



# The University of Texas at Austin Dell Medical School

Alternative Payment Models and DSRIP

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HEALTH

COMMUNITY

CARE

Rethink **Everything**

EDUCATION

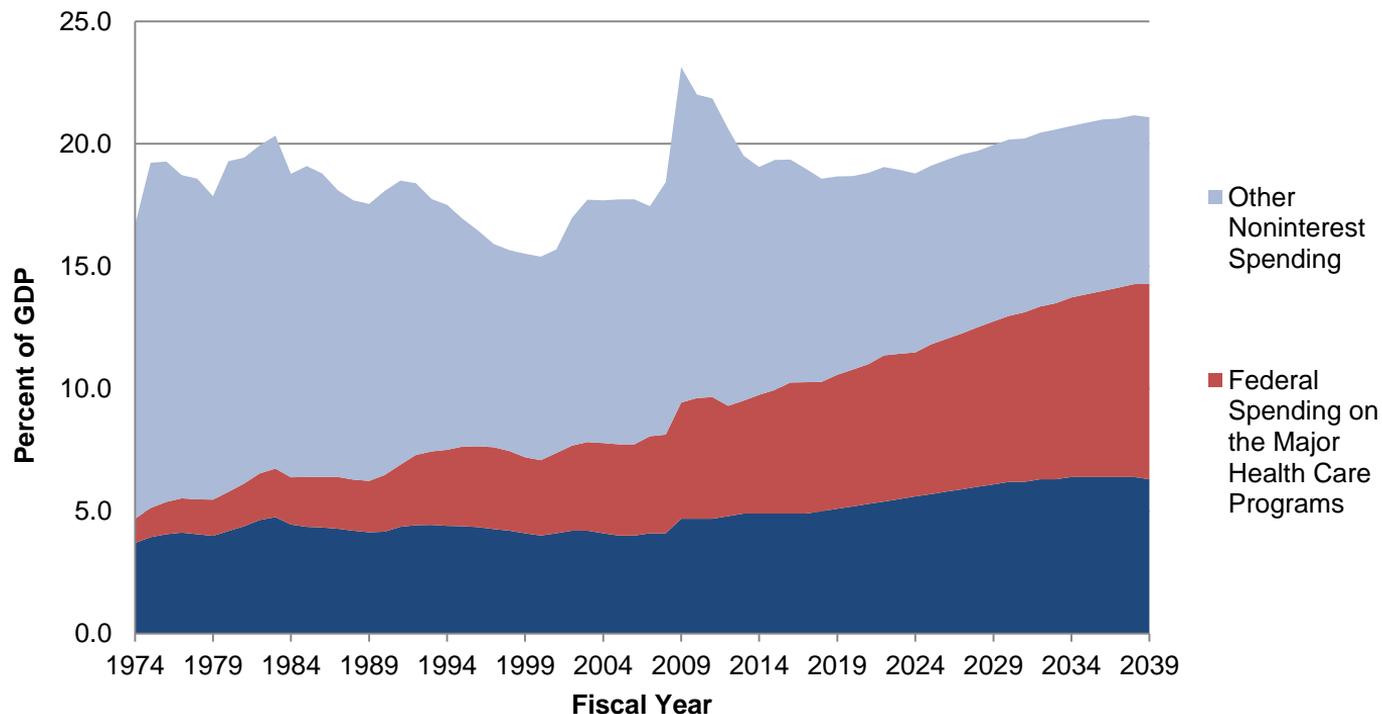
RESEARCH

INNOVATION

- Value-based care
- Alternative payment models
- Possible next steps for the Delivery System Reform Incentive Payment (DSRIP) program

