

VBPQI Workgroup #4 – Advancing APMs in Texas Medicaid

Policy Issues:

HHSC has established alternative payment methodology (APM) percentage targets and specifications for Medicaid managed care. While Medicaid MCOs and providers have developed a significant number of primary care and hospital-based value based payment (VBP) arrangements, there is less work among other provider types and among small and rural providers. (Throughout this paper, the terms APM and VBP are used interchangeably.) To recognize the full potential of APMs in Texas Medicaid, there is a need to incorporate multi-stakeholder input to develop strategies to increase adoption of effective APMs by Medicaid MCOs and providers. The ongoing lessons learned from COVID-19 response should be considered when developing new APM approaches both for the current pandemic as well as in planning for a health system that is more nimble and supportive in the event of future health crises. APMs are also an area of opportunity to incorporate effective Medicaid-focused Delivery System Reform Incentive Payment (DSRIP) program work into Medicaid managed care.

Recommendations:

1. Conduct a landscape assessment to determine the barriers and opportunities to advancing APMs. The landscape assessment should include:
 - Considerations and opportunities specific to rural and small providers and provider types not significantly represented in current APMs, including emerging models for these provider types
 - An assessment of the current Texas Medicaid APM requirements and targets for any modifications that could incentivize implementation of the highest impact models
 - Identification of opportunities for measure standardization to reduce provider administrative burden to participate in Medicaid APMs, while acknowledging flexibilities may be required to address specific regional or sub-population needs
 - Review of strong models related to maternal and newborn health, behavioral health, and opioid and other substance use identification and treatment
2. Convene Medicaid MCOs and provider stakeholders to share the results of the landscape assessment as well as discuss best and promising APM models in Texas and other states.
3. Leverage findings from the DSRIP Best Practices Workgroup and the DSRIP Transition Plan milestone analysis of DY 7-8 DSRIP quality data to identify key outcomes and effective interventions to inform HHSC strategies to advance alternative payment models.

4. HHSC should encourage MCOs to work with providers to make adjustments to APMs, including adjusting risk-based requirements, that acknowledge the barriers COVID-19 has posed to achieving metrics agreed upon prior to COVID-19 and engaging patients in certain preventive health care practices.

Discussion

Texas MCO Contract Requirements for APMs

Texas has chosen to advance the shift of Texas Medicaid payments to VBP arrangements by establishing target percentages for MCOs to achieve in total dollars spent in APMs or risk-based APMs relative to the total medical, pharmacy and long term care claims paid by the MCO.¹ The current contractual targets for APMs for Medicaid (STAR, STAR+PLUS, STAR Health and STAR Kids) and CHIP MCOs appear in Table X. Targets increase from calendar year (CY) 2018 to CY 2021. By CY 2021, MCOs are expected to have at least 50 percent of total provider payments for medical and prescription expenses in APMs, and at least 25 percent of the total must be risk-based.² If an MCO fails to meet the APM targets or certain allowed exceptions for high performing plans, the MCO must submit a corrective action plan, and HHSC may impose contractual remedies, including liquidated damages (up to \$.10 per member per month).

Texas Medicaid MCO Contract Targets for APMs

Period	Minimum Overall APM Target	Overall APM Target %*	Minimum Risk-Based APM Target	Risk-Based APM Target %*
Year 1 (CY 2018)	>=25%	>25%	>=10%	>=10%
Year 2 (CY 2019)	Year 1 Overall APM % +25% Growth	>=31.25%	Year 1 Risk-Based APM % +25% Growth	>=12.5%
Year 3 (CY 2020)	Year 2 Overall APM % +25% Growth	>=39.0625%	Year 2 Risk-Based APM % +25% Growth	>=15.625%
Year 4 (CY 2021)	>=50%	>=50%	>=25%	>=25%

¹ Uniform Managed Care Manual (UMCM), Sec. 8.10, *Alternative Payment Model Data Collection Tool, V 2.2.1*, retrieved from: <https://hhs.texas.gov/sites/default/files/documents/laws-regulations/handbooks/umcm/8-10.xlsx>

² APM targets, calculations, relevant definitions, and APM reporting instrument are included in UMCM, Sec 8.10

* An MCO could gain an exception to the targets based on high performance on metrics such as preventable hospital stays and emergency department visits.

