

# **Assessment of Financial Incentives for Alternative Payment Models**

---

**Texas Delivery System Reform  
Incentive Payment Program  
Transition Plan**

**Health and Human Services  
Commission**

**June 2021**



**TEXAS**  
Health and Human  
Services

# Table of Contents

<b>Executive Summary .....</b>	<b>1</b>
<b>1. Introduction .....</b>	<b>3</b>
<b>2. Managed Care and Alternative Payment Models .....</b>	<b>4</b>
Managed Care in Texas Medicaid .....	4
Alternative Payment Models .....	4
<b>3. Current Incentives and Performance .....</b>	<b>6</b>
Contract Requirements.....	6
Payment structure .....	8
Additional Quality Incentive Programs.....	11
Trends in APMs and Performance Measures.....	15
<b>4. Challenges to Expanding APMs .....</b>	<b>17</b>
MCO Perspective on Barriers to APMs.....	17
Provider Perspective on Barriers to APMs .....	19
<b>5. Opportunities for Expanding APMs .....</b>	<b>23</b>
Increasing Data Exchange .....	24
Reducing Administrative Burden .....	25
Sustaining successes from DSRIP .....	26
<b>6. Conclusion .....</b>	<b>28</b>
<b>List of Acronyms .....</b>	<b>29</b>
<b>Appendix A. Responses to HHSC MCO Survey on APMs question regarding general barriers to APMs .....</b>	<b>1</b>
<b>Appendix B. Responses to HHSC MCO Survey on APMs question regarding barriers to APMs with rural and specialty providers .....</b>	<b>1</b>
<b>Appendix C. Responses to HHSC MCO Survey on APMs question regarding changes to reduce APM barriers .....</b>	<b>6-1</b>
<b>Appendix D. Responses to HHSC MCO Survey on APMs question regarding the most effective ways to align incentives .....</b>	<b>6-1</b>

## Executive Summary

The Delivery System Reform Incentive Payment (DSRIP) pool in the Texas 1115 Healthcare Transformation and Quality Improvement Program Waiver is authorized through September 30, 2021. As DSRIP funding ends, the Centers for Medicare & Medicaid Services (CMS) required Texas to submit a DSRIP Transition Plan, which lays the groundwork to develop strategies, programs, and policies to sustain successful DSRIP activities and for emerging areas of innovation in health care.<sup>1</sup> According to the [DSRIP Transition Plan](#), the Texas Health and Human Services Commission (HHSC) must assess the financial incentives for Medicaid managed care organizations (MCOs) and providers to use meaningful quality-based alternative payment models (APMs) and identify opportunities to strengthen or align incentives.

Texas has financial and contractual mechanisms to incentivize MCOs and providers to engage in quality-based APMs:

- **Contract Requirements**—MCOs must meet quality goals and contractual minimums on performance measures or they could be subject to financial damages. They also agree to meet or exceed minimums for the percentage of payments to providers that must be paid through APMs and minimum quality performance thresholds.
- **Payment Structure**—MCOs are paid a fixed amount per member per month based on historical costs. MCOs are at financial risk if the cost of care exceeds this rate, which incentivizes them to improve care quality while keeping costs low. Other requirements incentivize MCOs to ensure they spend a certain amount of revenue on medical and quality improvement expenses, which includes care coordination. MCOs can include certain Quality Improvement as medical instead of administrative costs when calculating the experience rebate<sup>2</sup>, and some of those quality improvement costs may be factored into future rate setting.
- **Additional Quality Improvement Incentive Programs**—

---

<sup>1</sup> [DSRIP Transition Plan, HHSC, August 2020](#)

<sup>2</sup> Experience rebate is the process of determining the amount of profit earned through the Medicaid managed care program that a managed care organization (MCO) must share with the state of Texas.

- ▶ Under the Pay-For-Quality program, a percentage of capitation rates are at risk for recoupment if quality measures are not achieved. Recoupments can be re-distributed to high performing MCOs.
- ▶ The Value-Based Enrollment Incentive Program assigns Medicaid managed care members to high performing MCOs if members do not make their own selection during enrollment.
- ▶ Under the Hospital Quality-Based Payment Program, a percentage of total payments to hospitals are at risk for high rates of potentially preventable readmissions (PPRs) or potentially preventable complications (PPCs).<sup>3</sup>

In aggregate, Texas Medicaid MCOs met or exceeded contractual targets and national goals for the amount of payments associated with APMs in 2018 and 2019.<sup>4</sup> Similarly, MCOs exceeded expectations with their performance on the Medicaid medical Pay-for-Quality program in 2018 and 2019. MCO performance on quality measures not associated with a financial incentive has been mixed.

HHSC surveyed MCOs and DSRIP providers on the barriers and opportunities for using more robust quality-based APMs. HHSC also worked with the Texas Medical Association (TMA) to survey individual physicians about APMs. To enhance the use of APMs in managed care, MCOs and providers indicated improving access to timely data and reducing administrative burden would most effectively encourage the use of APMs. MCOs have flexibility to design APMs, which can allow for innovation, but also adds administrative complexity for providers contracted with more than one MCO.

To reduce administrative burden, HHSC could select certain performance measures and APMs that MCOs and providers could choose from, to better align quality measures and payment models across providers. The practices and measures considered most effective from the DSRIP program and the current managed care APM programs could be a starting point for these new models. All APMs will also have to account for the COVID-19 public health emergency, which significantly disrupted the health care system and will affect both performance and data collection for 2020 and beyond.

---

<sup>3</sup> [Texas Medicaid and CHIP Reference Guide, 13<sup>th</sup> edition, HHSC 2020](#)

<sup>4</sup> Data for 2020 is not yet available.

# 1. Introduction

The DSRIP pool in the Texas Healthcare Transformation and Quality Improvement Program Medicaid 1115 Demonstration (Waiver) has benefitted Texans and the Texas healthcare delivery system. Texas providers earned over \$19.8 billion in DSRIP funds from 2012 to January 2021, and served an average of 15.6 million unique individuals per year in DSRIP 2.0 from October 1, 2017 to September 30, 2020.

DSRIP is authorized through September 30, 2021. CMS required Texas to submit a DSRIP Transition Plan, which lays the groundwork to develop strategies, programs, and policies to sustain successful DSRIP activities and for emerging areas of innovation in health care.

Pursuant to the DSRIP Transition Plan, HHSC must assess the financial incentives for Medicaid MCOs and providers to use meaningful quality-based APMs and identify potential opportunities to strengthen or align incentives. This report presents the state's assessment of the financial incentives it is using to encourage MCOs and providers to increase their use of APMs to advance value-based care and presents feedback from MCOs and providers on remaining barriers and opportunities for alignment.

## 2. Managed Care and Alternative Payment Models

### Managed Care in Texas Medicaid

While some Texas Medicaid clients still receive services through the fee-for-service (FFS) model, as of 2019 over 94 percent of Medicaid and all Children’s Health Insurance Program (CHIP) beneficiaries received services through the managed care delivery system. A goal of transitioning from FFS to managed care is to provide value-based care. MCOs can achieve value-based care by improving or stabilizing member health and delivering services in a cost-effective manner through care coordination.<sup>5</sup>

Texas Medicaid managed care is an integrated service delivery system where HHSC contracts with MCOs to provide covered, medically necessary services to Medicaid or CHIP recipients.

HHSC pays each MCO a monthly capitation rate for every member enrolled in their plan based on historical costs and MCOs reimburse providers for services provided to their members. This model places MCOs at financial risk if the cost of care exceeds this rate, which incentivizes them to manage the care of their members, including by improving care quality while keeping costs low.

### Alternative Payment Models

In contrast to FFS, APMs tie payment to quality and efficiency. These models are also known as value-based payments (VBP). Rather than only paying providers based on the volume of services delivered, MCOs can use VBPs to encourage providers to engage in evidence-based practices, collaborate with peers, and connect people to appropriate services.<sup>6</sup>

HHSC uses the Healthcare Payment Learning and Action Network (HCP LAN) APM Framework (Figure 1) to help guide this effort. This framework provides a menu of payment models from which MCOs could choose to develop APM contracts with their network providers. Moving from one category to the next adds a level of risk

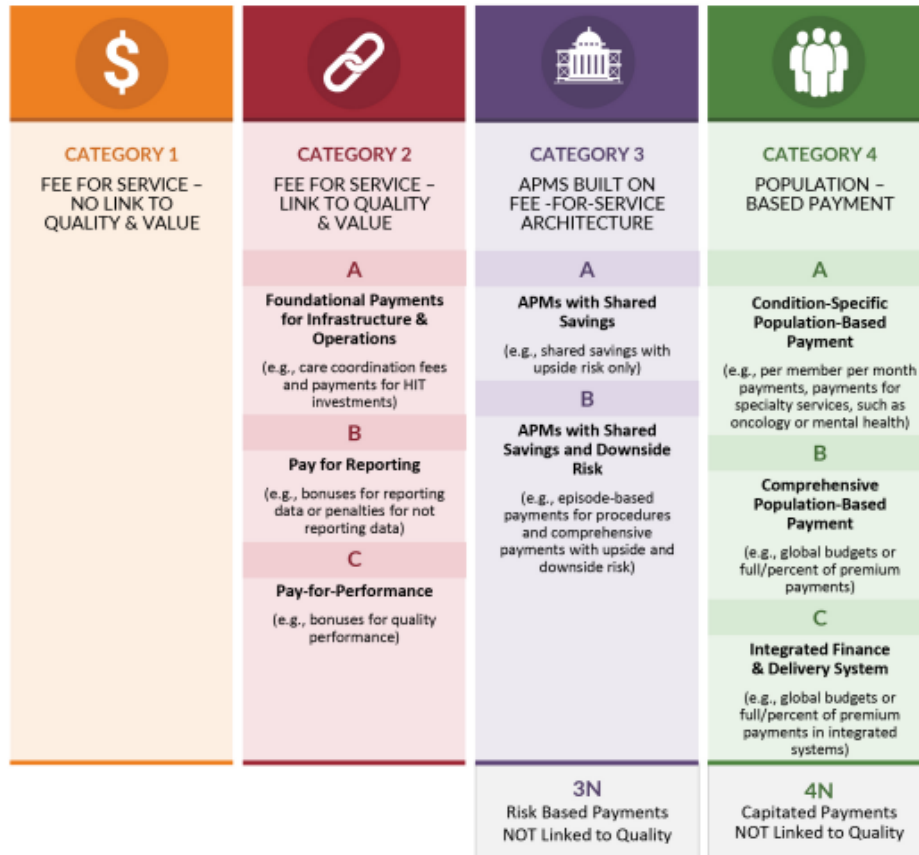
---

<sup>5</sup> [Texas Medicaid and CHIP Reference Guide, 13<sup>th</sup> edition, HHSC 2020](#)