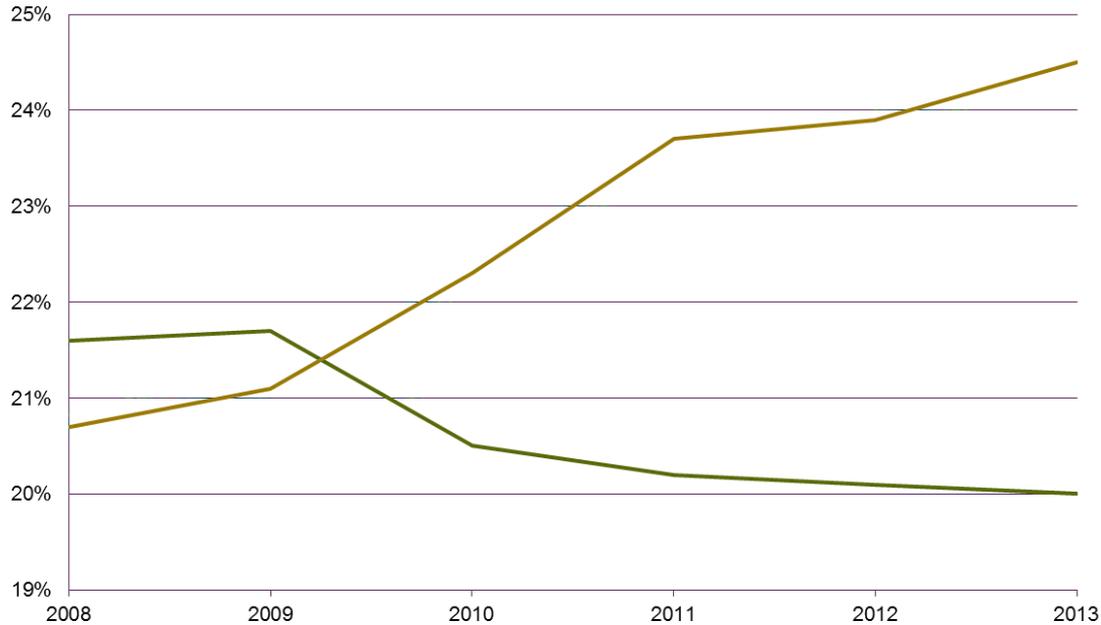
# Why focus on value-based care?

## Long-Term Federal Spending Projections, 1974-2039



Source: Congressional Budget Office, 2014 Long-Term Budget Outlook.

## State Expenditures on Medicaid and K-12 Education



Source: NASBO State Expenditure Reports



Better health is **inherently less expensive**  
than poor health.

$$\text{Value} = \frac{\text{Health Outcomes that matter to patients}}{\text{Cost of delivering the outcomes}}$$

**The most powerful way to increase value is to improve outcomes in ways that reduce costs.**

Cost containment is not the **only** goal

*The goal of health care  
is **BETTER HEALTH***



We need to measure health  
outcomes for every patient.

