Benchmarks for Managed Care Organizations

As Required by
2022-23 General Appropriations Act, Senate Bill 1, 87th Legislature, Regular Session, 2021 (Article II, Health and Human Services Commission, Rider 20)

Texas Health and Human Services
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Executive Summary

The Health and Human Services Commission (HHSC) submits the Benchmarks for Managed Care Organizations report in compliance with the 2022-23 General Appropriations Act, Senate Bill (S.B.) 1, 87th Legislature, Regular Session, 2021 (Article II, HHSC, Rider 20). Rider 20 requires HHSC to develop quality of care and cost-efficiency benchmarks for managed care organizations (MCOs) participating in Medicaid and the Children's Health Insurance Program (CHIP), pursuant to Texas Government Code, Section 536.052(b). Appropriations for Medicaid Contracts and Administration for fiscal year 2023 are contingent on development of the required benchmarks by September 1, 2022.

Prior to development of the Rider 20 benchmarks, HHSC implemented initiatives and benchmarks to monitor and incentivize efficiency and quality of care in Medicaid and CHIP managed care. The benchmarks discussed in this report complement existing initiatives.

The benchmarks cover five domains in three broad areas: medical and administrative cost-efficiency, health-related measures (quality of care), and member experience and MCO operational performance (experience of care). For each domain, benchmarks categorize performance as exceptional, high, satisfactory, marginal, or low. Due to continued uncertainty around the effects of the novel coronavirus (COVID-19) federal public health emergency (PHE), the benchmarks may need to be adjusted once the federal PHE ends and updated data is available.

HHSC plans to provide MCOs with an initial round of performance reporting on these benchmarks before the end of calendar year 2022. HHSC will continue to use the underlying data for MCO oversight, continue to assess potential new uses of the benchmarks, and continue efforts to align quality initiatives. HHSC also plans to report on this effort in HHSC's Annual Report on Quality Measures and Value-Based Payments.

1. Introduction

Rider 20 requires HHSC to develop quality of care and cost-efficiency benchmarks for MCOs participating in Medicaid and CHIP, pursuant to Texas Government Code, Section 536.052(b). This report satisfies the rider requirement to report on development of the benchmarks by August 15, 2022.

> **Benchmarks for Managed Care Organizations.** Pursuant to Government Code §536.052(b), the Health and Human Services Commission (HHSC) shall develop quality of care and cost-efficiency benchmarks for managed care organizations participating in Medicaid and the Children's Health Insurance Program (CHIP). Appropriations in Strategy B.1.1, Medicaid Contracts & Administration, for fiscal year 2023 are contingent on HHSC developing the required benchmarks by September 1, 2022. HHSC shall report on the development of the benchmarks to the Governor and the Legislative Budget Board by August 15, 2022.

Texas Government Code, Section 536.052(b) was added by S.B. 7, 82nd Legislature, First Called Session, 2011. The subsection requires HHSC to develop quality of care and cost-efficiency benchmarks, including benchmarks based on an MCO's performance with respect to reducing potentially preventable events and containing the growth rate of health care costs.

> Sec. 536.052. PAYMENT AND CONTRACT AWARD INCENTIVES FOR MANAGED CARE ORGANIZATIONS. (a) The commission may allow a managed care organization participating in the child health plan program or Medicaid increased flexibility to implement quality initiatives in a managed care plan offered by the organization, including flexibility with respect to financial arrangements, in order to:
>
> (1) achieve high-quality, cost-effective health care;
>
> (2) increase the use of high-quality, cost-effective delivery models;
>
> (3) reduce the incidence of unnecessary institutionalization and potentially preventable events; and

(4) increase the use of alternative payment systems, including shared savings models, in collaboration with physicians and other health care providers.

(b) The commission shall develop quality of care and cost-efficiency benchmarks, including benchmarks based on a managed care organization's performance with respect to reducing potentially preventable events and containing the growth rate of health care costs.

(c) The commission may include in a contract between a managed care organization and the commission financial incentives that are based on the organization's successful implementation of quality initiatives under Subsection (a) or success in achieving quality of care and cost-efficiency benchmarks under Subsection (b).

(d) In awarding contracts to managed care organizations under the child health plan program and Medicaid, the commission shall, in addition to considerations under Section 533.003 of this code and Section 62.155, Health and Safety Code, give preference to an organization that offers a managed care plan that successfully implements quality initiatives under Subsection (a) as determined by the commission based on data or other evidence provided by the organization or meets quality of care and cost-efficiency benchmarks under Subsection (b).

