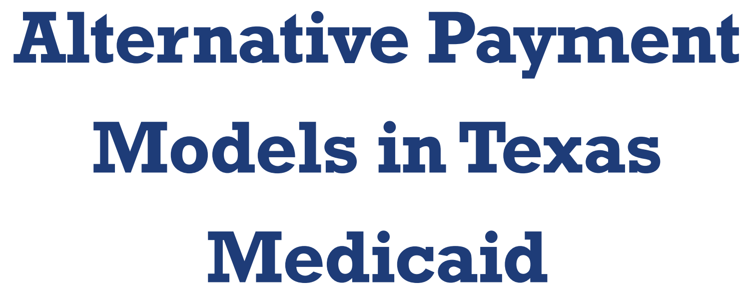

Texas Delivery System Reform

Incentive Payment Program

Transition Plan

Health and Human Services

Commission

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TEXAS
Health and Human
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Appendix A: Texas Medicaid and CHIP Programs A-1

Executive Summary

In alignment with the Texas Health and Human Services Commission's (HHSC) Managed Care Quality Strategy, Texas' objectives in the Medicaid program are to achieve better quality care for its beneficiaries, while controlling costs and improving population health. This report describes how the state uses value-based payment (VBP) reform to pursue these aims. Specifically, this document highlights the role of Alternative Payment Models (APMs) in managed care and the Delivery System Reform Incentive Payment (DSRIP) program, along with other aspects of the state's VBP strategy, that are helping to transform Texas Medicaid from a volume to a value-based system.

Texas Medicaid has made significant progress moving toward a value-based program that rewards providers based on outcomes rather than just volume. This transformation began with new contract provisions, first effective for 2018, requiring Medicaid managed care organizations (MCOs) to achieve targets for the percentage of medical, pharmacy and long-term services spending paid to providers through an APM. Two years into the requirements, MCOs generally perform at or above expectations and have leveraged the initiative to reward high performing providers.

Texas will continue to promote existing APMs and work with stakeholders to facilitate new and more advanced arrangements, as recommended by the Health Care Payment Learning and Action Network (HCPLAN). HHSC also continues to consider new program options for sustaining and deepening Medicaid transformation and VBP, starting from feedback and best practices from providers and MCOs.

To accomplish these goals and further advance VBP, HHSC seeks to increase the alignment of quality measures and financial incentives across Medicaid programs, providers and MCOs; reduce technological and logistical barriers for participating organizations; and implement lessons learned from existing initiatives, such as DSRIP, and from other programs, like Medicare. HHSC is studying ways APMs can reward successful efforts to address social determinants of health and evaluating flexibilities for telehealth and other changes due to the COVID-19 public health emergency. HHSC has involved stakeholders in the development of these strategies through the DSRIP Transition initiative, feedback from the Value-based Payment &

Quality Improvement Advisory Committee, surveys of MCOs and DSRIP performing providers about APMs, and meetings with providers and their associations throughout the state.

1. Introduction

In 2012, HHSC began assessing payment methodologies between MCOs and providers. That review indicated that while MCOs received a capitated payment, they still predominantly reimbursed their contracted providers using a fee-for-service approach, thus maintaining incentives for volume over value in the payment model. To help push value-based incentives to the provider level, HHSC added contractual targets requiring MCOs and dental maintenance organizations (DMO) to tie a minimum portion of provider payments to measures of value and quality using APMs. The initiative generally aligns with the HCPLAN, a public-private partnership launched in 2015 by the U.S. Department of Health and Human Services to accelerate the healthcare system's transition to value-based care.

The Texas Medicaid and CHIP programs are focused on improving the quality and efficiency of healthcare services and promoting value-based payments.[1] HHSC routinely monitors and reports on key indicators of healthcare quality and efficiency. Value-based payments reward MCOs, hospitals, doctors and other providers for delivering high quality, efficient clinical care. The state's Annual Report on Quality Measures and Value Based Payments[2] describes the quality improvement initiatives that HHSC has implemented relating to VBP. Key initiatives incentivizing MCOs and providers in managed care towards providing value-based care include:

- Medical and dental Pay-for-quality (P4Q) programs
- Value-based enrollment incentive program
- Hospital Quality-Based Payment (HQBP) program targeting reductions in potentially preventable events

The medical and dental P4Q programs use financial risks and rewards tied to specified measures to catalyze performance improvement. P4Q incentives encourage MCOs to pursue quality-based APMs with providers.[3] Beginning in SFY 2021, the impact of quality and efficiency incentives were strengthened, as HHSC

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[1] More detail regarding the structure of Texas Medicaid and CHIP programs is provided in Appendix A.