# Future Directions for High-Value Health Care

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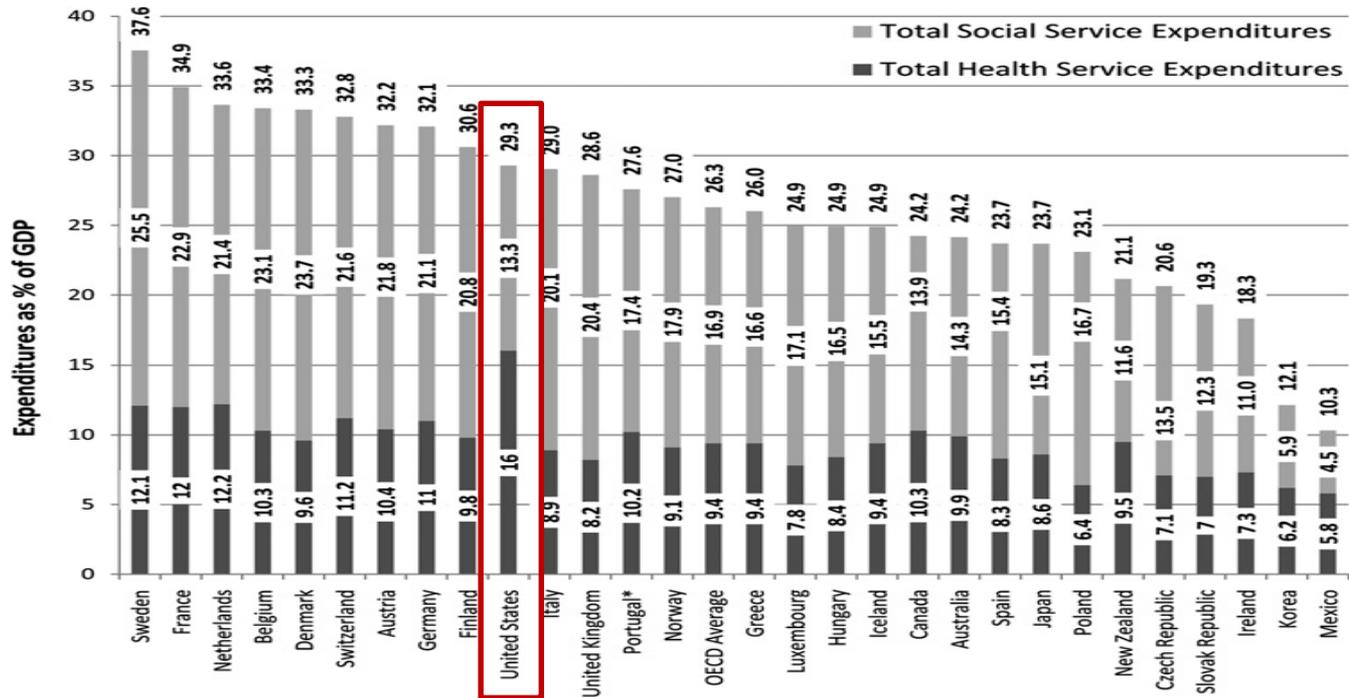
## **OFTEN COST INCREASING – USUALLY REIMBURSED**

- **Effective treatments for unmet health needs**

## **POTENTIALLY COST DECREASING – OFTEN NOT REIMBURSED**

- **Innovations to better target use of medical technologies to patients who will benefit**
- **Wireless/ remote personal health tools and supports, telemedicine**
- **Lower-cost methods of treatment or sites of care**
- **Better care coordination**
- **Non- medical strategies for health improvement – such as targeted assistance to high-risk individuals, and support for accessing social and community services to prevent complications**