(e) The commission may implement financial incentives under this section only if implementing the incentives would be cost-effective.

2. Background

Prior to the development of Rider 20 benchmarks, HHSC developed and implemented initiatives and benchmarks to monitor and incentivize efficiency and quality of care in Medicaid and CHIP managed care. Some initiatives were implemented pursuant to statutory or federal requirements and other initiatives were implemented to facilitate oversight of MCOs. Table 1 below details a few of the major initiatives, when they were implemented, the authority under which they were implemented, how they are currently used, and their general purpose. Additional information on these initiatives can be found in HHSC's Annual Report on Quality Measures and Value-Based Payments and the Texas Managed Care Quality Strategy.

Table 1. Select Medicaid/CHIP Managed Care Efficiency and Quality of Care Initiatives

Implementation Date	Initiative	Authority	Category of Use	Purpose
2014 (first publication date)	Managed Care Report Cards	Government Code, Section 536.051, Development of Quality-Based Premium Payments; Performance Reporting	Drive Enrollment/ Market Share	To empower prospective enrollees to make informed choices about MCOs in their service area.
January 1, 2018 (in current form)	Performance Indicator Dashboard	HHSC has broad statutory authority to operate the Medicaid program including authority found in Government Code Section 531.0055, Executive Commissioner: General Responsibility for Health and Human Services System, and Government Code Section 531.02113, Optimization of Medicaid Financing	MCO Oversight/ Contract Compliance	To monitor MCO performance across a broad range of quality measures based on minimum and high-performance standards, which are set based on rates for Texas Medicaid programs and national averages.

Implementation Date	Initiative	Authority	Category of Use	Purpose
January 1, 2018 (in current form)	Medical and Dental Pay for Quality Programs	Government Code, Section 536.004, Development of Quality-based Payment Systems	Financial Incentive/ Penalty	To incentivize performance improvement using financial risks and rewards, coupled with performance and improvement targets on quality measures.
January 1, 2018	Alternative Payment Model Targets	Government Code, Section 536.004, Development of Quality-based Payment Systems	MCO Oversight/ Contract Compliance	To increase MCO and DMO use of Alternative Payment Models, which link a portion of a provider's full health care payment to a measure or measures of quality, access, and/or efficiency or to other actions determined to advance quality, outcomes, or efficiency.
September 2020	Value-based Enrollment	Government Code, Section 533.00511, Quality-based Enrollment Incentive Program for Managed Care Organizations, and HHSC Rider 43, Quality- and Efficiency-based Enrollment Incentive Program (2020-21 General Appropriations Act, House Bill 1, 86th Legislature, Regular Session, 2019)	Drive Enrollment/ Market Share	Adjusts auto-enrollment enrollment for Medicaid managed care based on measures of quality and efficiency.

3. Development of Benchmarks

HHSC used the following guiding principles to develop the Rider 20 benchmarks:

- Select measures of cost-efficiency and quality, including operational performance and member and provider satisfaction.
- Select measures that are established and can be built upon, where feasible, and that align with other managed care oversight efforts.
- Select measures that can be calculated at the plan level, and as needed at the service area level.
- Select measures that capture the unique nature of different programs.
- Establish benchmarks based on national or other relevant standards, not current performance, to the extent possible.
- Identify opportunities to continue to evolve measurement once foundation is built.

HHSC first identified six relevant domains in three broad areas, then identified appropriate measures for five of the domains[1], and finally identified benchmarks for those measures. The methodology for setting the benchmarks may be more important than the identified benchmarks because uncertainty remains around the effects of the COVID-19 federal PHE on the selected measures. The actual benchmarks may need to be adjusted once the federal PHE ends and updated data is available.

The three broad areas and six associated domains are:

- Cost-Efficiency
    - Medical
    - Administrative
- Quality of Care
    - Health-related Measures

[1] HHSC was unable to develop benchmarks for provider experience because previous HHSC efforts to assess provider experience resulted in low response rates. HHSC recognizes the importance of provider experience in assessing overall plan performance and will continue efforts to establish meaningful benchmarks for this domain.

- Experience of Care
    - Member Experience
    - Provider Experience
    - MCO Operational Performance

HHSC engaged stakeholders, particularly MCOs, during the development of the benchmarks. HHSC held two meetings with MCOs and provided the opportunity to submit written feedback. HHSC presented a draft proposal for development of the benchmarks at the initial meeting and presented the benchmarks at the second meeting. Additionally, the draft proposal for development of the benchmarks was presented to the State Medicaid Managed Care Advisory Committee.

