



Value-Based Payment Roadmap

Texas Delivery System Reform Incentive Payment Program Transition Plan

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Executive Summary

In alignment with the Managed Care Quality Strategy, Texas' objective in the Medicaid program is to offer high-value care to its beneficiaries, achieve better quality while controlling costs, and improve population health through an equitable approach to care. This updated Value-Based Payment (VBP) Roadmap describes how the state plans to move forward with VBP, the status of its current programs, and guiding principles for success.

Specifically, the document highlights existing examples of Alternative Payment Models (APM) in managed care and the Delivery System Reform Incentive Payment (DSRIP) program, along with other components of the overall VBP strategy.

The Health and Human Services Commission (HHSC) plans to continue support for the APM initiative and work with stakeholders to facilitate new and more advanced arrangements as recommended by the Health Care Payment Learning and Action Network (HCP LAN). HHSC is considering new program options to sustain progress made in the DSRIP program and has gathered feedback from DSRIP performing providers and managed care organizations (MCOs) on ways to improve and encourage the use of APMs.

To accomplish these goals, HHSC will continue to increase the alignment of financial incentives between providers and MCOs, reduce technological and logistical barriers for MCOs, providers, and other participating organizations and implement lessons learned from existing initiatives and programs such as DSRIP and Medicare. HHSC is assessing ways to better incentivize addressing social determinants of health and evaluating flexibilities for telehealth and other modifications due to the COVID-19 public health emergency. HHSC involved multiple stakeholders in the development of the strategies through the Value-based Payment & Quality Improvement Advisory Committee, surveys of MCOs and DSRIP performing providers about APMs, and discussions with professional associations throughout the state.

Texas HHSC Healthcare Quality Goals

The Texas Health and Human Services (HHS) system administers many initiatives to improve the quality and outcomes of programs. Broadly speaking, these initiatives share similar aims to promote high-value care. To maximize alignment among its Medicaid healthcare quality improvement initiatives, the state has established the following broad goals:

- **Promoting optimal health for Texans** at every stage of life through prevention and by engaging individuals, families, communities, and the healthcare system to address root causes of poor health
- **Strengthening person and family engagement** as partners in their care to enhance respect for individual's values, preferences, and expressed needs;
- **Keeping patients free from harm** by building a safer healthcare system that limits human error;
- **Providing the right care in the right place at the right time** to ensure people can easily navigate the health system to receive timely services in the least intensive or restrictive setting appropriate
- **Promoting effective practices for people with chronic, complex, and serious conditions** to improve people's quality of life and independence, reduce mortality rates, and better manage the leading drivers of health care costs; and
- **Attracting and retaining high-performing Medicaid providers, including medical, behavioral health, dental, and long-term services and supports providers** to participate in team-based, collaborative, and high-value care.

A critical tool to help advance these key goals is healthcare payment transformation, also referred to as VBP or quality-based APMs. These models contrast with traditional fee-for-service payments, which reward the volume of services but do not directly incentivize quality.

Texas has increased its use of VBP in Medicaid through three main mechanisms: the managed care model, the Delivery System Reform Incentive Payment Program (DSRIP program), and the Medical Pay-for-Quality (P4Q) program. While managed

care continues, DSRIP program funding is scheduled to end in September 2021. As DSRIP winds down, new initiatives and VBP models are needed to drive further quality improvements within the managed care service delivery system and to build on the successes of the DSRIP program.

HHSC will continue to expand its use of value-based care to advance the transformation of the Texas Medicaid delivery system, to accomplish its Quality Strategy goals, and to produce:

- Aligned incentives between the state, MCOs, and providers;
- Optimal healthcare outcomes and patient experience driven by provider payment models that support patient and family-centered care; and
- Improved healthcare efficiency through MCO and provider accountability to meet both clinical and financial goals.

Moving Toward Value

Framework

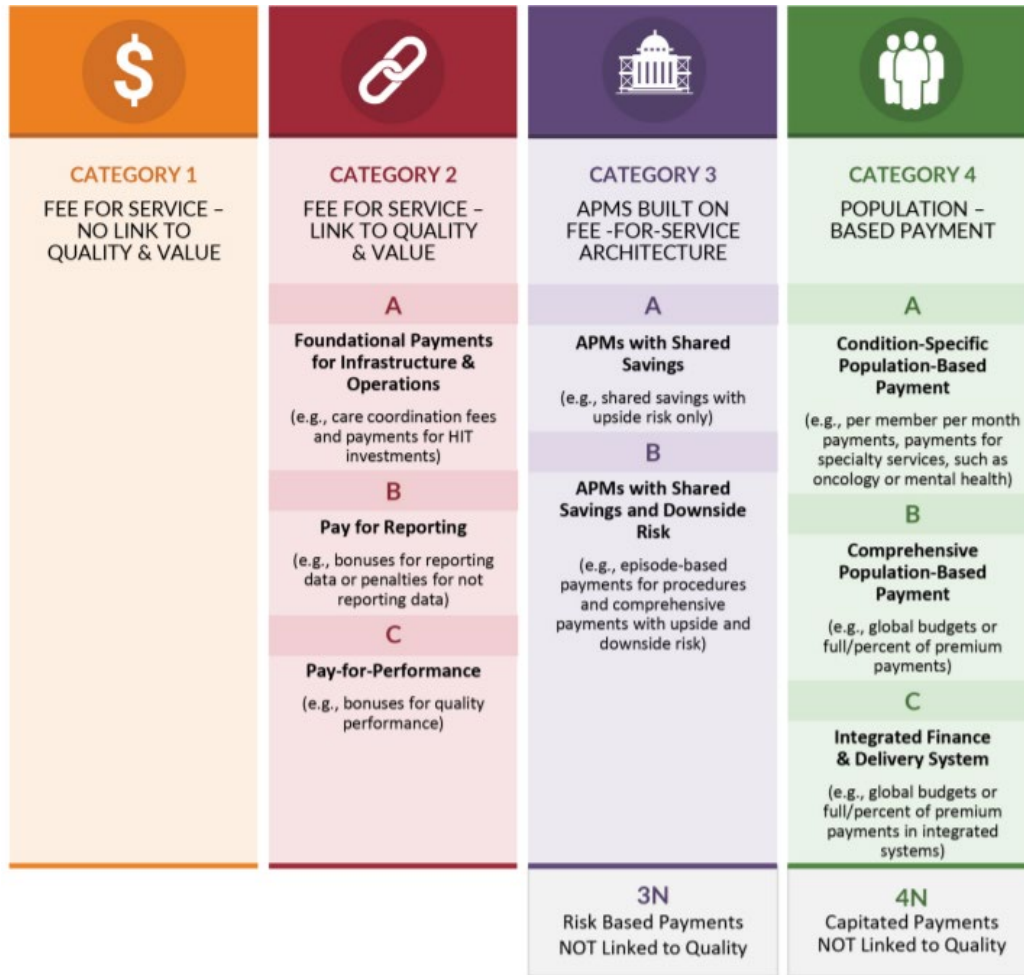
According to the Centers for Medicare & Medicaid Services (CMS), “VBP and APM have different meanings, but states often use these terms interchangeably. VBP refers to programs in which the state Medicaid agency holds providers or managed care plans accountable for the cost and quality of care. APMs are the specific payment arrangements and methods used in VBP programs.”¹ Some examples of APMs include providers receiving bonuses for achieving quality or reaching goals on performance measures, sharing savings for delivering services at a lower cost, or incurring financial losses for not meeting specified quality and cost benchmarks.