[2] Annual Report on Quality Measures and Value-Based Payments (December 2020). Available at: https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2020/hb-1629-quality-measures-value-based-payments-dec-2020.pdf

[3] Measures, associated benchmarks, and detailed methodology available at: https://hhs.texas.gov/sites/default/files/documents/laws-regulations/handbooks/umcm/6-2-14.pdf.

implemented a value-based enrollment program that awards a higher proportion of members to MCOs that perform better than their peers on metrics for quality, efficiency and effectiveness of care.

HHSC administers the HQBP program for hospitals in Medicaid and CHIP in both managed care and fee-for-service (FFS). Hospitals are measured on their performance for risk-adjusted rates of potentially preventable hospital readmissions (PPR) within 15 days of discharge and potentially preventable inpatient hospital complications (PPC) across all Medicaid programs and CHIP. Because hospitals have financial risk in HQBP, and hospital payment incentives and/or disincentives flow through MCO premium payments, all inpatient paid claims for hospitals within each MCO's network now count toward APM targets.

In summary, HHSC holds MCOs accountable for providing value in health care services through P4Q and the value-based enrollment incentive program, and hospitals through HQBP. By promoting APMs in managed care, HHSC encourages MCOs to promote accountability at the provider level, in a way that aligns with Medicaid objectives for better care, healthier individuals and communities, and lower costs.

2. Alternative Payment Models in Texas

The shift in Texas to a managed care system created conditions for the adoption of an effective VBP approach. Rather than paying providers based only on the volume of services delivered, MCOs have the flexibility and incentive to use VBP to encourage providers to engage in evidence-based practices, coordinate with peers, and connect people to appropriate clinical and nonclinical services.

The evolving shift to value-based care requires collaboration between HHSC, MCOs, providers and other stakeholders. HHSC's Value-Based Payment and Quality Improvement (VBPQI) Advisory Committee is an important forum for stakeholder discussions and consensus building on options for advancing value-based care. The VBPQI Advisory Committee has issued recommendations in both their 2018 report and 2020 report on the adoption of APMs in Texas Medicaid. In the more recent (November 2020) report, the committee provided ideas to:

- Align APMs and performance metrics;
- Support VBP methodologies that help address social drivers of health in ways that lower healthcare costs and improve outcomes;
- Increase availability of actionable data to support value-based care and payment;
- Develop strategies to increase adoption of effective APMs by Medicaid MCOs and providers, especially through administrative simplification; and
- Identify lessons learned during the COVID-19 public health emergency to strengthen care delivery and value-based care in Medicaid, such as through the increased deployment of tele-services.

The VBPQI has formed subcommittees to work with HHSC to address these priority areas.

As recognized by the VBPQI Advisory Committee, data sharing, whether by an MCO, DMO or provider, is essential in a VBP environment. For example, managed care providers with APM contracts need regular information from MCOs on their performance on agreed upon quality metrics. For HHSC, public reporting of MCO performance can be an effective strategy to accelerate improvement and establish a transparent and accountable system. HHSC provides information about VBP initiatives on its website, including payment arrangements between MCOs and their providers. HHSC is exploring additional ways to leverage its Texas Healthcare Learning Collaborative portal to support MCOs, DMOs and providers to pursue APMs that improve outcomes and efficiency.

Additionally, timely access to clinical data is critical to coordination of care. In November 2019, HHSC finalized and submitted to the Centers for Medicare and Medicaid Services (CMS) a Health Information Technology (Health IT) Strategic Plan that identifies strategies to promote greater sharing of electronic health records and other clinical data among providers, MCOs, DMOs and HHSC.

