
- Continual movement through the VBP continuum (toward more risk based models) is essential, difficult and slow
- A roadmap

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MCO Value Based Payment Models that HHSC is Observing

- Most VBP models based on fee for service fee schedule with add on payments for achievement of metric(s)

HEDIS

Potentially Preventable Events

After Hours Availability

- Mostly primary care, some specialist or other facility based providers
- Most have “upside” only
- Although, there are some partial capitation for primary care / group practices and bundled payment models
- MCOs are meeting providers “where they are at”

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Accountable Care Organizations

What are they? ACOs are groups of doctors and other health care providers who voluntarily work together to provide high quality, coordinated services at the right time in the right setting.

- In Medicaid/CHIP, thus far HHSC has seen a very limited numbers of ACOs

- Why? Many of the central features of an ACO create challenges

- Generally ACOs involve financial risk
- Unclear how much savings can be extracted from Medicaid
- Leadership and operational considerations: Need leaders who can organize groups of providers that are not necessarily clinically or financially aligned→ toward alignment
- Adoption of a population health mindset and possibly an alternative (non fee-for-service) payment model to support population health
- Legal/Governance/ Contracting
- DATA, DATA, DATA: for modeling, assessment of risk, care coordination
- Patient attribution and ACO methods for allocating risk/reward

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Accountable Care Organizations (cont.)

- HHSC has done some limited field research on ACOs: one very large, sophisticated ACO in Houston and one very small ACO in Central and West Texas. Both participate in the Medicare ACO initiative.

- Additionally, when HHSC collects information from MCOs on their "inventories" of VBP models (collected annually), we see provider types that have characteristics of ACOs. Our interactions with MCOs will shed more light on these models

- For ACOs or ACO-like entities: This journey starts with local champions and a desire to form the necessary collaborative relationships for improved population health management

Good slide deck on ACOs
https://www.acponline.org/system/files/documents/about_acp/chapters/md/kirschner.pdf

Other suggested reading: http://www.chcs.org/resource/medicaid-accountable-care-organizations-state-update/

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VBP at HHSC-Provider Level: Delivery System Reform Incentive Payment Program (DSRIP)

- Key Question: How do we sustain these efforts and continue the forward progress on high impact successes?

- HHSC is actively working toward aligning MCO quality efforts and the DSRIP program. HHSC is exploring ways that projects with a high impact to Medicaid can become integrated into managed care and working to facilitate collaboration between providers and MCOs
- A thoughtful, coordinated and sustained effort is needed

  - Challenges:
    - Getting the MCO's attention-what would help MCOs advance HHSC goals?
    - Packaging a proposal /Quantifying ROI
    - Having a sufficient number of Medicaid patients
    - Adapting to an MCO payment structure

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Can DSRIP Inform and Advance MCO VBP Efforts?

- Projects are based on locally identified problems with flexible interventions-could inform development of an effective VBP models
- Broad based provider collaborations have developed under RHP structure-could be leveraged to create a focus on population health
- Provider experience with metrics and tracking progress

Summary

- HHSC and DSHS have numerous VBP initiatives focused on quality and efficiency within Medicaid/CHIP programs designed to:
  - Improve care for individuals
  - Improve health for populations
  - Lower (or at least not increase) cost
- Many VBP models are underway, many are in development. Progress is slow, but this is complicated work and a paradigm shift
- The science , tools and methods are evolving
- Big lift-but very doable and this is where healthcare is going
- ACOs or ACO like entities need local champions and local commitment
- DSRIP can be a valuable guide for what works and what does not work in VBP

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Helpful Web-links

HHSC Main Quality Webpage (data on different HHSC initiatives) : https://hhs.texas.gov/about-hhs/process-improvement/medicaid-and-chip-quality-and-efficiency-improvement

Value Based Purchasing subpage (summary information on MCO VBP with providers):

https://hhs.texas.gov/about-hhs/process-improvement/medicaid-and-chip-quality-and-efficiency-improvement/value-based-payments

Potentially Preventable Events Page (data and reports related to hospital level PPR and PPC)

https://hhs.texas.gov/about-hhs/process-improvement/medicaid-and-chip-quality-and-efficiency-improvement/potentially-preventable-events

Data and Reports subpage (MCO/regional HEDIS and PPE measures over multiple time periods):

https://hhs.texas.gov/about-hhs/process-improvement/medicaid-and-chip-quality-and-efficiency-improvement/data-and-reports

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Q and A

HHSC Quality Website (includes links to DSHS sites):

https://hhs.texas.gov/about-hhs/process-improvement/medicaid-and-chip-quality-and-efficiency-improvement

Quality email box: HCPC_Quality@hhsc.state.tx.us

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