Texas Medicaid has adopted the Alternative Payment Model Framework developed by the Health Care Payment Learning & Action Network (HCP LAN).² **Figure 1** shows the framework from HCP LAN and the various categories of APMs.

¹ <https://www.medicaid.gov/medicaid/downloads/accel-adoption-vp-pay.pdf>

² <https://hcp-lan.org/apm-refresh-white-paper/>

Figure 1: HCP LAN APM Framework



Note: This framework represents payments from public and private payers to provider organizations (including payments between the payment and delivery arms of highly integrated health systems). It is designed to accommodate payments in multiple categories that are made by a single-payer, as well as single provider organizations that receive payments in different categories—potentially from the same payer. Although payments will be classified in discrete categories, the Framework captures a continuum of clinical and financial risk for provider organizations. The framework categorizes the full range of provider payments, with categories 2 A-C, 3 A-B, and 4 A-C considered APMs as long as payments are linked to metrics for quality and value. Source: HCP LAN

In Texas Medicaid and CHIP in 2018, 55 percent of APM contracts were in Categories 2 A-C (models that pay bonuses to providers that hit predetermined quality benchmarks, develop VBP infrastructure, or report their quality data); 38 percent were in Categories 3 A-B (shared savings models) and about seven percent were in categories 4 A-C (population-based payment models). Moving forward, Texas will continue to promote approaches that move a greater percentage of payments into Category 3 and Category 4 models.

VBP with MCOs

The Health and Human Services Commission (HHSC) has shifted its service delivery for Medicaid and the Children’s Health Insurance Program (CHIP) from the fee-for-service (FFS) model to managed care. There are now 17 managed care organizations (MCOs) serving 94 percent of Medicaid clients and all CHIP clients. Approximately 4.3 million Texans are enrolled in Medicaid and CHIP.

Managed care is an integrated service delivery system where HHSC contracts with MCOs to provide all covered, medically necessary services to people receiving Medicaid or CHIP benefits. HHSC pays each MCO a monthly capitation rate for every member enrolled in their plan, and MCOs reimburse providers for services provided to their members.

A goal of transitioning from FFS to managed care is to provide value-based care.

Pay for Quality

The Medical P4Q program puts a percentage of MCOs’ capitation payments at risk contingent on their performance on quality measures. Funds recouped from MCOs for poor performance form the pool for incentive payments to MCOs that performed well. Through the MCO Medical P4Q program, STAR, STAR+PLUS, and STAR Kids MCOs can lose or gain up to three percent of their capitated medical premiums³ based on performance on quality metrics. Results from 2018 can be found on HHSC’s [Texas Healthcare Learning Collaborative website](#). HHSC’s Dental P4Q program places 1.5 percent of dental management organization’s capitation at risk.

The P4Q programs are an effective catalyst for MCOs to advance value-based care. Generally, MCOs prioritize metrics for which they are held accountable by HHSC in their APM contracts with providers.

Performance Improvement Projects (PIPs)

As a federal condition for participation in managed care, MCOs must engage in Performance Improvement Projects (PIPs). The External Quality Review Organization (EQRO) recommends topics for PIPs based on MCO performance results. These projects present significant opportunities for performance

³ Pharmacy costs are included as a component of medical premiums.

improvement for each MCO. HHSC, with input from the MCOs, selects measurable goals that enable each MCO to target specific areas for improvement.

Value-Based Enrollment Incentive Program

When an individual enrolls in Medicaid, they are encouraged to select an MCO using MCO report cards and other information sent to the individual. If a Medicaid client does not select a health plan, HHSC uses a default assignment methodology to enroll the client in an MCO. Beginning in the state fiscal year 2021, HHSC began incorporating measures of quality and efficiency into this auto assignment process. Under the new value-based enrollment, plans that perform better on key risk-adjusted cost and quality measures and have higher member satisfaction, receive a greater share of these enrollments.⁴ Measures included in value-based enrollment align with the state's Managed Care Quality Strategy and the dimensions of the [Triple Aim](#) framework developed by the Institute for Healthcare Improvement.

Hospital Quality-based Potentially Preventable Readmissions and Complications Program

One APM that affects both MCOs and providers directly is the [Hospital Quality-based Potentially Preventable Readmissions and Complications Program](#), which focuses on reducing avoidable readmissions and inpatient stay complications. HHSC holds MCOs and hospitals financially accountable for potentially preventable complications and potentially preventable readmissions as defined by 3M Health Information Systems. For hospitals with lower performance on these measures, HHSC reduces the reimbursement rates for their inpatient fee-for-service claims by a fixed percentage. Similar reductions are made in each MCO's experience data, which affects capitation rates, based on the performance of the hospitals in their network. Overall, this program puts 4.5 percent of Medicaid payments to hospitals for inpatient services at risk.