<sup>6</sup> [Annual Report on Quality Measures and Value-Based Payments, HHSC December 2020](#)

to the provider in the payment model. MCOs can choose any of these models in categories 2 through 4 in their transition to a payment structure based on value.<sup>7</sup>

**Figure 1: HCP LAN Alternative Payment Model Framework**



Source: HCP LAN, hcp-lan.org

<sup>7</sup> [Annual Report on Quality Measures and Value-Based Payments, HHSC December 2020](#)

## 3. Current Incentives and Performance

### Contract Requirements

#### APMs

To accelerate adoption of APMs by MCOs, HHSC developed contractual requirements for MCOs that were effective as of calendar year 2018. MCOs and dental maintenance organizations (DMOs) must have a certain minimum percentage of their overall provider payments associated with an APM. For a certain percentage of these payments, the provider must have some degree of downside risk, meaning that the provider could face a payment reduction for not meeting a performance requirement established by the MCO/DMO. MCOs and DMOs are subject to contract remedies, potentially including liquidated damages, if these targets are not achieved.<sup>8</sup>

Additionally, MCOs have requirements to:

- Report to HHSC on APM models that are being deployed or are in the planning stage
- Dedicate sufficient resources for provider outreach and negotiation, assistance with data and report interpretation, and other collaborative activities to support APM and providers' improvement
- Establish and maintain data sharing processes with providers, require data and report sharing between MCOs and providers, and collaborate on common formats
- Dedicate resources to evaluate the impact of APMs on utilization, quality and cost, as well as return on investment

Figure 2 shows the targets for calendar years (CYs) 2018 through 2021. In the years in between, MCOs and DMOs must increase their APM ratios by 25 percent for overall APM targets and 10 percent for risk-based targets year over year, until they reach the target ratio for 2021. If an MCO does not achieve the target APM

---

<sup>8</sup> The provision related to alternative payment models for providers is outlined in the HHSC Uniform Managed Care Contract, Section 8.1.7.8.2 MCO Alternative Payment Models with Providers and data is reported with the tool provided in the [Uniform Managed Care Manual, Chapter 8-10](#).



percentages but performs better than the state average on potentially preventable emergency department visits (PPVs) and potentially preventable hospital admissions (PPAs) by 10 percent, liquidated damages are waived.

**Figure 2: Contractual Minimums for MCO and DMO payments associated with APMs**

Managed Care Plan Type	Minimum APM Ratio	Year 1 (CY 2018)	Year 2 (CY 2019)	Year 3 (CY 2020)	Year 4 (CY 2021)
MCO & DMO	Overall APM Ratio	>= 25%	Year 1 Overall APM Ratio +25%	Year 2 Overall APM % + 25%	>= 50%
MCO	Risk-Based APM Ratio	>= 10%	Year 1 Risk-Based APM Ratio +25%	Year 2 Risk-Based APM % + 25%	>= 25%
DMO	Risk-Based APM Ratio	>= 2%	Year 1 Risk-Based APM Ratio +25%	Year 2 Risk-Based APM % + 25%	>= 10%

Source: HHSC Uniform Managed Care Manual Chapter 8.10 Alternative Payment Models Data Collection Tool

For CY 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.<sup>9</sup> More details on these results can be found in the December 2020 [Annual Report on Quality Measures and Value-Based Payments](#).

In addition to minimum APM targets, HHSC expects Medicaid MCOs to meet or surpass the HHSC-defined minimum standard on more than two-thirds of the measures on Performance Indicator Dashboards. The Performance Indicator Dashboards for Quality Measures includes measures for the STAR, STAR+PLUS, STAR Health, and STAR Kids programs that assess different aspects of healthcare quality which HHSC has determined to be of greatest importance. The minimum standard is the program rate or the national average, whichever is lower, from two years prior to the measurement year. Beginning with measurement year 2018, an MCO whose per program performance is below the minimum standard on more

<sup>9</sup> [Annual Report on Quality Measures and Value-Based Payments, HHSC December 2020. The same APM requirements are included in other managed care contracts.](#)

than 33 percent of the measures on the dashboard is subject to remedies under the contract, such as placement on a corrective action plan.<sup>10</sup>

## Payment structure

The state's payment structure also creates incentives that affect MCOs' contracting with providers. Capitation rates are established each year based on actual, reported managed care costs. The capitation rates include provision for client services, administrative and quality improvement costs, premium taxes, and risk margin. If spending to provide contracted services exceeds their capitation rate payments, the MCOs will experience financial losses.<sup>11</sup>

For most managed care programs, HHSC employs a community-based rate with risk adjustment capitation model. This model sets capitation rates based on the collective experience of multiple MCOs and incentivizes competition among MCOs operating in the same program and service area. However, when a health plan invests in a strategy that reduces high cost services, such as a VBP initiative to reduce emergency department care or hospitalization, associated savings result in lower costs incorporated in the community rates. If HHSC lowers MCO payment rates the reductions are spread among the MCOs operating in the same program and service area via the community rates. It does not correlate to a particular MCO's capitation rates being reduced. The MCO that actually achieved the savings should benefit if they outperform the other MCOs in terms of savings.

An MCO is incentivized to invest in their operations and provide more efficient (lower cost) care because savings achieved in the short term create profit opportunity for the MCO and savings achieved long term allow the MCO to potentially operate at a lower cost than their competitors, creating further profit opportunities.

While capitated rates incentivize cost containment and efficiency, according to the Medicaid and CHIP Payment and Access Commission, some argue that a capitated payment system can also "create incentives to undertreat patients to minimize treatment costs."<sup>12</sup> The state uses many methods to ensure MCOs provide required and quality care. In addition to MCO monitoring and oversight, the state also uses

---

<sup>10</sup> [HHSC Uniform Managed Care Manual Chapter 10.1.14 Performance Indicator Dashboards for Quality Measures](#)

<sup>11</sup> [Texas Medicaid and CHIP Reference Guide, 13<sup>th</sup> edition, HHSC 2020](#)

<sup>12</sup> [Medicaid Managed Care Payment, Medicaid and CHIP Payment and Access Commission](#)

incentives for MCOs to provide high quality care for their members, including those discussed below. These incentives focus on provider payment models and quality measurement.

## **Medical Loss Ratio and Experience Rebate**

A medical loss ratio (MLR) is the proportion of premium revenues spent on clinical services and quality improvement.<sup>13</sup> CMS requires capitation rates for Medicaid MCO contracts starting in 2019 to be developed to reasonably achieve an MLR of at least 85 percent<sup>14</sup> to ensure that health plans spend at least that percentage on beneficiaries' medical care rather than on administration and profit.<sup>15</sup> Some states require MCOs that do not meet minimum MLR requirements to pay remittances.<sup>16</sup>

Instead of paying remittances for not meeting minimum MLR requirements, Texas uses an experience rebate system. Capitation rates paid to MCOs includes a risk or profit margin to account for fluctuations in predicted claims cost and provide financial incentive to participate. If actual costs are lower than expected, then the MCO may profit. However, MCO profits are contractually limited and any profits earned over three percent are recovered by HHSC through a tiered experience rebate system<sup>17</sup>, which is shown in Figure 3. HHSC does not share financial responsibility with MCOs for losses.

## **Quality Improvement Costs**

Federal rules ([42 C.F.R. § 438.8\(e\)\(3\)](#)) allow certain expenses<sup>18</sup> for activities that are designed to improve health care quality to be counted as medical costs in the MLR for Medicaid MCOs. When reporting their expenses to the state in the Financial Statistical Reports (FSRs), these expenses are called Quality Improvement (QI) costs.<sup>19</sup> Not only are they included in the MLR, but QI costs reported on the FSRs are used to develop future capitation rates and are not counted towards MCOs' administrative expense cap. Allowing expenses associated with an activity to be claimed as QI costs, instead of as administrative costs, incentivizes MCOs to engage

---

<sup>13</sup> [Medical Loss Ratio, CMS](#)

<sup>14</sup> [Medicaid Managed Care Payment, Medicaid and CHIP Payment and Access Commission](#)

<sup>15</sup> [States' Oversight of Medicaid Managed Care Medical Loss Ratios, HHS OIG](#)

<sup>16</sup> ["A View from the States: Key Medicaid Policy Changes: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2019 and 2020", KFF, 2019](#)

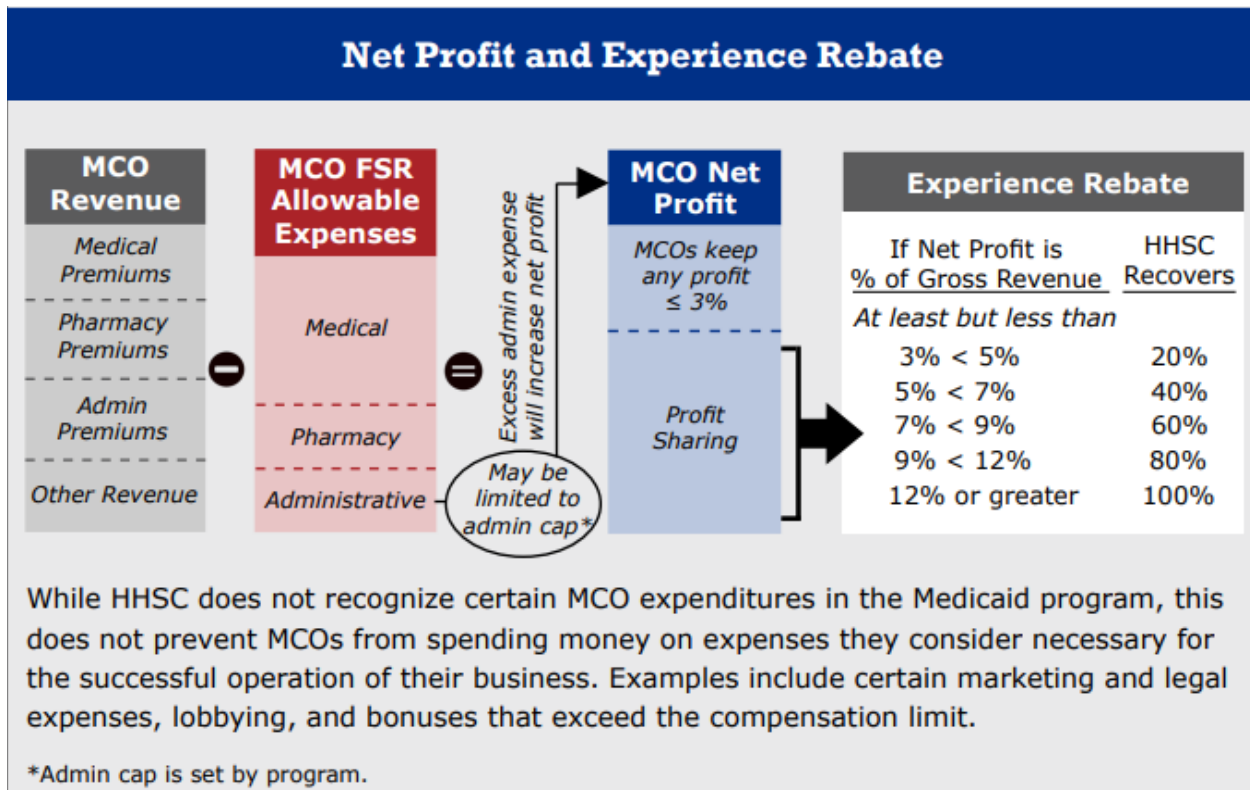
<sup>17</sup> [Texas Medicaid and CHIP Reference Guide, 13<sup>th</sup> edition, HHSC 2020](#)

