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Health and Human
Services Commission

Presentation to the Senate State Affairs Committee

Medicaid Cost Drivers

and

Proposed Quality Initiatives

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Current Medicaid Reimbursement Structure

- Medicaid providers are paid for services provided; payment is largely determined based on cost and/or volume.
- In general, payments are not based on quality of care, clinical outcomes, or comparative effectiveness of services offered.
- Incentives are not generally provided for quality of services.
- Quality-based payment methodologies are intended to:
  - Realign reimbursement methodologies to support quality of care, rather than volume or quantity of care provided; and
  - Provide incentives to appropriately control costs.

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Considerations for a Quality Framework

In looking toward moving to quality-based payments, research shows that structure and process lead to quality outcomes:

Structure
- Health care delivery system
- Medical Home
- Community

Process
- Evidenced-based guidelines
- Care coordination processes

Outcomes
- Clinical endpoints
- Patient-reported outcomes
- Treatment/medication adherence

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Quality Initiatives: Experience in Medicare

Medicare has implemented some outcome-based quality initiatives.

Successful strategies include:

- Nursing teams on the phone and in the field
- Utilizing community health educators to connect beneficiaries with local resources
- Nurses coaching patients after acute hospitalization
- Nurses coordinating delivery of actionable items to physicians

Lessons learned include:

- Flexible but rigorous evaluations to allow for rapid learning
- Selection of beneficiaries should focus on at-risk population – not those with escalating illness
- Tie payment to outcomes, not tactics
- Foster provider teams
- Engage the beneficiaries in shared decision-making

Delivery System Integration, Payment & Quality

Current outcome-based systems vary by degree of integration:

More highly integrated delivery systems can support higher risk and broader capitation as the basis for driving quality.

- Delivery models have more risk capacity, full capitation, and incentives drive quality
- Accountable care organizations (ACOs) serve as an example

Less integrated delivery systems can support less risk and capitation over limited care episodes.

- Delivery models have less risk capacity, fee-for-service payment structure, and little or no incentives drive quality
- Episodes of Care exemplifies a model with an intermediate level of integration
- A fee-for-service model demonstrates a less integrated delivery system

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Accountable Care Organizations

An ACO is a local health care organization and a related set of providers (at a minimum, primary care, physicians, specialists, and hospitals) that can be held accountable for the cost and quality of all care delivered to a defined population.

- This structure supports a patient-centric approach to care: each patient receives care from multiple providers over time and over episodes of care.
- Key components of an ACO include:
  - integrated delivery systems, and
  - a quality-based payment structure that supports coordination between physicians, hospitals and other provider types within the organization.
- ACOs focus on integrated outcomes for the patient, versus separate provider groups each focusing on separate payments.

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Various ACO Models

Features of Accountable Care Organizations include:

- Aligned financial incentives, electronic health records (EHRs), and team-based care
- Strong mechanisms to coordinate care, collaboration on practice redesign, and quality improvement efforts
- Can function like multispecialty group practices

Examples of ACO Models include:

- Integrated Delivery System
  - Geisinger, Kaiser Permanente
- Multispecialty Group Practice
  - Mayo Clinic, Cleveland Clinic
- Independent Practice Associations
  - Individual physician practices that group together for contracting
- Physician Hospital Organization
  - Often a subset of the hospital's medical staff

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Episodes of Care

The Episodes of Care model entails less risk, limited payment, and quality is focused on outcomes for a specific episode.

- The model operates by "bundling" certain services associated with a discrete episode of care, e.g., joint replacement, and paying one price for all services provided in the "bundle."
- Unlike ACOs, the model does not require the same level of integration, but has a focused approach to drive quality.
- This model is often tied to an inpatient stay and requires cooperation among physician groups and between provider settings.
- This model has been in use since 1991; initial results show increased quality and lower costs

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Episode Based Care: Hospital Inpatient Stays

- Because hospitals comprise an estimated 40 percent of health care costs, hospitals provide a good initial focus for quality-based payment initiatives.
- Quality-based payment analyses identify hospital-related admissions or events that are deemed to be potentially preventable:
  - Potentially Preventable Admissions (PPA)
  - Potentially Preventable Readmissions (PPR)

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Potentially Preventable Events

Potentially Preventable Admissions (PPA)

- PPAs are defined as inpatient stays that are potentially preventable if high-quality primary and preventive care had been previously provided.
- Higher rates of PPAs identify areas for potential interventions in the health delivery system to improve patient outcomes and reduce costs.
- PPAs are less directly reflective of a hospital's care than PPRs.
- PPAs accounted for as much as $31 billion, or 10 percent, of all hospitalizations in 2006.

Potentially Preventable Readmissions (PPR)

- HB 1218 (81st Session) defines a PPR as a return hospitalization within a specified period that results from deficiency in care provided during a stay, or from deficiencies in discharge follow-up.
- High PPR rates at a hospital indicate opportunities for hospital quality improvement and also identify good candidates for care management after discharge and improved discharge planning.
- Hospital payments can be adjusted based on PPR rates, as an indicator of quality of care provided.

Current HHSC Initiatives: PPR Reporting

- **Texas is currently implementing PPR analysis of hospital claims**
  - HHSC will establish state and hospital-specific PPR rates by disease condition and other variables
  - Results will be provided to hospitals
  - Hospitals will make PPR information available to providers
  - PPR reporting will be effective January 2011
- **3M software identifies PPRs, based on clinical analyses of diagnosis-related group (DRG) data from admissions and subsequent readmissions**
  - PPR software requires use of an alternative DRG coding system - All Patient Refined (APR) DRGs:
    - allows for comparison of hospital service lines, individual physician performance, and patient outcomes
    - can be used with existing Medicaid systems
    - must be in place before initiatives such as quality-based payments and bundled payments can be implemented
- **HHSC will begin implementation of the APR-DRG Medicaid reimbursement in 2013**
- **Hospital readmissions are expected to be reduced by PPR reporting**

HHSC Quality Initiatives: Health Homes in Medicaid

- **HHSC is implementing quality initiatives focused on care for children, including a Health Home pilot initiative:**
  - Medical practices address dental, behavioral, and other needs, in addition to primary care needs
  - Can include practice redesign for focused and efficient use of doctors' time, parental involvement, and Electronic Health Record support
- **HHSC will select up to eight pilots to start in Fall 2010 for 24 months.**

HHSC Quality Initiatives: HMO Incentives

- **HHSC has two initiatives to provide quality incentives within health maintenance organizations (HMOs):**
- **One Percent At-Risk:**
  - State withholds up to one percent of premiums paid to any managed care organization (MCO) that fails to meet performance targets.
  - When an MCO does not achieve specific performance levels, HHSC adjusts future monthly capitation payments.
- **Quality Challenge Award:**
  - HHSC reallocates the withheld funds to reward MCOs that demonstrate superior clinical quality, service delivery, access to care and/or member satisfaction.

Federal Quality Incentives

The federal health care reform law, the Patient Protection and Affordable Care Act (PPACA), provides for four separate Medicaid quality-based initiatives, demonstrations or pilots:

- **Bundled Payments**
  - Demonstration to study and evaluate bundling Medicaid payments for hospitals and physicians in up to 8 states.
- **Global Payment Demonstration**
  - Allows 5 or fewer states to adjust payment made to safety net hospitals from fee-for-service to global payment models.
- **Pediatric Accountable Care Organizations Demonstration**
  - Demonstration to allow recognition and payment as an ACO under Medicaid if certain quality guidelines met.
- **Establishes federal Center for Medicare and Medicaid Innovation (CMI) to test innovative payment and service delivery models**