Health and Human Services Commission (HHSC) Value-Based Purchasing Roadmap

June 2017

I. Introduction

HHSC's comprehensive plan for health care quality includes the following priorities for the state's Medicaid and Children's Health Insurance Program (CHIP) programs:

1. **Keeping Texans healthy**
2. **Providing the right care in the right place**
3. **Keeping patients free from harm**
4. **Promoting effective practices for chronic disease**
5. **Supporting patients and families facing serious illness**
6. **Attracting high performing providers**

A critical tool to help advance these key priorities is ***healthcare payment transformation*** (also referred to as *value-based purchasing* or *alternative payment models*).

Based on numerous studies and research articles related to categories of healthcare spending and opportunities for increased efficiencies[i], there is a widespread trend towards linking health care payments to measures of quality and/or efficiency (aka "value"). This is referred to in this document as **Value-Based Purchasing (VBP).** Texas Medicaid and CHIP programs are following this trend. 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.

In concert with other policy levers, VBP has the strong potential to accelerate improvement in healthcare outcomes and increase efficiency. The Texas Medicaid program is one of the largest Medicaid programs in the country, with almost $40 billion in expenditures annually.[1] Because it is such a significant payer, the Medicaid program can be a driving force behind payment transformation.

[1] Information about the Texas Medicaid and CHIP programs available at: https://hhs.texas.gov/sites/hhs/files//documents/laws-regulations/reports-presentations/medicaid-chip-perspective-11th-edition.pdf

II. Guiding Principles and Anticipated Outcomes of VBP

Guiding Principles of VBP

The following VBP guiding principles establish the framework for success:

1. **Continuous Engagement of Stakeholders:** Ongoing engagement of managed care organizations (MCOs), providers, trade associations, advocacy groups, and Medicaid enrollees is a critical activity to solicit input, ensure clarity of expectations, assess progress, identify and take advantage of opportunity areas, and remove barriers.

2. **Harmonize Efforts:** As described in this document, there are many VBP related initiatives within Texas Medicaid and CHIP. Additionally, Medicare and commercial insurers are moving aggressively down the VBP path. It is imperative that wherever there are opportunities for increased coordination and harmonization among the many VBP initiatives, that HHSC seize these opportunities. This will have the effect of magnifying the focus of initiatives and minimizing administrative complexity.

3. **Administrative Simplification**: VBP is inherently a more complex endeavor than traditional fee-for-service payment models. While the available research strongly suggests that fee-for-service provider payment models are a significant contributor to excess healthcare cost, these same studies also point to the high administrative costs as another major factor in rising healthcare costs. Therefore, it is important that VBP be pursued with this in mind, so that any efficiencies resulting from VBP are not offset by increased administrative costs.

4. **Data Driven Decision-Making:** Because performance measurement is such an integral part of VBP, the importance of data management and analytics cannot be underestimated. Processes for data sharing, analytics/interpretation, and transparency in measurement methods become much more prominent for both payers and providers operating in this environment. Support of and investment in infrastructure and processes to support these activities is essential.

5. **Movement through the VBP Continuum:** HHSC is relatively early in its VBP efforts. In its APM Framework[2], the Health Care Payment Learning Action Network presents a continuum of APM models.

[2] APM Framework found at: https://hcp-lan.org/workproducts/apm-whitepaper-onepager.pdf

In the Texas healthcare system, most VBP contracts are on the lower-risk end of the continuum -- provider incentives are built upon fee-for-service payment approaches. A continued, thoughtful movement toward VBP models that have higher degrees of financial risk on behalf of providers is considered essential for achieving maximum value.

6. **Reward Success:** VBP is predicated on the evidence that strengthening the linkage between payment and value (quality and/or efficiency) should provide a necessary incentive structure for MCOs and providers to pursue continued performance improvement. Creating sustainable approaches for rewarding success is essential for a successful, long term VBP strategy.

Anticipated Outcomes of VBP

1. **Aligned Incentives between State, Managed Care Organizations (MCOs) and Providers:** It is anticipated that a coordinated VBP approach, in which clinical and financial goals are aligned and healthcare value is prioritized and incentivized, will produce a more efficient healthcare system. Additionally, while not a VBP strategy, patient engagement strategies should be brought into the equation to further increase alignment.

2. **Optimal Healthcare Outcomes and Patient Experience:** It is anticipated that a healthcare system that is oriented toward patient-centric care, with provider payment models to support that care, will result in improved patient outcomes and enhanced patient experience of care.

3. **Improved Healthcare Efficiency:** It is anticipated that a healthcare system in which clinical and financial goals are aligned will deliver more effective care and result in a lower rate of healthcare cost growth.

III. HHSC's Array of Quality/VBP Initiatives

While the primary focus of this document is on provider payment approaches, there is a package of complementary initiatives promulgated by HHSC that contribute to the overall success of payment transformation. These initiatives are illustrated in Figure 1 below and described in Appendix A.

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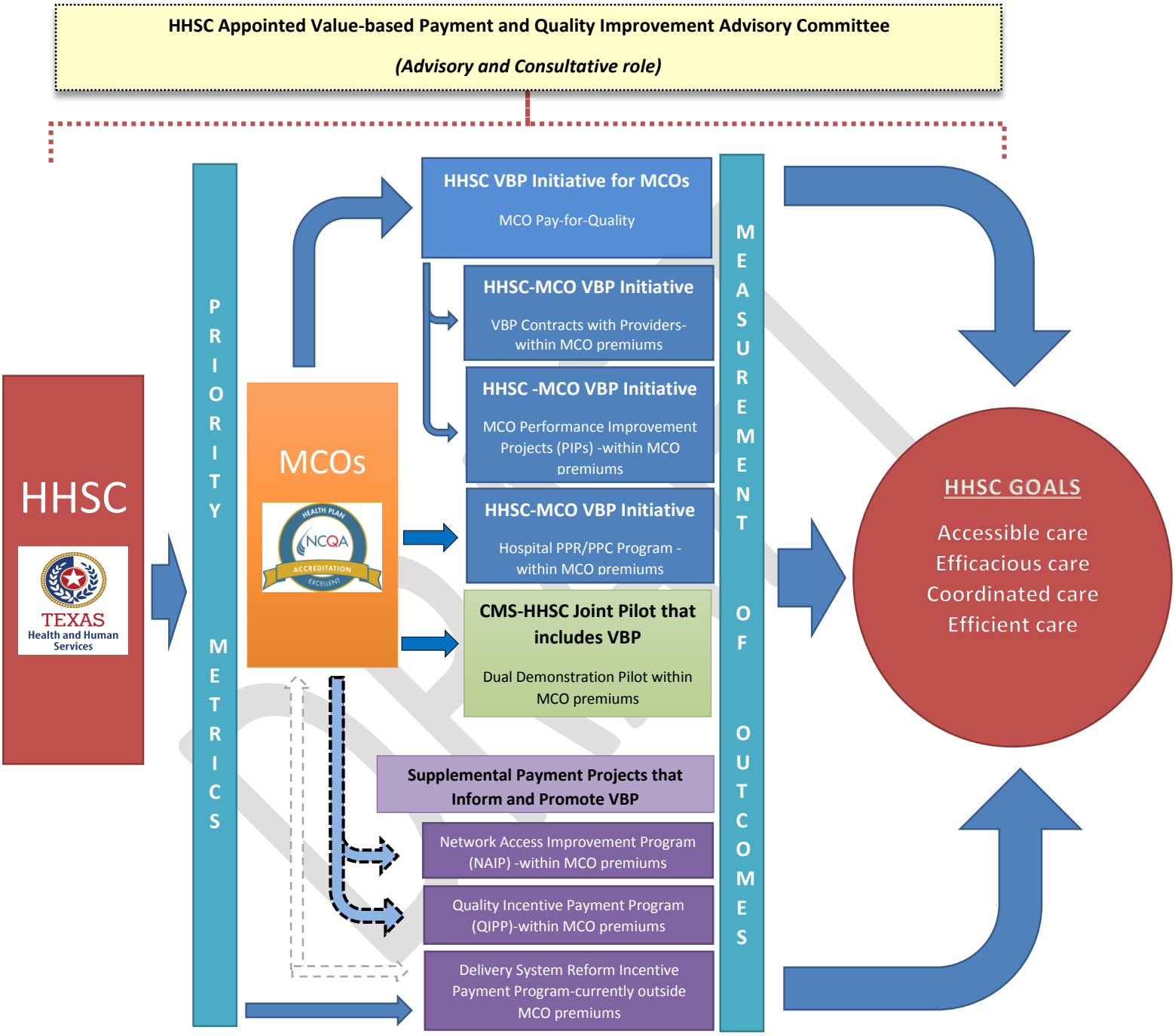
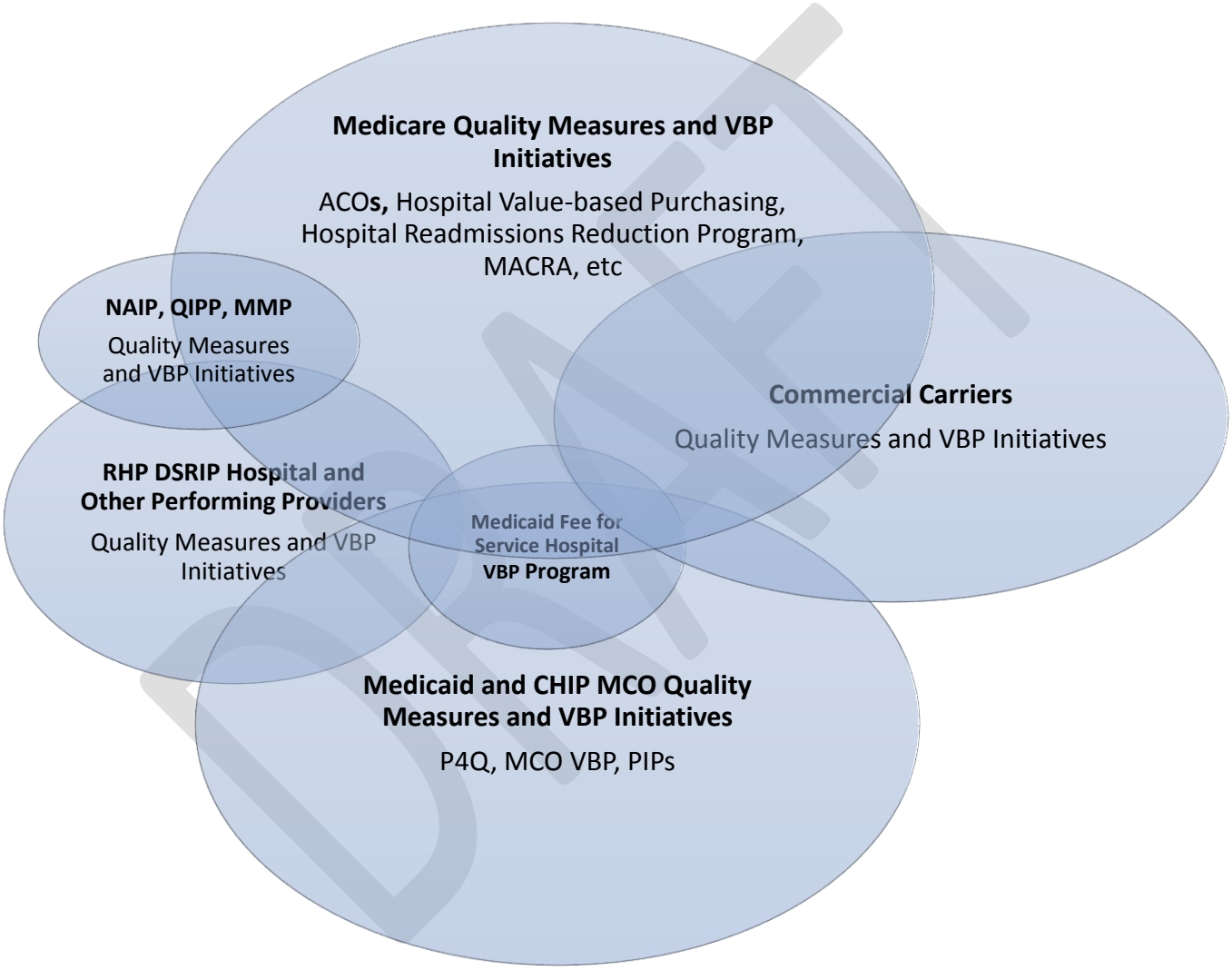
Figure 1: HHSC Initiatives Focused on Improving Access, Quality and Efficiency