<sup>18</sup> Activities that improve health care quality are described in 45 C.F.R. §158.150 and §158.151

<sup>19</sup> [Uniform Managed Care Manual, Chapter 6.1, Cost Principles for Expenses](#)

in that activity or provide that service. In Figure 3, which shows how the MCO’s net profit and experience rebate are calculated, QI costs would be included in the “Medical” section of the MCO FSR Allowable Expenses, even if under accounting guidelines they would be intrinsically classified as administrative expenses, such as staff salaries. Only the remaining non-QI portion may be subject to the administrative expense cap.

**Figure 3: Calculation of MCO Net Profit and Experience Rebate**



Source: HHSC

In its November 2018 report, HHSC’s Value Based Payment and Quality Improvement Advisory Committee (VBPQIAC) recommended that HHSC provide additional guidance to MCOs and providers on allowable QI costs.<sup>20</sup> The Uniform Managed Care Manual (UMCM) Chapter 6.1, Cost Principles for Expenses, provides some information on how MCOs should count QI expenditures. HHSC will release its *Quality Improvement Cost Guidance* to MCOs in fiscal year 2021 to provide

<sup>20</sup> [Texas Value-Based Payment and Quality Improvement Advisory Committee Recommendations to the 86th Texas Legislature, November 2018](#)

additional direction and support to MCOs and to promote their use of this quality improvement tool.

## **Other activities that improve health care quality**

MCOs have the flexibility to offer other services that are not covered by Texas Medicaid programs and are not QI costs. These additional services or benefits are generally intended to improve patient health and well-being, which can also lower costs and improve performance outcomes for MCOs. The financial incentives and reporting requirements vary for different types of additional benefits, and these differences could affect an MCOs' decision to offer a certain benefit through an APM.

Value-Added Services (VAS), Case by Case services, and Rewards and Incentives<sup>21</sup> may be counted in the numerator of the MLR, which can help the MCO meet their minimum MLR requirements, but they cannot be used when developing future capitation rates. In contrast, Flexible Benefits and "In Lieu of" services<sup>22</sup> may be counted in the numerator of the MLR and when developing future capitation rates.

Paying for these other services is only considered a VBP if it is tied to quality outcomes or otherwise integrated into an APM, such as a capitated or bundled payment. However, even when using an APM that may bundle several types of services, Medicaid managed care rules governing those services still apply.

## **Additional Quality Incentive Programs**

### **Pay-For-Quality Programs**

To improve quality, reward the use of evidence-based practices, and promote healthcare coordination and efficacy among MCOs, HHSC implemented medical Pay-

---

<sup>21</sup> VAS and Case-by-Case services are additional benefits that MCOs can provide to members beyond covered services. For more information, see [Texas Administrative Code §353.409](#) and UMCC version 2.30 Definitions for VAS and [UMCC Sec. 8.1.2.2](#) for Case-by-Case services. Rewards and Incentives in the MMP contract are positive incentives that HHSC determine will promote healthy lifestyles and improve health outcomes among Enrollees; for more information see [MMP Contract](#) Sec. 1.142.

<sup>22</sup> "In lieu of" services are services substituted for Medicaid State Plan services or settings, as allowed by 42 Code of Federal Regulations (CFR) §438.3(e). For more information on "In Lieu of" services, see [Medical Behavioral Health In Lieu Of Services Annual Report](#), HHSC, November 2020. Flexible Benefits are another category of additional services MCOs may offer beyond covered services; they are defined in the [MMP contract](#) Sec. 1.72.

for-Quality (P4Q) programs for STAR, STAR+PLUS, STAR Kids<sup>23</sup>, and CHIP, and a dental P4Q program. In the dental P4Q program, up to one and a half percent of DMO's capitation is at-risk. For the medical P4Q programs, up to three percent of each MCO's capitation is at-risk of recoupment if MCOs do not meet target performance thresholds. HHSC suspended the medical and dental P4Q programs for measurement year 2020 because of the COVID-19 public health emergency (PHE).

24

Recouped capitation dollars from low performing MCOs for at-risk measures are redistributed to high performing MCOs. If there are any remaining funds after the collection and redistribution process, they form a performance bonus pool to reward high-performing MCOs on specific measures. Because there are significant capitation dollars for an MCO to lose or gain, this program incentivizes MCOs to collaborate with providers to develop VBP models that can help ensure their success.<sup>25</sup> More details on these programs are available in the December 2020 [Annual Report on Quality Measures and Value-Based Payments](#). Results from the P4Q program for 2018 and 2019 are available online on the [Texas Healthcare Learning Collaborative \(THLC\) P4Q Performance Dashboard](#).

## **Value Based Enrollment Algorithm**

On September 1, 2020, HHSC began a phased implementation of a new value based enrollment (VBE) algorithm. As of December 1, 2020, HHSC is enrolling Medicaid recipients who did not select an MCO into plans based on a value-based enrollment methodology that incorporates results from key cost, quality and member satisfaction metrics into the existing method. This incentivizes MCOs to compete with other MCOs in their service delivery area on the following factors<sup>26</sup>:

- Risk-Adjusted Ratio of Actual to Expected Spending (Cost or Efficiency);
- Risk-Adjusted Potentially Preventable Events Ratios (Cost and Quality);
- Composite Report Card Scores (Quality and Member Satisfaction):
  - ▶ Member experience with doctors and the MCO – derived from results of member surveys;
  - ▶ Staying healthy – MCO performance on preventive care measures; and

---

<sup>23</sup> Evaluation of STAR Kids MCOs for the medical P4Q program will begin with calendar year 2021, instead of 2020 due to the COVID-19 PHE.

<sup>24</sup> [Annual Report on Quality Measures and Value-Based Payments, HHSC December 2020](#)

<sup>25</sup> [Value-Based Enrollment Incentive Program, HHSC January 2021](#)

<sup>26</sup> [Annual Report on Quality Measures and Value-Based Payments, HHSC December 2020](#)

- ▶ Controlling chronic diseases – MCO performance on important quality measures regarding care for asthma, Attention Deficit Hyperactivity Disorder, Chronic Obstructive Pulmonary Disease, depression, or diabetes, depending on the program.

Based on May 2021 enrollment data, the VBE algorithm resulted in some STAR MCOs gaining up to 12 percent enrollment and others losing up to 12 percent compared to the previous approach, which did not incorporate performance on quality/value metrics. In the STAR Plus Program, the analysis showed gains of up to two percent and losses up to five percent. For the STAR Kids Program, MCOs gained up to nine percent and lost up to five percent.

An evaluation of the impact of the implementation of the VBE algorithm on overall Medicaid will be possible after an entire year of enrollment data is gathered.

### **Hospital Quality-based Payment Program**

In addition to the financial incentives for MCOs, HHSC administers the Hospital Quality-Based Payment Program in which hospitals (both in FFS and managed care) may experience recoupment of a percentage of their total payments for inpatient stays for high rates of PPRs or PPCs.<sup>27</sup> Hospitals can experience reductions of up to two percent for high rates of PPRs and 2.5 percent for PPCs.<sup>28</sup> This arrangement is an APM itself which could incentivize hospitals to enter into APMs for services that improve care transitions to reduce PPRs or improve hospital safety to reduce PPC rates. This program also provides an incentive to hospitals to notify MCOs about patient hospitalizations so that MCOs can provide required case management and care coordination. MCOs count payments under the Hospital Quality-Based Payment Program towards contractual targets for risk-based APMs.