Alternative Payment Model Requirements for MCOs

Texas has advanced the shift of Texas Medicaid payments to VBP arrangements by establishing contract requirements for MCOs, including target percentages for total dollars spent in APMs or risk-based APMs relative to total MCO-paid medical, pharmacy and long-term care expenditures.[4] HHSC's MCO and DMO contracts require them to reach APM targets each year, beginning with calendar year 2018.[5]

The current contractual targets for APMs for Medicaid (STAR, STAR+PLUS, STAR Health and STAR Kids) and CHIP MCOs appear in Table 1. Targets increase from calendar year (CY) 2018, the first year of the targets, to CY 2021. STAR Kids APM requirements launched one year later in CY 2019.[6] 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 in a risk-based model.[7] If an MCO fails to meet the APM targets or certain allowed exceptions[8] for high performing plans, the MCO may be subject to contract remedies, including corrective action plans (CAPs) and liquidated damages (up to $.10 per member per month). For DMOs, overall APM targets are the same, starting at 25 percent and growing to 50 percent, but risk-based targets are lower: two percent in CY 2018 growing to 10 percent by CY 2021.

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[4] 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.

[5] The provision related to APMs with providers is outlined in the HHSC Uniform Managed Care Contract (PDF), Section 8.1.7.8.2 "MCO Alternative Payment Models with Providers".

[6] The first-year target for STAR Kids APM target is the same as the 2018 targets for the other programs.

[7] APM targets, calculations, relevant definitions and APM reporting instrument are included in UMCM, Sec 8.10.

[8] An MCO may be exempted from the APM targets with high performance on two quality measures: potentially preventable hospital stays and emergency department visits. An MCO is exempt if their actual to expected (A/E) ratio on Potentially Preventable Emergency Department Visits (PPV) is <=0.90 and their 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 is based on the monthly Potentially Preventable Events (PPE) reports produced by the External Quality Review Organization (EQRO).

Table 1. 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%

HHSC uses the HCPLAN Alternative Payment Model (APM) Framework (Table 2) to help guide the APM initiative. This framework provides options of payment models from which MCOs can choose to develop APM contracts with their providers. Moving from a lower to a higher category adds a level of risk to the payment model. MCOs can choose any of these models in their transition to a payment structure based on value.

HHSC will consider alignment with some aspects of the revised APM objectives established by the HCPLAN in the Fall of 2019 that were revisited in light of the COVID-19 public health emergency in the Fall of 2020. The newly developed objectives are oriented to quality, patient experience and equity at lower cost. The HCPLAN considers two-sided risk APMs the most effective way to achieve these objectives and has proposed new goals for their adoption. Specifically, they established a goal to have 50 percent of APMs in states' Medicaid programs be two-sided risk APMs by 2025. This goal is significantly higher than HHSC's target for MCOs of 25 percent by 2021. HHSC will consider this target and other recommendations from the HCPLAN, along with state factors, when setting future VBP requirements for Medicaid and CHIP MCOs.

Table 2. Health Care Payment Learning and Action Network's APM Framework

CATEGORY 1: FEE FOR SERVICE – NO LINK TO QUALITY & VALUE	CATEGORY 2: FEE FOR SERVICE – LINK TO QUALITY & VALUE	CATEGORY 3: APMs BUILT ON FEE-FOR-SERVICE ARCHITECTURE	CATEGORY 4: POPULATION-BASED PAYMENT
	CATEGORY 2A: Foundational Payments for Infrastructure & Operations (e.g. care coordination fees and payments for HIT investments)	**CATEGORY 3A: APMs with Shared Savings** (e.g. shared savings with upside risk only)	**CATEGORY 4A: Condition-Specific Population-Based Payment** (e.g. per member per month payments for specialty services, such as oncology or mental health)
	Category 2B: Pay for Reporting (e.g. bonuses for reporting data or penalties for not reporting data)	**Category 3B: APMs with Shared Savings and Downside Risk** (e.g. episode-based payments for procedures and comprehensive payments with upside and downside risk)	**Category 4B: Comprehensive Population-Based Payment** (e.g. global budgets or full/percent of premium payments)
	Category 2C: Pay for Performance (e.g. bonuses for quality performance)		**Category 4C: Integrated Finance & Delivery Systems** (e.g. global budgets or full/percent of premium payments in integrated systems)
		3N: Risk Based Payments NOT Linked to Quality	4N: Capitated Payments NOT Linked to Quality

To further support transformation to value-based care and payment and achievement of the MCO targets, other APM-related MCO contract requirements include:[9]

- 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.