Note: To the extent possible, all VBP approaches will focus on and measure priority measures. This concentrates and magnifies efforts and their effect

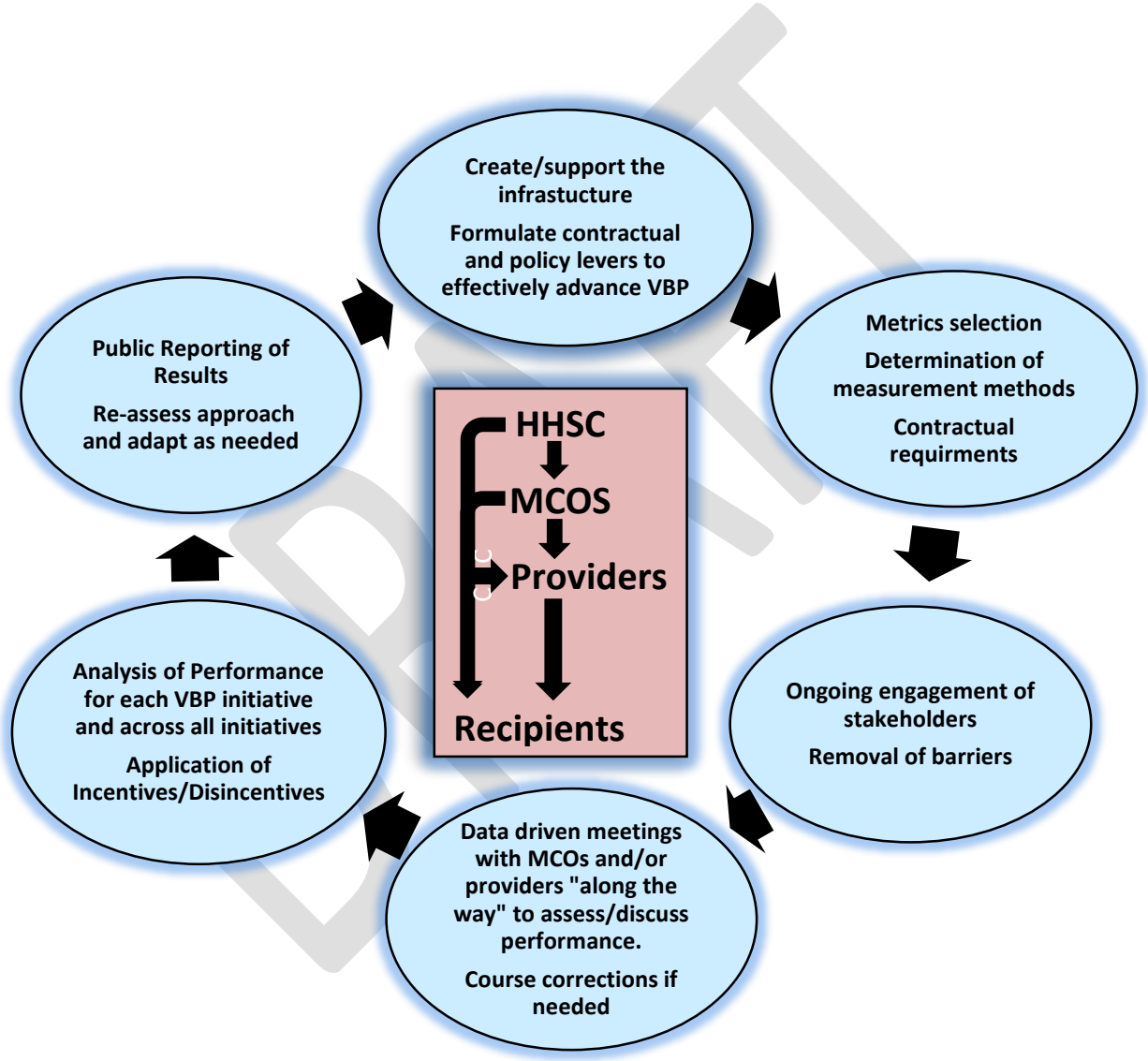
Because the healthcare ecosystem is so large and complex, and is comprised of many subsystems, each pursuing VBP in different ways, it is essential that HHSC's VBP efforts are coordinated. This coordination will minimize administrative complexity for providers who operate in many of the subsystems.

Figure 2: The Healthcare Ecosystem and Associated Challenges of VBP: Many Payers and Multiple Initiatives



As HHSC proceeds down a VBP path, each initiative follows a basic cycle. While the steps involved in each initiative's cycle differ slightly (some have more steps which occur at different intervals), the basic cyclical process is represented below.