# Total Health-Service and Social-Service Expenditures for OECD Countries

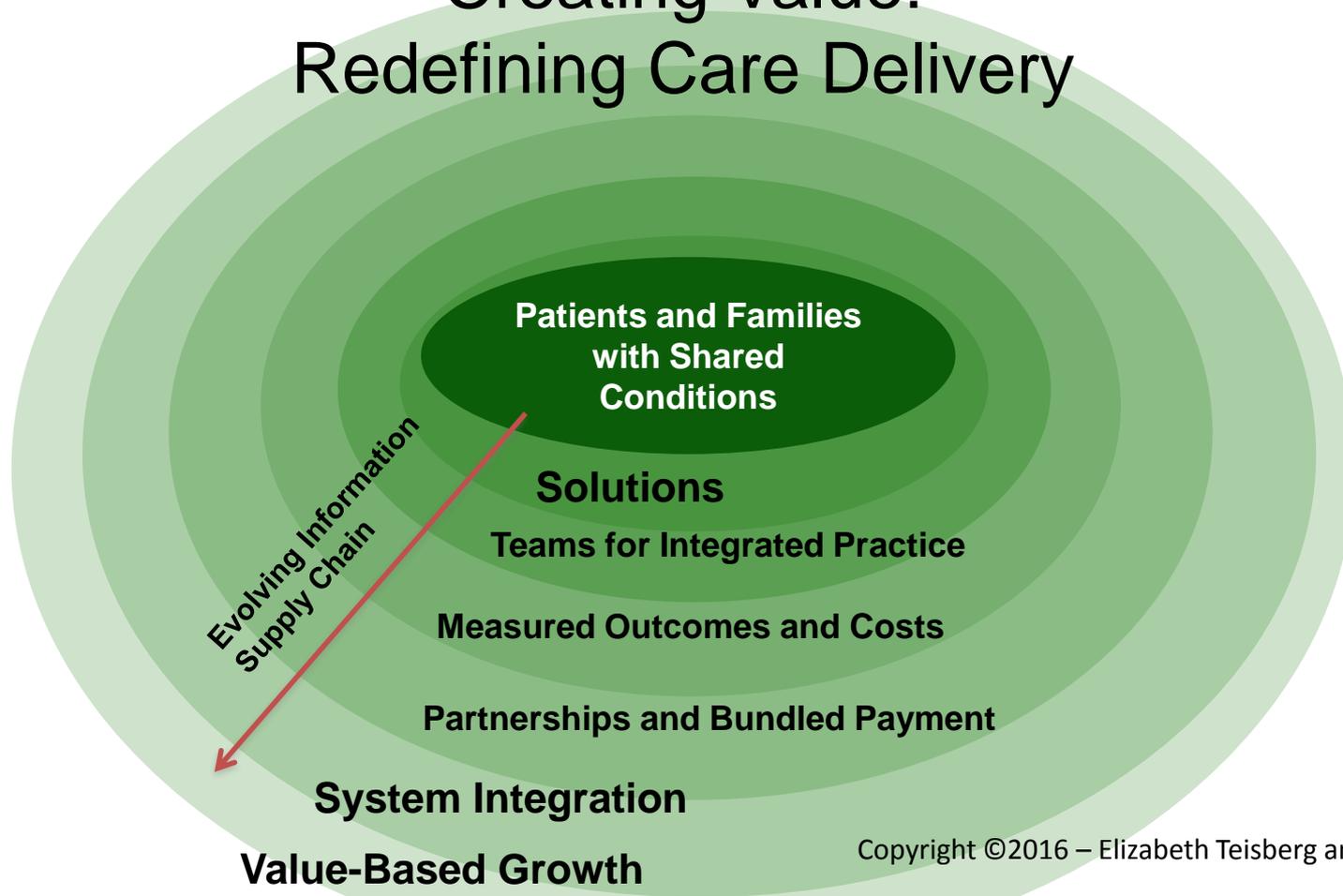


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**“I’d like you to eat more fruit and vegetables, but they’re not covered by your health insurance plan.”**

# Creating Value: Redefining Care Delivery



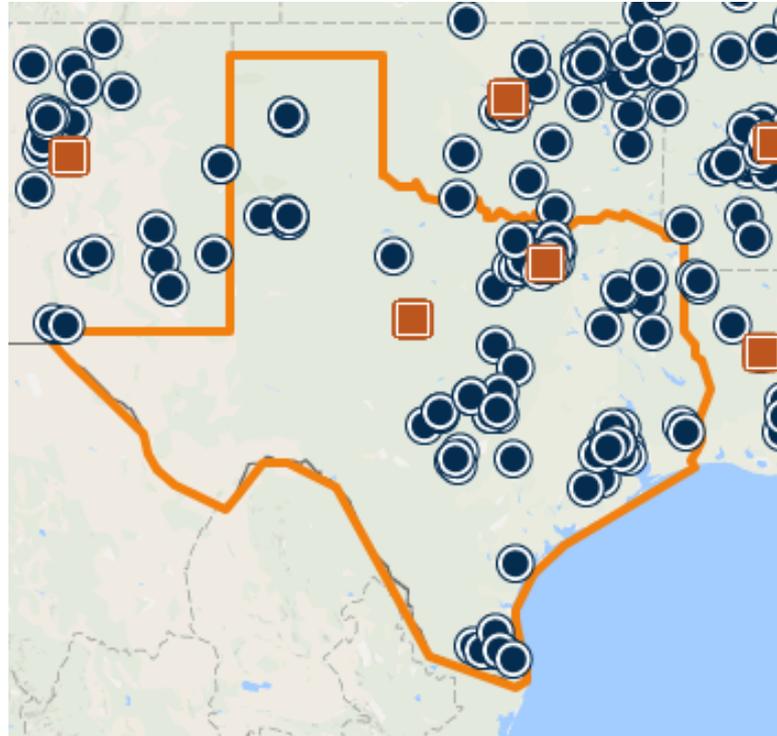
# Integrated Practice Units Under Development at the Dell Medical School