### **Nursing Facility Quality Incentive Payment Program (QIPP)**

QIPP is a directed payment program which seeks to improve quality and innovation in nursing facility (NF) services. Both public and private NFs can participate in the program, and over 880 of the state's 1,200 facilities (almost 100 percent of Medicaid-enrolled NFs) are enrolled for state fiscal year 2021. Payments are made monthly and quarterly by the STAR+PLUS MCOs to the NFs, based on their

---

<sup>27</sup> [Texas Medicaid and CHIP Reference Guide, 13<sup>th</sup> Edition, HHSC December 2020](#)

<sup>28</sup> [Annual Report on Quality Measures and Value-Based Payments, HHSC December 2020](#)

completion of required quality improvement activities and performance on CMS-approved quality measures.<sup>29</sup>

HHSC evaluates participating NFs' performance on quality measures on a quarterly basis. After two full years of data became available, HHSC compared the performance of facilities enrolled in QIPP and facilities not enrolled in QIPP. Results indicate that QIPP was successful in achieving performance gains by participating NFs on program measures of residents' health and safety. Overall quality gradually improved for QIPP participating facilities for all four metrics. Three of four metrics showed significant improvements when compared to non-QIPP facilities. These three metrics showed positive correlation between the implementation of QIPP and improved performance, suggesting QIPP participation may influence NF quality improvements. There was little difference between QIPP and non-QIPP NFs on their percentage of residents who received an antipsychotic medication. In addition to QIPP, multiple statewide initiatives to improve NF performance on this metric have already yielded very positive results<sup>30</sup> and may have lessened the measurable impact of QIPP. To continue incentivizing NFs to improve quality and innovation, HHSC adopted new quality measures, eligibility requirements and financing components for QIPP that began in program Year Three (fiscal year 2020) and continue through Year Four (fiscal year 2021). The new measures were developed by a workgroup comprised of stakeholders and HHSC staff and were approved by CMS.<sup>31</sup>

---

<sup>29</sup> [Texas Medicaid and CHIP Reference Guide, 13<sup>th</sup> Edition, HHSC December 2020](#)

<sup>30</sup> [News Release: Texas Decreases Use of Antipsychotic Drugs in Nursing Facilities, April 30, 2021](#)

<sup>31</sup> [Texas Managed Care Quality Strategy, HHSC March 2021](#)



## Trends in APMs and Performance Measures

In aggregate, Texas Medicaid MCOs met or exceeded contractually-required targets and national goals for the amount of payments associated with APMs in 2018 and 2019—the only years of data available—though performance varied somewhat by program.<sup>32</sup>

Results for the 2018 medical P4Q program show most MCOs met or exceeded goals on key quality of care measures. Only one MCO in STAR was subject to recoupment and 15 MCOs earned payments. In STAR+PLUS, all five MCOs performed well enough on the P4Q measures to earn a payment, however, none were subject to recoupment and therefore no money was available to redistribute.<sup>33</sup> For 2019, again most MCOs achieved medical P4Q performance requirements: 14 of the 16 STAR MCOs earned payments, and three of the five STAR+PLUS MCOs earned payments.

In addition to the P4Q program measures, HHSC monitors MCO performance using a performance indicator dashboard—a combination of 25 to 50 national and state-developed measures by program. Contracts require MCOs to perform above the minimum standard on more than two-thirds of the dashboard measures. Figure 4, below, shows the aggregate performance of MCOs on the dashboard measures, per program, for 2018 and 2019. Detailed, interactive results by program, MCO, measure, and year are available on the [THLC Portal](#) - Performance Indicator Dashboard.

**Figure 4: Performance Indicator Dashboard – Number of MCOs that performed above the minimum standard on more than two-thirds of measures, by program, 2018 and 2019.**

Program	2018	2019
<b>STAR</b> (17 MCOs in 2018, 16 MCOs in 2019)	8	6
<b>STAR+PLUS</b> (5 MCOs)	4	4

MCOs that do not achieve the minimum performance standard on this dashboard are not subject to a financial remedy under the contract. Lower performing MCOs are placed under a corrective action plan (CAP) to improve performance.

<sup>32</sup> [Annual Report on Quality Measures and Value-Based Payments, HHSC December 2020](#)

<sup>33</sup> [Annual Report on Quality Measures and Value-Based Payments, HHSC December 2020](#)

For potentially preventable events at hospitals, results have varied by program. Overall, between 2014 and 2019, rates for PPVs, PPAs, PPRs, and PPCs did not consistently decrease across all programs (lower rates are better). Detailed results are available in the December 2020 [Annual Report on Quality Measures and Value-Based Payments](#).

HHSC and MCOs are taking actions to improve these trends. To address PPV rates, many MCOs have instituted VBP models with providers that focus on reducing emergency department usage.<sup>34</sup> In state fiscal year 2020, HHSC reduced Medicaid and CHIP capitation rates by approximately \$21.4 million with the expectation that MCOs would increase efforts to reduce their rates of PPRs by at least 10 percent. HHSC also added some of these metrics to the value-based enrollment methodology that took effect December 1, 2020.<sup>35</sup>

The COVID-19 PHE has also changed financial and practical conditions and considerations for both MCOs and providers. According to the VBPQIAC report:

“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.”<sup>36</sup>

To expand the use of quality-based APMs, both MCOs and providers must have aligned incentives and sufficient technical and staff resources to make the necessary process changes.

---

<sup>34</sup> [Annual Report on Quality Measures and Value-Based Payments, HHSC December 2020](#)

<sup>35</sup> [Annual Report on Quality Measures and Value-Based Payments, HHSC December 2020](#)

<sup>36</sup> [Texas Value-Based Payment and Quality Improvement Advisory Committee Recommendations to the 87th Texas Legislature](#)

## 4. Challenges to Expanding APMs

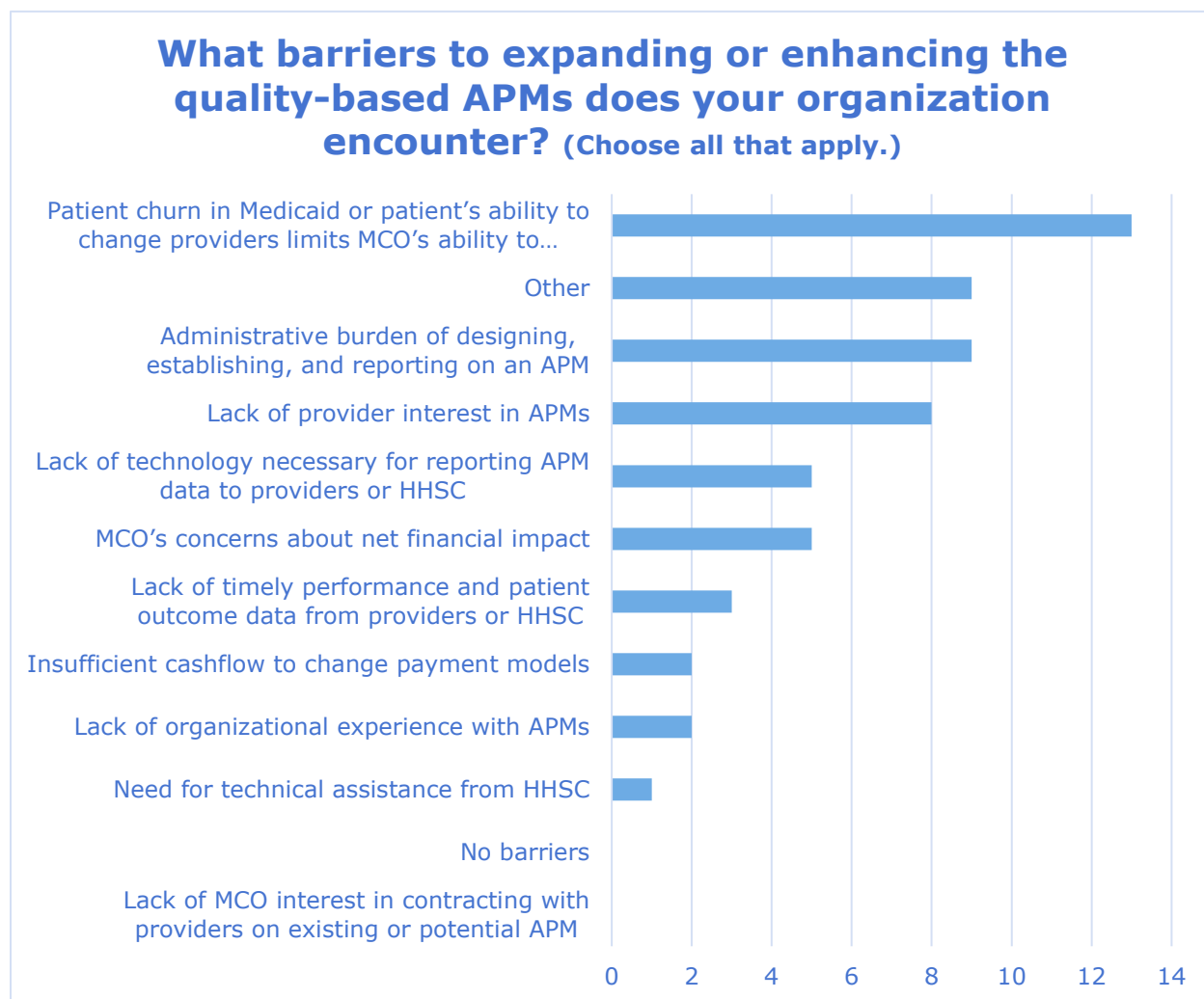
### MCO Perspective on Barriers to APMs

In April 2020, HHSC surveyed MCOs for feedback on the challenges and opportunities associated with APMs. Out of 20 MCOs and DMOs, 15 responded, for a response rate of 75 percent.

#### General barriers to expanding APMs

MCOs were asked what barriers they encounter to expanding or enhancing quality-based APMs and could select all options that applied and provide their own responses. As shown in Figure 5, the most common response selected was “Patient churn or patient’s ability to change providers limits MCO’s ability to measure outcomes attributable to provider”, with 13 of 15 MCOs selecting that option. The next most common response was “Other”, and MCOs were required to fill in the blank. The nine “Other” responses to this question can be found in **Appendix A**, and include provider reluctance to take on downside risk, insufficient start-up funding or reimbursement rates, and administrative burden. Nine MCOs also selected “Administrative burden of designing, establishing, and reporting on an APM”.

**Figure 5: Question from HHSC MCO Survey on APMs**



Source: HHSC

### **Specialty and Rural Barriers to APMs**

When MCOs were asked what barriers they encounter specific to engaging in APMs with rural or specialty-care providers, 80 percent responded that the provider's Medicaid panels were too small to support the cost of implementing an APM to either the MCO or provider or both, or that denominators would be inadequate for actuarially-based quality measures. MCOs also indicated that rural providers' lack of infrastructure—such as electronic health records (EHRs), health information exchange (HIE) participation and staff available to collect data—inhibit the use of more APMs. One MCO also indicated their own information technology (IT) system did not have the capability to automate their APMs, therefore they created manual

processes that limited their economies of scale with smaller providers. For APMs with specialty providers, MCOs indicated that it can be challenging to determine the appropriate provider to whom to attribute outcomes or the appropriate share of the total cost of care. Such attribution challenges can occur when members change provider or when multiple providers or facilities are involved in a single episode of care. Two respondents indicated a lack of common measures and measures designed for the specialty population were barriers. All qualitative responses to this question can be found in **Appendix B**.

### **Potential policy, contractual, or statutory changes**

When asked if there were policy, contractual, or statutory changes that would reduce barriers to using more quality-based APMs, 73 percent of MCOs said there were. Their suggestions for changes to reduce barriers to APMs included limiting enrollment changes for members to reduce churn, changes to rate setting to reflect the use of APMs, covering additional expenses related to social determinants of health (SDOH) in Medicaid, and more guidance from HHSC on developing APM models and performance measures. All qualitative responses to this question can be found in **Appendix C**.