Figure 3: Activities within the Cycle of Quality/VBP Initiatives



Description of Initiatives

Health and Human Services and Managed Care Organization Value Based Payment Structure

Medical and Dental Pay-for-Quality (P4Q) Programs

Background/Description:

This program is required for all MCOs and dental maintenance organizations (DMOs), and is a VBP model at the HHSC-MCO/DMO level. In general, the concept employs financial risks and rewards, coupled with performance metrics, to catalyze performance improvement. For the medical P4Q program, each MCO has a percentage of its premiums at-risk. MCOs that do not meet target performance thresholds for the P4Q metrics could lose premium dollars that are at-risk. Performance is measured based on performance against benchmarks (performance within the year relative to state norms or established standards) as well as performance against self (year over year improvement over self). Recouped premium dollars from low performing MCOs for at-risk metrics are redistributed to high performing plans for at-risk metrics. Any remaining funds are pooled to form a performance bonus pool to reward the highest performing MCOs on bonus pool metrics. Because there are significant MCO premium dollars to be lost or gained by MCOs through this program, it provides the necessary incentive for MCOs to collaborate with providers to develop value - based payment models that can help ensure their success. Core metrics for the medical program are being finalized, but will be based on high impact process and outcome measures. This core metric set creates the urgency for MCOs to formulate strong provider VBP arrangements based on some degree of shared savings/shared risk, which are believed to be the most effective VBP models.

For the dental P4Q program, each DMO also has a percentage of its premiums at-risk. Performance is calculated for each plan separately based on its own performance compared to past years. DMOs that decline in performance overall could lose some of their at-risk premiums. Recouped premium dollars from a DMO that declines overall may be redistributed to a DMO that improved. The measures in the dental P4Q program assess the extent to which members receive regular oral evaluations and primary prevention services for dental caries.

Key Issues Going Forward:

- For January 1, 2018 implementation (for CY2018 period): finalization of metrics and measurement methods, technical specifications document
- Once program is operational, HHSC will establish an ongoing process of engagement with MCOs "along the way" to track metrics and discuss progress
- Knowledge transfer to MCOs and providers through annual quality forums and webinars
- Tracking how MCOs utilize P4Q measures to promote VBP contracts downstream with providers
- Continued measurement of indicators of progress based on priority metrics

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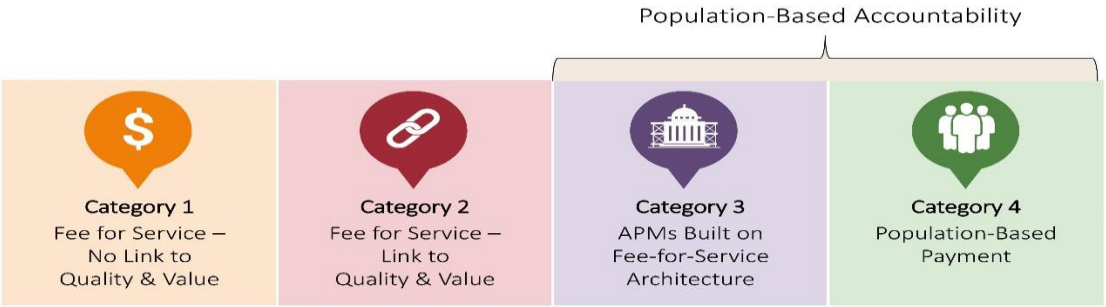
MCO Value-Based Purchasing with Contracted Providers

Background/Description:

While a strong medical P4Q program creates the conditions for MCOs to pursue value-based payment models with providers to support and advance quality improvements, MCO contractual requirements are necessary to ensure that all MCOs are pursuing VBP in all managed care programs in all service areas. HHSC is utilizing the Health Care Payment Learning and Action Network (LAN) Alternative Payment Model (APM) Framework to help guide this effort.[3] This framework is illustrated at a high level in Figure 4.

In 2012, HHSC began assessing the payment methodologies that contracted MCOs pay providers. This assessment confirmed that while MCOs were paid based on a capitated payment model, they were largely paying providers based on a fee-for-service payment model, unlinked to quality metrics. In 2014, HHSC initiated a contract provision into the managed care contracts that required MCOs to implement VBP models with providers and to submit to HHSC annual reports on their VBP activities. This began the process of "signaling" to the MCOs HHSC's interest in moving provider payments to VBP. This contract provision was augmented with one-on one "quality" meetings with MCOs. A priority topic for these web-based meetings was the identification of opportunity areas and barriers related to provider VBP. Data driven discussions related to MCO performance on key quality/efficiency metrics was woven into the discussions. If a MCO had positive trends for quality metrics, it led to discussion of clinical and/or payment models put in place which may have led to the positive trends. Conversely, if a MCO had negative trends on quality metrics, it became an opportunity to explore underlying reasons, and whether VBP could improve the trends. This framework, based on regular, *individual* interactions with MCOs centered on VBP and performance trends, leveraging existing publicly reported data, set expectations and provided a constructive forum for MCOs to more openly discuss their performance, as well as their VBP direction.

Figure 4: Guiding APM Framework[4]



[3] Complete APM Framework found at: http://hcp-lan.org/workproducts/apm-whitepaper-onepager.pdfHCP- LAN White Paper found at: http://hcp-lan.org/workproducts/apm-whitepaper.pdf

[4] Complete APM Framework found at: http://hcp-lan.org/workproducts/apm-whitepaper-onepager.pdf

To continue this forward progress on MCO VBP efforts, HHSC is strengthening the MCO contract requirements to include:

1. **Establishment of MCO VBP Targets:** Overall *and* Risk-Based VBP contractual targets based on MCO expenditures on VBP contracts relative to all medical expense. Each MCO's targets will begin for calendar year 2018, beginning at 25% of provider payments in Overall VBP and 10% of provider payments in Risk Based VBP. These targets will increase over four years to 50% overall VBP and 25% Risk-Based VBP in calendar year 2021. For Dental Managed Care Organizations (DMOs), these targets are set at 25% Overall VBP and 2% Risk Based VBP in 2018. The targets increase to 50% Overall VBP and 10% Risk Based VBP in 2021.
2. **Requirements for MCOs to adequately resource this activity:** MCOs must dedicate sufficient resources for provider outreach and negotiation, assistance with data and/or report interpretation, and other collaborative activities to support VBP and provider improvement.
3. **Requirements for MCOs to establish and maintain data sharing processes with providers:** Requires data/report sharing between MCOs and providers.
4. **Requirements for MCOs to have a process in place to evaluate VBP models:** Requires that the MCO dedicate resources to evaluate the impact of APMs on utilization, quality and cost, as well as return on investment.

Key Issues Going Forward:

- HHSC to maintain ongoing strategic engagement with MCOs and providers
- Maintaining administrative simplicity while increasing volume of VBP activity
- HHSC must be mindful that there is a wide range of sophistication and administrative infrastructure among provider types, and explore workable solutions
- Data analytics and business intelligence infrastructure at the HHSC level, MCO level, and provider levels needs to be supported
- Staying abreast of the evolving science and methods is critical to ensuring a sustainable VBP approach
- Appropriately crediting MCO costs for quality improvement as medical expense (although HHSC efforts in this area are progressing)
- Investments may be needed to advance VBP in a meaningful way
- It is essential that there be steady movement through the VBP continuum toward more risk-based models
- While pursuing a coordinated VBP strategy, HHSC must evaluate its role relative to MCOs and providers, and examine ways it can properly support this effort
- HHSC will evaluate the MCO VBP contract requirements and make adjustments as necessary to ensure forward progress
- HHSC is exploring acquiring and integrating Medicare data with Medicaid data to routinely assess quality of care for dual eligible enrollees not in the Dual Demonstration (about 50% of individuals in the STAR+PLUS Program)
- Continued measurement of indicators of progress based on priority metrics

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Challenges

- VBP tends to work more effectively with providers with large patient panels-Texas has many providers with small patient panels, and solutions are needed
- MCO premium setting methods may need to evolve based on accelerating deployment of VBP models
- Certain risk-based VBP models potentially disincentivize submission of complete data on patient encounters. Ensuring MCO encounter data integrity and completeness while pursuing VBP is critical
- It is a challenge to develop effective VBP models when multiple providers are involved in a patient's care

Hospital Quality Based Payment Program

Background/Description:

Even though HHSC Medicaid is almost exclusively managed care, HHSC continues to administer this program for all hospitals in Medicaid/CHIP. This hospital specific program[5] is operationalized in both managed care and fee-for-service (FFS) systems. All hospitals are measured on their performance for risk adjusted rates of potentially preventable readmissions (PPR) and potentially preventable complications (PPC) across all Medicaid and CHIP programs, as these measures have been determined to be reasonably within the hospital's control. Hospitals can experience up to a 4.5% reduction to their payments for inpatient stays for high rates of PPR and/or PPC, and if they are safety net hospitals, could receive bonus payments above their base payments for low risk adjusted rates of PPR and/or PPC rates. Measurement and application of disincentives/incentives is on an annual cycle.