The intent of this APM initiative is to encourage MCOs to engage in negotiations with providers; therefore, these contract requirements apply only to MCOs. No provider is required to enter an APM contract with an MCO.

MCO Alternative Payment Model Achievement

HHSC collects annual MCO and DMO reports on their APM initiatives. In general, most of the reported APMs involve primary care providers, are rewards-based and build on a FFS payment approach with financial distributions for achieving established quality measures and lowering total cost of enrollee care. Additionally, MCOs have reported APMs with specialists (including obstetricians/gynecologists), behavioral health providers, hospitals, nursing facilities and long-term services and supports providers.

In 2018, the first year for HHSC's Medicaid MCO APM targets, MCOs reported that 40 percent of their payments to providers were in an APM, with about 22 percent in a risk-based APM.[10] As a whole, the Texas Medicaid and CHIP programs performed at or above contractually-required thresholds and national goals in 2018, though performance varied somewhat by program (Figures 1 and 2).

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[9] 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.

[10] 2018 APM targets include the STAR, STAR+PLUS, CHIP and STAR Health programs. STAR Kids requirements are effective beginning in 2019 and will be included in future calculations of these targets. STAR Health results encompass a single plan and thus are not reported here, though the program remains on schedule to meet the 2021 targets.

Figure 1 shows data comparisons in overall APM achievement for STAR, STAR+PLUS and CHIP for calendar years 2017, 2018 and 2019. Year 2017 was a baseline year when MCOs measured and reported the APMs established with their providers prior to the effective date of the contract requirements. Overall, APM achievement from 2017 to 2019 increased for all participating programs (STAR, STAR+PLUS and CHIP).

Figure 1. Overall APM Achievement by Program CY 2017-2019

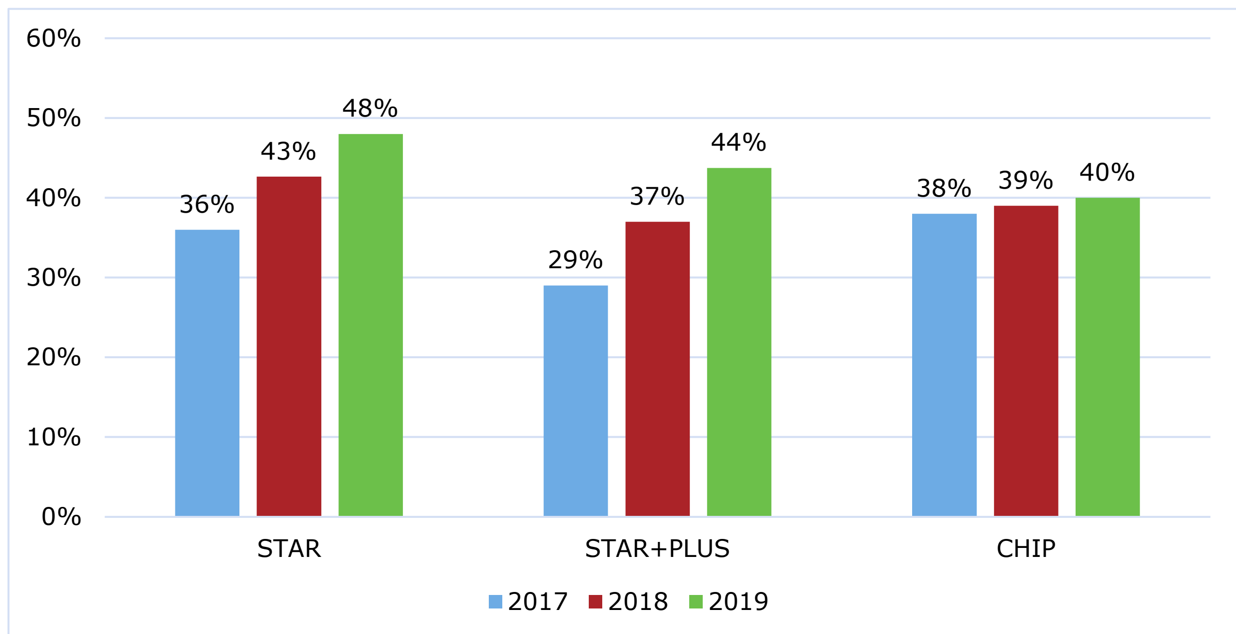


Figure 2 shows data for risk-based APM achievement for STAR, STAR+PLUS and CHIP for calendar years 2017, 2018 and 2019, again showing improvement across the three years.