VBP with Providers

While payments from HHSC to MCOs are capitated, at-risk arrangements (LAN Category 4), payments from MCOs to providers have historically remained fee-for-service based on fee schedules. HHSC continues to explore ways to increase the use of APMs with providers in the managed care model. Rural providers may face

⁴ [Value-Based Enrollment Incentive Program](#), Health and Human Services Commission, January 2021.

unique challenges compared to urban providers and MCOs should consider these challenges when developing value-based approaches and payment methodologies.

HHSC APM Targets

In 2014, HHSC began requiring MCOs to implement VBP models with providers and to submit to HHSC annual reports on their VBP activities.⁵ HHSC publishes an annual summary of the APM models implemented in Medicaid managed care, including the quality measures used.⁶ In 2018, Texas shifted from APM reporting requirements to APM performance requirements by setting targets in the MCO contracts for percentages of payments made to providers through APMs. **Figure 3** outlines the required percentages through Calendar Year (CY) 2021.

Figure 3: Texas Medicaid MCO Contract Targets for APMs

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

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

Per HHSC’s contracts with the MCOs, MCOs must also:

- implement processes to share data and performance reports with providers on a regular basis;

⁵ [Uniform Managed Care Manual Chapter 8.10 Alternative Payment Model Data Collection Tool](#)

⁶ [HHSC Value-Based Care APM Summaries](#)

- dedicate sufficient resources for provider outreach and negotiation, assistance with data and/or report interpretation, and other activities to support provider improvement;
- within service areas, collaborate with other MCOs on the development of standardized formats for performance reports and data requested from providers; and
- dedicate resources to evaluate the impact of APMs on utilization, quality and cost, and return on investment.

Preliminary analysis of MCO-reported data showed that as of 2017, the year prior to implementation of required APM targets, the total amount MCOs paid providers through an APM was approximately \$7.15 billion (about 38 percent of total medical expenses.)⁷ During CY 2018, the MCOs paid providers over \$8.12 billion through APMs (about 40 percent of medical expenses), an increase of almost \$1 billion over the prior year. In 2018, provider payments through risk-based APMs reached 22 percent of their medical expenses. These results indicate that MCOs are on their way to meeting HHSC's 2021 targets.

As Texas continues to monitor MCOs' compliance with its APM targets, HHSC plans to evaluate impact on three major domains: quality, outcomes, and costs. See **Appendix A** for more information about these targets.

Directed Payment Programs

HHSC administers the [Quality Incentive Payment Program \(QIPP\)](#) for nursing homes. QIPP encourages nursing facilities to improve the quality of their services. Improvement is based upon several indices of success, including quality metrics that are collected by CMS for its five-star nursing home rating system. Facilities who meet or exceed their achievement goals earn incentive payments.

As part of the DSRIP Transition, HHSC is pursuing additional quality-based directed payment programs to apply some of the lessons learned from the DSRIP Program in Medicaid managed care. HHSC has submitted to CMS preprints for four directed payment programs to begin September 2021 for hospitals, physicians, community mental health centers, and rural health clinics.

⁷ The APM contract requirements count include pharmacy costs as a medical expenditure. Calculations on the percent of dollars in an APM for 2017 and 2018 are based on data for STAR, STAR+PLUS and CHIP. STAR Kids requirements are not in effect until 2019.

VBP and the DSRIP Program

DSRIP has been an incubator for testing how flexible payment models can support patient-centered care and clinical innovation. In the DSRIP Program, lump sum payments are made directly from HHSC to performing providers based on achieving certain performance goals rather than on service utilization.

Beginning in federal fiscal year (FFY) 2018 (October 2017), the DSRIP program structure evolved from a focus on projects and project-level reporting to system-level interventions with targeted measure bundles or measures, depending on performing provider type. Providers transitioned to reporting on more clinical outcome measures, some of which Medicaid MCOs may wish to adopt in new APMs. Please see **Appendix B** on the DSRIP program for more information.

HHSC is partnering with DSRIP providers and Medicaid MCOs to explore transitioning promising DSRIP practices into managed care. One of those efforts included establishing the Best Practices Workgroup (BPW) comprised of 84 total members including DSRIP Performing Providers, DSRIP Anchors, and Executive Waiver Committee (EWC) members to support the sustainability of delivery system reform best practices, the successful completion of DSRIP Transition Plan milestone deliverables, and the development of the next phase of delivery system reform in Texas.

Accountable Health Communities Model

In 2016, three Texas entities were awarded federal grant funds from CMS to participate in an [Accountable Health Communities \(AHC\) Model](#). This five-year (2017–2021) nation-wide initiative was developed to test whether systematically identifying and addressing the health-related social needs of Medicare and Medicaid beneficiaries' through screening, referral, and community navigation services would impact health care costs and reduce health care utilization. According to CMS, the AHC Model addresses a critical gap between clinical care and community services in the current health care delivery system.

The AHC Model also tests a VBP model. Funds for this model support the infrastructure and staffing needs of AHC entities that link beneficiaries with community services. The funds pay for navigation to appropriate service providers but do not pay for the services they deliver. CMS is evaluating this model and will post results when available. Please see **Appendix C** for more information on this program.

Guiding Principles of VBP

HHSC aims to ensure VBP arrangements adhere to certain guiding principles, identified below.

Engagement of Stakeholders

Ongoing engagement of MCOs, providers, trade associations, advocacy groups, and Medicaid enrollees is a critical activity to solicit input, ensure clarity of expectations, assess progress, identify and capitalize on opportunity areas, and remove barriers.

A key collaborative effort in Texas is the Value-Based Payment and Quality Improvement (VBPQI) Advisory Committee. Established by HHSC in 2016, it submits a biennial report to the Texas Legislature.⁸ The Committee has diverse representation from providers, health plans, academia, and other experts. The mission of the committee is to promote broad-based partnerships and collaborations for better health care, smarter spending, and healthier communities.