Key Issues Going Forward:

- HHSC must continue to engage hospital associations, individual hospitals and MCOs to discuss potential program enhancements, gaps in knowledge, and/or performance trends
- Staff will explore program enhancements and their impacts
- Staff will seek to align measurement methods with P4Q methods (composite measurement of within year performance and year over year improvement)
- Knowledge transfer to Hospitals and MCOs (i.e., face-to-face presentations and webinars regarding best practices in reducing PPR and/or PPC, successful strategies from the field, etc.)
- Continued measurement of indicators of progress based on priority metrics

MCO Performance Improvement Projects (PIPs)

Background/Description:

[5] Information for PPR/PPC Program, found at: https://hhs.texas.gov/about-hhs/process-improvement/medicaid-chip-quality-efficiency-improvement/potentially-preventable-events

PIPs [6]are designed to achieve, through ongoing measurements and interventions, significant improvement sustained over time in clinical care, or non-clinical care areas that are expected to have a favorable effect on health outcomes. HHSC, in consultation with the Institute for Child Health Policy (ICHP), the Texas External Quality Review Organization (EQRO) determines topics for performance improvement projects based on historical MCO performance. MCOs create a PIP plan, report on their progress annually, and provide a final report on their PIP. The EQRO evaluates the PIPs in accordance with the Centers for Medicare and Medicaid Services (CMS) EQRO Protocols. HHSC requires each MCO and DMO to conduct two PIPs per program. One PIP must be a collaborative with another Medicaid/CHIP MCO, DMO, or Delivery System Reform Incentive Payment project.
Ideally, over time, PIPs should incorporate value-based payment approaches between MCOs and providers, and leverage measures identified in medical Pay-for-Quality program. A phased-in approach should be taken to require any new or upcoming PIP to be focused on a metric(s) identified in the medical P4Q program and to implement a VBP approach.

Key Issues Going Forward:

- HHSC will determine how to incorporate VBP into PIP design and evaluation
- HHSC will ensure that there is alignment between PIP topics and HHSC priority metrics
- Continued measurement of indicators of progress based on priority metrics

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Initiatives funded via Local Intergovernmental Funds Transfer (IGT) with Funds Flowing through MCO Premiums

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Network Access Improvement Program (NAIP)

Background/Description:

In 2013, the Rider 79 of the Texas Legislature underscored the importance of ensuring primary care access to the Medicaid population through Health Related Institutions (HRIs). The initiative directed HHSC to fund per-member per-month payments to HRIs and to establish primary care incentive payments to HRIs for the provision of primary care services to Medicaid and CHIP enrollees. This is referred to as the Network Access Improvement Program, or NAIP. NAIP funding flows through MCO premiums (state share funded by local IGT) which are linked to specific projects. These projects are designed to increase the availability, quality, coordination and effectiveness of primary care for Medicaid clients by providing incentive payments administered by the MCOs to participating HRIs and public hospitals. MCOs and NAIP providers collectively determine the NAIP projects and metrics that trigger NAIP payments. A link to NAIP projects is found here.

[6] Information on MCO PIPs, found at: https://hhs.texas.gov/about-hhs/process-improvement/medicaid-chip-quality-efficiency-improvement/performance-improvement-projects

The goals of NAIP are to:

- Increase in the availability, quality and coordination of primary and specialty care services provided by public hospitals
- Increase provider education on Medicaid program requirements and the specialized needs of Medicaid recipients
- Improve care access and physician compliance with selected quality objectives.

Key Issues Going Forward:

- HHSC to maintain ongoing strategic engagement with MCOs and NAIP providers
- Pending continuation of NAIP, HHSC will explore incorporation of a limited set of outcome metrics (based on administrative data) that will measure the impact of improved primary care access. These metrics would align with the same metrics used in other VBP initiatives
- HHSC will explore options related to incorporating a VBP component to the NAIP payments, thus creating a more accountable and value-based NAIP program that is better aligned with other VBP initiatives
- Continued measurement of indicators of progress based on priority metrics

Quality Incentive Payment Program (QIPP)

Background/Description:

MPAP, the Nursing Facility Minimum Payment Program, historically provided enhanced payment rates to participating qualified skilled nursing facilities. Under the proposed QIPP [7], additional payments to nursing facilities will be based upon improvements in quality and innovation in the provision of nursing facility services. This includes payment incentives to improve the quality of care for their residents. Facilities will be able to achieve this goal by showing an improvement over baselines as they relate to each of the four quality measures:

- High-risk residents with pressure ulcers;
- Percent of residents who received an antipsychotic medication (long-stay);
- Residents experiencing one or more falls with major injury; and
- Residents who were physically restrained.

Key Issues Going Forward:

- HHSC to maintain ongoing strategic engagement with MCOs and QIPP providers

[7] QIPP information found at: https://hhs.texas.gov/services/health/provider-information/quality-incentive-payment-program-nursing-homes

- HHSC will incorporate a limited set of outcome metrics (based on administrative data) that will measure the impact of the incentive funds. These metrics would align with the same metrics used in other VBP initiatives
- HHSC is exploring acquiring and integrating Medicare data with Medicaid data to routinely assess quality of care for dual eligible enrollees not in the Dual Demonstration (about 90% of individuals in nursing facilities)
- Similar to NAIP, HHSC will be developing options related to the VBP component of the QIPP payments, thus creating a more accountable and value-based QIPP program that is better aligned with other VBP initiatives
- Continued measurement of indicators of progress based on priority metrics

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Initiatives funded via Local Intergovernmental Funds Transfer (IGT) with Funds Flowing Outside of MCO Premiums

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Delivery System Reform Incentive Payment Program (DSRIP)

Background/Description:

The Texas Healthcare Transformation and Quality Improvement Program 1115 Waiver[8], enabled Texas to implement Medicaid managed care statewide, achieving program savings while preserving locally-funded supplemental payments to hospitals. The supplemental funds are distributed through two pools: Uncompensated Care and DSRIP.

The first five years of DSRIP initiated statewide transformation through projects created to improve access to care, transform the quality of care (measured through process and outcome measures), and address regional needs. Performing Providers earned incentive payments for achievement of goals, including serving greater numbers of the targeted Medicaid and Low-Income or Uninsured population, and achievement of process milestones and outcome metrics.

Going forward, the proposed DSRIP program structure will evolve from a focus on projects and project-level reporting towards targeted *measure bundles* that are reported by DSRIP performing providers as a provider system. This allows for ease in measure selection and approval (i.e. reduced DSRIP provider administrative complexity), increases standardization of measures across the state for providers with similar activities, facilitates the use of regional networks to identify best practices and share innovative ideas, continues to build

[8] Information on Texas Healthcare Transformation and Quality Improvement Program accessed at: https://hhs.texas.gov/laws-regulations/policies-and-rules/waivers/medicaid-1115-waiver

on the foundation set in the initial waiver period, and provides additional opportunities for transforming the healthcare system and bending the cost curve.

Measure bundles consist of measures that share a unified theme, apply to a similar population, and are impacted by similar activities. HHSC worked with clinical resources and stakeholders to finalize a menu of measure bundles. Measure bundles include a mix of related process measures and patient clinical outcomes. HHSC is also mindful of statewide priority metrics and is working to align the selected measures with Medicaid MCO and Medicaid quality program goals.

Because DSRIP has been a very effective incubator for testing how alternative, value based payment models can support patient centered care and clinical innovation, HHSC continues to work closely with MCOs and DSRIP providers on ways to incorporate promising clinical models into the Medicaid MCO provider payment stream in the form of a VBP model. There are a number of challenges to incorporating DSRIP into the MCO model, most especially because of the funding of DSRIP with IGT as state match and timelines of MCO premium settings and incentive payment structures. Nevertheless, HHSC believes DSRIP is building the capacity for providers to participate in a VBP model with MCOs through better utilization of Health Information Technologies and better measurement processes. While HHSC continues to aggressively pursue this effort, it is anticipated that the transition away from specific projects and discrete measures toward broader measure bundles will stimulate a movement toward greater coordination among DSRIP providers, and improved population health. HHSC anticipates that DSRIP providers will be able to market themselves more effectively to MCOs , and that MCOs will be more receptive to negotiating mutually beneficial VBP arrangements with DSRIP providers based on shared interests.

Key Challenges to integrating DSRIP into MCO for VBP:

- The timelines for DSRIP extension implementation and MCO premium development, in addition to budget certainty requirements for MCO payments, have been prohibitive for integrating DSRIP payments through managed care to date.
- In the current DSRIP payment structure, IGT amounts are determined based on incentives earned. In a managed care structure, IGT would be incorporated prospectively into rates. IGT partners are concerned that, based on Federal Medicaid managed care guidelines, MCOs would keep the funding not earned by providers in the incentive program, including the IGT.
- Many DSRIP providers have small Medicaid patient panels; as discussed previously, small Medicaid practices pose a challenge for Medicaid MCOs implementing VBP.