### **Provider Perspective on Barriers to APMs**

In September 2020, HHSC surveyed DSRIP performing providers on their experiences with APMs. DSRIP performing providers include hospitals, community mental health centers, local health departments, and certain physician practices affiliated with academic health science centers. Out of 288 total providers, 142 responded, for a response rate of 49 percent. Of those responding, 68 considered themselves rural providers.

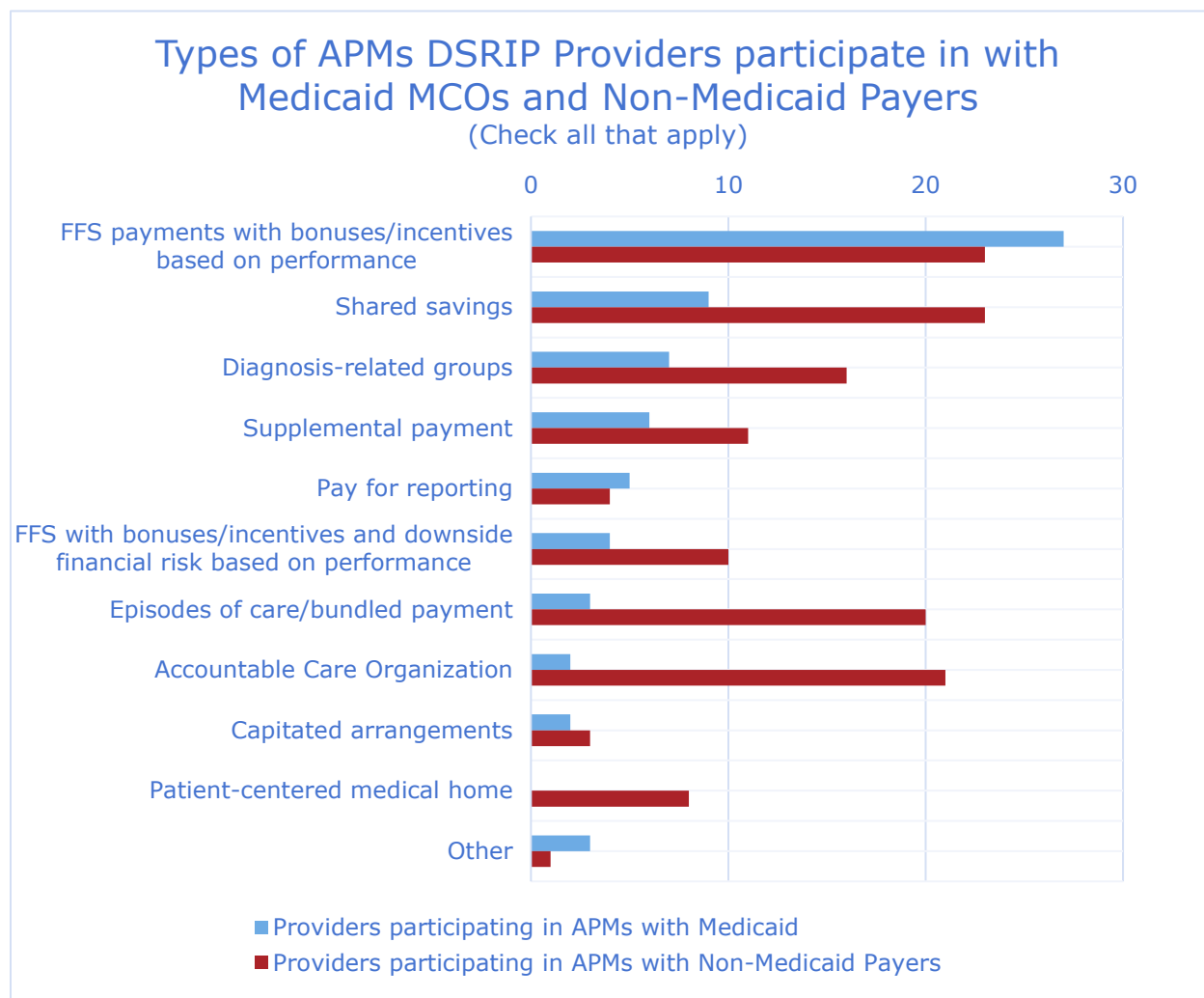
To augment data on the provider perspective, HHSC worked with the TMA to survey individual physicians on their feedback on APMs, also in September 2020. Out of 36,846 physicians surveyed, 1,908 responded, for a response rate of 5 percent.

### **Participation in APMs by type**

As shown in Figure 6, the DSRIP providers responding participated in different types of APMs, both with Medicaid MCOs and non-Medicaid payers. However, more DSRIP providers participated in APMs with non-Medicaid payers than with Medicaid MCOs. For example, there were 23 providers who participated in shared savings

arrangements with non-Medicaid payers but nine who participated in shared savings arrangements with Medicaid MCOs.

**Figure 6: Question from HHSC DSRIP Provider Survey on APMs**



Source: HHSC

This data indicates that these DSRIP providers have the ability and infrastructure to participate in these types of arrangements.

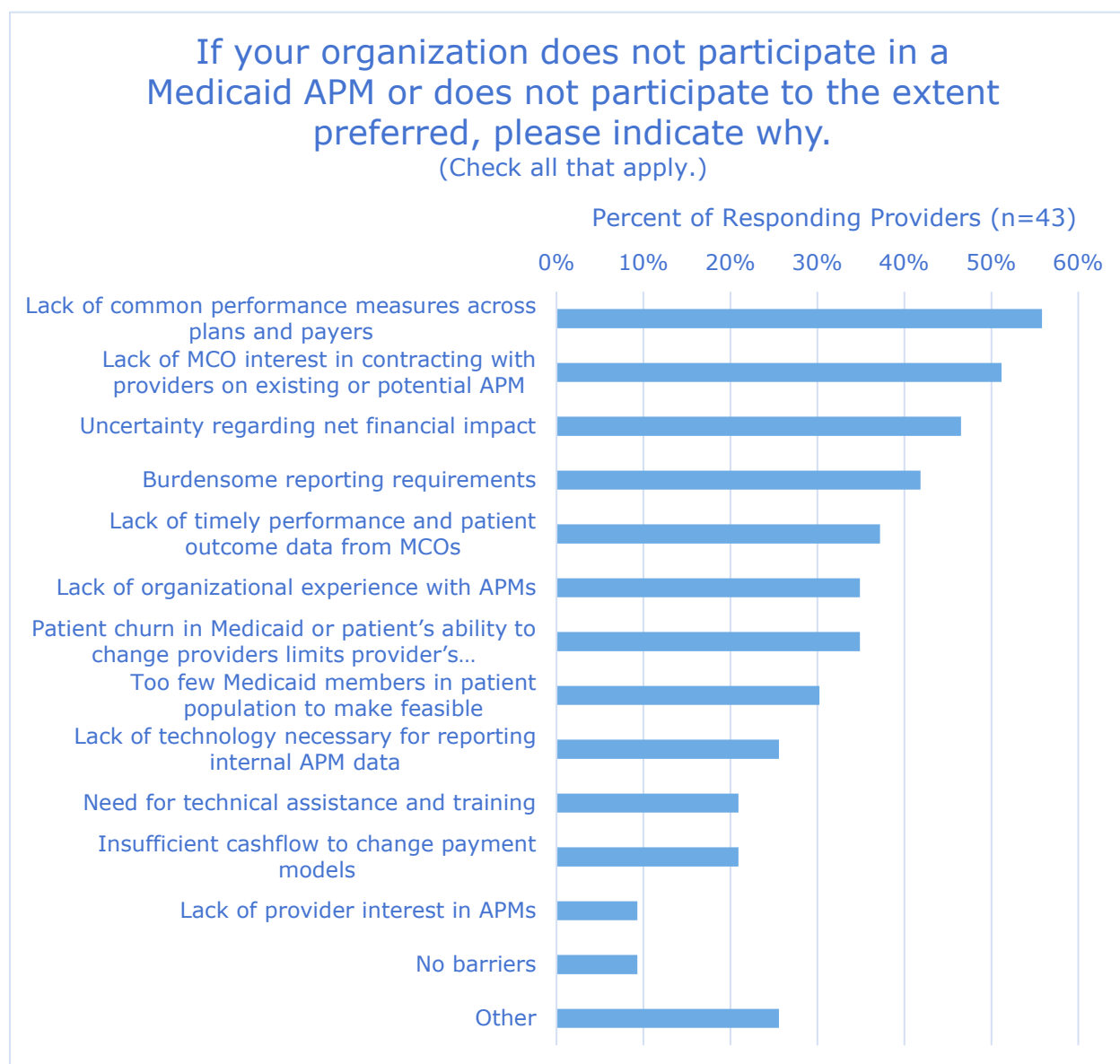
Of the respondents to TMA’s survey, 11 percent said they participate in an APM, with Accountable Care Organization being the most common arrangement reported and FFS with bonuses being the second most common arrangement.<sup>37</sup>

<sup>37</sup> Survey of Texas Physicians Medicaid Alternative Payment Models Selected Research Findings, Texas Medical Association 2020

## **Barriers to participation**

Providers were asked why they did not participate in Medicaid APMs and were allowed to select multiple options and provide their own responses. Figure 6 shows the responses DSRIP providers gave when asked “If your organization does not participate in a Medicaid APM or does not participate to the extent preferred, please indicate why”. As Figure 7 shows, the most common response was “Lack of common performance measures across plans and payers”, from 56 percent of respondents. The second most common selection (51 percent) was “Lack of MCO interest in contracting with providers on existing or potential APMs”. The third most common selection (47 percent) was “Uncertainty regarding net financial impact”.

**Figure 7: Question from HHSC DSRIP Provider Survey on APMs**



Source: HHSC

According to the TMA survey of individual physicians, burdensome reporting requirements (46 percent) and uncertainty about net financial impact (42 percent) were the most common concerns. Responses from both TMA respondents and DSRIP providers reflect that the primary barriers for providers relate to administrative burden of reporting, especially the lack of common performance measures, and concerns about financial impacts.



