Value-based purchasing (VBP) models are utilized in government health insurance programs to shift payments from volume to value.[1] Several terms are used, sometimes interchangeably, to describe efforts to tie payments for care delivery to the quality and efficiency of care provision including value-based purchasing, programs or payments, as well as alternative payment models (APMs). This review explores how VBP has evolved nationally, Texas' implementation and a discussion of potential program integrity challenges and considerations related to the OIG's future work in this space.

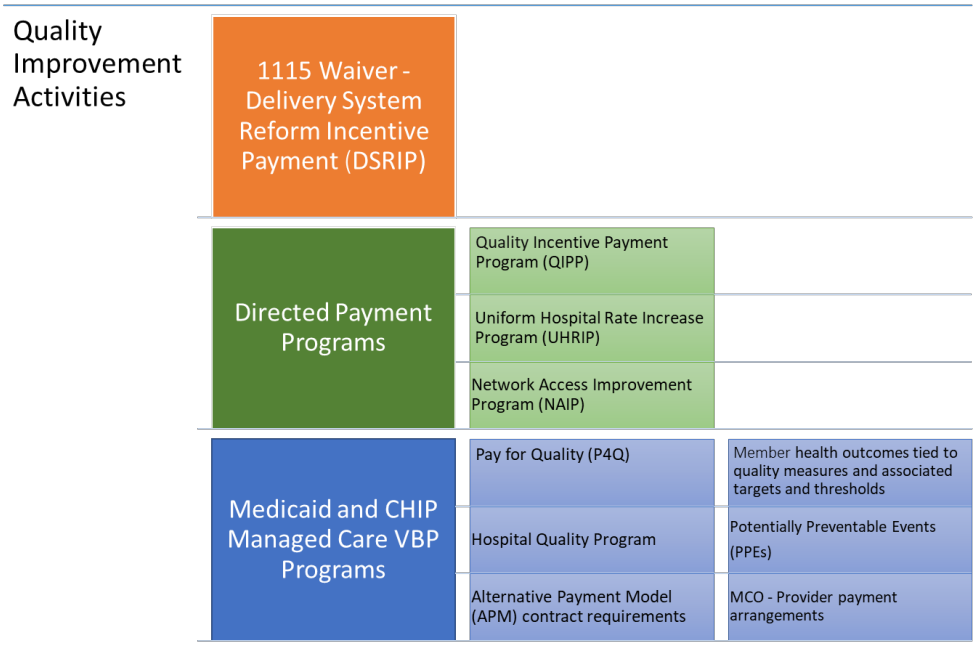
NATIONAL LANDSCAPE

Over the last decade, the federal government has prioritized the use of VBP in the provision of health-care services by enacting and implementing key legislation requiring VBP. Since 2010, there have been several federal requirements, as well as guidance from the Centers for Medicare & Medicaid Services (CMS), to prioritize VBP in Medicare, Medicaid and the Children's Health Insurance Program (CHIP). Federal requirements allow states flexibility to develop and implement their own requirements, measures and programs to promote value in provider reimbursement models in Medicaid and CHIP.

VBPS AND APMS IN TEXAS MEDICAID AND CHIP

The shift to paying for value versus volume in state health-care programs is a priority in Texas. Texas has followed national trends to link Medicaid and CHIP health-care payments to quality and efficiency by enacting legislation and implementing VBP programs and APM requirements.[2] The Texas Health and Human Services Commission (HHSC) administers various programs to improve health-care quality and outcomes while containing costs. These activities are shown in Figure 1.

Figure 1: HHSC Quality Improvement Activities



Source: Developed by OIG[3]

[1] Brown, Bobbi. HealthCatalyst.com. Value-Based Purchasing 2020: A 10-Year Progress Report. April 1, 2020. Retrieved from: https://www.healthcatalyst.com/insights/value-based-purchasing-2020-10-year-progress-report.
[2] Texas Health and Human Services Commission (HHSC). Value-Based Purchasing Roadmap. August 2017. Retrieved from: https://hhs.texas.gov/sites/default/files/documents/about-hhs/process-improvement/quality-efficiency-improvement/draft-texas-vbp-apm-roadmap-august-2017.pdf.
[3] Figure developed by OIG. Based on HHSC Quality Improvement Activities. See: HHSC. Annual Report on Quality Measures and Value-Based Payments.