Another important stakeholder engagement effort has been the DSRIP Best Practices Workgroup (BPW), mentioned above. Based on the input of Workgroup members, there is strong consensus that the following 10 key measures represent promising areas for advancing VBP collaboration between providers and MCOs:

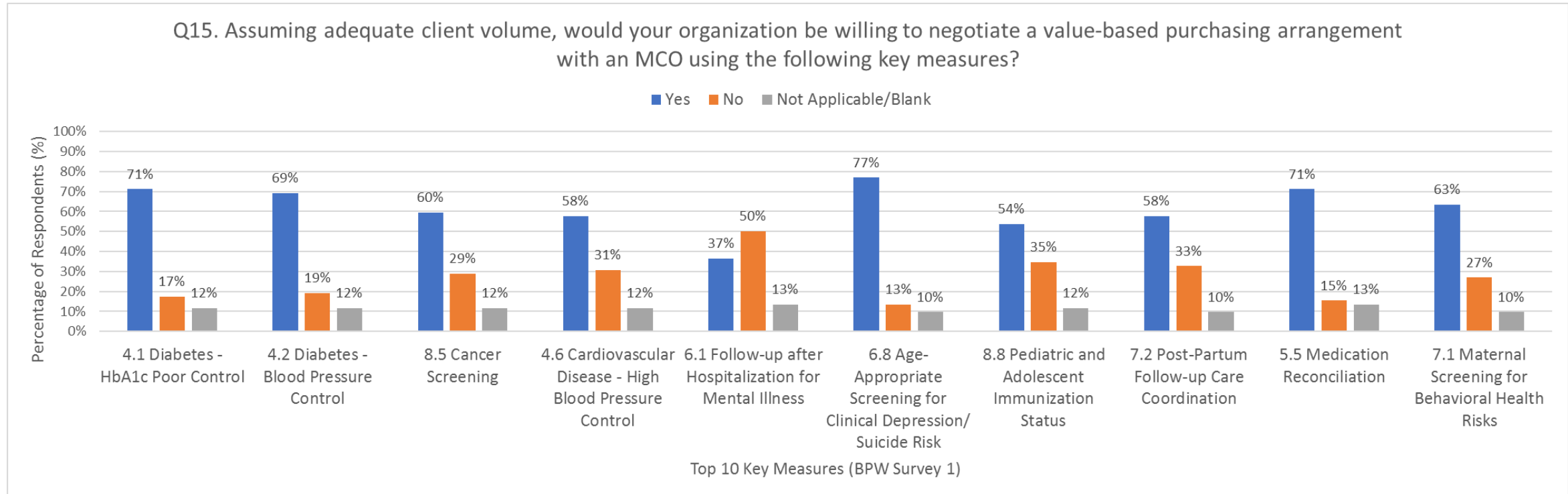
- Diabetes - HbA1c Poor Control
- Diabetes - Blood Pressure Control
- Cancer Screening
- Cardiovascular Disease - High Blood Pressure Control
- Follow-up after Hospitalization for Mental Illness
- Age-Appropriate Screening for Clinical Depression/ Suicide Risk (Adult, Child, and Adolescent)
- Pediatric and Adolescent Immunization Status
- Post-Partum Follow-up Care Coordination
- Medication Reconciliation
- Maternal Screening for Behavioral Health Risks

⁶ Texas Value-Based Payment and Quality Improvement Advisory Committee Recommendations to the 87th Texas Legislature, November 2020, Revised January 2021.

For nine of the 10 key measures, most of the surveyed Workgroup members expressed their organization's willingness to negotiate a VBP arrangement with an MCO on these quality measures. As shown in **Figure 4** below, "Age-Appropriate Screening for Clinical Depression/Suicide Risk" (Key Measure 6.8), "Medication Reconciliation" (Key Measure 5.5), and "Diabetes – HbA1c Poor Control" (Key Measure 4.1) were the quality measures showing the strongest level of willingness among respondents to be used in VBP arrangements with MCOs. The one quality measure with mixed results was "Follow-up after Hospitalization for Mental Illness" (Key Measure 6.1) since only 37 percent of respondents were willing to use this quality measure in a VBP arrangement with MCOs.

Workgroup members were also surveyed on their organization's willingness to negotiate a VBP arrangement using utilization-based measures that focused on reducing emergency department (ED) visits and hospitalizations. However, the majority of respondents were unwilling to use such measures, expressing that even when initiatives are implemented with goals of reducing preventable hospital and ED utilization, it is difficult to demonstrate improvement due to factors outside of the provider's control, such as primary care provider (PCP) assignment, medication adherence, and social determinants of health. A few respondents expressed willingness to use these utilization-based measures, only if denominator attribution were restricted to patients with an existing PCP relationship.

Figure 4: Using BPW Top 10 Key Measures in a VBP Arrangement with MCOs



Coordinated Efforts

As described in this document, there are many VBP related initiatives in Texas Medicaid. Additionally, Medicare and commercial insurers are moving aggressively through the APM continuum. It is imperative that HHSC take opportunities to increase coordination among these many VBP initiatives. This will magnify the focus and impact of initiatives and minimize administrative complexity.

In Texas, there are a number of health care payers, including the Employees Retirement System (ERS), Teachers Retirement System (TRS), Texas Department of Criminal Justice (TDCJ), Medicare, Medicaid, and commercial payers. Commercial payers include market-based plans, fully-insured employer group plans, and other plans that are self-insured by large employers and are operated by third-party administrators or administrative service organizations. Texas can leverage multi-payer data to identify and prioritize areas for quality improvement and support multi-payer VBP initiatives.