- An [integrated practice unit \(IPU\)](#) brings together the full range of providers and support staff who address a specific disease or clinical condition (for example, musculoskeletal care or complex gynecology).
- The care provided is integrated, patient-centered, and driven by evidence-based protocols.
- Outcomes, costs and other key metrics are tracked and used to drive improvement across all areas.
- Enter into value-based contracts (such as bundled payments) that reward improving value for the patient

# Alternative Payment Models

- Medicare, commercial payers, and Medicaid all are moving to alternative payment models to provide higher-value care
- The Center for Medicare and Medicaid Innovation (CMMI) at the Centers for Medicare & Medicaid Services (CMS)
- The Health Care Payment and Learning Action Network

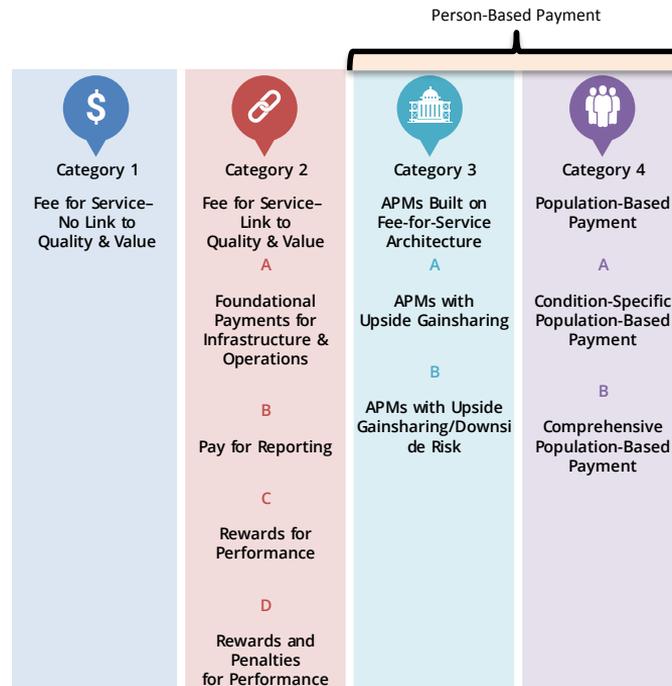
# CMMI Innovation Models Are Being Tested Throughout Texas



# Framework for Alternative Payment Models

The [framework](#) is a first step toward the goal of better care, smarter spending, and healthier people.

- for generating evidence about what works and lessons learned
- for payment reform capable of supporting the delivery of person-centered care



# Types of Accountable Care Payment Models

## Episode Based

Payment linked to quality and cost for a **specified episode of care**

Examples:

Elective procedure episodes

Hospital admission episodes

Diagnosis-based episodes (e.g., pregnancy, back pain)

Chronic disease episodes (e.g., CHF, cancer)

## Whole Patient

Payment linked to quality and cost for a **specified population**

Examples:

Accountable care organizations

Medical home with pop. health accountability

Comprehensive care for high-risk patients

Specialty-based care teams with accountability

Capitated care with pop. health accountability

# Medicare Paying for Quality

## Hospitals

- Hospital Acquired Conditions
- Hospital Readmission Reductions
- Hospital Value Based Purchasing (inpatient payment adjustment based on specified quality measures)

