Medicaid Quality and Value-Based Care

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Medicaid quality
Healthcare Quality Plan (Senate Bill 200)

• Improve the effectiveness of healthcare quality initiatives across HHS system agencies, emphasizing accountability by individuals, payers, providers, and health related public programs.

• Target improvement efforts on value rather than on quality or cost containment alone.

• Build on existing initiatives that support the transformation of healthcare from a volume to a value-based system.

Value-Based Care
Measured in three dimensions, not just quality or cost.

Source: Institute for Healthcare Improvement
Healthcare Quality Plan
Strategic priorities

1. Keeping Texans healthy.
2. Providing the right care in the right place at the right time.
3. Keeping patients free from harm.
4. Promoting effective practices for chronic disease.
5. Supporting patients and families facing serious illness.
6. Attracting and retaining high performing providers and other healthcare professionals.
## Value-based care
Nine programs and initiatives

| 1. | MCO/DMO Pay-for-Quality (P4Q) |
| 2. | MCO Alternative Payment Models (APM) |
| 3. | Hospital Quality Payment Program |
| 4. | Delivery System Reform Incentive Payment (DSRIP) Program |
| 5. | Nursing Home Quality Incentive Payment Program (QIPP) |
| 6. | Value-Based Payment (VBP) Toolkit for Stakeholders |
| 7. | MCO Performance Indicator Dashboard |
| 8. | Texas Healthcare Learning Collaborative Portal |
| 9. | Advisory Committees and Workgroups |
Medical P4Q program

- 3.0% of MCO capitation is placed at risk, contingent upon performance on quality measures.

- MCO performance is evaluated in three ways:
  1. Performance compared to benchmarks
  2. Performance compared to self
  3. Bonus Pool measures
     - Examples: Percentage of low-birthweight births (STAR); Member access to urgent care (per survey).
     - Remaining funds after recoupments and distributions from 1 and 2 yield a pool of funds for incentive payments to MCOs that excel on Bonus Pool measures.

- The 2018 medical P4Q program measures focus on prevention, chronic disease management (including behavioral health), and maternal and infant health.

Dental P4Q program

• 1.5% of each DMO’s capitation is at risk.

• DMOs no longer receive up-front adjustment for potential increased utilization.

• DMO performance compared to performance from two years prior.

• 2018 dental P4Q measures were selected to focus on annual oral evaluations and primary prevention against dental caries (cavities).

• Measurement year began January 1, 2018.
MCO Alternative Payment Models

Requirements

Contract requirements include:

• Exceptions for high quality
• Penalties for low performance
• Provider data sharing

Goal:
Mutual progress – by MCOs and providers – along the continuum of alternative payment models through aligned incentives.
MCO Alternative Payment Models Requirements

- HHSC MCO contract requires a minimum percentage of provider payments linked to quality-based Alternative Payment Models (APMs).

- Measurement year began in January 2018, to coincide with P4Q start date.

- Annual percentage increases to 4th year target.

<table>
<thead>
<tr>
<th>Period</th>
<th>Minimum Overall APM Ratio</th>
<th>Minimum Risk-Based APM Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1  (CY 2018)</td>
<td>&gt;= 25%</td>
<td>&gt;= 10%</td>
</tr>
<tr>
<td>Year 2  (CY 2019)</td>
<td>Year 1 Overall APM % +25%</td>
<td>Year 1 Risk-Based APM % +25%</td>
</tr>
<tr>
<td>Year 3  (CY 2020)</td>
<td>Year 2 Overall APM % + 25%</td>
<td>Year 2 Risk-Based APM % + 25%</td>
</tr>
<tr>
<td>Year 4  (CY 2021)</td>
<td>&gt;= 50%</td>
<td>&gt;= 25%</td>
</tr>
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Value-based care
Challenges

The shift to value-based care is an evolutionary change to the entire healthcare system.

- **HHSC Role: directive v. permissive**
  - Directive: consistency for providers
  - Permissive: facilitates MCO innovation

- **Varying levels of provider readiness for alternative payment models**
  - Rural and small providers
  - Risk-based payment models

- **Health Information Technology**
  - Transformed healthcare system is dependent on good data, interconnectivity, analytics, and security.
Value-based care
Next steps and recommendations

Collaborate with stakeholders to advance value-based care:
  - Align quality measures and reduce administrative complexity.
  - Develop tools to support stakeholders at every juncture of the delivery system.

Develop sustainable financing models that align financial incentives to reward success.

Improve state data and system capabilities to support and monitor value-based care initiatives.
State agency collaboration
Article IX, Special Provision 10.06

Workgroup of state agencies that have large, state-funded healthcare expenditures:

*HHSC, DSHS, ERS, TRS, and TDCJ*

**Objectives:**

Develop recommendations and a comprehensive plan for integration of data to support analyses.

Identify potential opportunities for improved quality and efficiency of health care.

**Output:**

Report to the Legislature in May 2018 with:

- Costs for recommendations and plan;
- Any necessary statutory changes; and
- Potential impacts to data governance planning at each agency.
State agency collaboration
Article IX, Special Provision 10.07

Cross-agency Collaboration on Value-based Payment Strategies:

*HHSC, ERS, and TRS*

- Developing potential value-based payment strategies, including opportunities for episode-based bundling and pay for quality initiatives.
- Cross-agency collaboration on these strategies is ongoing.