Other obligations for MCOs related to APMs include:³

- MCOs must implement processes to share data and performance reports with providers on a regular basis.
- MCOs shall dedicate sufficient resources for Provider outreach and negotiation, assistance with data and/or report interpretation, and other activities to support provider improvement.
- To the extent possible MCOs within service areas should collaborate on development of standardized formats for performance reports and data requested from providers.
- MCOs must dedicate resources to evaluate the impact of APMs on utilization, quality and cost, as well as return on investment.

Need to Assess Barriers and Opportunities for Advancing APMs

HHSC has established contractual targets for Medicaid and CHIP MCOs to connect provider payments to value using APMs. As in other state Medicaid programs, the design of APM participation requirements can be a driver for the types of APMs in which payers and providers engage. A significant portion of Texas Medicaid/CHIP APMs revolve around achievement of measures driven by primary and hospital care. However, there is little participation by smaller and rural providers nor by certain provider types, like pharmacy and home health.

HHSC should perform a landscape assessment of the barriers and opportunities for participation in APMs by a broader spectrum of providers. This should review the current Texas program to see if contractual APM targets have been achieved and the effectiveness of the program structure in encouraging the highest impact APMs. The landscape assessment also should review best practice models in other states. Collectively, this information will inform conclusions regarding if the program is designed in an optimal way to achieve the objectives that Texas Medicaid would like to promote.

Texas also must consider ways to minimize any barriers to providers participating in APMs. Many stakeholders perceive the push to risk-based APMs as a key barrier to provider participation. They consider risk-based APMs unnecessary when well-structured upside-only APMs can help control costs and improve quality. A continued push toward risk-based APM targets may be particularly detrimental now as it could further penalize providers already struggling during the COVID-19 response at a time when a robust healthcare workforce is most critical.

³ For STAR, STAR+PLUS, CHIP, see [Uniform Managed Care Contract](#), sec. 8.1.7.8.2 *MCO Alternative Payment Models with Providers*. Substantively similar provisions exist as sec. 8.1.7.9.2 in the [STAR Health Managed Care Contract](#) and the [STAR Kids Managed Care Contract](#).

The landscape assessment should include a summary of how each of the MCOs' contractual obligations intended to reduce provider burden is being implemented, and any limitations on their implementation. The state can attempt to reduce administrative burdens for provider participation through measure standardization, ensuring adequate data sharing, and facilitating reporting, for example. There should be processes to perform data-driven risk adjustment, when appropriate. The state also should engage providers in the development of workable provider approaches. For example, New Mexico has placed in its managed care contracts a requirement for MCOs to engage a provider-led behavioral health workgroup to design a full risk-based VBP model.

Following up on the recommendations in this committee's December 2018 report, the landscape assessment should include a review of strong models for certain areas of care that are high impact for the Texas Medicaid population – maternal and newborn health, behavioral health, and opioid and other substance use identification and treatment.⁴

All these considerations and any more identified by MCOs and providers underrepresented in APM arrangements, such as rural, small, home health, and pharmacy providers, should be included in the APM landscape assessment.

Considerations for MCO APM Target Calculation and Incentivizing the Highest Impact APM Models

HHSC requires participation in the Hospital Quality Based Payment Program for Potentially Preventable Readmissions and Complications (PPRs and PPCs) to incentivize quality and efficiency among hospitals. Since this program meets the definition of an APM that entails down-side risk, associated MCO hospital inpatient expenditures are allocated to total risk-based APMs. This has multiple implications:

- MCOs cannot get additional credit for APMs either with hospitals or other providers that attempt to reduce unnecessary hospital costs and/or lower total cost of care.
- If a pharmacy or other APM provider model aims to reduce unnecessary hospital costs or total cost of care, HHSC might be "double counting" these payments since it already has the PPR/PPC hospital inpatient APMs.