Next Steps:

- HHSC to maintain ongoing strategic engagement with DSRIP providers and MCOs
- HHSC to continue to facilitate collaboration between DSRIP projects and MCOs with the goal of MCOs partnering with the DSRIP providers on VBP payment models

- Continued measurement of indicators of progress based on priority metrics (DSRIP provider level, Regional Healthcare Partnership (RHP) level, Population level, State Level).-

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CMS and HHSC Joint Pilot Project for Medicare and Medicaid Populations

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Texas Dual-Eligibles Integrated Care Demonstration Project (The Dual Demonstration)

Background/Description: The Dual Demonstration[9] is a CMS and HHSC joint project designed to test whether an innovative and coordinated payment and service delivery model can improve coordination of services for recipients who have Medicare and Medicaid benefits (dual eligible enrollees), enhance quality of care, and reduce costs for both the state and the federal government. By having one Medicare-Medicaid plan (MMP), Medicare and Medicaid benefits work together to better meet the member's health-care needs.

The key objectives of MMP are:

1. Make it easier for clients to get care.
2. Promote independence in the community.
3. Eliminate cost shifting between Medicare and Medicaid.
4. Achieve cost savings for the state and federal government through improvements in care and coordination.

As part of this initiative, participating MCOs have value-based payment arrangements with providers.

Key Issues Going Forward:

- Ongoing management of initiative by HHSC staff, in concert with CMS
- HHSC to maintain ongoing strategic engagement with MCOs and providers
- Continued measurement of indicators of progress based on priority metrics

IV. The Path Forward: Building on Success

HHSC has seen significant overall progress over the last four years on a variety of measures of quality and efficiency. This is evidenced in the latest published HHSC Legislative Report on Quality Initiatives[10] within Medicaid/CHIP. To help ensure the continued success of HHSC's coordinated VBP plan that consistently

[9] Information on MMP is found at: https://hhs.texas.gov/services/health/medicaid-chip/programs/childrens-health-insurance-program-chip/chip-comparison-charts/texas-dual-eligible-integrated-care-project

[10] Annual Report on Quality found at: https://hhs.texas.gov/sites/hhs/files//sb7-rider-46.pdf

advances better care for individuals, better health for populations, and lower cost, HHSC will be systematically addressing the following issues:

- **HHSC and MCO Roles:** VBP is a significant paradigm shift and compels a change in roles for providers, MCOs, and HHSC. With VBP and aligned incentives, more collaborative partnerships tend to emerge based on shared interests. Additionally, data for modeling, tracking of progress and calculation of final performance is critical. Because HHSC has a statewide view of data, there is likely a need for HHSC to be an active business partner in this area.

- **Continue to Utilize Policy and Financial Levers to Support VBP:** VBP is designed to align incentives toward value, which includes rewarding success at both the MCO and provider levels. HHSC has an effort underway to recognize different quality improvement investments by MCOs as medical expense, rather than administrative cost. This will promote quality improvement activities and investments by MCOs, as these costs will not be limited by administrative cost caps. Additionally, the process for setting MCO premiums may need to evolve to keep pace with HHSC's contractually-directed expansion of VBP models.

- **Establishment of Broad-Based Metrics of Value[11]:** Consistent with HHSC's Quality Plan, establishment of broad metrics of cost-quality (value) should be used to evaluate the effectiveness of the different VBP initiatives. This will concentrate and magnify stakeholder efforts, and thus maximize the impact. Finalization of these priority measures of healthcare value will be determined over the next several months.

- **Continue to Grow Internal and External Analytical Capacity:** HHSC has made substantial progress in this area. Analytic tools and resources to support data driven decision-making is key to translating voluminous amounts of data into actionable information. This includes leveraging data from health information exchanges (HIE). To the extent possible, accelerating the timelines for transformation of data to information will enable course corrections more quickly. This effort extends to MCOs and Providers.

- **VBP Harmonization/Administrative Simplification:** As referenced previously in this document, VBP is inherently a more complex endeavor than traditional fee-for-service payment models. While the literature strongly suggests that the traditional fee-for-service provider payment model is a chief contributor to excess healthcare cost, it often points to the high administrative costs as another major factor in rising costs. To the extent feasible, it is imperative that VBP within Medicaid/CHIP be pursued in a coordinated manner with other VBP initiatives, to retain providers, and to ensure that any gains achieved through VBP are not offset in increased administrative costs.

- **Embrace a Collaborative Quality Improvement Culture:** HHSC began this process in 2015 with one-on-one quality calls with MCOs, and continued with one-on- one meetings with MCOs starting in 2016. . This process

[11] Value=improved quality/lower cost

will expand to provider groups. These small group interactions ensure that HHSC has continuous "touch points" with key stakeholders. Through this process, HHSC is able to share and discuss data on progress (or lack of progress), understand the myriad considerations within a VBP environment, and if needed, react to them through policy and/or contractual levers.

- **Improved Public Reporting:** Public Reporting is a proven strategy to advance priorities. About three years ago, HHSC began to enhance this process by increasing the online availability of performance data[12] as part of the HHSC Quality Website[13]. HHSC, in collaboration with its External Quality Review Organization (EQRO), is developing a new Tableau-based public reporting portal, which will utilizes latest technology and data visualizations. This solution has different accessibility permissions, enabling HHSC, MCOs, legislators and stakeholders, researchers, the general public, MCOs, and potentially hospitals to view and more easily understand performance trends.

- **Leveraging Expertise of Healthcare Professionals and Research Partnerships:**

  - **Stakeholder Input:** MCOs and providers have to function in a VBP environment, and it is essential that HHSC solicit their input. HHSC surveyed MCOs in 2014 early on in its VBP efforts. Extending that information gathering to providers of all types will help ensure barriers are identified and that VBP is successful.
  - **VBP Workgroup:** HHSC has established a workgroup to help work through operational considerations of VBP. This will be a broad workgroup consisting of professionals for different provider types including DSRIP providers, as well as MCOs. This will help HHSC navigate through this complex environment.
  - **Value-Based Payment and Quality Improvement Advisory Committee:** The Value-Based Payment and Quality Improvement Advisory Committee[14] is a newly formed HHSC advisory committee of healthcare experts that provides a forum to promote public-private, multi-stakeholder collaboration in support of quality improvement and value-based payment initiatives for Medicaid, other publicly funded health services and the wider health care system. This committee will help shape the vision and direction of VBP within the Medicaid/CHIP programs, but also extends beyond Medicaid/CHIP.
  - **Other HHSC Advisory Committees:** HHSC has numerous advisory committees focused on different topics. These committees, which consist of healthcare experts and consumers, are valued partners in helping HHSC understand the system it oversees, and advises HHSC on workable solutions to identified problems. Examples are:
    - State Medicaid Managed Care Advisory Committee

[12] HHSC Healthcare Data and Reports page found at: https://hhs.texas.gov/about-hhs/process-improvement/medicaid-chip-quality-efficiency-improvement/medicaid-chip-quality-efficiency-improvement-data-reports
[13] Main HHSC Quality Webpage found at: https://hhs.texas.gov/about-hhs/process-improvement/medicaid-chip-quality-efficiency-improvement
[14] Information on this committee found at: https://hhs.texas.gov/about-hhs/leadership/advisory-committees/value-based-payment-quality-improvement-advisory-committee

- STAR Kids Managed Care Advisory Committee
- Task Force for Children with Special Needs
- Intellectual and Developmental Disability System Redesign Advisory Committee
- Executive Waiver Committee
- Behavioral Health Advisory Committee
- Behavioral Health Integration Advisory Committee
- Women's Health Advisory Committee

- **Environmental Scans of State Medicaid, Federal and Commercial Programs:** To help ensure that HHSC is kept abreast of best practices in VBP, there will be ongoing interactions with federal and state partners, as well as commercial payers. Understanding what is effective and advances quality and efficiency in real world systems will be a central activity of HHSC.
- **Leveraging Expertise of Academia and other Research Partners:** There is a deep well of experienced healthcare research capacity and robust analytical bandwidth that HHSC will draw upon to assist it in identifying opportunity areas, trends and impacts on quality/cost, and how to integrate the results of that work into HHSC operations. ICHP is a nationally-recognized for its expertise in managed care quality. In addition, HHSC has a collaborative research effort underway with its EQRO, Dartmouth Institute, and the University of Texas to study quality and cost variations for newborn care with the Medicaid program. Through this effort, HHSC seeks to understand underlying reasons and where there are opportunities for quality improvement and cost savings, and to create a surveillance system for monitoring this domain of care. The research partners have tremendous expertise in this area, and their expertise is critical to helping HHSC understand where to focus its attention. Given that Texas Medicaid covers more than 50% of all births in Texas, there are likely rich opportunities for improvements related to newborn care, which could include incorporating VBP as a potential tool to advance value.

