MCO and DMO Value-Based Contracting
Evaluation Summary for Plans Received November 2014

Introduction

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

For Texas Medicaid-CHIP in the managed care model, value-based approaches differ according to health plan size, population health needs, and provider capacity. The following table indicates what HHSC would expect to see over the next few years as Medicaid-CHIP moves from volume-based to paying for value.

Volume-Based	**Supporting Quality Improvement**		**Paying for Higher Quality**		**Paying for Value**		
Fee-for-Service	**Pay for Reporting**	**Care Coordination Payments**	**Pay for Performance**	**Shared Savings**	**Bundled Payments**	**Full or Partial Capitation**	**Full Risk Model**
Rewards volume, not quality Does not support coordination across providers	Process Measures Outcome measures Registry participation	Patient Centered Medical Homes Health Homes	Bonus payments for quality/ outcomes Penalties for potentially preventable events	Spending targets Up and downside risk	Can include one setting of care (e.g., hospital only) or cross settings of care (hospital & post-acute) Pathway to full capitation	Generally used across settings of care, e.g., all physical health & behavioral health services. Can have certain services carved out that still are paid as FFS.	Providers at full risk

Overview of Submitted Plans

Of the value-based contracting (VBC) plans submitted by the 19 managed care organizations (MCOs) that provide Texas Medicaid-CHIP, two had no plan for SFY 2014 and have not finalized a plan for SFY 2015. One MCO developed a plan for SFY 2014, but was unable to deploy it and did not develop any other plan for SFY 2015. The plans submitted by the two dental maintenance organizations had information for SFY 2014 and 2015.

Geographic Diversity

In general, the alternative payment structures the MCOs implemented for their providers include all service areas and programs in which they serve. The extent of geographic coverage depends on a plan's experience with this payment reform strategy. Some plans have had several years of experience and are rolling out programs based on their successes, while other plans chose to start small with pilot programs. A smaller number chose to be inclusive of their entire provider network within a service area and program.

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 only a limited number of providers that would serve a specified

size of panel/membership ranging from 130 to 750 members. In addition to primary care providers such as family practice and general practice, specialist providers from internal medicine, OB/GYN, pediatrics, surgery and pharmacies were involved in the new payment arrangements. In some instances, the type of providers and services selected in the alternative payment structures were influenced by MCO clinical and administrative priorities (e.g., preventive versus acute care).

Payment Structures

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

- FFS with bonus payments for achievement of a specific measure or measures, either for administrative or quality measures, or access (such as well child visits or other timely visits, or expanded after-hours access)
- Partial capitation with or without bonuses for quality
- Shared savings approaches based on reductions/avoidance in ER, admissions/readmissions or pharmaceutical spending
- Pay for Performance with FFS claims or capitation.

The table below shows the different strategies used by Medicaid-CHIP MCOs:

Capitation only												x					x	
FFS + Bonus			x			x			x						x			
FFS + Bundled Payment												x						
FFS + Capitation			x															
FFS + mgmnt fees + P4P bonus															x			
FFS + shared savings												x						
FFS only		x										x						
FFS+ Pay For Performance													x					
FFS+Bonus										x			x					x
Global payment (some)										x		x						
Non-financial												x						
Other														x				
P4P + shared savings															x			
Pay for Performance only	x				x	x	x	x			x				x	x	x	
Supplemental								x										

Pool of Providers

The number of providers participating in MCO incentive programs varied depending on whether the providers were engaged individually or in group practices. This ranged from one provider group to more than 700 providers. One plan reported their incentives covered providers for more than 70 percent of all members.

Members Impacted and Provider Payments Relative to MCO Capitation

There was an effort to estimate the number of potential members who may be impacted by these types of payment structures (relative to the MCO membership) and the amount of money involved (relative to the MCO capitation amount). Such information can be calculated only when the overall membership and capitation amount of each

MCO is known. Generally, these estimates suggest that the money and the number of members impacted are low relative to overall capitation payments and membership (except for subsets of members such as pregnant women).

Metrics Used

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

- HEDIS measures (well child, asthma care, HgbA1c, prenatal/postpartum care, breast cancer screening, dental)
- Potentially preventable hospital admissions, readmissions, and emergency department visits
- Others: admin related and accessibility.

MCO Evaluation Plans

As HHSC reviews MCOs evaluation strategies for assessing the impact of value-based contracting, HHSC is recommending that MCO Evaluation plans become more rigorous in empirically determining the expected proportion of reduction or improvement in the agreed upon rate and/or establish with the providers what is the intended metric expectation.

Promising Practices

Compensation for improved quality care is a multifaceted issue that can be related to either the provider or the beneficiary. One plan found the best incentive was to show providers how they compared to their peers, with concrete and mutually acceptable data[1]. The competitive nature of providers means they will then want to know who did better and reach out for new approaches. The added compensation was seen as a means to 'make them whole' and enhance the ability of the practice to provide better quality rather than as a reward for meeting a process metric.

Two plans tried to stimulate provider performance by increasing member compliance through gift cards for getting to their appointments. The plans reported that members are much more receptive when receiving appointment reminders from the providers and not from the plan. However, such an approach implies collaboration between the plan and provider to improve health outcomes.

Not all payment incentives need necessarily be centered on clinical outcomes. One plan is incenting providers to use the plan's portal for record submissions, decreasing the data lag and cost to the plan. Providers reported that use of the portal reduced their workload and increased their practice efficiency.

Tiered payment approaches appeared to motivate providers to continually improve their practice approaches to achieve incremental changes. However, most plans used a "met/did not meet" method which providers find less compelling or rewarding.

Plans noted a person-to-person approach with providers who did not meet standards, focusing on the provider's lost opportunities for added reimbursement. One example noted was a provider who had a high hospital admission rate. After the plan presented the hospital admission information to the provider there was a change in the provider's practice approaches and a marked decrease in hospital admissions. Plans that proactively worked with providers to improve use of data and modify practice workflows and processes appear to have had better provider engagement. In one plan, a provider utilized the incentive payment to build out their technology infrastructure.

Conclusions

A majority of the MCOs support the Quality Improvement Initiatives and focused on the measure included in the four percent At-Risk set of measures. Most alternative payment arrangements included primary care physicians/providers and obstetricians-gynecologists with panels of 75-100 members. Overall the directionality of process, measurement and financial commitments on behalf of the MCOs in supporting the value-based/focused contracting efforts with their contracted providers is positive and increasing for FY 2015.

[1] http://www.advisory.com/research/medical-group-strategy-council/practice-notes/2015/physician-compensation-and-motivation