In addition, the PPR/PPC specifications themselves could benefit from a provider workgroup review to make measures more clinically relevant, timely, and actionable. Potentially Preventable Readmissions, Complications, Admissions, and ED Visits measures are developed and owned by 3M™ Health Information Systems. Providers report challenges in understanding how the PPRs and PPCs for which they are held accountable are calculated and knowing who among their patient panel is included in the metrics. Providers suggest the 3M calculations are not peer

⁴ <https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2019/value-based-payment-qual-improvement-recommendations-nov-2018.pdf>

reviewed and do not always account for clinical best practice guidelines for different patient populations, such as pediatric patients.

The unintended consequences of the way that PPRs and PPCs are counted in the APM percentage target calculation highlight the opportunity to look at best practice models for APM approaches around the country. A recent Medicaid and CHIP Payment and Access Commission (MACPAC) report on state Medicaid VBP arrangements discussed three approaches to VBP in Medicaid managed care contracts.

Approach	State Example
<p>Establishing a VBP target(s) for MCOs related to the percentage of payments, members, or providers to be engaged in APMs by a specified date.</p>	<p>New Mexico, similar to Texas, has VBP targets for the percentage of provider payments associated with APMs. The total percent increases over the course of four years, as does the percent associated with each of three levels of APMs associated with increasing levels of risk.</p> <p>In addition, New Mexico requires participation of specific provider types – physical health, small providers, behavioral health, long term care, and nursing facilities – and includes percentage targets specific to BH and physical health providers in Level 3 APMs.</p> <p>Additional New Mexico information in appendix and attachment.</p>
<p>Requiring and/or incentivizing MCOs to implement one or more delivery system reform models with providers but allowing health plans flexibility in how the models are designed and implemented.</p>	<p>New York has VBP targets and through measurement year 2019, providers could choose to implement the following VBP arrangements, which were not subject to a review requirement:</p> <ul style="list-style-type: none"> • Total Care for General Population • Integrated Primary Care Arrangement, which includes 18 episodes from preventive care episodes to various chronic episodes (e.g., episodes for diabetes, hypertension, low back pain, asthma)⁵ • the Maternity Care Arrangement (episodes: Pregnancy, Vaginal Delivery, C-Section, Newborn);⁶ • Total Care for Special Needs Subpopulations - HIV/AIDS, members included in a Health and Recovery Plan (HARP), Managed Long-Term Care (MLTC) members and members with significant developmental disabilities. <p>'Off menu' options were permissible as long as they supported the underlying goals of payment reform</p>

⁵ https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/vbp_library/2019/2019-03-14_ipc.htm

⁶ https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/vbp_library/2018/2018-02-09_maternity.htm

	and sustained the transparency of value (costs versus outcomes). 'Off menu' subject to review. Appendix includes additional detail.
Requiring and/or incentivizing MCOs to implement one or more delivery system reform models with providers as defined by the state, with little variation across MCOs.	In South Carolina, MCOs must make additional per-member-per-month payments to PCMHs that obtain NCQA certification; Ohio mandates Perinatal Episodes of Care Model.

Texas should consider in the landscape assessment what kind of approach to high impact APMs the state would like to incentivize in its APM strategy. The state should then assess if the current program structure helps achieve the overall program priorities or if lessons could be learned from other state approaches.

Measure standardization

Providers report significant administrative burdens to collect data on and report performance metrics for a multitude of disciplines. Different payers and quality incentive programs may require varying measures for participation in APMs even within the same discipline. Further, when similar measures are required, the measure specifications and reporting periods may vary.

Some providers report that the administrative burden of collecting and reporting on performance metrics exceeds the incentives they can achieve by participating in APMs. Further, when measurement of similar provider and service types varies, it is challenging to assess the relative efficacy of the interventions measured.

The landscape assessment should identify opportunities for measure standardization, including specifications and reporting period alignment, to reduce provider administrative burden to participate in Medicaid APMs. In developing the assessment, the state should leverage existing resources, like measure sets developed for DSRIP and measures such as HEDIS that have been tested nationally. The state also should convene key stakeholders to build consensus around common measures to endorse that would establish a foundation for payers and programs to consider when implementing quality initiatives. Stakeholders could include representatives of varying provider associations, health plan associations, and consumer representatives. Flexibility should be maintained to implement alternative measures when dictated by regional and local community needs.

