Frequently Asked Questions
Texas Medicaid Alternative Payment Models Initiative
With both Payer and Provider Perspectives
(In-Progress DRAFT)

General: For both MCOs and Providers:	
Questions	**Answers**
What are Fee-for-service (FFS) Payments?	Reimbursement system where providers are paid based on the volume of services delivered (i.e. visits, tests, treatments, procedures, etc.). In a FFS system, there is no incentive to prevent services with more effective coordination and management
What is value-based payment (VBP)?	VBP is a general term used to describe new payment models where providers are paid for keeping people healthy and for good patient outcomes rather than for the volume of services delivered. VBP arrangements can span from pay-for-performance contracts built on fee-for-service architecture to full capitation contracts with comprehensive population-based payments paid on a per member per month basis.
What are Alternative Payment Models (APMs)?	APMs are value-based contracting models where providers assume increased provider accountability for both quality and total cost of care. The term is often used synonymously with VBP but may also refer to a more systematic approach to VBP where APMs exist along a continuum with progressively greater emphasis on the management of a population (e.g. shared savings, bundled payments, and capitation).
What is Upside Risk (i.e. Upside Gainsharing)	In an upside risk contract, providers share in the savings and not the risk of loss. When the total cost of care is lower than the projected budgeted cost, providers receive a defined percentage of the difference between actual costs and budgeted costs (shared savings). However, if the actual total cost of care exceeds the projected budgeted cost, providers are not responsible for the difference.

What is Pay-For-Performance?	An incentive opportunity for providers to receive additional reimbursement for meeting defined quality and/or efficiency performances targets. Pay-for-performance incentives are typically associated with existing fee-for-service contracts. Pay-for performance is sometimes used as an umbrella term for initiatives aimed at improving the quality, efficiency, and overall value of health care
What is Downside Risk?	In a downside risk contract, providers share in savings and potential losses. Providers may earn upside gains, but when the total cost of care is greater than the projected budgeted cost, providers are responsible for a defined percentage of the excess costs. Typically, providers assume downside risk for an opportunity for greater financial rewards (e.g. a higher defined percentage of shared savings).
What are Shared Savings?	Reimbursement methodology that evaluates providers on quality and cost of care. Shared savings contracts often include quality targets that must be achieved to be eligible for shared savings. When the actual total cost of care is lower than the projected budgeted cost of care, shared savings are achieved. Providers receive a defined percentage of the savings as defined in the contract. Shared savings contracts give providers an opportunity to share in the savings they generate. In contrast, if savings were achieved within a fee-for service contract, all savings would accrue to the payer.
What is Capitated Payment (i.e. Population-based Payments; Global Payment)?	Reimbursement methodology where payments are paid on a per-member per- month (PMPM) basis. Providers are paid a fixed-rate per member to cover a set of services for a specified population. Providers assume full financial risk and are responsible for costs exceeding the fixed capitated amount but also receive full financial gains when costs are less than the fixed amount. To qualify as an APM under this initiative, a capitated model also should link a portion of reimbursement to outcomes and quality. In this model, providers accept full accountability for managing the total cost of care, quality, and outcomes for a defined patient population across a defined continuum of care.
What is Risk Adjustment?	Risk adjustment is an actuarial methodology used to calibrate payments (i.e. healthcare costs) based on the relative health of the at-risk population. Risk adjustment methodologies often use a patient's age, gender, as well as medical diagnoses and prescription medication history, and other factors to assess patient risk. Risk adjustment methodologies are used to set benchmarks, adjust payer payments, and evaluate provider/ practice performance. Risk-adjusted costs normalize costs for medical complexity to facilitate more meaningful comparisons across practices and providers.
What consensus framework does HHSC use to guide the APM initiative?	The state's APM initiative generally aligns with the work of the Healthcare Payment Learning Action Network: https://hcp-lan.org/APM. A framework one pager is available here: hcp-lan.org/work products/apm-whitepaper-onepager.pdf.