The primary vehicle in Texas for associating health-care payments to measures of quality and/or efficiency has been through managed care. In Texas Medicaid and CHIP managed care, VBP and APM initiatives financially reward managed care organizations (MCOs)[4] and providers to improve health outcomes for members by providing high-quality health care. All Medicaid and CHIP MCO contracts include policies and programs to align financial incentives with member health outcomes. For state fiscal year (SFY) 2021, MCO contracts target payments tied to APMs constitute 50 percent, and payments tied specifically to risk-based APMs 25 percent, of all MCO-reported medical and pharmacy expenditures.[5]

PROGRAM INTEGRITY CHALLENGES AND CONSIDERATIONS

Program integrity refers to ensuring taxpayer dollars are spent appropriately on quality, necessary care and preventing fraud, waste, and abuse (FWA).[6] With the introduction of VBP and associated complex contractual arrangements, there are new program integrity considerations for both MCOs and regulators to examine. Nationally and in Texas, regulators are working to understand the complexities of these contracting methods and the resultant program integrity considerations in this space. Based on targeted research and programmatic observations, the OIG outlines two areas of operational challenge and related program integrity considerations within value-based contracting:

1. **Data Sharing and Integrity** – The impacts and program integrity considerations tied to accurate and complete data and timely sharing between providers, MCOs and the state.
2. **Payment Integrity** – Behaviors or schemes that may result from VBPs and APMs and the potential integrity issues tied to the complexity of these models.

1. Data Sharing and Integrity

The federal OIG noted the importance of monitored financial incentives to ensure, to the extent possible, quality and efficiency goals are achieved, and undesirable outcomes are avoided. This type of monitoring requires consistent review of encounter, financial and clinical data. As VBPs and APMs increase and mature, timely and accurate data is critical for monitoring and prevention of improper payments. The federal OIG recommends analyzing data systems in value-based payments for timeliness, accuracy and completeness.[7] Operational challenges to share and receive data and to promote data integrity pose challenges and potential risks for consideration.

Provider Information Technology (IT) Capabilities: VBPs and APMs are data-driven and rely on the exchange of timely information to ensure appropriate care coordination between MCOs, providers and members.[8] There may be several providers participating in a VBP program with different data collection and data sharing programs that may not 'talk' with other data programs. Interoperability between Electronic Health Records (EHR) and other data sharing programs and providers continues to be a challenge in VBP.[9] These challenges may create data integrity issues, compromising reporting and appropriate payments.

December 2019. Retrieved from: https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2019/hb-1629-quality-measures-value-based-payments-dec-2019.pdf.

[4] For the purposes of this review, the term 'MCOs' is inclusive of Dental Maintenance Organizations (DMOs) unless otherwise noted.

[5] Uniform Managed Care Contract (UMCC). Version 2.31. Contract Attachment B1, §8.1.7.8.2 MCO Alternative Payment Models with Providers (APMs) Uniform Managed Care Manual (UMCM) Chapter 8. Retrieved from: https://hhs.texas.gov/services/health/medicaid-chip/managed-care-contract-management.

[6] Medicaid and CHIP Payment and Access Commission (MACPAC) Website. Program Integrity. Retrieved from: https://www.macpac.gov/subtopic/program-integrity/.

[7] United States Department of Health and Human Services (U.S. HHS) Office of the Inspector General (OIG) (2013). Management Challenge 2: Transitioning to Value-Based Payments for Health Care. Retrieved from: https://oig.hhs.gov/reports-and-publications/top-challenges/2013/challenge02.asp.

[8] Kirsch, Lisa. UT Austin Dell Medical School. "Five Ways to Maximize Value-Based Care." December 20, 2018. Retrieved from: https://dellmed.utexas.edu/blog/value-based-care-in-texas.