The 2020-21 General Appropriations Act (GAA), House Bill (H.B.) 1, 86th Legislature, Regular Session, 2019 (Article IX, Health Related Provisions, Section 10.06) requires five key agencies⁹ that pay for the health care of Texans to coordinate data to identify outliers and improvements for efficiency and quality that can be implemented by each healthcare system.¹⁰ The University of Texas Health Science Center at Houston (UTHealth) Center for Health Care Data (Data Center) holds health care utilization data from a variety of payers for more than 65 percent of the state population and is supporting the Five-Agencies Project Workgroup to facilitate compliance with Sec. 10.06.

Representatives from the five agencies and the UTHealth Data Center have been successful in collecting and aggregating disparate data in varying formats from multiple sources on an extremely large scale. The agencies created data warehouses and portals that allow for incorporating and comparing data across agencies. For the first time, meaningful analytics can be efficiently performed across the state's health care agencies. Recommendations to reduce cost and

⁹ Department of State Health Services (DSHS) which promotes and protects the health of all Texas residents; Employees Retirement System of Texas (ERS) for active and retired State and certain higher education employees and their dependents; Health and Human Services Commission (HHSC) for persons enrolled in Medicaid and the Children's Health Insurance Program (CHIP); Texas Department of Criminal Justice (TDCJ) for incarcerated persons in the State prison system; and Teacher Retirement System (TRS) for active and retired school and public education employees and their dependents.

¹⁰ [Cross-Agency Coordination on Healthcare Strategies and Measures First Year Report: Building the System, HHSC et. al. September 2020](#)

improve the quality of care in each health care system are expected in fiscal year 2021. Ultimately, this data platform is expected to support advanced multi-agency/multi-payer collaborations on projects and programs to improve value in Texas health care.¹¹

The workgroup will also use this data to develop common strategies for responding to critical health care issues. With the data aggregation platform, a future analysis could, for example, provide a wider view of the impacts of the current COVID-19 pandemic on the state's health care systems and population than is currently available.

In addition to state agencies coordinating efforts, Texas Medicaid also coordinates with Medicare to serve certain clients. The Dual Eligible Integrated Care Demonstration Project, or Dual Demonstration, is a fully integrated managed care model for individuals age 21 and older who are dually eligible for Medicare and Medicaid and required to be enrolled in the STAR+PLUS program. This capitated model involves a three-party contract between an MCO with an existing STAR+PLUS contract, HHSC, and CMS for the provision of the full array of Medicaid and Medicare services. The Dual Demonstration project is testing an innovative payment and service delivery model to alleviate fragmentation and improve coordination of services for dually-eligible members, enhance quality of care, and reduce costs for both the state and the federal government.¹²

Administrative Simplification

In March 2020, HHSC surveyed Medicaid MCOs for feedback on APMs. MCOs were asked what barriers to expanding or enhancing quality-based APMS their organizations encountered. Nine out of fifteen MCOs responded that the administrative burden of designing, establishing, and reporting on an APM was a barrier.

In a similar survey of DSRIP providers in September 2020, 63 percent of providers who participate in Medicaid APMs indicated that "increased paperwork or administrative complexity" was a factor that was not going well with their APMs. Of the same group, 56 percent also said "lack of common performance measures across plans and payors" was one reason they may not participate in APMs to the extent preferred and 47 percent agreed that HHSC should require increased multi-

¹¹ [Cross-Agency Coordination on Healthcare Strategies and Measures First Year Report: Building the System, HHSC et. al. September 2020](#)

¹² [Texas Medicaid and CHIP Reference Guide, Twelfth Edition, HHSC 2018](#)

payer alignment of metrics and measurement methods. Among all providers who responded to the survey, which included those who do not currently participate in Medicaid APMs, 23 percent said stronger alignment of performance measures across plans and payers would be among the most effective ways to encourage their participation in APMs.

VBP can be a more complex endeavor than traditional fee-for-service payment models. While the available research strongly suggests that fee-for-service provider payment models are a significant contributor to excess healthcare costs, these same studies also point to high administrative costs as another major factor in rising healthcare costs. Therefore, it is important that VBP arrangements be designed so that any efficiencies resulting from VBP are not offset by increased administrative costs. To the extent possible, MCOs within a Texas managed care service area should collaborate on the development of standardized formats for the provider performance reports and data requested from providers.¹³ Additionally, HHSC is reviewing potential approaches to improve measure alignment between MCOs, for example, to provide a menu of APM options for MCOs for certain focus areas.

When developing or updating VBP programs, HHSC aims to align quality measures between its programs and to use common, nationally-recognized measures when feasible. Texas VBP programs primarily incorporate Healthcare Effectiveness Data and Information Set (HEDIS) measures from NCQA and measures from other measure stewards, including the Dental Quality Alliance, National Quality Foundation (NQF), Agency for Healthcare Research and Quality, and CMS (including Adult and Child Core Measure Sets and Five-Star Quality Rating System).

Data Driven Decision-Making

Effective value-based and quality improvement initiatives require an informatics strategy that enables near real-time learning and incorporates both clinical and administrative data into robust measures of performance.

Extensive, searchable data on Texas MCO performance is available publicly via the [Texas Healthcare Learning Collaborative](#) (THLC) portal. This is a public-facing tool that provides data on potentially preventable events, medical and dental quality of care measures, and CMS core measures.

¹³ Uniform Managed Care Contract Section 8.1.7.8.2 MCO Alternative Payment Models with Providers

However, while the dashboard provides transparency, it relies on data from healthcare claims payments that are not available in near real-time. If more providers connected their clinical data to a health information exchange (HIE), “the near real time availability of electronically exchanged clinical data would significantly accelerate the time horizon for clinical and evaluative decision making, expanding the possibilities for rapid-cycle improvement approaches.”¹⁴

The Texas Medicaid HIE Connectivity Project, a key part of the Health Information Technology (Health IT) Strategic Plan¹⁵, will increase the adoption and use of HIEs by providing connectivity and infrastructure within the state’s Medicaid system and HIE Texas. This project will allow for Texas healthcare providers to exchange clinical data electronically, which will improve the coordination and quality of care for Medicaid clients throughout the state. As Medicaid MCO payment models change, health information sharing across the state’s Health IT ecosystem becomes more relevant.