➢ **Pursuit of Promising Models to Advance VBP**

- **Delivery System Reform Incentive Payment Program (DSRIP) as a Key Incubator for VBP:** DSRIP has been instrumental to advancing HHSC's understanding of how payment approaches, coupled with quality metrics, support innovation and patient centered care. Future versions of DSRIP will be re-oriented from focus on specific projects and hundreds of metrics toward triggering payment based on performance on "measure bundles" for DSRIP providers. This will move this initiative into closer alignment with population health principles while achieving administrative simplification.
- **Uniform Hospital Rate Increase Program (URHIP):** This program[15] is currently under review by the Centers for Medicare & Medicaid Services (CMS). HHSC seeks to implement the Uniform Hospital Rate Increase Program (UHRIP) for hospital services beginning September 1, 2017. If approved, the rate increases would reduce hospitals' Medicaid shortfall in the managed care service delivery areas in which the program is implemented. If approved, HHSC will evaluate if it is appropriate incorporate a VBP component to this payment model.

[15] UHRIP information found at: http://legacy-hhsc.hhsc.state.tx.us/rad/hospital-svcs/uniform-hosp-rate-prgm.shtml

- **Accountable Health Communities (AHC):** Many community organizations within Texas have applied to the CMS Accountable Health Communities [16] grant. HHSC, as the state Medicaid agency, will be partner to this grant. This grant will test whether identification and/or linkages to the health-related social needs of enrollees impacts total health care costs, improves health, and quality of care. This grant will inform HHSC on ways to structure and support effective VBP approaches.
- **Certified Community Behavioral Health Clinics (CCBHC):** HHSC received a CMS/SAMHSA planning grant for CCBHC[17], and this supported the development of the clinic certification process as well as the payment model to support patient centered, integrated care. HHSC applied for, but did not receive a demonstration grant award for model implementation. HHSC is exploring ways to leverage the experience it gained from the CCBHC planning grant to implement the model. It is envisioned that the model would incorporate many characteristics envisioned in the CCBHC design, to include a strong VBP component.
- **Accountable Care Organizations (ACO):** HHSC has been closely evaluating ACOs and how ACO models within Medicare could be advanced within Medicaid/CHIP. The Texas Medical Association (TMA) recognizes that many physician practices within Texas have small patient volumes, and have a physician led ACO solution, called Practice Edge. This may address VBP barriers with small physician groups within Medicaid, and could inform future VBP efforts.
- **VBP to Support Interventions for Populations with Complex Needs and High Cost (i.e., "Superutilizers"):** All HHSC contracted MCOs are required to have targeting, outreach and intervention strategies in place for enrollees with complex needs and high cost[18]. . In addition to participation in the CMS Innovation Accelerator Program for Beneficiaries with Complex Needs and High Cost, in 2019, HHSC will require MCO Performance Improvement Projects (PIPs) to address the needs and improving outcomes for this population. A flexible, population based VBP model is an ideal payment model for supporting patient centered care for this complex population.

[16] Information on AHC found at: https://innovation.cms.gov/initiatives/ahcm/
[17] Information on CCHC found at: https://www.medicaid.gov/medicaid/financing-and-reimbursement/223-demonstration/index.html
[18] Information on this initiative found at: https://hhs.texas.gov/about-hhs/process-improvement/medicaid-chip-quality-efficiency-improvement/super-utilizers

V. Conclusion

HHSC is committed to a thoughtful, concerted and sustained effort across all initiatives. The package of VBP initiatives that HHSC oversees maximizes available funding and promotes MCO and provider accountability for value. The complementary nature of these initiatives, coupled with HHSC's support for healthcare innovation are showing results. HHSC is well positioned to build on the gains it has made through the expansion of managed care and emphasis on value. It is a fundamental change for Texas Medicaid and CHIP from paying for health care services to a new mission of better care for individuals, better health for populations, and lower cost.

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Appendices

Appendix A: References Related to Healthcare "Waste"

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Appendix B: Table of HHSC Initiatives Focused on Quality Improvement and/or VBP

INITIATIVE	DESCRIPTION	TARGETED POPULATION	PROVIDER TYPES	QUALITY AND/OR EFFICIENCY MEASURES UTILIZED	FINANCING
MEDICAL PAY FOR QUALITY	Budget neutral program that creates incentives and disincentives for managed care organizations based on their performance on quality measures identified by HHSC. Health plans that excel on meeting the measures are eligible for additional funds above their existing premium payments; health plans that don't meet their measures can lose funds.	All Medicaid and CHIP Populations Enrolled In Managed Care (Dual Eligible enrollees and STAR Health and STAR Kids members excluded)	All providers within MCO networks	HEDIS, AHRQ, CMS, CAHPS, 3M Potentially Preventable Events	Financed by MCO premium dollars. State General Revenue (GR) for non-federal share, matched with federal funds
MCO VALUE-BASED CONTRACTING WITH PROVIDERS	HHSC Contractual requirement for MCOs to develop value-based payment models with providers.	All Medicaid and CHIP Populations Enrolled In Managed Care (Dual Eligible enrollees excluded)	All providers within MCO networks	Measures typically follow those established in MCO Pay for Quality, but are at the MCOs discretion	Financed by MCO premium dollars. State General Revenue (GR) for non-federal share, matched with federal funds
MCO PERFORMANCE IMPROVEMENT PROJECTS (PIPS)	PIPs are designed to achieve significant and sustainable improvements in both clinical and non-clinical care areas through ongoing measurements and interventions. Projects must be designed to achieve, through ongoing measurements and interventions, significant improvement, sustained over time, in clinical care and nonclinical care areas that have a favorable effect on health outcomes and enrollee satisfaction. Value-Based Payments can be an important feature of PIPs.	All Medicaid and CHIP Populations Enrolled In Managed Care (Dual Eligible enrollees excluded)	All providers within MCO networks	HHSC, in consultation with the external quality review organization (EQRO) determines topics for performance improvement projects based on health plan performance. Health plans create a PIP plan, report on their progress annually, and provide a final report on their PIP.	Financed by MCO premium dollars. State General Revenue (GR) for non-federal share, matched with federal funds
HOSPITAL QUALITY BASED PAYMENT PROGRAM FOR PPR/PPC	Hospital program designed to improve rates of readmissions and complications though incentives and disincentives. Program is operated in both managed care and fee-for-service.	All Medicaid and CHIP Populations served within a hospital setting (inpatient)	Hospitals (inpatient)	Potentially Preventable Readmissions and Potentially Preventable Complications	Financed by MCO premium dollars. State General Revenue (GR) for non-federal share, matched with federal funds

DELIVERY SYSTEM REFORM INCENTIVE PAYMENT (DSRIP) PROGRAM	Incentive payments to hospitals and other providers that develop programs or strategies to enhance access to health care, increase the quality of care, the cost-effectiveness of care provided and the health of the patients and families served.	Low Income Uninsured and Medicaid	Hospitals, Physician Practices, Community Mental Health Centers and Local Health Departments	Menu of measures developed/approved by HHSC (with stakeholder input) and CMS	Intergovernmental Transfer (IGT) for non-federal share, matched with federal funds
NETWORK ACCESS IMPROVEMENT PROGRAM (NAIP)	NAIP is designed to further the state's goal of increasing the availability and effectiveness of primary care for Medicaid beneficiaries by incentivizing health-related institutions (HRIs) and public hospitals to provide quality, well-coordinated, and continuous care.	Medicaid recipients	Health related institutions (HRIs) and public hospitals	MCOs, in conjunction with HRIs and public hospitals, are responsible for developing program methodology that furthers the state's objectives and complies with the general NAIP requirements set out by HHSC. For example, MCOs develop metrics by which to determine provider performance in the program. Further, the MCOs and providers must negotiate the amounts to be paid to providers when goals are achieved, and the frequency of those payments.	Intergovernmental Transfer (IGT) for non-federal share, matched with federal funds
QUALITY INCENTIVE PAYMENT PROGRAM (QIPP)	QIPP is designed to incentivize nursing facilities to improve quality and innovation in the provision of nursing facility services, using the CMS five-star rating system as its measure of success.	Medicaid Recipients in nursing facilities	Non-state government owned nursing facilities and private nursing facilities	1) High-risk residents with pressure ulcers; 2) percent of residents who received an antipsychotic medication (long-stay), 3) residents experiencing one or more falls with major injury, 4) residents who were physically restrained	Intergovernmental Transfer (IGT) for non-federal share, matched with federal funds
DUAL DEMONSTRATION PILOT	A joint Medicare and Medicaid demonstration designed to integrate care for Texas beneficiaries who have both Medicare and Medicaid. Beneficiaries participating in the Demonstration will receive both Medicare and Medicaid coverage, including Part D prescription drugs, from a single, integrated Medicare-Medicaid plan (MMP).	STAR+PLUS Dual Eligible enrollees > 21 years of age, reside in Bexar, Dallas, El Paso, Harris, Hidalgo, or Tarrant counties	All providers within MCO MMP networks	Developed by MMP MCO	Medicaid Financed by MCO premium dollars. State General Revenue (GR) for non-federal share, matched with federal funds. Medicare services funded by CMS.