[9] Yelina, Yana. DigitalCommerce360.com. "The Push for Electronic Health Records Tied to Value-Based Outcomes." April 16, 2018. Retrieved from: https://www.digitalcommerce360.com/2018/04/16/the-push-for-electronic-health-records-tied-to-value-based-outcomes/.

MCO Data Sharing with Providers: Based on a 2019 nationwide survey, more than half of surveyed Medicaid MCOs (53 percent) noted that data reporting to providers was the top operational barrier in implementing VBPs/APMs.[10] MCOs may face operational barriers with providing real-time and accurate data to providers to inform day-to-day clinical decisions. Texas managed care contracts require MCOs to share data with providers; however, there are no requirements regarding the frequency or common data elements. These challenges may create data integrity issues, compromising reporting and appropriate payments.

MCO Reporting: To qualify for APMs, most providers need to submit additional data to MCOs or another entity. In Texas, Medicaid and CHIP MCOs also report aggregate APM information to the state in the APM Data Collection Tool.[11] The accuracy of the data in the reporting tool is essential to evaluate performance and determine if MCOs follow state requirements and meet established target percentages.

Data Accuracy: Providers must submit claims to MCOs to receive payment. If a provider submits inaccurate information on a claim, it may lead to inaccurate encounter data. Another scenario is when providers submit accurate claims data, but the MCO reports inaccurate encounter data to the state. Due to the complexity of some VBP models, there may be increased potential for challenges with reporting complete and accurate encounter data.[12]

Management Information Systems: State Medicaid Management Information Systems (MMIS) and required MCO reports may lack data elements or capacity to capture additional information, such as provider arrangements or accountability structures.[13] Absent the ability to capture these new structures, it may be challenging to determine the appropriateness of the payment(s) within the structure. When recovering payments that are determined to be inappropriate, this may also pose a challenge as the OIG works to determine which part of the payment should be recovered if multiple providers are involved.

2. Payment Integrity

Payment Integrity captures FWA schemes resulting in improper payments and inherent complexities within VBP and APMs, which may present new integrity concerns tied to associated payments to providers. While many FFS FWA schemes extend to managed care, changing financial incentives in VBPs and APMs result in new and different schemes. Each of the following considerations are key as the OIG deploys its tools to promote program integrity in VBP.

Payment Integrity Requirements: Since VBP and APM arrangements are relatively new requirements in state Medicaid and CHIP contracts and are maturing in complexity, identifying methods to improve regulators' ability to track and trend payments tied to VBP and APM arrangements will be imperative to determine the appropriateness of payment(s) and if any overpayments occurred. For the future, HHSC is exploring how to capture the requisite information to strengthen its ability to track and trend payments in VBP and APM arrangements.[14]

Provider Detection and Investigations: Investigations, audits, inspections and reviews to prevent, detect and deter FWA in VBP requires access to a variety of data sources including claims data, encounter data, clinical data and provider

[10] Institute for Medicaid Innovation (IMI). Medicaid Access & Coverage to Care in 2018: Results from the Institute for Medicaid Innovation's 2019 Annual Managed Care Survey," September 2019. Page 24. Retrieved from: https://www.medicaidinnovation.org/_images/content/2019_Annual_Medicaid_MCO_Survey_Results_FINAL.pdf.
[11] UMCM, Chapter 2, 8.10. Alternative Payment Model Data Collection Tool, Version 2.3, October 15, 2019. Retrieved from: https://hhs.texas.gov/sites/default/files/documents/laws-regulations/handbooks/umcm/8-10.xlsx.
[12] HHSC. Value-Based Purchasing Roadmap. August 2017. Page 10. Retrieved from: https://hhs.texas.gov/sites/default/files/documents/about-hhs/process-improvement/quality-efficiency-improvement/draft-texas-vbp-apm-roadmap-august-2017.pdf.
[13] National Association of Medicaid Directors (NAMD) and Bailit Health (2016). The Role of State Medicaid Programs in Improving the Health Care System. Page 25. Retrieved from: https://medicaiddirectors.org/wp-content/uploads/2016/03/NAMD_Bailit-Health_Value-Based-Purchasing-in-Medicaid.pdf.
[14] UMCM, Chapter 2, 8.10. Alternative Payment Model Data Collection Tool, October 15, 2019. Retrieved from: https://hhs.texas.gov/sites/default/files/documents/laws-regulations/handbooks/umcm/8-10.xlsx.

credentialing data.[15] Data affiliated with bundled payments or an episode of care may require multiple data collection points and crosswalks that may present new complexities and extend the level of effort needed to conduct OIG work in this area.