Figure 2. Risk-based APM Achievement by Program, CY 2017-2019

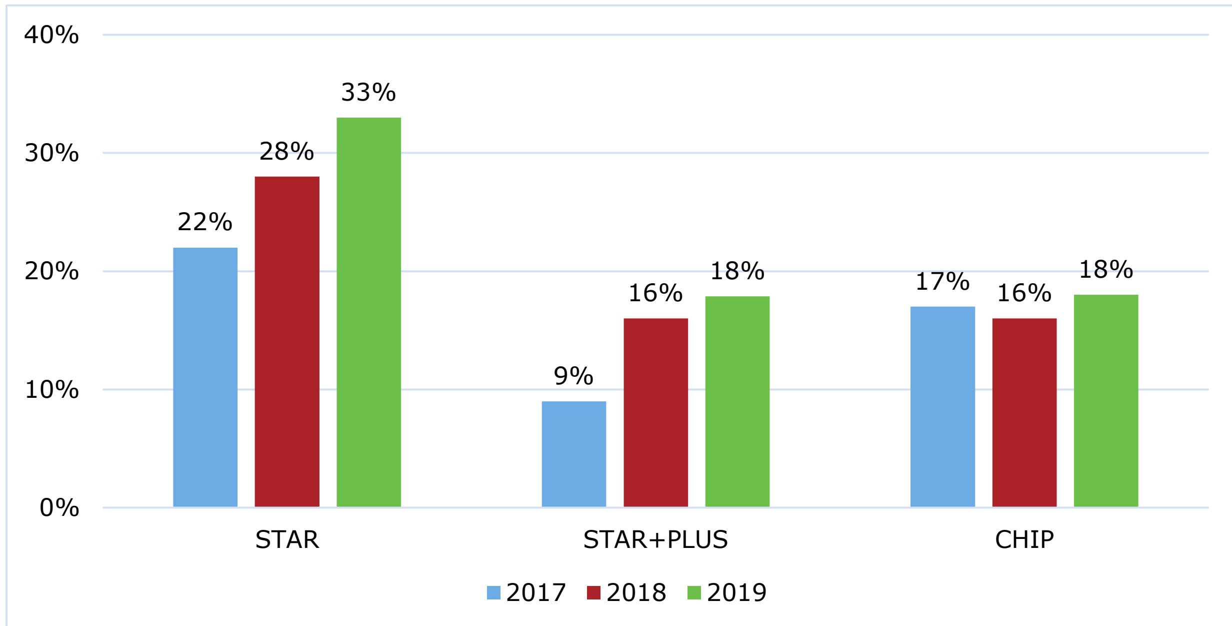


Table 3 shows the number and percent of APMs with and without downside risk across all product lines and members served. From CY 2017 to CY 2019, the total number of models increased rapidly, with the ratio between upside only and downside risk models remaining about the same. Just under 30 percent of the models involve both upside incentives and downside risk for the provider.

Table 3. Distribution of APMs by Type of Financial Risk, CY 2017-2019

Type of Financial Risk for Providers	2017 APM Count	2017 Percent of APMs	2018 APM Count	2018 Percent of APMs	2019 APM Count	2019 Percent of APMs
Upside Incentives Only	184	72%	249	71%	284	71%
Upside Incentives and Downside Risk	72	28%	102	29%	115	29%
TOTAL	256	100%	351	100%	399	100%

As shown in Table 4, since 2017, APMs established in Medicaid have tended to focus on primary care, followed by hospitals and specialists/behavioral health providers. For 2018, nearly three-fourths of all models were for those provider types, with over 40 percent in primary care alone. For 2019, the emphasis on primary care continued, as these models grew to comprise 45 percent of all models.