The assessment should also identify patient sub-populations and provider types for which performance measures may be more limited to assess specific opportunities to introduce innovative measures. If new measures are introduced to facilitate APMs for specific sub-populations or provider types, the measures should initially be pay for reporting to see if the measures are operationally feasible before tying

payment to performance. Data collection behind those new measures should also be standardized.

Convene Stakeholders around Landscape Assessment Findings and Best Practice Discussions

HHSC should convene Medicaid MCOs and provider stakeholders in a structured way to share the results of the landscape assessment as well as discuss best and promising APM models in Texas and other states. HHSC should also encourage health plans to share available evaluation information regarding their strongest models. If health-safety needs dictate, stakeholders could be convened through web-enabled presentations and discussions.

Identifying Best Practice Models for Specific Provider Types

Through carefully planned and facilitated discussions, provider groups and MCOs could share models that have been implemented in Texas or elsewhere that help target APM participation by small and rural providers and provider types not significantly represented in current APM models. For example, APMs related to pharmacy and home health, two provider types that represent significant Medicaid spending, are very limited. The convened groups could discuss the promising models in these areas, specifically how they could be implemented in Texas, and what, if any, challenges need to be surmounted to implement those models.

An example of a promising pharmacy APM model is an accountable pharmacy organization (APO), which could provide enhanced services subject to performance measurements that determine payment. An example of the APO model is the Community Pharmacy Enhanced Services Network (CPESN), which is a clinically integrated network with over 115 Texas participating pharmacies as of June 2020.⁷ All CPESN pharmacies provide enhanced pharmacy services like immunizations, medication reconciliation to avoid medication errors, and clinical medication synchronization to enhance adherence for better disease management. Other pharmacy VBP models can incentivize pharmacies to address social determinants of health as part of comprehensive service sets (e.g., Mental Health, Asthma Management, Diabetes). Network pharmacies document care by using Systematized Nomenclature of Medicine--Clinical Terms (SNOMED CT) codes and Health Level Seven (HL7) compliant Pharmacist eCare Plan platforms.

In home health, an APM model could improve member satisfaction, health outcomes, and savings on total cost of care. An innovative approach could be to employ a quality rating system, similar to Medicare's Home Health Compare tool.⁸ Home Health Compare establishes a quality rating for home health entities using a combination of claims system-derived process and outcomes measures and survey

⁷ <https://www.cpesn.com/>

⁸ Medicare Home Health Compare: <https://www.medicare.gov/homehealthcompare/search.html>

results from the Home Health Consumer Assessment of Healthcare Providers and Systems. Texas could establish APMs based on a similar quality rating system that would enable home health entities to receive higher than the standard reimbursement for higher quality performance and lower than the standard reimbursement for lower performance.

Incorporating Strong Medicaid-Focused DSRIP Work into APMs

The DSRIP program ends on September 30, 2021. HHSC, with input from state leadership and DSRIP stakeholders, have developed a draft DSRIP Transition Plan intended to describe how the state will further develop its delivery system reform efforts and associated funding after DSRIP ends.⁹ Many of the initiatives undertaken through DSRIP have been transformative and should not be lost. A pathway to sustaining some key DSRIP practices and outcomes would be via Medicaid managed care APMs, though the state must be realistic in considering that many DSRIP initiatives supported the uninsured to a greater degree than Medicaid recipients. The draft Transition Plan contains multiple milestones and supporting work that could inform this transition of DSRIP work to Medicaid managed care.

The milestone to Advance APMs to Promote Healthcare Quality entails updates to the Texas Medicaid Quality Strategy and Texas Value-Based Payment (VBP) Roadmap to address program and stakeholder goals, such as promoting data sharing and transparency, advancing APMs for Medicaid recipients with high costs and high needs, and developing statewide initiatives that focus on improving quality and outcomes. This is also the milestone expressing commitment that at least 25 percent of all Medicaid MCO payments to providers will be associated with quality-based APMs.