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Appendix C. Summary of Texas Medicaid-CHIP MCO and DMO VBP Initiatives in 2016

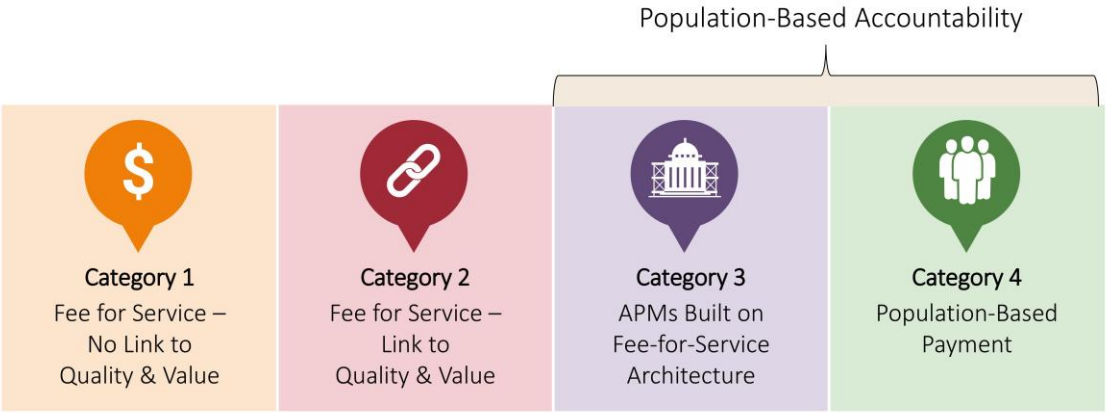
Introduction

There are multiple initiatives at national and state levels to move healthcare payments away from the customary volume-based FFS reimbursement model towards models that incentivize improved health care outcomes and increased efficiencies. In January 2015 the United States Department of Health and Human Services (HHS) set a goal of tying 30 percent of all traditional (FFS) Medicare provider payments to quality or value through alternative payment models, such as Accountable Care Organizations (ACOs), Patient Centered Medical Homes (PCMH) or "bundled payment" arrangements by the end of 2016, and tying 50 percent of payments to these models by the end of 2018.[i] HHS also set a goal of tying at least 85 percent of all traditional (FFS) Medicare payments to quality and value by 2016 and 90 percent by 2018 through programs such as the Hospital Value-based Purchasing[i] and the Hospital Readmissions Reduction Programs.[i]

These efforts go by various names, such as pay-for-performance (P4P), pay-for-quality (P4Q), value-based payments/purchasing (VBP), alternate payment models (APM), or value-based contracting (VBC). Texas at this time uses the term value-based contracting in its uniform managed care contract requirements.

As Medicaid-CHIP moves from volume-based payment to paying for value, HHSC would expect to see a gradual transition of payment models over the next few years following the Alternative Payment Models (APM) Framework (Figure 1).

Figure 1: APM Framework (At-a-Glance)



Source: Alternative Payment Model (APM) Framework and Progress Tracking Work Group

This framework has been created at the behest of CMS by the Health Care Payment Learning & Action Network. A more detailed view of the APM framework is available here, along with a white paper that explores the topic fully.

Overview of Submitted Plans

Texas HHSC requires all Medicaid-CHIP managed care organization (MCOs) and dental managed care organizations (DMOs) to submit an annual deliverable that details their various VBC initiatives. In 2016 all of Texas' 19 Medicaid-CHIP MCOs and both DMOs offer some form of VBC. For Texas Medicaid-CHIP health plans involved in the managed care model, value-based contracting approaches differ according to health plan size and level of VBC sophistication, composition/characteristics of provider network, geographic diversity, and beneficiaries' needs. The following is a summary of the reports received from the plans for 2016.

Geographic Diversity

In general, the VBC structures the MCOs implemented for their providers include all service delivery areas and programs in which they serve. The extent of geographic coverage depends on a plan's experience with payment reform. Some MCOs have had several years of experience and rolled out programs across larger geographic regions based on their successes, while other plans chose to start small with pilot programs. A smaller number of MCOs chose to be inclusive of their entire provider network within a service area and program. The local provider culture may also play a role in which VBC models expand within a region. It is well documented that primary care doctors are earning less than specialists, especially in regions where they are a common sight. Some managed care organizations started changing the way that doctors are paid and valuing primary care in a way that improves access and quality. For example, the Lower Rio Grande Valley and El Paso markets are known for expanded primary care clinic hours and walk-in appointments. In contrast, the Nueces region has a large penetration of the capitated model into primary care, so that the physicians can be paid on the number of members they are assigned.

Provider Types

The types of providers engaged in alternative payment structures proposed by MCOs varied. Some MCOs include all provider types in the network, while others have a limited type of providers that would serve a certain size of panel/membership. Minimum patient panel size is also a factor in participation in more sophisticated or risk-based VBC models. Examples would be using a FFS base with a bonus or a partial capitation model for small-to-medium size providers, with a fully capitated medical home or shared-savings ACO type of model for large multi-specialty practices. For one plan, qualifying providers must have a combined CHIP/STAR minimum panel size of 30 members. Another plan makes available to all physicians with a significant panel size and membership an incentive plan that encourages quality care. Other plans offer their physicians a fixed amount per-member per-month based on their panel size as an incentive for care coordination and management.

In addition to primary care providers such as family practice and general practice, specialist providers from internal medicine, OB/GYN, pediatrics, surgery, therapy services, durable medical equipment, and pharmacies were involved in the new VBC arrangements. In some instances, the type of providers and services selected in

the alternative payment models were influenced by MCO clinical (e.g. preventive versus acute care) and administrative priorities.

The number of providers participating in different MCO incentive programs often varied depending on whether the providers were engaged individually or in group practices. The number of participating providers ranged from few practitioners to entire provider groups (networks) with hundreds of physicians. In general, the larger the size of the physician practice or group (network), the more advanced the VBC approaches. Some sophisticate forms of VBC arranged with large medical providers may serve hundreds or even thousands of a plan's members. Forms of VBC that involve sophisticated population health management to facilitate shared savings (and perhaps downside risk) tend to need large patient panel sizes.

Members Impacted and Provider Payments Relative to MCO Capitation

There is an ongoing effort to estimate the number of potential members who may be associated with the new types of payment structures (relative to the total MCO membership in the respective plan) and the amount of money involved (relative to the MCO capitation amount of the respective plan) and the extent to which members may be impacted by the VBC arrangements. Such information can be calculated only when the overall membership and capitation amount of each MCO is known. HHSC is contemplating various evaluation methodologies for calculating VBC penetration rates. One way is to look at the number of members associated with the new types of payment structures. Another way is to evaluate the penetration by analyzing the funding spent in VBC out of the total MCOs revenue. These are complicated endeavors as the financial contractual agreements between MCOs and providers are confidential.

Care must also be taken to choose measures that don't inadvertently mislead rather than inform. For example, one type of VBC can give the impression of a very high rate of penetration with a small bonus on top of a standard FFS arrangement. However, there may turn out to be little positive change as a result of this arrangement. In the meantime a more robust program that targets a smaller population may have greater overall impact on the transformation of health care to a value-based model. One has to consider how all of the VBC efforts blend together and leverage each other, which may require a degree of subjective evaluation. There is a tipping point to be achieved where value overtakes volume and transformation starts to occur.

Common Measures Used

The MCOs generally use recognized quality indicators for determining triggers for incentives:

- Healthcare Effectiveness Data and Information Set (HEDIS) measures (such as well child visits, asthma care, HbA1c, prenatal/postpartum care, breast cancer screening, dental).
- Potentially preventable events like potentially preventable emergency department visits, potentially preventable hospital admissions, potentially preventable hospital readmissions, potentially preventable hospital complications and potentially preventable ancillary services
- Other administrative-related and accessibility based measures.

Payment Structures

As described by the MCOs, the types of alternative payment structures varied, but generally they were representing the following major combinations:

- FFS with bonus payments for achievement of a specific measure or measures, either for administrative activities (use of electronic health records, for example) and quality outcomes (such as HEDIS scores or lower emergency department use), or access to care (i.e., the practice accepts new Medicaid patients, offers same-day appointment options and/or expanded after-hours/weekend access)
- Partial capitation with or without bonuses for quality improvement and/or bundling of various medical episodes (such as a pregnancy or cardiac care) and various medical home models
- Shared savings approaches based on lowering their patient population total cost of care, reductions/avoidance in ER, admissions/readmissions or pharmaceutical spending.