## 5. Opportunities for Expanding APMs

While measuring performance on quality metrics is a necessary component of APMs, HHSC and MCOs can work to reduce barriers to participation in APMs by automating and streamlining data collection where possible. To address concerns about financial impact to providers, APM design and provider education are key. Some APMs offer providers more financial stability, particularly prospective payment models. According to the TMA, some Medicaid MCOs offered certain physician practices supplemental or prospective payments to increase practice cash flow in response to the disruptions associated with COVID-19.<sup>38</sup>

In addition to reducing barriers, HHSC also asked MCOs what would be the most effective ways to strengthen or align incentives to encourage the MCOs to engage in additional or more robust quality-based APMs with Medicaid providers. Common themes in MCOs' responses to this included HHSC encouraging providers to participate in APMs, additional funding for MCOs to establish APMs, and more standardization of data and performance measures across MCOs. One MCO indicated they did not want HHSC to require particular APM models as that would limit their ability to innovate. All qualitative responses to this question can be found in **Appendix D**.

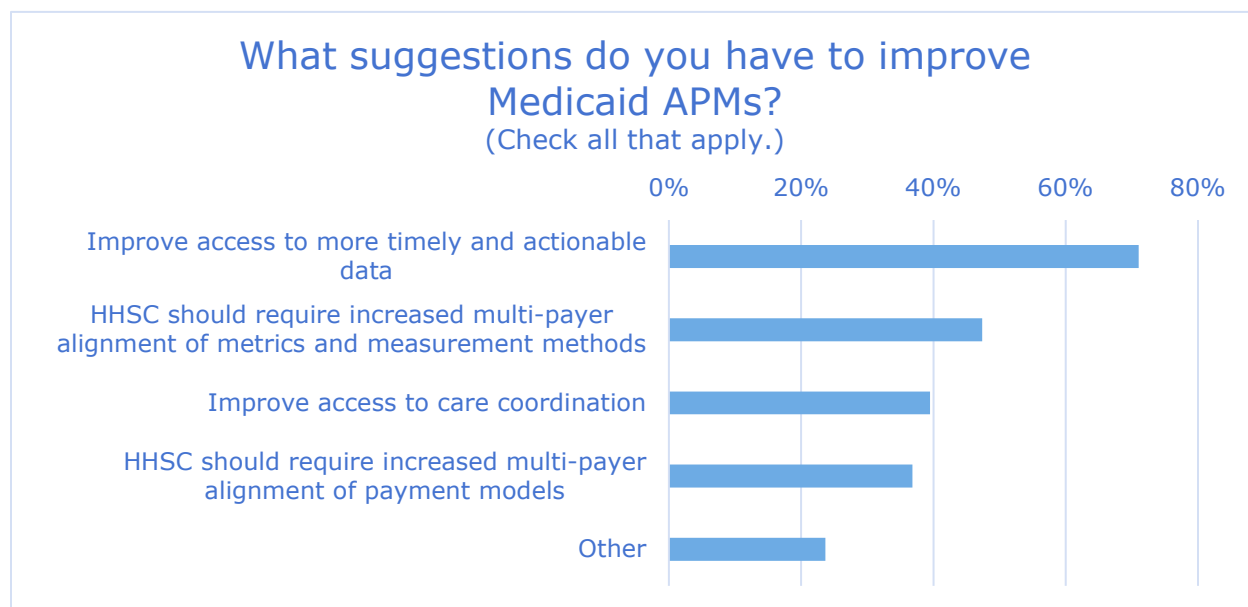
Providers focused mostly on data issues and common metrics. To improve APMs in Medicaid, 71 percent of DSRIP providers recommended improving access to more timely and actionable data, and 47 percent wanted to increase alignment of metrics across payers<sup>39</sup>, as shown in Figure 8.

---

<sup>38</sup> Survey of Texas Physicians Medicaid Alternative Payment Models Selected Research Findings, Texas Medical Association 2020

<sup>39</sup> Based on other stakeholder feedback, this refers to both across programs such as Medicare and commercial insurance, and across plans within Medicaid.

**Figure 8: Question from HHSC DSRIP Provider Survey on APMs**



Physicians surveyed by the TMA prioritized reducing administrative burden (81 percent) and improving opportunities for shared savings or increased Medicaid payments (40 percent).<sup>40</sup>

## Increasing Data Exchange

While MCOs are already contractually required by HHSC to implement processes to share data with providers and encouraged to collaborate on common formats, HHSC’s [Health IT Strategic Plan](#) also includes goals to increase participation in HIEs that connect to the Texas Health Services Authority (THSA). THSA provides a statewide framework for HIE-to-HIE connectivity and supports connectivity to national HIE networks. The Health IT Strategic Plan also includes a strategy to establish the Emergency Department Encounter Notification (EDEN) system. Using EDEN, Medicaid clients’ admission, discharge or transfer status will be transmitted to Texas Medicaid and MCOs. EDEN will evolve to support the exchange of patient information with primary care physicians (PCPs) and other care team members. Information about hospital admissions, discharges and transfers are of great value to PCPs for care coordination.<sup>41</sup>

<sup>40</sup> Survey of Texas Physicians Medicaid Alternative Payment Models Selected Research Findings, Texas Medical Association 2020

<sup>41</sup> [HHSC Health Information Technology Strategic Plan, November 2019](#)

Federal rule changes that increase the automatic transfer of patient data between providers recently took effect. As of May 1, 2021, it is a Condition of Participation in Medicare and Medicaid for hospitals to send electronic event notifications of patient's admission, discharge, or transfer to another health care provider or practitioner. According to CMS, this will improve care coordination by allowing a receiving provider, facility, or practitioner to reach out to the patient and deliver appropriate follow-up care in a timely manner.<sup>42</sup> In the stakeholder feedback to the proposed rule, "commenters noted that the availability of notification information is especially important for the success of value-based payment models, such as ACO initiatives, where participants may be financially at risk for costs associated with poor care transitions."<sup>43</sup> CMS highlighted the potential for reduced hospital readmissions, which are a performance measure for hospitals and MCOs in Texas.

Data exchange is also important for verifying that payments and performance are reported accurately. According to the HHSC Office of Inspector General, "as VBPs and APMs increase and mature, timely and accurate data is critical for monitoring and prevention of improper payments."<sup>44</sup>

## **Reducing Administrative Burden**

To reduce administrative burden, HHSC must continually weigh the relative benefits of both standardization and flexibility for MCOs and providers. If the state provides an overall VBP target and lets the MCOs design the initiatives, MCOs and providers can choose the models that have the most mutual benefit. However, this flexibility can lead to variation between MCOs that results in provider burden due to having to negotiate and implement multiple models. Implementing a variety of models simultaneously can also complicate evaluations of those models.

To date, HHSC has required and standardized certain quality goals and performance measures through contracts and evaluations, but generally left models to achieve those goals to the MCOs and providers to negotiate.

---

<sup>42</sup> [Interoperability and Patient Access Fact Sheet, CMS March 2020](#)

<sup>43</sup> [Medicare and Medicaid Programs; Patient Protection and Affordable Care Act; Interoperability and Patient Access for Medicare Advantage Organization and Medicaid Managed Care Plans, State Medicaid Agencies, CHIP Agencies and CHIP Managed Care Entities, Issuers of Qualified Health Plans on the Federally-Facilitated Exchanges, and Health Care Providers](#)

<sup>44</sup> [Value Based Purchasing Program Integrity Considerations, HHSC OIG December 2020](#)

In order to lower the burden of designing APMs, HHSC could create a menu of approved APMs and/or measures that MCOs could choose from for priority focus areas. According to the VBPQIAC, anti-trust provisions often prohibit health plans from sharing specific payment models,<sup>45</sup> so HHSC would need to create standardized models or measures based on national research while allowing for local feedback. According to the VBPQIAC, “the state should leverage existing resources, like measure sets developed for DSRIP and measures such as HEDIS that have been tested nationally.”<sup>46</sup>

Having standardized models and/or measures could also help lower the burden for smaller rural and specialty providers who may not have staff to design and maintain multiple custom arrangements. It may also lower the threshold of patients necessary to incentivize an MCO to pursue an APM with a smaller provider.

Standardization across programs, where feasible, may also help simplify measurement and reporting. According to recent CMS guidance on the adoption of VBP, states should “strongly consider aligning payment incentives and performance measures across their healthcare systems to reduce the burden on providers who participate in multiple programs.”<sup>47</sup>

## **Sustaining successes from DSRIP**

The [DSRIP Transition Plan](#) includes several milestones related to sustaining promising DSRIP practices, increasing the use of APMs, and creating new value based programs within managed care.

One milestone required HHSC to conduct a preliminary analysis of Demonstration Years 7 and 8 DSRIP quality data and related core activities to identify interventions associated with improvement in health outcomes and any lessons learned or best practices in health system performance measurement and improvement. The resulting report, [Provider Performance in the Delivery System Reform Incentive Payment Program, Demonstration Years 7 and 8](#), provides information on key measures, practices, and activities most commonly associated with high

---

<sup>45</sup> [Texas Value-Based Payment and Quality Improvement Advisory Committee Recommendations to the 87th Texas Legislature, November 2020](#)

<sup>46</sup> [Texas Value-Based Payment and Quality Improvement Advisory Committee Recommendations to the 87th Texas Legislature, November 2020](#)

<sup>47</sup> [State Medicaid Director Letter #20-004, RE: Value-Based Care Opportunities in Medicaid, CMS, September 2020](#)

performance on pay for performance measures. This analysis, along with engagement from DSRIP stakeholders, research into emerging areas of innovations in healthcare, and value-based initiatives in other states, will help inform HHSC strategies for continuing to advance APMs and further develop delivery system reform.<sup>48</sup>

The DSRIP Transition Plan also required HHSC to analyze options for new programs, and HHSC has completed [proposals for programs](#) that would start in Demonstration Year (DY) 11 per the milestone deliverable. These proposals include several directed payment programs that would operate through managed care. They target participating provider groups of the DSRIP program to continue progress and maintain some funding stability, but also broaden participation opportunities for other Medicaid providers to expand the impact of quality improvement. The proposed DY 11 programs provide a foundation for continued innovation and advancement of value-based care in future years. Per the approved DSRIP Transition Plan, proposed DY 12 programs will be submitted by September 2021.

---

<sup>48</sup> [DSRIP Transition Plan, HHSC, August 2020](#)

## 6. Conclusion

Texas incentivizes MCOs to engage in quality-based APMs through a variety of mechanisms. MCOs are meeting or exceeding contractual requirements for the percentage of payments involved in APMs, indicating success in their efforts with Texas providers to enter into APMs.