# Medicare Paying for Quality

## Physicians and other clinicians

- **Medicare Access & CHIP Reauthorization Act of 2015 (MACRA)** Medicare Part B Fee-For-Service (FFS) Quality Payment Program has two paths
  - Merit-Based Incentive Payment Systems (MIPS) – Payment adjustment up to 4% in 2019, then increasing in later years, for performance on quality, resource use, clinical practice improvement activities, and advancing care information
  - Advanced Alternative Payment Models (APMs) - 5% bonus payment 2019-2024 and a higher fee schedule beginning in 2026

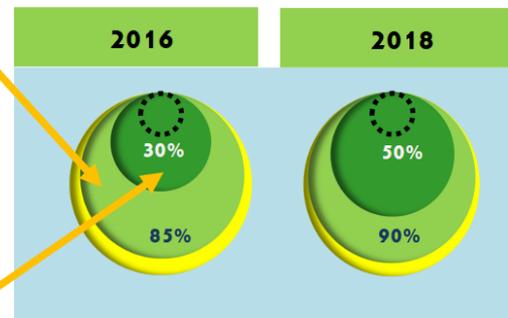
# Medicare's Payment Reform Strategy – Increase % of FFS Payments Linked to Quality and APMs

**MACRA** moves us closer to meeting these goals...

The new **Merit-based Incentive Payment System** helps to link **fee-for-service payments** to quality and value.

The law also provides incentives for **participation in Alternative Payment Models** in general and bonus payments to those in the most highly advanced APMs

**New HHS Goals:**



**All Medicare fee-for-service (FFS) payments (Categories 1-4)**



**Medicare FFS payments linked to quality and value (Categories 2-4)**



**Medicare payments linked to quality and value via APMs (Categories 3-4)**



**Medicare Payments to those in the most highly advanced APMs under MACRA**

# Texas Medicaid Alternative Payment Models

- Texas Medicaid requires its managed care organizations (MCOs) to report on value based payments to providers, but does not require a particular model or threshold for value based payment
- MCOs submit annual plans with proposed payment methods that encourage quality outcomes and reduce inappropriate utilization of services.
- In 2015, of 19 MCOs:
  - At least 10 plans had adopted fee-for-service plus bonus payments (such as for child well-checks)
  - At least 6 plans had adopted partial capitation with or without bonuses (such as for pregnancy or cardiac care)
  - At least 6 plans had adopted shared savings models (such as for reducing total cost of care, pharmaceutical spending, and reducing potentially preventable emergency department and hospital utilization; includes accountable care organization models)

[http://www.hhsc.state.tx.us/hhsc\\_projects/ECI/docs/2015-MCO-DMO-VBC-summary.pdf](http://www.hhsc.state.tx.us/hhsc_projects/ECI/docs/2015-MCO-DMO-VBC-summary.pdf)

# Medicaid Alternative Payment Models Approaches in Managed Care

- Require MCOs to adopt a standardized value based purchasing (VBP) model
  - TN requires its Medicaid MCOs to implement its patient-centered medical home (PCMH) and retrospective episode-of-care models
- Require/incentivize MCOs to make a specific percentage of provider payments through approved VBP arrangements
  - AZ 1% quality withhold – MCOs that meet a VBP threshold (20% in 2015) can earn quality payments from this pool
- Require the MCOs to move toward implementation of more sophisticated VBP approaches over the life of the contract
  - NY Roadmap – Five year goal - by 2020, have 80-90 percent of provider payments in VBP, and 35 percent in risk-based arrangements
- Require MCOs to actively participate in a multi-payer VBP alignment initiative (TN)
- Require MCOs to launch VBP pilot projects subject to state approval (NM, MN)

# Medicaid Alternative Payment Models

## Key Considerations

- Significant resources required to design, implement, and oversee APMs
- Importance of data collection, exchange and integrity
- Varying provider/panel size and readiness
- Stakeholder engagement, and in particular providers, early in the planning process
- Financial incentives for providers and health plans to participate - new and innovative rate setting considerations may be needed in managed care to support alternative payment models

# Texas DSRIP

An incentive program to:

- develop improved care delivery throughout the state and
- move toward quality-based payment systems

During year 4 of the waiver, 265 of the active DSRIP projects served 50% or more Medicaid recipients and 460 projects served 50% or more low income uninsured individuals.

