Texas Medicaid Project to Advance Value Based Care
Dr. Mark McClellan
February 16, 2018
Today’s Goals

1. Brief refresh on national and Texas Medicaid context for value based payment (VBP)
2. Update on Dell Med/EHF project with Texas Medicaid, including December symposium
3. Options to advance VBP in Texas Medicaid
4. Discussion
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.
Healthcare and the Federal Budget

Source: Congressional Budget Office, 2017 Long-Term Budget Outlook.
Medicaid is a Growing Share of the Texas State Budget
(in Billions)

Texas Medicaid and CHIP in Perspective, HHSC, February 2017
Alternative Payment Models (APMs)

Traditional

Category 1
Fee for Service – No Link to Quality & Value

Category 2
Fee for Service – Link to Quality & Value

Category 3
APMs Built on Fee-for-Service Architecture

Category 4
Population-Based Payment

“Pay for Performance”

Payment linked to patient not services:
Limited
More Complete
The Alternative Payment Model framework is a step toward the goal of better care, smarter spending, and healthier people...

- For payment reform capable of supporting the delivery of person-centered care
- For generating evidence about what works and lessons learned
2016 LAN Payer Survey

40 HEALTH PLANS and TWO Medicaid States, responded directly to the LAN.

Representing over 128 MILLION AMERICANS, and...

Approximately 44% of the COVERED POPULATION

LAN PARTICIPANTS BY SERVICE LINE

<table>
<thead>
<tr>
<th>Service Line</th>
<th># of Plans</th>
<th>Covered Lives</th>
<th>% of Covered Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>COMMERCIAL</td>
<td>26</td>
<td>90M</td>
<td>44%</td>
</tr>
<tr>
<td>MEDICARE ADVANTAGE</td>
<td>23</td>
<td>10M</td>
<td>58%</td>
</tr>
<tr>
<td>MEDICAID</td>
<td>28 +2 FFS States</td>
<td>28M</td>
<td>38%</td>
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TRADITIONAL MEDICARE

- 38 Million Medicare FFS beneficiaries
- 100 % of the covered population
2016 Results

25% ...

In Categories 3 & 4

% of Healthcare Dollars

22% COMMERCIAL
41% MEDICARE ADVANTAGE
18% MEDICAID
30%* TRADITIONAL MEDICARE

*The “25%” above does not include the “30%” traditional Medicare.
Value-Based Payment and HHSC

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

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

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

• Starting this year, a certain percent of each health plan’s payments to providers must be in quality based payment models/alternative payment models, with possible health plan monetary penalties if thresholds aren’t met. Thresholds increase over time.

• New Quality Improvement category allowed to be counted as medical (vs. administrative) expenses.

• Three (3) percent of each health plan’s payment is at risk for a Pay for Quality (P4Q) program, so certain outcome measures must be met to earn these funds.
VBP Contractual Targets for Managed Care Plans

Contract change to establish managed care organization (MCO) VBP targets as of 9/1/2017

• Overall and Risk based VBP contractual targets based on MCO expenditures on VBP contracts relative to all medical expense

• The targets began September 1, 2017 (FY2018 contract year) with 25% overall VBP and 10% Risk Based VBP in FY2018

• These targets increase over 4 years to 50% overall VBP and 25% Risk Based VBP in FY2021

• Requires data/report sharing between MCOs and providers

• To the extent possible, MCOs within service areas should collaborate on development of standardized formats for the provider performance reports and data requested from providers
Quality Improvement Costs

Effective FY17, the MCO contracts allow certain quality improvement costs to be included as covered services when calculating the capitated rate.

Eligible expenses must increase the likelihood of good health outcomes and be grounded in evidence-based medicine or widely accepted best clinical practices.

Examples of activities

- Case management, chronic disease management, care coordination
- Patient-centered education and counseling
- Quality reporting
- Discharge planning
- Health information technology to support these activities

*Full definitions in §45 CFR 158.150 and 151*
## P4Q Program: STAR Measures

<table>
<thead>
<tr>
<th>STAR At-Risk Measures</th>
<th>STAR Bonus Pool</th>
</tr>
</thead>
<tbody>
<tr>
<td>Potentially Preventable Emergency Room Visits (PPVs)</td>
<td>Potentially Preventable Admissions (PPAs)</td>
</tr>
<tr>
<td>Appropriate Treatment for Children with Upper Respiratory Infection (URI)</td>
<td>Low Birth Weight (LBW)</td>
</tr>
<tr>
<td>Prenatal and Postpartum Care (PPC)</td>
<td>CAHPS Children with good access to urgent care (child)</td>
</tr>
<tr>
<td>• Timeliness of prenatal care</td>
<td>CAHPS Adults rating their health plan a 9 or 10 (adult)</td>
</tr>
<tr>
<td>• Postpartum care</td>
<td></td>
</tr>
<tr>
<td>Six or more Well Child Visits in the First 15 months of Life (W15)</td>
<td></td>
</tr>
</tbody>
</table>
### P4Q Program: STAR+PLUS Measures

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

Pick 1-3 focused areas and take concrete next steps to advance VBP in those areas.