Another milestone requires HHSC to conduct a preliminary analysis of DY 7-8 (October 1, 2017 - September 30, 2019) DSRIP quality data and related core activities to identify interventions associated with improvement in key health outcomes and any lessons learned or best practices in health system performance measurement and improvement. HHSC should use the DY 7-8 analysis, along with engagement from DSRIP stakeholders, research into emerging areas of innovations in healthcare, and value-based initiatives in other states, to help inform HHSC strategies for continuing to advance alternative payment models and further develop delivery system reform.

HHSC established a DSRIP Best Practices Workgroup of current DSRIP performing providers, DSRIP anchors, and executive waiver committee members to support the sustainability of delivery system reform best practices, the successful completion of DSRIP Transition Plan milestone deliverables, and the development of the next phase of delivery system reform in Texas. Texas Medicaid should leverage the

⁹ <https://hhs.texas.gov/sites/default/files/documents/laws-regulations/policies-rules/Waivers/medicaid-1115-waiver/1115-medicaid-waiver-tools-guidelines-regional-healthcare-partnership-participants/draft-revised-dsrrip-transition-plan.pdf>

findings from the Best Practices Workgroup for consideration in advancing APMs, including workgroup findings on key outcomes and the most effective interventions for successful DSRIP work.

Texas also could encourage MCOs to pursue APMs that align with the key focus areas of DSRIP transition and are measurable by the DSRIP state priority measure bundles, as identified in the DSRIP Transition Plan.

Flexibilities in APMs in Response to COVID-19

Providers are encountering unprecedented challenges in response to COVID-19. Some hospitals and providers are overwhelmed dealing with surging COVID-19 cases while others may see their patient load dwindle as patients delay routine care for their chronic conditions or routine preventive care. Meanwhile, the severity of the non-COVID-19 patients seeking care may be increasing.

Providers who are already engaging in APMs such as prospective payments may be at a fiscal advantage over providers who still receive fee-for-service reimbursement and have less certainty in their payments. However, providers under APMs may also struggle to meet their APM contract requirements. For example, they may be unable to meet reporting deadlines or they may see a reduction in their quality scores as patients delay or cancel preventive care and the acuity of their average visit increases.

In a time during which it is so critical to keep provider networks intact, there are several steps to granting flexibility that the state should endorse. At the MCO contract level, HHSC should consider decreasing risk-based requirements so MCOs and providers can focus on providing the best care possible in light of the current challenges they are facing. HHSC also should encourage MCOs to consider flexibilities in their APM contracts, such as extending reporting deadlines, removing outliers, and adjusting benchmarks or performance year expenditure targets. While certain flexibilities could be granted and objectives may be modified, MCOs should not revert to payment methodologies that lack accountability.

Appendix: New Mexico VBP Requirements

- Requires a mix of Physical Health (including at least 2 small providers), Behavioral Health, Long-Term Care and nursing facility Providers
- Three tiers of VBP arrangements (targets in table below) include:
 - Level 1: Fee schedule based with bonus or incentives and/or withhold payable only when outcome/quality scores meet agreed-upon targets.
 - Level 2: Fee schedule based, upside-only shared savings-- available when outcome/ quality scores meet agreed-upon targets (may include downside risk).
 - Level 3: Fee schedule based or capitation with risk sharing (at least 5% for upside and downside risk); and/or global or capitated payments with full risk.
- Contains glide path for certain provider types' participation. BH example for level 3: requirement for BH providers for period 1 is a provider-led workgroup to design a full risk-based model, period 2 is develop the full-risk BH model, period 3 implement BH full-risk model
- Examples of additional requirements pertain to:
 - full delegation of care coordination for level 3 arrangements,
 - high volume hospitals,
 - requiring avoidable readmission reduction targets
 - providers in VBP arrangements must have access to data that provides information about Members' utilization of services including total cost of care on a quarterly basis