# CMS Goals

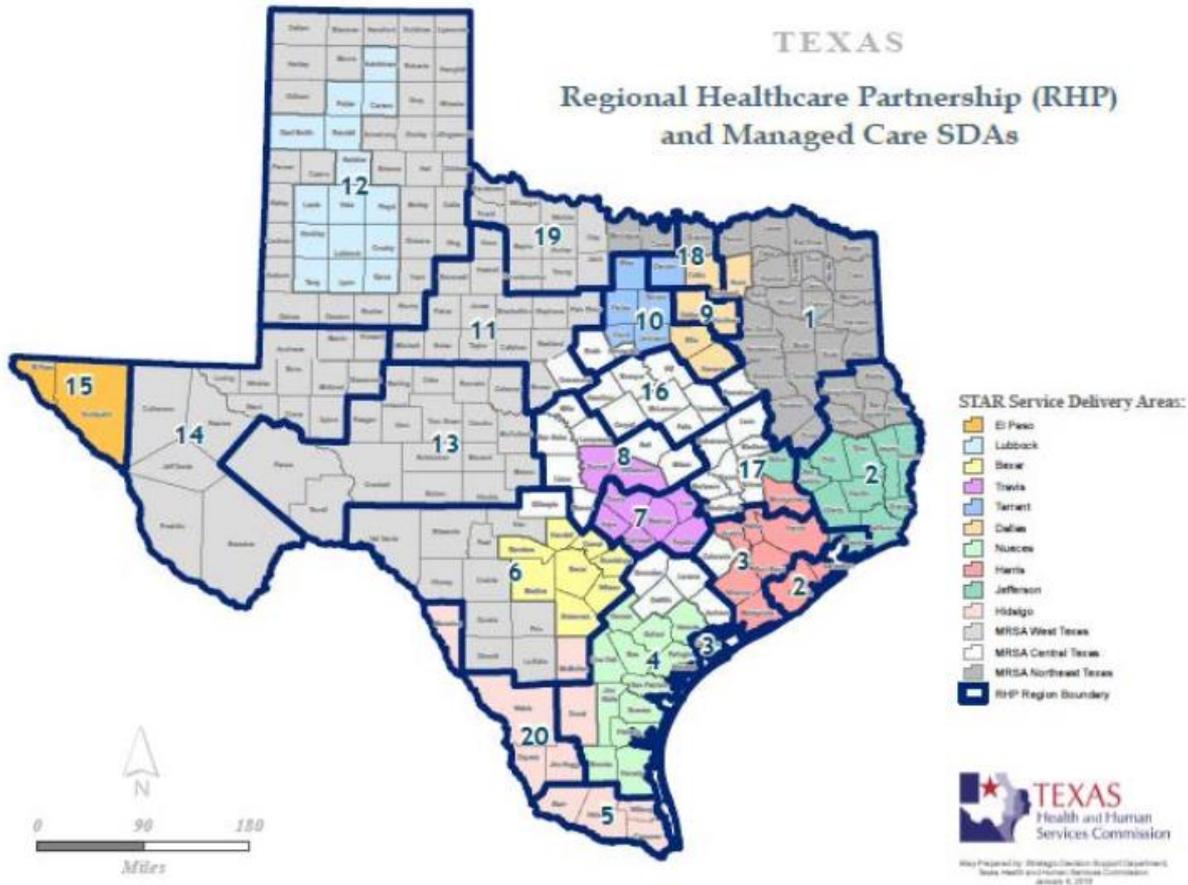
- Support sustainability of effective DSRIP initiatives without the ongoing need for supplemental payments
- Increase value based payment (alternative payment methodologies), including through Medicaid managed care