Member Solicitation: Providers may solicit members and/or select healthier members as part of their panel for APMs.[16] As a result, members with higher needs may be excluded from participation.[17] This may lead to access-to-care concerns.

Bundled Payments: APMs that bundle payments to a single provider for a group of services (e.g., global surgery fees, which provide one fee for the surgery and related pre- and post-surgical care) may limit members' participation if they need an individualized set of services.[18] Bundled payment models may also result in underutilization due to "stinting"[19] (providers supplying less services in exchange for a bundled payment) and access-to-care concerns.

Condition-Based Payments and Coding: Some MCO and provider VBP arrangements are directed towards achieving certain condition-based metrics, including diagnosing members with specific chronic medical conditions (e.g., diabetes and asthma) or increasing visits (e.g., well-child). It is important to understand the VBP arrangements and the providers' requirements to receive incentives. In some scenarios, there may be an underlying perverse incentive for providers to provide non-necessary services or inaccurate diagnoses to earn higher payments.[20] Validating condition-based payments requires clinical expertise to determine if members' diagnoses are accurate.[21]

Payment Methodology and Calculation: The OIG has the authority to recoup overpayments in Texas Health and Human Services programs resulting from FWA.[22] With VBP arrangements, identifying the potential overpayment amount may be challenging due to several factors. Under an APM, a managed care provider may receive payment from an MCO based on the Medicaid fee schedule along with an incentive payment; however, the payment structure may differ for each MCO within their respective provider contracts. Further, multi-provider arrangements or bundled payments may create additional complexities in identifying the actual overpayment amount. To mitigate such challenges, the federal OIG has stressed evaluation of value-based payments and methodologies to ensure appropriateness and calculation accuracy.[23]

Vertical Integration and Consolidation: Consolidation of independent physician practices and vertical acquisitions of physician groups and health plans by hospital systems has increased in recent years. To provide robust oversight over the consolidated entities, states are exploring policies to monitor billing practices and ensure the appropriateness of

[15] Deloitte (2017). Health Policy Brief – Alternative Payment Models in Medicaid. Page 20. Retrieved from: https://www2.deloitte.com/us/en/pages/life-sciences-and-health-care/articles/medicaid-alternative-payment-models.html.
[16] LaPointe, Jacqueline. Revcycle Intelligence. "AMA Seeks Alternative Payment Models for Vulnerable Populations," June 12, 2019. Retrieved from: https://revcycleintelligence.com/news/ama-seeks-alternative-payment-models-for-vulnerable-populations.
[17] Shryock, Todd. Rethinking the kickback laws for a value-based world," January 6, 2020. Retrieved from: https://www.medicaleconomics.com/news/rethinking-kickback-laws-value-based-world.
[18] Miller, Harold. Center for Healthcare Quality and Payment Reform. How to Create an Alternative Payment Model: Designing Value-Based Payments That Support Affordable, High-Quality Healthcare Services. Page 37. December 2018. Retrieved from: http://www.chqpr.org/downloads/How_to_Create_an_Alternative_Payment_Model.pdf.
[19] U.S. HHS.) OIG. Management Challenge 2: Transitioning to Value-Based Payments for Health Care. Retrieved from: https://oig.hhs.gov/reports-and-publications/top-challenges/2013/challenge02.asp.
[20] Miller, Harold. Center for Healthcare Quality and Payment Reform. How to Create an Alternative Payment Model: Designing Value-Based Payments That Support Affordable, High-Quality Healthcare Services. December 2018. Retrieved from: http://www.chqpr.org/downloads/How_to_Create_an_Alternative_Payment_Model.pdf.
[21] Health Care Compliance Association New York Regional Meeting. Compliance Challenges Raise by Value-Based Purchasing. May 11, 2018. Retrieved from: https://assets.hcca-info.org/Portals/0/PDFs/Resources/Conference_Handouts/Regional_Conference/2018/new-york/Belfortprint2.pdf.
[22] 1 Texas Administrative Code § 371.11. HHSC Office of the Inspector General. Scope.
[23] U.S. HHS OIG (2013). Management Challenge 2: Transitioning to Value-Based Payments for Health Care. Retrieved from: https://oig.hhs.gov/reports-and-publications/top-challenges/2013/challenge02.asp.