Federal rule changes should encourage the increased transfer of patient data between providers. Under the new rules, beginning May 2021, CMS will make it a condition of participation in Medicare and Medicaid that hospitals send electronic event notifications of a patient’s admission, discharge, or transfer (ADT) 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.¹⁶ In the stakeholder feedback to the proposed CMS rule, “commenters noted that the availability of notification information is especially important for the success of value-based payment models, such as accountable care organization (ACO) initiatives, where participants may be financially at risk for costs associated with poor care transitions.”¹⁷ CMS highlighted the potential for reduced hospital readmissions, which are a performance measure for hospitals and MCOs in Texas.

Movement through the APM Continuum

In its APM Framework², the HCP LAN presents a continuum of APM models. A continued, thoughtful movement toward VBP models that have higher degrees of financial risk and that are alternatives to fee-for-service is considered essential for

¹⁴ [Accelerating the Adoption of Value-Based Payment in Medicaid by Linking Delivery System Reform to Managed Care Payment, CMS December 2019](#)

¹⁴ [Health Information Technology \(Health IT\) Strategic Plan, HHSC November 2019](#)

¹⁵ [Health Information Technology \(Health IT\) Strategic Plan, HHSC November 2019](#)

¹⁶ [Interoperability and Patient Access Fact Sheet, CMS March 2020](#)

¹⁷ [Federal Register Final Rule 85 FR 25510 CMS May 2020](#)

achieving maximum value. HCP LAN considers two-sided risk APMs the most effective way to achieve these objectives and has proposed new goals for their adoption. Specifically, they established a goal to have 50 percent of APMs in states' Medicaid programs be two-sided risk APMs by 2025. This goal is significantly higher than HHSC's target for MCOs of 25 percent by 2021. HHSC will consider this target and other recommendations from the HCP-LAN, along with state factors, when setting future VBP requirements for Medicaid and CHIP MCOs.

However, performance measurement needed for APMs across domains and populations has not been uniformly available. According to the National Committee for Quality Assurance (NCQA)¹⁸:

Although quality measurement has been critical for improving care for chronic conditions such as diabetes and cardiovascular disease, evidence shows that quality measurement for behavioral healthcare lags behind physical health measures and shows less improvement over time. Challenges to measuring the quality of behavioral healthcare include lack of standardization in treatment protocols, limited standardized data sources to capture outcomes and lack of linked electronic health information.

One intervention to address this concern is the development and implementation of the Certified Community Behavioral Health Clinic (CCBHC) model. CCBHCs are required to provide comprehensive mental health and substance use disorder services. The CCBHC model has helped to improve the quality measurement infrastructure in community mental health centers in Texas because to achieve certification, CCBHCs must collect, use, and report certain data to the state, and develop a data-driven continuous quality improvement plan for clinical services and management.¹⁹

Texas has added CCBHCs and supports the certification of more providers. The vision for CCBHCs is to shift to a prospective payment system. Texas continues to explore this payment structure, with the goal to transform service delivery to improve the lives and health outcomes of persons with persistent mental illness, emotional disturbances, and substance use disorders by creating a more efficient

¹⁸ [NCOA Supports better measurement for serious mental illness and emotional disturbances, NCOA May 2018](#)

¹⁹ [Criteria for the Demonstration Program to Improve Community Mental Health Centers and to Establish Certified Community Behavioral Health Clinics, SAMHSA May 2016](#)

and coordinated system.²⁰ As part of the DSRIP Transition, HHSC has developed a Medicaid DPP to incentivize the CCBHC model.

Rewarding Success

VBP is predicated on evidence that strengthening the linkage between payment and value (quality and/or efficiency) provides a necessary incentive structure for MCOs and providers to pursue continued performance improvement. Creating sustainable approaches for rewarding success is essential for a long term VBP strategy.

Successful VBP models that improve outcomes while lowering the total cost of care connect people to the most appropriate services for their circumstances, whether clinical or nonclinical. Value-based care is increasingly including strategies to address social determinants of health (SDOH). **Figure 5** shows the five key areas (determinants) according to the Office of Disease Prevention and Health Promotion’s Healthy People 2020²¹.

Figure 5: Key Social Determinants of Health



Source: Office of Disease Prevention and Health Promotion, U.S. Department of Health and Human Services

²⁰ [Certified Community Behavioral Health Clinics, HHSC](#)

²¹ [Social Determinants of Health, Office of Disease Prevention and Health Promotion, HealthyPeople.gov](#)

There is attention at both the state and federal levels to advance value-based care specific to SDOH. As part of the DSRIP Transition, HHSC is assessing which social factors are correlated with Texas Medicaid health outcomes to help inform strategies to advance APMs and further develop delivery system reform post DSRIP.²²

Texas Medicaid is also participating in a first of its kind SDOH learning collaborative with its MCOs and other key stakeholders.²³ The learning collaborative is facilitated by the Center for Health Care Strategies (with funding support from the Episcopal Health Foundation and the Robert Wood Johnson Foundation). The collaborative, now entering its second year, provides a regular forum for MCOs to share best practices, learn about efforts in other states, and participate in professionally facilitated discussions on key areas/approaches for addressing SDOH while lowering the total cost of health care and improving member outcomes.

At the federal level, CMS outlined opportunities for states to better address SDOH in a January 2021 Medicaid and CHIP State Health Official Letter²⁴, which includes shifting toward value-based care through APMs. The letter provides an inventory of strategies that states can use in various categories of services for addressing SDOH: housing-related services and supports, non-medical transportation, home-delivered meals, educational services, employment, community integration and social supports, and case management. "CMS provides states with flexibility to design an array of services to address SDOH that can be tailored, within the constraints of certain federal rules, to address state-specific policy goals and priorities, including the movement from volume-based payments to value-based care, and the specific needs of states' Medicaid and CHIP beneficiaries."