# Opportunities to Further Integrate DSRIP and Managed Care

- Pediatrics
- Maternity care
- Behavioral healthcare, including integration with primary care and substance use disorders
- Complex needs/high cost (super-utilizers)
- Patient centered medical homes

# Challenges to Integrating DSRIP and Managed Care

- Financing mechanism (IGT) and the new CMS Medicaid managed care rules
- Appropriate incentives for MCOs and providers
- DSRIP projects, as incentive projects, have the ability to provide some services that are not Texas Medicaid benefits, such as supports related to the social determinants of health, community paramedicine, community health workers, and broad use of peer support specialists
- Most DSRIP projects are not 100% Medicaid since they are delivery system reform initiatives (many serve low-income uninsured, Medicare and others)
- Certain types of DSRIP providers (e.g. local health depts.) and projects (e.g. health promotion and prevention) are more challenging to integrate into managed care



# HHSC Activities to Further Integration

- Encouraging DSRIP and MCO relationships and collaboration opportunities
  - Performance Improvement Project (PIP) requirements
  - Milestones proposed for the waiver extension period that relate to sustainability efforts
  - Quarterly calls with MCOs
  - Connecting MCOs and providers/RHP anchors
- Developing prototype/models for collaboration
- Looking at Medicaid policies to facilitate integration (i.e. Quality Initiative costs, other social services)
- Analyzing DSRIP project reported outcomes (Category 3)
- Feedback from Clinical Champions – Transformational Impact Summaries
- Working to clarify and emphasize aligned goals (Pay-for-Quality program, statewide analysis)
- Developing VBP roadmap
- Working internally and with CMS to overcome barriers to integration

# What Can DSRIP Providers Do?

- Reach out to MCOs in the service areas
- Develop health information technology capacity and participate in health information exchange
- Focus on achieving outcomes
- Work to increase number of Medicaid clients served
- Make a business case to MCOs – cost benefit analysis of the project intervention
- What if project does not lend itself to high Medicaid participation?  
Consider other community partners – grants, county funding (including criminal justice), non-profits

# What Can MCOs Do?

- Reach out to DSRIP projects in their area
- Develop and implement VBP/APM models
- Encourage member providers to utilize health information technology
- Share data with providers to improve interventions and outcomes
- Participate in health information exchange

# Next Steps for Integrating DSRIP and Managed Care

- Continue to focus on aligning HHSC's various Medicaid quality initiatives
- Propose to CMS a glide path for integrating certain DSRIP initiatives into managed care
  - Projects initially could be standalone, intergovernmental transfer (IGT)- supported initiatives (similar to the Network Access Improvement Program) during the next phase of the waiver renewal
  - This would allow time for MCOs and DSRIP providers to better assess the value of the initiatives to further integrate them into managed care

# Other Ways to Increase Value

- HHSC should request to continue to use the DSRIP pool to further improve systems of care for Medicaid and the low income uninsured
  - DSRIP has provided a critical source of funds to improve access to care and quality of care
  - Build on effective DSRIP initiatives

# Possible DSRIP Next Steps

Evolve from current DSRIP projects to more coordinated care delivery systems for Medicaid and the low-income uninsured (inpatient, primary care, behavioral health, pharmacy, etc.)

- Focus on community care, population health and social determinants of health
- Care coordination for individuals with the most complex needs
- Improvements in data collection, reporting, analysis and exchange
- Better measurement of program outcomes
- Increased use of alternative payment methodologies for providers
- Cost sharing and other strategies to encourage personal accountability to use community-based services rather than hospital-based services when appropriate

**We must continue  
down the path of  
high-value health  
care**