Table 4. Distribution of APMs by Provider Type, CY 2017-2019

Provider Type	2017 APM Count	2017 Percent of APMs	2018 APM Count	2018 Percent of APMs	2019 APM Count	2019 Percent of APMs
Primary Care	103	40.2%	143	40.7%	181	45.4%
Hospitals	51	19.9%	62	17.7%	60	15.0%
Specialist, Behavioral Health, Mental Health	26	10.2%	50	14.3%	51	12.8%
Accountable Care Organization	19	7.4%	36	10.3%	43	10.8%
Obstetrics/Gynecology	27	10.5%	27	7.7%	29	7.3%
Pharmacy and Lab	9	3.5%	17	4.8%	16	4.0%
Health Home, Nursing Facilities and Home Care	17	6.6%	9	2.6%	13	3.3%
Emergency Services and Urgent Care	4	1.6%	7	2.0%	5	1.3%
Case Management	0	0.0%	0	0.0%	1	0.3%
Total	**256**	**100%**	**351**	**100%**	**399**	**100%**

While HHSC continues to prioritize expanding VBP through MCO contract requirements, the ultimate goal is not for MCOs to just meet APM targets but rather to push the Medicaid program to achieve the highest quality and most efficient care. To this end, MCOs appear to be leveraging the APM initiative to reward providers they measure as high performing. Not counting the HQBP, which is downside risk only, as of 2019, physicians and other providers were receiving about $95 million annually in net incentive payments, typically in addition to a standard contracted rate.

Moving Forward with Value-Based Payment Reform

HHSC publicly reports MCO APM data on its Value-Based Care website.[11] MCOs are required to submit annual reports to HHSC outlining past and proposed APMs. The reports include amounts of incentive payments to doctors, hospitals and other providers. HHSC has released annual summaries of the value-based contracting

[11] HHSC Value-Based Care website: https://hhs.texas.gov/about-hhs/process-improvement/improving-services-texans/medicaid-chip-quality-efficiency-improvement/value-based-care

arrangements reported by the MCOs since 2014. In 2016, the detail available in these summaries expanded to include, among other items, descriptions of quality measures used in the payment models.

In addition, the Delivery System Reform Incentive Payment (DSRIP) program has been an incubator for testing how alternative payment models can support patient-centered care and clinical innovation. In the DSRIP Program, lump sum payments are made directly from HHSC to performing providers based on achievement of certain performance goals rather than fee-for-service utilization. Beginning in 2017, the DSRIP program structure evolved and providers transitioned to reporting on more clinical outcome measures, some of which Medicaid MCOs may wish to adopt in new APMs.

Efforts to increase adoption of effective APMs by Medicaid MCOs and providers benefit from high levels of multi-stakeholder input. This includes input from providers and MCOs who have had to adapt quickly to the COVID-19 public health emergency to safely treat patients, both for COVID-19 and for ongoing care. These adaptations included expanding telemedicine and telehealth reimbursement and increasing prospective provider payment arrangements with MCOs. HHSC is studying ways to better reward success for addressing social determinants of health and evaluating flexibilities for teleservices and other changes made in response to the COVID-19 public health emergency. The ongoing lessons learned from the COVID-19 response should be considered when developing new APM approaches both for the current and future emergencies.

3. Conclusion

Promoting APMs through managed care continues to play an important role in the transformation of Texas’ Medicaid and CHIP programs into a more accountable value-based healthcare delivery system. Overall, MCOs have performed at or above contractually required targets in 2018 and 2019 and appear to be leveraging this initiative to provide incentive dollars to high-performing providers. Texas plans to promote existing APMs and work with stakeholders to facilitate new and more advanced arrangements.

To accomplish these goals, HHSC will work to increase the alignment of quality measures and financial incentives between VBP initiatives, reduce technological and logistical barriers for participating organizations and implement lessons learned from existing initiatives such as DSRIP and from other programs such as Medicare. HHSC will continue to track and review emerging trends and engage stakeholders to find timely solutions that advance quality and value in Medicaid and CHIP for better care, healthier people and communities and lower costs.