Aggregate VBP Targets			
Contract Period 1 (Jan 1 – Dec 31, 2019)	Contract Period 2 (Jan 1 – Dec 31, 2020)	Contract Period 3 (Jan 1 – Dec 31, 2021)	Contract Period 4 (Jan 1 – Dec 31, 2022)
<ul style="list-style-type: none"> • Level 1: 8% • Level 2: 11% • Level 3: 5% • Total: 24% 	<ul style="list-style-type: none"> • Level 1: 10% • Level 2: 13% • Level 3: 7% • Total: 30% 	<ul style="list-style-type: none"> • Level 1: 11% • Level 2: 14% • Level 3: 8% • Total: 33% <p>HSD reserves the right to modify the percentage in Year 3 increasing 5% from Contract Period 2.</p>	<ul style="list-style-type: none"> • Level 1: 12% • Level 2: 15% • Level 3: 9% • Total: 36% <p>HSD reserves the right to modify the percentage in Year 4 increasing 5% from Contract Period 3. ¹⁰</p>

¹⁰<https://www.hsd.state.nm.us/uploads/files/Looking%20For%20Information/General%20Information/Contracts/Medical%20Assistance%20Division/MCO's%20Centennial%20Care%202.0/BCBS%20Contract%20PSC%2018-630-8000-0033%20A1.pdf>

VBP Level 2 – Minimum Requirements			
Level 2: Fee schedule based, upside-only shared savings—as available when outcome/quality scores meet agreed-upon targets (may include downside risk).			
Contract Period 1	Contract Period 2	Contract Period 3	Contract Period 4
11%	13%	14%	15%
<ul style="list-style-type: none"> • Traditional PH providers with at least 2 small Providers. • Behavioral Health (BH) providers (whose primary services are BH). • Actively build readiness for Long-Term Care Providers (see definitions). • Actively build readiness for nursing facilities. 	<ul style="list-style-type: none"> • Traditional PH providers with at least 2 small Providers. • Behavioral Health (BH) providers (whose primary services are BH). • Actively build readiness for Long-Term Care Providers (see definitions). • Actively build readiness for nursing facilities. 	<ul style="list-style-type: none"> • Traditional PH providers with at least 2 small Providers. • Behavioral Health (BH) providers (whose primary services are BH) • Long-Term Care providers including nursing facilities 	<ul style="list-style-type: none"> • Traditional PH providers with at least 2 small Providers. • Behavioral Health (BH) providers (whose primary services are BH) • Long-Term Care providers including nursing facilities

Appendix: New York Approach to VBP Arrangement Standardization

From the [New York A Path toward Value Based Payment: Annual Update](#):^{11*}

In searching for the right balance between flexibility and standardization, consistency in VBP arrangement definitions has been identified as a key success factor in VBP implementation both national and globally. This includes:

- Services to be included and excluded from each VBP model;
- Members eligible for attribution to each model;
- Selection and specifications of quality and outcome measures for each model; and
- Methods to calculate the risk-adjusted cost of care in each model and in benchmarks used by the State to reflect changes in the clinical and demographic mix of attributed members.

Such consistency enables transparency in performance between MCOs and VBP contractors, adequate monitoring of the quality and expenditures of the overall Medicaid system, and significantly reduces the administrative burden for both MCOs and providers. Especially for smaller providers, varying definitions of a VBP arrangement between MCOs and/or differences in reporting requirements could cripple their ability to fulfil their role. The statewide definitions and quality measures have been set based on national standards and the recommendations from the Clinical Advisory Groups and the Technical Design Subcommittees. Measure results at VBP Contractor level will be made available between MCO and Contractor on a regular basis for monitoring. MCOs have to report these measures to the State. MCOs are encouraged to share quality measure reporting with VBP contractors to enable provider and MCO partnerships to improve the quality of care.

* The VBP arrangements detailed in New York's VBP Roadmap work were identified as part of DSRIP redesign. However it's understood that at least a part of the New York VBP arrangement options continue for measurement year 2020 despite CMS' declining approval of New York's DSRIP extension request.

¹¹ https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/vbp_library/2020/docs/2019-09_final_vbp_roadmap.pdf