Because of the significant capitation dollars at risk, MCOs have primarily targeted medical P4Q quality measures in their APMs. In the first two years of the redesigned P4Q program, 2018 and 2019, MCOs' efforts appear to be yielding positive results. Fifteen of 17 Medicaid MCOs in 2018 and 13 of 17 MCOs in 2019 earned medical P4Q payments by exceeding performance requirements.

However, Texas Medicaid MCOs have not met all performance outcome and quality targets consistently. This could indicate that current financial incentives and APMs are not sufficient to achieve the state's targets. MCOs may also face other challenges to achieving these targets that cannot be addressed by financial incentives and APMs alone. HHSC will continue to evaluate performance and refine its quality improvement programs to ensure targets reflect state priorities and progress continues.

The disruptions to the healthcare system caused by the COVID-19 PHE also impacted performance measurement for 2020. HHSC can focus on trends prior to 2020 to identify areas to prioritize for quality improvement but must also account for changes to the health care delivery system during and after the PHE.

# List of Acronyms

<b>Acronym</b>	<b>Full Name</b>
ACO	Accountable Care Organization
APM	Alternative Payment Model
CAP	Corrective Action Plan
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare and Medicaid Services
CY	Calendar Year
DMO	Dental Maintenance Organization
DSRIP	Delivery System Reform Incentive Payment
DY	Demonstration Year
EDEN	Emergency Department Encounter Notification
EHR	Electronic Health Record
FFS	Fee-for-Service
FSR	Financial Statistical Report
HCP LAN	Healthcare Payment Learning and Action Network
HHSC	Health and Human Services Commission
HIE	Health Information Exchange
MCO	Managed Care Organization
MLR	Medical Loss Ratio
MMP	Medicare-Medicaid Plan
P4Q	Pay-for-Quality
PCP	Primary Care Physician
PPA	Potentially Preventable Admission
PPC	Potentially Preventable Complication
PPR	Potentially Preventable Readmission
PPV	Potentially Preventable Visit
QI	Quality Improvement
QIPP	Quality Incentive Payment Program
SDOH	Social Determinants of Health
THSA	Texas Health Services Authority
TMA	Texas Medical Association
UMCM	Uniform Managed Care Manual
VAS	Value-added Services
VBE	Value Based Enrollment
VBP	Value-based Payment
VBPQIAC	Value Based Payment and Quality Improvement Advisory Committee

## **Appendix A. Responses to HHSC MCO Survey on APMs question regarding general barriers to APMs**

**Question:** What barriers to expanding or enhancing the quality-based APMs does your organization encounter? (Choose all that apply):

**Responses** if MCO selected "Other" and filled in the blank:

- Lack of pediatric centered bundles or episodes of care
- Provider reluctance to take on downside risk because of lack of experience and concern over financial impact
- Many Providers are uncomfortable with the downside risk as they feel they are already facing lower reimbursement for providing services to Medicaid and CHIP Members. On some measures, such as reducing PPVs, Providers feel they have limited capabilities to produce a significant impact.
- Some providers have a need for start-up funding, especially those with very low margins (e.g., FQHCs), to handle the additional administrative burden or FTEs required to implement APMs.
- More support through 3M and other measurements that the state keeps so that the MCO can mirror outcomes to align with HHSC goals. Also measuring quality by provider and member attribution should be more clearly defined by HHSC.
- 1) Provider lack of experience with APMs, 2) developing infrastructure such as, staffing, training and oversight and monitoring of a program in order to maximize program
- 1) Quality-robust programs are perceived as difficult and challenging when other MCOs are incentivizing providers for easy to achieve non-robust measures. 2) Promoting partnerships with high quality providers ensure the best care and outcomes for Medicaid members. This is counter-intuitive to the prevailing perception that more providers is best. Meeting access through high-quality engaged providers is optimal.
- Provider's aversion to risk; Lack of Member cost-sharing responsibility and engagement to help manage the total cost of care.



## **Appendix B. Responses to HHSC MCO Survey on APMs question regarding barriers to APMs with rural and specialty providers**

**Question:** Please explain barriers that specifically apply to engaging in APMs with rural providers, smaller providers, or specialty-care providers.

### **Responses:**

- APM requires specific procedures that are not available in our current IT system. Therefore, we created manual process to administer the program. As a result, it is difficult to administer those programs to rural providers and smaller providers due to the lack of economies of scale.
- [MCO] has identified the following barriers that specifically apply to engaging APMs with rural providers, smaller providers or specialty-care providers:
  - ▶ Insufficient volume of members with any single entity
  - ▶ Lack of infrastructure to support more complex APM models
  - ▶ Overlap with other APMs for specialty care providers
  - ▶ Attribution challenges with specialty care providers
- Lack of contemporary practice management systems, i.e. Epic, AllScripts, NextGen, etc.
- The majority of our APM programs are based on membership attribution. To increase APM participation, we developed a Medicaid APM program to include practices with an enrollment of as little as 250 members. A gap still remains for rural and smaller group practices. We have also been able to add rural and smaller group practices via Shared Savings and Risk programs with IPA providers that include large, small, urban and rural practices. Other barriers include IT resources and a lack of understanding or appreciation of the value and positive impact APM programs can have on their practice and the health outcomes of their patients.
- As mentioned in the previous response, Providers are uncomfortable with facing downside risk on factors they sometimes feel are out of their control. One example is Providers feel they have very little to no influence on a Member to get them from going to the ER for a non-emergency. In the case of Medicaid Members, who face no copay or other penalty from going to the ER, PCPs may offer after hours or night clinic services and feel like they still cannot reduce ER over utilization.

- Small and rural providers report difficulty starting APMs due to lack of funding for FTEs or programs. Funding a new APM is costly for both the MCO and provider. HHSC might consider some form of additional payment for the first few months to help with the administrative cost for labor and data collection for providers. Potentially this could be funded by modifying UHRIP or DSRIP payments. For rural providers, many do not have sufficient volume with any one MCO to sustain additional FTEs even if they perform and achieve some shared savings or bonus for the APM. We believe some form of service-area-wide or Statewide model might assist small and rural providers. Some specialty providers are interested in extending their DSRIP models but the funding mechanisms are challenging.
- The creation of an APM designed to accommodate the infrastructure needed for smaller, solo, or rural Providers has been a challenge. Some Providers may not have the funding, staffing, or resources to initiate the transitioning to a more robust APM. Some Providers service a very small volume of Medicaid members, therefore the Provider may not see the worth or value especially with managing financial risk. With smaller plans/membership it's challenging to develop an APM program with meaningful dollars for providers, especially considering the administrative component of each APM program (internally/externally). Recommend that HHSC provides guidance around selection of APM program measures. There are challenges in development of APMs as each MCO selects different measures. This is especially challenging in rural communities as the dollars may not be meaningful to providers where membership isn't as high. If HHSC developed a set of measures to choose from then the dollars received wouldn't be a barrier as there would be uniformity of program/measures across all plans.
- The barriers to engaging in APMs with rural and smaller providers include:
  - ▶ Provider organizations lack of infrastructure and resources
  - ▶ Increased variability with small membership numbers
  - ▶ The financial opportunity is not valuable enough to the providers.
 The barriers to engaging with specialty-care providers include:
  - ▶ Lack of national metrics and proven ROI.
  - ▶ Member attribution and member ability to freely see multiple providers, limits the opportunity for programs to be effective.
- Small and rural providers report difficulty starting APMs due to lack of funding for FTEs or programs. Funding a new APM is costly for both the MCO and provider. HHSC might consider some form of additional payment for the first few months to help with the administrative cost for labor and data collection for providers. Potentially this could be funded by modifying UHRIP

or DSRIP payments. For rural providers, many do not have sufficient volume with any one MCO to sustain additional FTEs even if they perform and achieve some shared savings or bonus for the APM. We believe some form of service-area-wide or Statewide model might assist small and rural providers. Some specialty providers are interested in extending their DSRIP models but the funding mechanisms are challenging.

- Barriers with specialty care include:
    1. Identifying an effective model for each specialty in a predominantly pediatric population
    2. Therapy (specialty) services are difficult to measure as there are few standardized quality metrics established.
- Barriers with smaller and rural providers include:
1. Panel sizes limit downside risk contracts with smaller practices so [MCO] is working on identifying ways to redesign our capitation models.
  2. adequate panel sizes also impact actuarial based quality measures.
- Being able to qualify for a APM program if the provider has too small of a member panel to meet program requirements.
  - - Lack of provider interest/experience with APMs
    - Lack of assigned members to meet the minimum number established by the MCO for participation
    - Insufficient staff to help drive the APM measures to be successful in the program
    - Rural providers need more support for infrastructure: internet connectivity, EMR, HIE
  - With respect to barriers in engaging APMs in rural markets/smaller providers/specialty care providers: (a) the level of membership needed to support the effort; unlike urban settings there are no medium/large size provider groups with sufficient membership to support an ATM [sic]; (b) the lack of appetite of rural providers for more Medicaid members; too much paperwork, not enough money; add to it the perceived instability of membership and providers are not comfortable looking at ATMs; (c) the cost of technology and staff experience needed to support an ATM; most rural providers are single provider offices and are not equipped to handle any high level of work associated with an ATM.
  - Low Membership; Aversion to downside risk; Lack of Member cost-sharing responsibility and engagement to help manage the total cost of care.

## **Appendix C. Responses to HHSC MCO Survey on APMs question regarding changes to reduce APM barriers**

**Question:** Are there policy, contractual, or statutory changes that would reduce barriers to using more quality-based APMs? If so, what policy, contractual, or statutory changes would be involved and how would these changes reduce a barrier to quality-based APMs?