Addressing SDOH within Medicaid and CHIP has the potential to lower health care costs, improve health outcomes, and increase the cost-effectiveness of health care services and interventions. However, realizing the full value from many VBP arrangements can require a long-term return on investment perspective. In HHSC's March 2020 survey, 86.7 percent of MCOs that responded indicated a barrier to expanding or enhancing quality-based APMs was "Patient churn in Medicaid or patient's ability to change providers limits MCO's ability to measure outcomes attributable to providers." Strategies that minimize enrollment changes while

²² [Delivery System Reform Incentive Payment \(DSRIP\) Transition Plan, HHSC August 2020](#)

²⁴ [Texas Managed Care Organization Social Determinants Of Health Learning Collaborative: Kickoff Meeting Summary, Episcopal Health Foundation, December 2019](#)

²⁴ [Social Determinants of Health \(SDOH\) State Health Official \(SHO\) Letter #21-001, CMS January 2021](#)

maintaining patients' freedom of choice could enhance the effectiveness of incentives for VBP by better rewarding success.

Lastly, providers and health plans have had to adapt quickly to the COVID-19 public health emergency to safely treat patients, both for COVID-19 and for ongoing care. These adaptations included expanding the use of telemedicine and telehealth and increasing prospective provider payment arrangements with health plans (vs. fee for service payments). There is an opportunity to review activities by providers and health plans for "lessons learned" that could strengthen population health. Despite these adaptations, changes in care are affecting performance measurement trends and achievement of outcome goals, and HHSC and MCOs will have to determine how to adjust VBP models for these impacts.

Conclusion

HHSC has charted a course towards paying for the value of healthcare services in the Medicaid and CHIP programs. Achieving this transformation into a value-based system requires continued coordination and improvement efforts spanning numerous stakeholders from the Medicaid program itself to MCOs, providers, patients and families, policymakers, community-based organizations, and others. Working collaboratively, HHSC can achieve its mission to improve the health, safety, and well-being of Texans with good stewardship of public resources.

This update of the Value-Based Payment Roadmap describes the state's progress on important complementary initiatives underway in Texas for improving services in Medicaid managed care and assesses new challenges and opportunities that have emerged since the publication of the state's first Roadmap in 2017. Advancing value-based reforms with concerted and sustained effort remains a priority for HHSC. Lessons identified through DSRIP, ongoing feedback from stakeholders, and monitoring of key performance measures and industry trends have positioned the state to complete the transformation of Medicaid into a program that fully emphasizes value, quality, and results.

Appendix A. MCO and Dental Maintenance Organization (DMO) VBP with providers and APM Targets

Purpose

In 2012, HHS began tracking payment methodologies between MCOs/DMOs and their providers. This review indicated that while MCOs/DMOs received capitated premiums from HHSC, they were still predominantly reimbursing their providers using a fee-for-service approach, thus maintaining incentives for volume over value in the payment model. In 2014, HHSC incorporated a provision into the Medicaid managed care contracts that required MCOs and DMOs to implement APM models with providers and to submit annual reports to HHSC on their APM activities. To help push value-based incentives to the provider level, HHSC created contractual requirements for MCOs/DMOs to connect their provider payments to value starting in calendar year 2018.

Desired Outcome

The VBP approach uses the nationally-recognized [Healthcare Payment Learning and Action Network \(HCP LAN\) Alternative Payment Model \(APM\) Framework](#) to help guide this effort. This framework provides a range of payment model concepts, encompassing varying degrees of risk on providers, from which MCOs/DMOs can develop VBP contracts with providers. The desired outcome is to move most of the payment arrangements to population-based models (two-sided risk).

The contractual APM targets began in CY 2018 and were reported in July 2019. For MCOs and DMOs the first-year and fourth-year targets are presented below.

| Targets | | |
|----------------|---------------------------------------------------------|--------------------------------------------------------------------------------|
| Year | Overall VBP target | Risk Based VBP Target |
| 2018 | 25% of medical expense in a VBP model for MCOs and DMOs | 10% of medical expense in a Risk Based VBP model for MCOs; 2% for DMOs |
| 2021 | 50% of medical expense in a VBP model for MCOs and DMOs | 25% of medical expense in a Risk Based VBP model for MCOs; 10% for DMOs |

Challenges to address

An MCO/DMO that fails to meet the VBP targets is subject to graduated contractual remedies, up to and including liquidated damages. MCOs that demonstrate high performance on select quality metrics, such as preventable hospital stays and preventable emergency department visits, can gain an exemption from the targets.

Successes

Analysis of MCO-reported data showed that in 2017, the year prior to implementation, the amount of dollars paid to providers through an APM had reached about \$7.15 billion (38% of medical expenses).²⁵ According to the LAN Framework, 56% of APMs developed for 2017 were in Categories 2 A-C, 33% in Categories 3 A-B, and 11% in Categories 4 A-B. In 2018, the first target year, Category 2 A-C APMs held steady at 55% of the models, APMs in Category 3 A-B increased to 38%, and those in Category 4 A-B declined to 7%. However, in addition to the APMs reported above, in 2018, MCOs implemented 10 additional population-based models with financial risk that did not include quality metrics (Category 4N). The total amount spent on APMs in 2018 increased by almost \$1 billion compared to 2017 to \$8.12 billion (40% of medical expenses). In addition, dental plans reported APM expenses of over \$1.1 billion in 2017 and \$1.3 in 2018.

Next steps

HHSC will consider alignment with LAN 2.0 objectives established in the Fall of 2019 and revisited in light of the COVID-19 public health emergency in the Fall of 2020. The newly developed objectives are oriented towards quality, patient experience, and equity at a lower cost. Two-sided risk alternative payment models (APMs) are considered a way to achieve these objectives and LAN proposed new goals for their adoption. However, HHSC will consider additional state-level factors, based on the most recently available data and input from stakeholders, as it develops proposals to advance the APM initiative beyond its initial contract targets.

²⁵ For 2017 and 2018, percent of medical expenses in an APM are calculated using data from the STAR, STAR+PLUS and CHIP programs. STAR Kids requirements are not in effect until 2019.