DO SOMETHING.
High-Impact Areas of Opportunity

• **Data sharing initiatives** with plans, providers and consumers to support care coordination
  – *Lack of access to data is a barrier to providers and without data, population health management is impossible.*

• **Value-based maternity/newborn care** - Consider an HHSC-supported episode of care with provider incentives based on quality and cost
  – High volume, high cost area for Texas Medicaid with below average outcomes and significant variation in services

• **Patient centered medical homes/health homes** (including integrated behavioral health and screening for social determinants)
  – Many current MCO incentive programs focus on primary care and chronic care management incentives, and DSRIP focused heavily on health homes and integrated care

• **Telemedicine/telehealth**
  – Potential to increase access through telemedicine/telehealth, spurred by SB 1107
High-Impact Areas of Opportunity

• **Foundational steps to VBP for small and rural providers**
  – Small and rural providers have fewer resources to transform their practices, so need support to engage with health plans in VBP arrangements

• **Feasible steps to support investments in integrating medical and social services to address social determinants of health care utilization and outcomes for high-risk individuals**
  – *There is emerging evidence that addressing health-related social needs through enhanced clinical-community linkages can improve health outcomes and reduce spend, particularly for high needs, high cost patients*

• **Next phase of DSRIP** – How it can be leveraged to advance value-based purchasing
  – During the next few years, TX stakeholders need to collaborate to sustain successful DSRIP initiatives and build on DSRIP’s increased access and improved outcomes for Medicaid and the uninsured.

• **Opioid overuse and management**
  – Medicaid should explore VBP models to support improved treatment and access to medication assisted therapy.
Initial Options to Consider to Help Advance VBP in Texas Medicaid Information Sharing (Transparency and Stakeholder Involvement)

- Establish a standard webinar series to share best practices from around the state and country on various VBP related topics.
- Facilitate more face-to-face meetings.
  - Workgroup of health plan and provider representatives to have more detailed discussions of barriers and opportunities
  - Pilot meetings in 2-3 managed care service areas for health plans and providers to discuss VBP initiatives
  - Smaller workgroup meetings on specific topics (e.g., maternity episode based payment bundles, how to leverage the new Medicaid Quality Improvement cost category to support high-value, non-billable services; what’s high opportunity and viable for small providers and in rural areas to advance VBP)
Initial Options to Consider to Help Advance VBP in Texas Medicaid
Information Sharing (Transparency and Stakeholder Involvement)

Areas in which HHSC could provide more information and guidance to help health plans and providers

• At a high level, share the types of value-based purchasing arrangements each health plan has adopted in each service delivery area

• Compile Texas Medicaid VBP Toolkit to help plans, providers and others understand HHSC’s VBP strategy and how best to engage. Possible new materials include:
  – Summary information on VBP arrangements by health plan and service area
  – Layperson’s guide to the THLC portal
  – Texas Medicaid VBP “Myths and Facts” similar to summary used by NY Medicaid
Initial Options to Consider to Help Advance VBP in Texas Medicaid
Data Sharing to Support Care Coordination

• Explore options to further leverage the Texas Healthcare Learning Collaborative portal. (Convene user workgroups to determine what might be most helpful for plans and providers.) For example:
  – Standardized measure dashboard for HHSC key outcome measures (by provider across health plans)
  – Show provider-specific measure information across an SDA (e.g. PPR rates by hospital in STAR PLUS Harris SDA)
  – Pilot sharing provider-specific information on a targeted area via the portal, e.g. maternity/newborn care information (similar to information used for the Community Health Choice pilot)
  – Primary C-section rates by hospital
Initial Options to Consider to Help Advance VBP in Texas Medicaid
Data Sharing to Support Care Coordination

• Develop an effective implementation plan for HHSC’s Medicaid HIE funds available in the near term to:
  – help connect providers to HIEs,
  – connect HIEs to HIETexas, and
  – support transmission of admit, discharge and transfer (ADT) data for care coordination.
• Leverage the HIE Strategic Plan requirement in the recently approved 1115 waiver renewal to build a strong Medicaid HIE foundation to enable VBP.
  – The state will use Health IT to link services and core providers across the continuum of care to the greatest extent possible. The state is expected to achieve minimum standards in foundational areas of Health IT and to develop its own goals for the transformational areas of Health IT use.
Maternal/Newborn Care

Maternal and newborn care is one clinical area where Medicaid is well poised to drive change as the major payer for services.

- In 2014, Texas Medicaid covered 54 percent of all births and spent over $1 billion on newborn care.
- Texas rates for pre-term births, low birth weight babies, and maternal mortality are above national averages.
- The Texas NICU Project, which is still in process, so far has found significant Medicaid variations across regions and hospitals in service utilization. Relatively little of the variation is explained by risk differences.
- Texas leadership and stakeholders recognize the importance of continuing to collaborate to make improvements in maternity care.
Maternal/Newborn Care

The Health Care Payment Learning and Action Network recognizes maternity care as one of the areas with greatest potential for episode-based payment to improve patient care, increase coordination across services and providers, and lower costs. Episode-based payment is particularly effective where there are high costs, or when there is significant variation in the cost associated with managing a particular condition or treatment.