these relationships.[24] Vertical integration may pose program integrity risks related to a reduction in patient choice, incomplete or inaccurate information on subcontractor performance and/or lack of access to or falsification of information,[25] which may be exacerbated by VBP models.

FEDERAL INPUT RELATED TO PROGRAM INTEGRITY AND VBP

In response to the expansion of VBP models in the United States health-care system, and related program integrity considerations, federal agencies have issued guidance and solicited information on efforts to combat FWA in this space.

- **2018 Federal OIG Advisory Opinion on VBP** - The federal OIG has examined specific value-based arrangements and issued guidance through advisory opinions, indicating compliance (or not) with program integrity federal laws.[26]
- **2019 CMS Request for Information on the Future of Program Integrity in VBP** – The CMS Center for Program Integrity sent out a request for information (RFI) on the future of program integrity with a focus on VBP programs.[27]
- **2020 CMS Roadmap for States to Accelerate VBP –** CMS issued guidance to state Medicaid directors designed to advance the adoption of VBP strategies across healthcare systems and align provider incentives across payors.[28]
- **2020 Revisions to Federal Regulations Implementing Stark Law, Federal Anti-Kickback Statute, and Civil Monetary Penalties** – U.S. Health and Human Services changes to federal regulations provide greater flexibility to providers engaging in VBP arrangements.[29]

OIG WORK IN VBP

To prevent, detect and deter FWA in managed care VBP and APM arrangements the OIG is working to address these program integrity considerations to ensure taxpayer dollars are spent appropriately on quality and necessary services for Texas Medicaid and CHIP managed care members.

VBP and APM payment arrangements are designed to improve member health outcomes while containing costs, and it is the OIG's responsibility to independently validate paymentsand if the stated outcomes were achieved in compliance with federal and state statutes, regulations, and contract requirements. These payment arrangements continue to increase and become more complex, presenting new program integrity challenges for the OIG to consider in its VBP-related work.

[24] Brown, Erin Fuse JD, MPH. National Academy for State Health Policy (NASHP). State Policies to Address Vertical Consolidation in Health Care. August 7, 2020. Retrieved from: https://www.nashp.org/state-policies-to-address-vertical-consolidation-in-health-care/#toggle-id-3
[25] MACPAC (2017). Program Integrity in Medicaid Managed Care. See: https://www.macpac.gov/wp-content/uploads/2017/06/Program-Integrity-in-Medicaid-Managed-Care.pdf.
[26] U.S. HHS. OIG. OIG Advisory Opinion No. 18-11. October 18, 2018. Retrieved from: https://oig.hhs.gov/fraud/docs/advisoryopinions/2018/AdvOpn18-11.pdf.
[27] Centers for Medicare and Medicaid Services (CMS). Center for Program Integrity. Request for Information on the Future of Program Integrity, October 21, 2019. Retrieved from: https://www.cms.gov/About-CMS/Components/CPI/Downloads/Center-for-Program-Integrity-Future-of-PI-RFI.pdf.
[28] CMS. Value-Based Care Opportunities in Medicaid State Medicaid Director Letter. SMD # 20-004 RE: Value-Based Care Opportunities in Medicaid. September 15, 2020. Retrieved from: https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/smd20004.pdf.
[29] CMS (2020). Final Rule. Medicare Program: Modernizing and Clarifying the Physician Self-Referral Regulations. 2020-26140. Retrieved from: https://public-inspection.federalregister.gov/2020-26140.pdf.