Appendix B. DSRIP Program

Goal

The Delivery System Reform Incentive Payment (DSRIP) program aims to encourage delivery system transformation through innovation, coordination, and accountability for performance. The program builds capacity for providers to use data, track improvements, and advance value, ultimately to meet the goal of increasing the use of alternative payment models in the Medicaid program.

Description

The DSRIP program in the Texas Healthcare Transformation and Quality Improvement Program Medicaid 1115 Demonstration (Waiver) benefits Texans and the Texas healthcare delivery system. DSRIP is locally driven, based on community needs, and provides incentive payments based on reporting and performance.

The first five years of DSRIP initiated statewide transformation through more than 1,400 projects delivered by 300 performing providers. The first phase of DSRIP required reporting for each project on outcome measures and providers could earn performance-based payments each year. During the Waiver renewal period, new DSRIP program protocols were developed to evolve from project-level reporting to provider system-level reporting. The measures used shifted to focus on health care quality rather than process measures.

DSRIP performing providers include hospitals (public and private), community mental health centers, physician practices (largely academic health science centers), and local health departments. The inclusion of mental health centers and local health departments in DSRIP as performing providers enabled greater integration and coordination between physical, behavioral, and public health.

Successes

DSRIP significantly expanded healthcare quality measurement in Texas. In the initial phase of the Waiver, most providers succeeded in achieving their outcome goals, including goals related to diabetes and high blood pressure control, reducing emergency department visits for ambulatory care sensitive conditions, and reducing the risk-adjusted congestive heart failure hospital readmission rate.

DSRIP enables increased collaboration between diverse healthcare providers and stakeholders and investments in infrastructure and innovation to improve systems of care. Texas' DSRIP projects resulted in increased access to primary and preventive care, emergency department (ED) diversion, and enhanced services for individuals with behavioral health needs.

Texas providers earned over \$15 billion in DSRIP funds from 2012 to January 2019, and they served 11.7 million people and provided 29.4 million encounters from October 1, 2013 to September 30, 2017. For calendar year 2019, providers reported improvements in over 2000 measures of healthcare quality.

Next steps and Key Focus Areas

Through the [DSRIP Transition Plan](#), Texas will pursue the following goals as it explores new programs and policies:

- Advance APMs that target specific quality improvements.
- Support further delivery system reform that builds on the successes of the Waiver and includes current priorities in health care.
- Explore innovative financing models.
- Develop cross-focus areas such as social drivers of health that use the latest national data and analysis to continue to innovate in Texas.
- Strengthen supporting infrastructure for increased access to health care and improved health for Texans.

These efforts will be prioritized for the following key focus areas:

- Sustaining access to critical health care services;
- Behavioral health;
- Primary care;
- Patient navigation, care coordination, and care transitions, especially for patients with complex conditions that have high costs and high utilization;
- Chronic care management;
- Health promotion and disease prevention;
- Maternal health and birth outcomes, including in rural areas of the state;
- Pediatric care;
- Rural health care;
- Integration of public health with Medicaid;
- Telemedicine and telehealth; and
- Social drivers of health.

Appendix C. Texas Accountable Health Communities Project

Goal

The Accountable Health Communities Model is based on emerging evidence that addressing health-related social needs through enhanced clinical-community linkages can improve health outcomes and reduce costs. Unmet health-related social needs, such as food insecurity and inadequate or unstable housing, may increase the risk of developing chronic conditions, reduce an individual's ability to manage these conditions, increase health care costs, and lead to avoidable health care utilization.

Desired Outcome

Over a five-year period, the model provides support to community bridge organizations to test promising service delivery approaches aimed at linking beneficiaries with community services that may address their health-related social needs (i.e., housing instability, food insecurity, utility needs, interpersonal violence, and transportation needs):

- Assistance Track – Provide community service navigation services to assist high-risk beneficiaries with accessing services to address health-related social needs.
- Alignment Track – Encourage partner alignment to ensure that community services are available and responsive to the needs of the beneficiaries.

To implement each approach, bridge organizations will serve as 'hubs' in their communities, forming and coordinating consortia that will:

- Identify and partner with clinical delivery sites (e.g., physician practices, behavioral health providers, clinics, hospitals) to conduct systematic health-related social needs screenings of all beneficiaries and make referrals to community services that may be able to address the identified health-related social needs;
- Coordinate and connect beneficiaries to community service providers through community service navigation; and
- Align model partners to optimize community capacity to address health-related social needs (Alignment Track only).

Description

This model promotes clinical-community collaboration through:

- Screening of community-dwelling beneficiaries to identify certain unmet health-related social needs;
- Referral of community-dwelling beneficiaries to increase awareness of community services;
- Provision of navigation services to assist high-risk community-dwelling beneficiaries with accessing community services; and
- Encouragement of alignment between clinical and community services to ensure that community services are available and responsive to the needs of community-dwelling beneficiaries.

Three entities obtained the grant in Texas:

- CHRISTUS Santa Rosa Health Care Corporation, located in San Antonio;
- Parkland Center for Community Innovation (PCCI), located in Dallas; and
- University of Texas Health Science Center (UTHSC) School of Public Health located in Houston.

While the first two entities are part of the Assistance Track, the third is on the Alignment track. All bridge organizations participating in the AHC Model are required to have signed MOUs with their State Medicaid Agency. The state Medicaid agency at a minimum:

- Reports or facilitate the reporting of Medicaid claims data to CMS and its contractors for purposes of model monitoring and evaluation;
- Champions appropriate data sharing across clinical delivery sites and community service providers consistent with federal, state, and local law;
- Ensures alignment with existing Medicaid policy, and, as appropriate, waivers and State Plan Amendments to achieve scalability and sustainability if the model is successful;
- Provides a point of contact for data collection and reporting; and
- Performs an annual review to ensure that CMS funding under the AHC model is not used to duplicate any service that a community-dwelling Medicaid beneficiary would otherwise be eligible to receive under a program administered by that state Medicaid agency.

In addition, the bridge organizations worked with HHSC to receive Medicaid claims data for AHC beneficiaries for their own tracking and evaluation purposes.