For each of the five domains (medical cost-efficiency, administrative cost-efficiency, quality of care, member experience, and MCO operational performance) for which measures are identified (see Figure 1), benchmarks categorize performance as exceptional, high, satisfactory, marginal, or low. This categorization provides more information about an MCO's performance than a single benchmark would capture and allows for greater differentiation between plans. The following sections describe how the measures and benchmarks for the five domains were identified.

Figure 1. Benchmark Domains by Area

Cost-Efficiency

The selected measure for Medical Cost-Efficiency is the risk-adjusted spending ratio. The spending ratio is currently one component of Value-based Enrollment, a quality initiative that has already been subject to substantial internal and external review and was reported on in January 2021. Calculation of the measure is straightforward and transparent with substantial information available in the annual

managed care rate-setting actuarial analysis reports.[2] Directed and supplemental payments, the amounts of which are outside of the MCOs' control, and administrative expenses are excluded from the measure. One limitation of the measure is that it excludes most long-term services and supports. In the future, HHSC will consider how to include these expenditures, which represent a substantial expense in STAR+PLUS and STAR Kids.

The spending ratio is calculated as actual expenditures divided by expected expenditures. Actual and expected expenditures are calculated by the state's External Quality Review Organization. Actual expenditures are calculated from MCO encounters for the applicable period. The expected expenditures are not based on amounts included in the premiums paid to the MCOs, unlike for administrative expenditures (described below). Expected expenditures are calculated using the Chronic Illness and Disability Payment System (CDPS), a diagnostic classification system designed to be used for Medicaid programs, and actual Texas Medicaid data.

HHSC developed a similar spending ratio to measure Administrative Cost-Efficiency. While this measure is not currently in use, it mirrors the spending ratio selected to measure Medical Cost-Efficiency by comparing actual expenditures as reported in the administrative financial statistical reports (FSRs) to expected expenditures, which are derived from administrative components of the premiums paid to each MCO. These components include fixed and variable administrative amounts. Both actual and expected expenditures include amounts for quality improvement and service coordination, which are not included in the medical cost expenditures.

For both medical and administrative cost-efficiency, spending ratios above 1 identify plans for which actual expenditures exceed expected expenditures (relatively inefficient plans) and spending ratios below 1 identify plans for which actual expenditures were below expected expenditures (relatively efficient plans). While the spending ratio can be calculated for each program,[3] plan, and service area combination, the calculation of expected expense does not adjust for regional variation in health care expenditures. HHSC attempted to identify a methodology for regional adjustment, but there was not definitive evidence that any region(s) should be expected to have higher or lower costs, since all regions had plans with

[2] These reports are available by program and effective date on HHSC's Provider Finance Department, Managed Care Services webpage.
[3] Since there is only one MCO serving the entire state for STAR Health, no spending ratio is calculated for that program.

spending ratios above and below 1[4]. HHSC will continue to consider the need for regional adjustment. Spending ratios are calculated for each plan and program by combining actual and expected expenditures across all service areas where a plan is contracted to provide services.

One of the basic tenets of managed care is allowing MCOs some flexibility in how they manage spending, and MCOs may elect to spend more on administrative costs, including for quality improvement, with the intention to control medical costs or spend less on administrative costs with the potential that medical costs could be higher. Relying solely on medical cost may not reflect an MCO's overall cost-efficiency. Eventually, HHSC may develop a single measure of cost-efficiency that incorporates both medical and administrative spending, which may also address differences in how expected expenditures are derived for the medical and administrative spending ratios. Any evaluation of performance across the measures and benchmarks should consider medical and administrative spending together and whether low performance on one is offset by high performance on the other.

The benchmarks for each category of performance for Medical Cost-Efficiency are:

- Exceptional: Spending Ratio no more than .95
- High: Spending Ratio exceeds .95 but is no more than 1
- Satisfactory: Spending Ratio exceeds 1 but is no more than 1.06
- Marginal: Spending Ratio exceeds 1.06 but is no more than 1.15
- Low: Spending Ratio exceeds 1.15

The benchmarks for each category of performance for Administrative Cost-Efficiency are:

- Exceptional: Spending Ratio no more than .95
- High: Spending Ratio exceeds .95 but is no more than 1
- Satisfactory: Spending Ratio exceeds 1 but is no more than 1.54
- Marginal: Spending Ratio exceeds 1.54 but is no more than 1.99
- Low: Spending Ratio exceeds 1.99

[4] Based on review of spending ratios for fiscal years 2018 and 2019 and the pre-COVID data set (March 2019 to February 2020).