It must be stressed there is often a combination of different payment models. The same MCO may have a provider receiving, for example, a capitated rate with a shared savings element. Various strengths and weaknesses of these VBC categories are described below.

FFS with Bonus Payments

Purpose: to compensate for achievement of a specific measure or measures, either for better administrative or quality outcomes, or increased access (such as well child visits or other timely visits, or expanded after-hours access). For instance, one MCO pays (among several items) a $10 for each adolescent well child visit, $20 for each prenatal and post-partum visit, and $25 for members with diabetes whose HbA1c (blood sugar level) is kept under control.

Strengths/benefits

- Relatively easy to implement for both the MCO and the provider.
- Can generally be done with administrative data.
- Minimal provider resistance, especially if done with few provider time/labor/resources required.
- Can be done with providers with smaller member panel sizes.
- Can be used to target a measure with special need for improvement, often with a focus on the measures used in the Medicaid-CHIP Pay-For-Quality program. This could include measures like Potentially Preventable Events (PPE) such as ED visits and hospital admissions/readmissions that could have been avoided though better care.

Weaknesses/challenges

- Payment incentives may not be big enough to change behavior. A minimum tipping point may be needed.
- Still rooted in FFS and continues the volume-based model.
- May not lead to notable practice management changes or population health management.

- Providers with very small panel sizes may not have enough numerator size to calculate some measures accurately.

Considerations

- While a straightforward approach is relatively easy to implement, the gains may be minimal without a lot of MCO work with the providers. Practice transformation assistance is important no matter what VBC model is implemented.
- The MCO may place requirements for providers to participate in their incentive program, such as having an open panel (accepting new Medicaid patients) or extended clinic hours. A provider would have to agree to these items as a pre-condition to access the bonus payment program.

Number of MCOs using it

- Very common, as at least ten health plans have adopted this model.
- May be used as a first effort or as part of a suite of incentive programs.

Partial Capitation (+/-) with or without Bonuses

Purpose: Incentivize for quality and/or bundling of various medical episodes (such as a pregnancy or cardiac care) and various medical home models.

Strengths/benefits

- Can generally be implemented with administrative data, but EHR and HIE are often used as leverage
- Can still be done with providers with somewhat smaller member panel sizes. However, the benefits of the model increase as panel size gets larger
- Creates incentives for improved practice management changes and population health management
- If done properly, provides an incentive to manage a population efficiently
- Can be scaled, from relatively small PMPM bonus amounts for simple improvements progressively to advanced models where capitation covers a large portion of the provider's revenue
- Moves away from being rooted in FFS and continues the evolution toward a more complex value-based model

Weaknesses/challenges

- PMPM payment incentives must be significant enough to change behavior
- The provider must commit to the work involved in implementing the model. This is a major change in how their practice operates
- Providers with very small panel size of members may not have large enough numerators to calculate some measures accurately

- MCOs may have difficulty doing the practice transformation work with providers with small panel sizes. The health plans need a certain critical mass of members to justify the resources involved
- May be faced with more provider resistance and require much more provider time/labor/resources to do effectively
- Can require much more involvement to implement from both the MCO and the provider

Considerations

- Practice transformation assistance from MCOs becomes very important as providers move to capitation
- MCO must commit to supporting the model with actionable data for providers to manage a population
- Capitation can be coupled with shared savings
- Requires multiple considerations on the part of the MCO when establishing the capitation for providers and the expectations involved for earning it

Number of MCOs using it

- Not as common, though growing, at least six plans have implemented it.
- There are regions of the state with greater penetration of this model, such as in the Nueces area.

Shared Savings Approaches

Purpose: Compensation based on lowering total cost of care, reductions/avoidance in ER, admissions/readmissions or pharmaceutical spending

Strengths/benefits

- Can generally be implemented with administrative data, but EHR and HIE are often used as leverage. ADT feeds are seen as highly important. This model requires permanent data flow
- Can be done with providers with somewhat smaller member panel sizes. However, the benefits of the model increase as panel size gets larger
- May create the strongest incentives for improved practice management changes and population health approach
- When done properly, may create the highest incentive to manage a population efficiently
- The amount of shared savings in play and what counts for/against the calculation can be customized. It can vary from simple structures all the way to ACO (like) arrangements
- Moves away from being rooted in FFS and continues the evolution toward a complex value-based model

Weaknesses/challenges

- The shared savings amounts must be significant enough to change provider behavior
- The provider and the MCO must both commit to the work involved with leveraging this model to maximize the benefits

- Providers with very small panel sizes may not have large enough numerators to calculate some measures accurately
- MCOs may have difficulty doing the practice transformation work with providers with small panel sizes. Health plans need a certain critical mass of members to justify the resources involved
- May be more provider resistance and may require much more provider time/labor/resources to do it effectively. The upside of greater revenue has to offset the additional time/labor/resources required

Considerations

- Practice transformation assistance from MCOs becomes very important as providers move to a shared savings model
- MCO must commit to supporting the model with actionable data for providers to manage a population
- Shared savings can be coupled with capitation
- Requires a lot of consideration on the part of the MCO when figuring out the shared savings for providers and the expectations involved for earning it
- HHSC may also have a greater role in data sharing through efforts like the ongoing hospital admissions-discharge-transfer (ADT) feeds project. Timely data is critical to a population-health management model

Number of MCOs using it

- Not as common, though growing, as at least six plans have embraced this model. How common it is really varies by how mature the model is at the time of deployment. Simple shared savings approaches are more common, though ACO arrangements also growing. Since the practice is only at risk for additional revenue through the shared savings, the practice is only sharing in the upside risk.
- Mostly lends itself to large multi-specialty practices with substantial panel sizes. However, may also be used with large single specialty practices, such as Ob/Gyn.

Summary of Common Considerations for VBC Models

- Regardless of the model chosen, there must be a sufficient incentive or disincentive (i.e., a tipping point) to change provider practice management/behavior. This may vary by the provider type, region, or other considerations.
- Gains may hinge as much on the support/collaboration between the MCO and the providers as much as on the specifics of the model. As the MCO and provider's VBC relationship matures, there is a fundamental change in how they do business together. An MCO is no longer just paying a provider, as the provider is now the MCOs partner. A trusting relationship and continuous dialogue between payers and providers is critical to success.
- The switch to a value-based model has implications for HHSC, ranging from MCO capitation rate calculation to selection/use of quality improvement measures. HHSC may have a role in facilitating data sharing, promoting best practices, researching outcomes, and the development of quality measures that mesh with a health plan system. Of particular importance is ensuring that success in payment reform is rewarded and not penalized.

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- A larger issue is that MCO rate-setting is still built largely on paying for member's medical care (i.e., paying for illness). The Legislature, stakeholders and HHSC will have to contemplate on what a future Medicaid-CHIP financial system that pays for optimizing "health" looks like when setting MCO payments and moving toward better systems of care.
- As VBC models mature, there is a growing awareness of a combination between medical care and social services for the Medicaid-CHIP beneficiaries. The managed care industry and the Medicaid-CHIP Program are grappling with how to reconcile the needs of a whole person with the current health care approach which seem fragmented. This issue is common across multiple states and is also on CMS's radar. This has implications for multiple business units in the State Health and Human Services System.
- An advantage Texas has is a large number of Delivery System Reform Incentive Payment (DSRIP) projects and a well-organized set of Regional Healthcare Partnerships within the healthcare transformation initiated by the 1115 Waiver Demonstration Project. DSRIP helps create a collaborative atmosphere that could help advance VBC. The efforts underway in various RHPs to bring MCOs and DSRIPs together are promising. The RHP infrastructure helps support these efforts.

Conclusion

All MCOs and DMOs providing services to members in Texas Medicaid and CHIP have some level of VBC with their providers. While VBC efforts may vary in size and scope across the MCOs, the evidence is clear that the Texas Medicaid and CHIP market is continuously shifting towards outcomes-based payments. This creates changes in how plans and providers work together (payer vs. partner), the mindset (individual patient encounters vs. population health management), and the overall goals of the health care system (largely acute sick care vs. promoting prevention and better overall health).

Appendix D. Acronyms

ACO - Accountable Care Organizations

AHC - Accountable Health Communities

APM - Alternative Payment Models

CCBHC - Certified Community Behavioral Health Clinics

CHIP - Children's Health Insurance Program

CMS - Centers for Medicare and Medicaid Services

DSRIP - Delivery System Reform Incentive Payment Program

EQRO - External Quality Review Organization

HHSC - Health and Human Services Commission

IGT - Intergovernmental Funds Transfer

LAN - Learning and Action Network

MCO - Managed Care Organizations

NAIP - Network Access Improvement Program

PIP - Performance Improvement Projects

PPC - Potentially preventable complications

PPR - Potentially preventable readmissions

QIPP - Quality Incentive Payment Program

URHIP - Uniform Hospital Rate Increase Program

VBP - Value-Based Purchasing

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