Maternity episode payment has been implemented by commercial payers and Medicaid programs (TN, AK, OH). TN Medicaid and Horizon BCBS of NJ have demonstrated savings.

One STAR health plan, Community Health Choice, has a maternity/newborn episode-based payment pilot underway with UTMB and UT Health physician groups in Southeast Texas.

– The partners are enthusiastic about the pilot and publishing their results.
– Early lessons learned: importance of: timely data to providers, strong communication with practitioners and patients, and flexibility. Collecting consistent quality data across clinics can be a challenge.
Maternity and Newborn Episode

Key:
- Irrelevant
- Either typical or PACs
- Claims with potentially avoidable complications (PACs)
- Claims for typical care and services

- Episode is triggered by delivery
- Services for the Mother are evaluated as typical (e.g. ultrasound, anesthesia, office visits, etc.) or complications (obstetrical trauma, fetal distress, c-section in low risk pregnancy, etc.)
Initial Options to Consider to Help Advance VBP in Texas Medicaid
Maternal/Newborn Care

- HHSC development and endorsement of a maternity/newborn episode of care payment bundle similar to the model being piloted by Community Health Choice.
- Start by tracking total cost of care for maternity episodes (risk adjusted) by provider group & reporting on a few core measures.
- Convene a targeted group of stakeholders to discuss possible next steps.
- Pilot sharing provider-specific information on a targeted area via the portal, e.g. maternity/newborn care information (similar to information used for the Community Health Choice pilot).
DSRIP 2.0

• CMS approved a 5-year renewal of the TX 1115 waiver in December.
• DSRIP providers will have the ability to earn DSRIP funds over the next four years, primarily for reporting on and achievement of outcome measures.
• Texas must submit a transition plan to CMS by October 1, 2019, describing how the state will further develop its delivery system reform efforts without separate DSRIP funding and/or phase out DSRIP funded activities. Milestones may relate to the use of alternative payment models, the state’s adoption of managed care payment models, payment mechanisms that support providers’ delivery system reform efforts, and other opportunities.
  – A challenge of integrating DSRIP into Medicaid managed care is that DSRIP initiatives benefit not only Medicaid enrollees, but also the low income uninsured along with Medicare and commercial patients.
Determinants of Health Outcomes

Determinants of Health and Their Contribution to Premature Death

- Genetic predisposition: 30%
- Behavioral patterns: 40%
- Social circumstances: 15%
- Environmental exposure: 5%
- Health care: 10%


- Sexual Behavior: 20
- Alcohol: 35
- Motor Vehicle: 41
- Guns: 29
- Drug Induced: 17
- Obesity and Inactivity: 365
- Smoking: 435

Adapted from Mokdad et al.
Social Determinants

There is emerging evidence that addressing health-related social needs through enhanced clinical-community linkages can improve health outcomes and reduce spend—particularly for high needs, high cost patients

- Individual health plans and providers already are working to address social determinants of health together with community partners.
- Much DSRIP work includes “connecting” services that help address social determinants and often are not billable (e.g., peer support specialists, community health workers, patient care navigation, housing supports).
  - DSRIP projects that address Medicaid high-cost, high-needs patients (often STAR+PLUS enrollees), such as patient navigation projects, may be particularly well suited for Medicaid VBP and include activities that appear to fall under Medicaid Quality Improvement costs.
Initial Options to Consider to Help Advance VBP in Texas Medicaid

DSRIP 2.0 / Social Determinants

- Identify best and promising practices from DSRIP (better evaluate available data from DSRIP initiatives)
- Explore post-DSRIP options to continue strong behavioral health-related DSRIP work (e.g. integrated behavioral health/primary care, Certified Community Behavioral Health Clinics [CCBHC]).
- Provide more guidance on how health plans can pay for currently non-billable, high value services as part of their VBP arrangements.
  - Targeted meetings with HHSC, health plans, and providers to inform the post-DSRIP sustainability plan.
  - One high opportunity area could be patient navigation to assist individuals with high cost/high utilization of services. This was a focus of many DSRIP projects, and also is the focus of upcoming Performance Improvement Projects by the health plans.
- Consider Pay for Success models to test and evaluate whether targeted interventions are effective and save money (e.g. SC Medicaid nursing home visiting program expansion).
Initial Options to Consider to Help Advance VBP in Texas Medicaid

Reduce Administrative Burdens

• Relying on national approaches, work with health plans and providers to develop approaches that reduce administrative burden and facilitate VBP participation. (See provisions in SB 200 for HHSC to pilot a standardized VBP model across health plans in a service area and language in current HHSC managed care RFPs about working to align select VBP efforts across plans.)

• Work with HHSC and TX HHS OIG to provide additional guidance on what types of administrative burden reduction are allowable VBP strategies (e.g. reduced prior authorization requirements for high quality providers).
Discussion

• How best to advance VBP in TX Medicaid to improve outcomes and spending?
  – Information and data sharing
  – Maternal/newborn care
  – DSRIP 2.0 / Social determinants of health
  – Reduce administrative burdens

• Potential to drive broader reforms, including through multi-payer initiatives and to affect the quality and cost of care for the uninsured?