The two highest levels of performance (exceptional and high) require actual expenditures to be below expected. The benchmarks of 1.06 and 1.15 for medical cost-efficiency and 1.54 and 1.99 for administrative cost-efficiency are one and two standard deviations above average based on actual plan performance.[5] These are the only benchmarks calculated based on actual historical performance data. HHSC was unable to find an alternative methodology to identify significant outliers. HHSC expects to use the same methodology when the benchmarks are implemented, but the actual benchmark values will vary based on updated performance data.

Quality of Care and Member Experience

The selected measure for the Quality of Care and Member Experience benchmarks is performance on the Performance Indicator Dashboard. HHSC already uses the dashboard to promote quality improvement and MCO accountability. The dashboard is based on program-specific measures that align with state and federal health care quality initiatives. Data by plan and program as well as supporting documentation are already publicly available on thlcportal.com. The dashboard reflects a broader range of quality measures than Value-based Enrollment, MCO Report Cards, or Pay for Quality, which should prevent plans from being advantaged or disadvantaged by selection of a narrow set of measures. Additionally, performance is comparable across years.

The dashboard includes measures that can be grouped into the following categories: Prevention, Chronic Disease Management, Behavioral Health, Maternal Health, Avoidable Hospitalizations, and Member Experience. As shown in Table 2, the number of measures in each category varies by program.

Table 2. Number of Dashboard Measures by Program and Category, 2022[6]

Category	STAR	STAR+PLUS	STAR Kids	STAR Health	CHIP
Prevention	13	8	13	8	12
Chronic Disease Management	7	20	4	0	2
Behavioral Health	21	20	10	8	4
Maternal Health	5	2	0	0	0
Avoidable Hospitalizations	9	8	6	2	5

[5] For Medical Cost-Efficiency, HHSC used the pre-COVID data set that is based on March 2019 to February 2020 expense. For Administrative Cost-Efficiency, HHSC used fiscal year 2019 data, the most recent pre-COVID data available.
[6] MCOs will not be evaluated on measures that have been retired or undergone specification changes; therefore, MCOs may be evaluated on fewer measures than identified in Table 2.

Category	STAR	STAR+PLUS	STAR Kids	STAR Health	CHIP
Member Experience	13	10	12	7	4
TOTAL	**68**	**68**	**45**	**25**	**27**

Each underlying measure has its own standard for high performance and minimum performance. The methodology for setting dashboard standards is published in the Uniform Managed Care Manual, Chapter 10.1.14. The standards are found under Resources at thlcportal.com. HHSC will continue to assess the measures in the dashboard.

The dashboard identifies the:

- Percentage of measures for which the high-performance standard is exceeded;
- Percentage of measures for which the minimum performance standard is met or exceeded but the high-performance standard is not met; and
- Percentage of measures for which the minimum performance standard is not met.

Benchmarks were developed for Quality of Care based on all dashboard measures, including Member Experience. Separate benchmarks were developed for Member Experience alone.

The benchmarks for each category of performance for Quality of Care are:

- Exceptional: Exceeds the high-performance standard for at least 70 percent of measures and below the minimum performance standard for no more than 20 percent
- High: Exceeds the high-performance standard for at least 60 percent of measures and below the minimum performance standard for no more than 30 percent, but doesn't meet "Exceptional"
- Satisfactory: Below the minimum performance standard for no more than 33.33 percent of measures, but doesn't meet "High"
- Marginal: Below the minimum performance standard for more than 33.33 percent of measures but not more than 50 percent of measures
- Low: Below the minimum performance standard for more than 50 percent of measures

The benchmarks for each category of performance for Member Experience are:

- Exceptional: Exceeds the high-performance standard for all survey measures
- High: Exceeds the high-performance standard for at least 75 percent of survey measures and below the minimum performance standard for no measures, but doesn't meet "Exceptional"
- Satisfactory: Below the minimum performance standard for no more than 33.33 percent of measures, but doesn't meet "High"
- Marginal: Below the minimum performance standard for more than 33.33 percent of measures but not more than 50 percent of measures
- Low: Below the minimum performance standard for more than 50 percent of measures

As noted in the Uniform Managed Care Manual, Chapter 10.1.14, the two lowest levels of performance align with current policy for dashboard performance that is subject to contractual remedies, including placement on a corrective action plan (CAP). The differences in exceptional and high benchmarks for Quality of Care and Member Experience reflect the smaller number of measures for Member Experience.