List of Acronyms

Acronym	Full Name
APM	Alternative Payment Models
BPW	Best Practices Workgroup
CAP	Corrective Action Plan
CHIP	Children Health Insurance Program
CMS	Centers for Medicare and Medicaid Services
CY	Calendar Year
DMO	Dental Maintenance Organization
DSRIP	Delivery System Reform Incentive Payment
EWC	Executive Waiver Committee
EQRO	External Quality Review Organization
FFS	Fee-For-Service
FFY	Federal Fiscal Year
HCPLAN	Health Care Payment Learning and Action Network
HHSC	Health and Human Services Commission
HQBP	Hospital Quality-Based Payment
LAN	Learning and Action Network

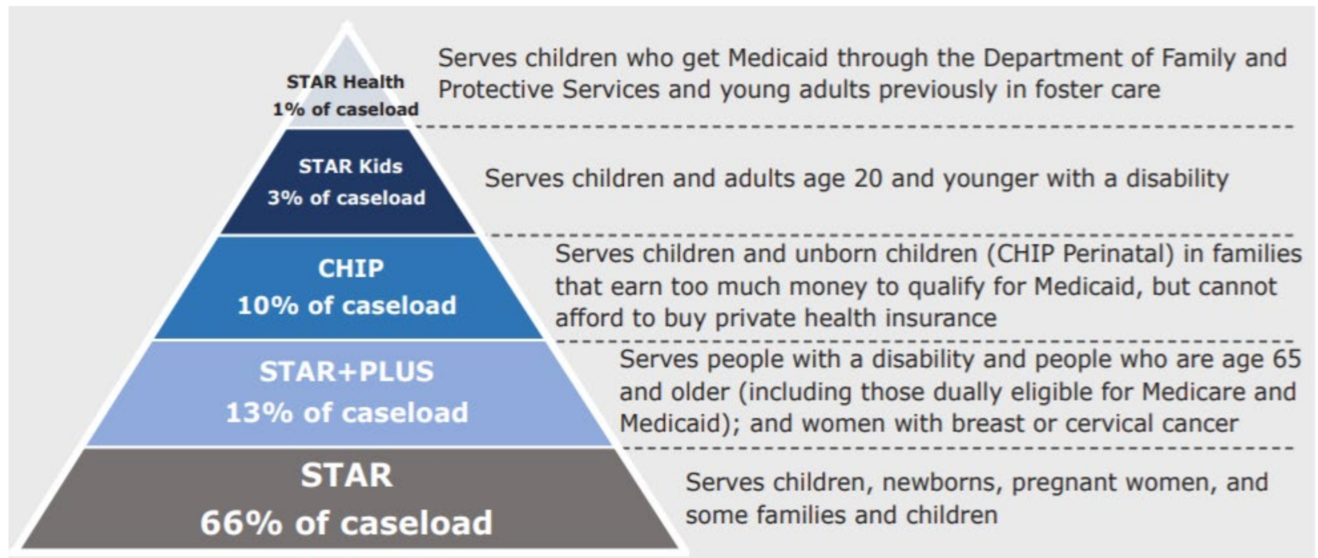
Acronym	Full Name
MCO	Managed Care Organization
P4Q	Pay-for-Quality
PPC	Potentially Preventable Hospital Complications
PPA	Potentially Preventable Hospital Admissions
PPE	Potentially Preventable Events
PPR	Potentially Preventable Hospital Readmissions
STAR	State of Texas Access Reform
STAR+PLUS	State of Texas Access Reform Plus
VBP	Value-Based Payment
VBPQI	Value-Based Payment and Quality Improvement Advisory Committee

Appendix A: Texas Medicaid and CHIP Programs

Over 95 percent of Texas Medicaid and 100 percent of the Children's Health Insurance Program (CHIP) clients are enrolled in managed care. HHSC contracts with 17 MCOs and three DMOs that manage networks of healthcare providers in their respective service areas. High-level descriptions of Texas' Medicaid and CHIP managed care programs are as follows:[12]

- State of Texas Access Reform (STAR) mainly covers pregnant women and children.
- STAR+PLUS is for adults who have a disability or who are 65 and older. It also covers people who are enrolled in both Medicaid and Medicare.
- STAR Kids serves youth and children with disabilities.
- STAR Health serves children in the conservatorship of the Department of Family and Protective Services and some young adults previously in foster care.
- CHIP covers lower income children and youth who do not otherwise qualify for Medicaid, typically because their family income is just above Medicaid limits.

Figure 3. Texas Medicaid Managed Care Programs



[12] Further detail on Texas' Medicaid and CHIP programs can be found in the HHS Texas Medicaid and CHIP Reference Guide, Thirteenth Edition (December 2020). Available at: https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2020/medicaid-chip-perspective-13th-edition/13th-edition-complete.pdf.