What is the Health Care Payment Learning and Action Network (LAN) and what resources do they make available for technical assistance?	The Health Care Payment Learning & Action Network (LAN) is a public-private partnership established to accelerate transition in the healthcare system from a fee-for-service (FFS) payment model to ones that pays providers for quality care, improved health, and lower costs. Resources provided by LAN can be found in the link: https://hcp-lan.org/about-us/
What resources does HHSC provide to support VBP and the APM initiative?	
Where else can we get more information about the Texas Medicaid APM initiative and other initiatives focused on improving quality?	Information for Value-based Payment and other Texas Medicaid Quality initiatives can be found at the link:
How can I provide feedback or input?	The Value-Based Payment and Quality Improvement Advisory Committee meets regularly to serve as a forum for public engagement on the APM and other Medicaid quality focused initiatives. More information about the committee is available at this website: You may also contact HHSC staff directly. Matt Ferrara serves as lead staff for the initiative: Matt.Ferrara@HHSC.state.tx.us, 512-380-4371.
From the MCO Perspective:	
Questions	**Answers**
What are the MCO targets?	There are two APM targets: 1) Overall APM target (which includes risk and non-risk based APMs) and 2) Risk based APM target. The MCO targets start at 25% overall and 10% risk based for year one (CY 2018) growing to 50% overall and 25% risk based by year four (CY 2021).
How were the targets determined?	HHSC has been tracking MCO APM contracting with providers since 2014. The first year (2018) APM target corresponds roughly to the average performance reported by MCOs for 2016.
What exactly is included in the numerator and denominator for the targets and what is excluded?	
Will LTSS services be counted as 'medical expenses' in the denominator?	Yes
What about directed payment programs such as the Uniform Hospital Rate Increase Program (UHRIP), are they included?	No. Since they have no linkage to a value metric, pass-through payments made to MCOs by HHSC, and likewise by MCOs to providers (like UHRIP) should be excluded from the numerator and denominator.

Is the numerator for the APM target equal to the total amount of incentives or disincentives paid to providers?	No. The numerator represents all dollars connected to the APM, even if only a small portion is actually "at risk" or in play as an incentive or disincentive. For example, a primary-care APM that pays a 2% bonus to providers based on total cost of care and positive quality measures could count 100% of primary care reimbursement as part of the APM numerator.
Are the APM percentage calculated based on each service area and business line or for the overall population	The percentages will be calculated by MCO across each program (business line).
If a plan meets the PPA/PPV exception for one Line of Business, but not another, is it possible to receive the exception for that line of business while attempting to meet a target in another LOB?	Yes
What measurement year is used for the exception criteria?	Financial penalties will be waived if the MCO's actual to expected (A/E) ratio on Potentially Preventable ED Visits (PPV) is <= 0.90 AND the MCO's A/E ratio on Potentially Preventable Hospital Admissions (PPA) is <= 0.90 for the period that aligns with the APM reporting period. The data source for determining A/E ratios will be the monthly Potentially Preventable Events (PPE) reports produced by the External Quality Review Organization (EQRO).
Can "gold carding" a provider (waiving pre-authorization, other administrative relief) qualify as VBP/APM?	Yes. we recognize that providers value these arrangements in lieu of financial incentives, and so these can be included as an incentive in an APM. We also recognize that "gold carding" may include different types of performance measurement than standard value/quality metrics.
Who determines the measures for the APMs?	HHSC encourages that APMs be based on measures generally recognized in the industry (such as HEDIS). However, measures for any specific APM will be determined as part of an MCO's contracting process with its providers.
How does an MCO determine if a payment model qualifies as an APM?	
From the Provider Perspective:	
Questions	**Answers**
As a provider, I am interested in VBP. How do I get started?	
Are providers required to participate in APMs?	No
Does a provider have to take on financial risk?	No

What requirements do providers have as part of the APM initiative?	Provider requirements are set by terms of their contractual arrangements with MCOs. HHSC does not have specific requirements for providers as part of the APM initiative.
Are MCO's required to collaborate with providers to develop programs?	HHSC encourages collaborative efforts between MCOs and providers and believes that enhanced collaboration will be essential for success in a value-based environment, particularly if MCOs are to meet the risk based targets in the APM initiative.
Are MCO's required to inform providers about APM opportunities?	MCOs have contractual obligations with HHSC to meet the minimum APM targets, and thus should be incentivized to inform providers about these opportunities. However, there are no specific requirements regarding MCO outreach to providers to participate in APMs.
What information are MCOs required to report to providers?	
If there is a dispute with payment between a provider and MCO, including on the accuracy of data, metrics, or panel size what is the course of action to resolve the issue?	Payment disputes for APMs would be adjudicated based on contractual provisions between an MCO and a provider.
Is there a dispute resolution appeal process directly with HHSC after all avenues are exhausted with an MCO?	Dispute resolution involving an appeal to HHSC related to an APM payment would go through the same process as any other appeal regarding an MCO payment.