MCO Operational Performance

The managed care contracts include requirements for MCO performance for each contractual standard. MCOs are expected to meet or exceed all HHSC standards for the specified measures. If the MCOs fail to meet or exceed, HHSC may assess contractual remedies. The two most common remedies are CAPs, which specify the MCO's plan to address the identified non-compliance issue(s), and liquidated damages (LDs), which are financial remedies. LDs increase based on the significance of the non-compliance issue(s), including variance from the contractual standard, and the length of time during which the issue(s) has occurred. HHSC also performs enhanced monitoring, including targeted reviews, for severe or ongoing non-compliance issues. HHSC may employ other remedies specified in the managed care contracts for severe or ongoing non-compliance issues, including suspending member enrollment, disenrolling existing members, contract suspension, or contract termination.

For the MCO Operational Performance benchmark, a measure was created to assess compliance with contractual standards. Nine contract requirements in four categories were selected. The measure is a percentage calculated with a numerator of the number of times each MCO meets the standards in a fiscal year and a denominator of the number of opportunities an MCO had to meet the standards.

Table 3 shows the selected categories, measures, contractual standards, and frequency of measurement (number of opportunities to meet the standard).

Table 3. MCO Operational Performance Measure

Category	Measure	Contractual Standard	Annual Frequency (Opportunities to Meet Standard)
Appeals	Member Appeals	98 percent resolved within specified timeframes for standard and expedited appeals	Monthly (12)
Claims Timeliness	Clean Claims (Acute Care)	98 percent processed within 30 days	Monthly (12)
Claims Timeliness	Appealed Claims (Acute Care)	98 percent resolved in 30 days	Monthly (12)
Complaints Resolution	Member Complaints	98 percent resolved in 30 days	Monthly (12)
Complaints Resolution	Provider Complaints	98 percent resolved in 30 days	Monthly (12)
Network Adequacy	Hospital	90 percent of members meet time/distance standards	Quarterly (4)
Network Adequacy	Outpatient Behavioral Health	90 percent of members meet time/distance standards	Quarterly (4)
Network Adequacy	Obstetrician/ Gynecologists	90 percent of members meet time/distance standards	Quarterly (4)
Network Adequacy	Primary Care Providers	90 percent of members meet time/distance standards	Quarterly (4)

The selected measure includes a total of 76 opportunities to meet standards. HHSC will continue to assess including additional key operational performance measures (for example, encounters), which would increase the number of opportunities to meet standards. HHSC intends to exclude from the numerator and denominator any instance where a standard cannot be met, such as instances where an MCO has no member appeals, appealed claims, or complaints. The contractual standards for Network Adequacy require an MCO to meet the time/distance standards in each county where the MCO is contracted to provide services. For purposes of this measure, the calculation of percent of members who meet the time/distance standards will be made across all counties where the MCO is contracted to provide services. This should prevent MCOs who are contracted to provide services in rural

areas, where time/distance standards can be more challenging to meet, from being disadvantaged.

The categories of performance/benchmarks for MCO Operational Performance are:

- Exceptional: At least 95 percent compliance
- High: At least 90 percent, but less than 95 percent, compliance
- Satisfactory: At least 85 percent, but less than 90 percent, compliance
- Marginal: At least 80 percent, but less than 85 percent, compliance
- Low: Less than 80 percent compliance

Implementation Plan

HHSC plans to provide MCOs with an initial round of performance reporting before the end of calendar year 2022. Updated administrative expenditure data are expected in Fall 2022, which will align the fiscal year available (fiscal year 2021) for medical and administrative cost-efficiency and MCO operational performance. Quality of Care and Member Experience data will be from the 2020 dashboard. Due to timing of data releases, Quality of Care and Member Experience data will lag other domains.

HHSC will continue to assess potential uses of the benchmarks and continue efforts to align quality initiatives. These benchmarks are not intended to replace existing initiatives. HHSC also plans to report on this effort in future years in HHSC's Annual Report on Quality Measures and Value-Based Payments.

List of Acronyms

Acronym	Full Name
CAP	Corrective Action Plan
CDPS	Chronic Illness and Disability Payment System
CHIP	Children's Health Insurance Program
COVID-19	Coronavirus disease of 2019 (novel coronavirus SARS-CoV2)
FSR	Financial Statistical Report
HHSC	Health and Human Services Commission
LD	Liquidated Damage
MCO	Managed Care Organization
PHE	Public Health Emergency