### **Responses:**

- Open enrollment for members once a year, once a member chooses a plan they must stay with that plan until annual enrollment.
- Transparency in rate-setting: The rate setting process for determining the MCO's premium rate is based on Fee-for-Service claims activity, with little transparency of how APM activities are included. We want to make sure that the APM payments are fully accounted for in our premium PMPM. It would be helpful to have itemized APM expenditure in the rate setting process. It might also be beneficial to have the comparative benchmarking with other MCOs for transparency and awareness.
- -The Texas State Legislators would need to extend the enrollment period for pregnant women. This extension would allow for more robust APM models related to pregnancy and improved maternal and fetal outcomes to address social determinants of care, infant mortality and mom mortality.  
-HHSC would need to make modifications to the accepted encounter data inputs available to MCOs to account for cost structures that are not within the traditional fee-for-service model to properly convey the care management and population based health management work undertaken in the more advanced APM models.  
-Lock in of members to an MCO after a set opt-out period to allow MCOs to track and follow the member through any quality-based APM without patient churn.  
-Allow social determinants of health to be included as a reimbursable expense to expand APM models.
- In general, HEDIS measures and scoring is not always conducive to STAR and CHIP populations.
- - Relax APM YoY targets as they are aggressive. More focus should be spent on guiding MCOs and providers in developing APM programs.  
- HHSC providing incentives to MCOs to deliver APMs

- There is currently a lot of overlap between QIPP measures, NFI measures and eventually the Quality Monitoring Program. This makes it challenging for providers to keep up with different incentive programs by MCO along with HHSC QIPP program.
- Recommendation for HHSC to provide a list of measures by provider type for MCOs to choose from in developing APMs. There are a lot of different programs across all MCOs and there has been a lot of provider feedback in regards to successfully managing these programs from MCO to MCO.
- There are several policy, contractual and statutory changes that can reduce these barriers including:
  - ▶ Including member behavior and lack of accountability and its impact on cost and quality.
    - Member does not have to see their assigned PCP
    - Members may freely use the ED inappropriately without consequence
  - ▶ Members can change health plans every month; lack of MCO lock in.
  - ▶ Provider or FQHC inability to assume risk
  - ▶ Payment program incentives could drive up costs in the short-term
  - ▶ HHSC rate-setting methodology does not reward upfront and costly innovation.

In order to reward providers for robust quality-based programs, there needs to be the ability to provide the services to members without diffusion among MCOs, providers, and agencies. Regardless of the efforts of the MCO and their engaged providers, the member behavior and lack of accountability cannot be ignored on the impact on cost and quality.

- Provider sponsored plans have participated in certain APMs to promote quality, including incentive payments to providers for maintaining or improving quality measures. Challenges have been noted above including start-up funding for providers, the timing of clinical data to determine compensation, and a non-standard approval process. We would also want to address the approval of capitation agreements with providers (both related and non-related) to assist providers with up-front funding in order to build their quality programs. Funding programs to incentivize providers would have to be written into current MCO contracts and factored into statutory reporting. In addition, the standardization of approved incentive programs would avoid delays in implementation.
- - Permit Urgent Care classification as a provider type in the master provider file for stand alone ER's operating as urgent care centers.

- Require mid-level credentialing for provider member attribution.
- Establish stricter parameters around ER utilization.
- Automatic 60 day enrollment of all newborn babies delivered by mothers enrolled in a Medicaid MCO plan under distinct ID's with the same MCO the mother is enrolled in.
- Specifically, a policy change on the frequency in which members can make MCO changes from monthly to annually would improve a provider's (and the MCO's) ability to manage the members care and outcomes more effectively under APM models. Additionally, a more robust HIE would allow providers more opportunity to coordinate care in a timely and fully informed manner which would improve member outcomes. As mentioned above, limiting the member's ability to transfer from MCO to MCO on a monthly basis would reduce barriers to using more quality-based APMs. We would like to see a program similar to CHIP whereby members have an annual open enrollment and stay with a health plan for a year.
- Eliminate the requirement for downside risk

## **Appendix D. Responses to HHSC MCO Survey on APMs question regarding the most effective ways to align incentives**

**Question:** What would be the most effective ways to strengthen or align incentives to encourage your MCO to engage in additional or more robust quality-based APMs with Medicaid providers?

### **Responses:**

- Align incentives methodologies for specific provider groups between the MCO's. This would give providers an opportunity to align all the books of business in the same manner.
- Standardized episodes of care definition and data sharing through THLC: The state's development of the THLC website produced transparency and awareness to the quality performance of all the MCOs. Similar to that, a standardized APM tool, deployed through THLC, to classify the episodes of care or bundles, and bring awareness and consistency of methodology to providers would be helpful. Data that can be sliced and diced at the provider level is an important feature for us. We would like to leverage the THLC tool to share data with providers in the network. Pediatric focused: Because Texas Medicaid is pediatric focused, we need bundling/episode of care methodology adjusted for the conditions that are specific of the pediatric population. Many of the bundling tools on the market are focused on the adult population.
- [MCO] finds the most effective way to strengthen or align incentives is to offer shared savings arrangements with large physician groups that measure both financial outcomes and quality outcomes. These types of arrangements align incentives between [MCO] and the providers to deliver on the triple aim of improving the patient experience, improving health outcomes, and reducing the cost of healthcare. Shared Savings arrangements with a "quality gate" that allows a financial reward for the provider only when quality is improved and/or maintained for high performing groups. The quality measures in the Shared Savings program align with HHSC quality programs with the MCO.
- Prioritize primary care incentives and focus on patient centered medical home and clinical integration goals.

- Medicaid providers still lean heavily towards FFS versus quality and performance outcomes. [MCO] has developed APM programs that align with HEDIS and P4Q metrics. Educating providers, encouraging APM engagement and moving reimbursement from strictly FFS to performance or accompanying quality metric would increase effectiveness.
- According to our own internal calculations, we estimate a 40% overall APM ratio and 26% at-risk ratio for our STAR product for calendar year 2018. Those rates are a little lower for our CHIP line of business even though our APM contracts with our Providers encompass both STAR and CHIP. The difference in CHIP is that total inpatient hospital costs are lower compared on a per member per month basis. We would suggest allowing the health plan to calculate APM ratios by combining both the STAR and CHIP population.
- We are interested in creating quality-based APMs with providers. HHSC can assist by developing incentives to create demand for the provider community. A specific carved-out session in the annual Quality meeting to discuss feedback from providers, lessons learned, best practices, etc would be helpful. It would also be helpful to get a semi-annual update on the 2020 Blueprint timeline on deliverables to know if HHSC is on track (i.e. expansion of CCHBCs, LMHAs, etc).
- - Establish workgroup calls where MCOs can openly discuss how they're addressing challenges in development of APMs such as data sharing with providers, internal reporting, etc.
  - Establish recommended measures for MCOs to choose from by provider type when developing APM programs. The lack of uniformity with APMs across all health plans has been a challenge for Providers to participate, especially for providers with smaller volume.
  - Establish MCO incentives for MCOs to continue to engage in additional quality-based APMs with Medicaid providers. If MCOs were to be financially incentivized for developing of APM programs then additional dollars could be used to create more robust programs and cover costs of additional investments in data analytics software or other technology.
- [MCO] has several quality-based APM programs in place and is already highly motivated to engage in new programs. These programs have evolved over time and promote the shared values of HHSC and [MCO]. It is necessary to ensure incentive metrics are aligned from HHSC to the MCO, and from the MCO to the provider. HHSC should encourage use of national metrics to improve quality (HEDIS, PPE) to reduce the variability of measures. HHSC should not mandate incentives or programs, as the goal is to not restrict MCO diversity and innovation.



Robust quality-based measures should provide value through incentives based on cost and quality. Programs that are based on population health, which promote preventive services, management of chronic conditions and reduction of preventive events, provide the most value. The programs with upside and downside risk are most beneficial, as the programs require active provider practice changes to make a significant difference improvement in the metrics and outcomes.

HHSC can promote and continue open discussion between MCOs and HHSC for design and reporting requirements, through programs such as the Dell Medical School VBC collaborative.

- We are interested in creating quality-based APMs with providers. HHSC can assist by developing incentives to create demand for the provider community. A specific carved-out session in the annual Quality meeting to discuss feedback from providers, lessons learned, best practices, etc would be helpful. It would also be helpful to get a semi-annual update on the 2020 Blueprint timeline on deliverables to know if HHSC is on track (i.e. expansion of CCHBCs, LMHAs, etc).
- - Covering mothers after delivery for longer period of times to ensure continuity of care of their mental health and increasing intra-pregnancy intervals which can put new pregnancies and babies at risk.
  - Manage patient churn more effectively.
  - Remove the penalty currently in place if APM's are not implemented and instead incentivize to monetarily support creative/effective APM programs.
- Increase collaboration between stakeholders (i.e. MCO, providers and HHSC).
- [MCO] recommends that the State consider adjusting the ability of members to make MCO changes to once per year. Member movement across MCOs creates disruption to an effective robust quality-based Alternative Payment Model. The most effective way to strengthen incentives and have a strong long term goal and outcome is to limit the member's ability to transfer within that yearly timeframe.

[MCO] also recommends HHSC continue to use the HCP-LAN APM framework as a value-based continuum and work with all MCOs to transform the care delivery system, creating a fully integrated system of care by aligning incentives to improve health outcomes, enhancing member satisfaction, and better managing costs. The framework effectively accommodates independent provider clinical and quality needs while allowing each MCO the autonomy to maximize the use of technology, integrate health care assessments, risk assessments, and use of data analytics to create APMs such as those that address targeted populations, and disease state that have

the greatest impact on costs and thereby, effectiveness in incentivizing improvements in quality and efficiency in person centered care. We recommend continued transparency among MCOs for respective outcome measures used in conjunction with those provider incentive APMs to create administrative and reporting efficiency for providers in their use of outcome measures. Based on [MCO] experience with more than 2.3 million Medicaid members nationally, providers achieve success in adopting the Health Care Payment-Learning Action Network (HCP-LAN) alternative payment models (APMs) by incrementally increasing their knowledge and practice of value-based payment (APM) programs.

- [MCO] is already engaged in very basic quality-based APMs with Medicaid providers. In order for [MCO] to initiate additional and/or more robust quality-based APMs, inclusion of "bridge money" in the arrangement with each MCO for use in exploring APM models and/or enhancements to its core system (or an add-on system) to pull and monitor the data needed to develop and manage ATMs would be beneficial. This money could also be used by MCOs to assist providers in "upgrading" staff/system resources to be more aggressive in participating in ATMs. The reluctance on the part of Medicaid providers is generally focused on the cost of starting an ATM and its potential impact on their bottom line for a program whose reimbursement is suspect. Additionally, a more robust positive reinforcement arrangement for each MCO or service area could help. The opportunities for a multi-site MCO versus a single market MCO to create and manage multiple ATMs successfully presents an unequal challenge. Just like for providers there [are] associated cost that impact an MCOs ability to be creative and robust in their efforts.
- Create a framework that physicians and physician organizations are willing to accept and manage, which means eliminate the requirement for MCOs to include downside risk with providers. Providers are very reluctant to accept downside risk given the already low reimbursement rates afforded by the Texas Medicaid program.