

The seal of the State of Texas is a large, light blue circular emblem on the left side of the slide. It features a five-pointed star in the center, surrounded by a wreath of olive and live oak branches. The words "STATE OF TEXAS" are inscribed around the perimeter of the seal.

# Managed Care Organization Performance and Accountability

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Health and Human  
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# Rates Overview

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- All rate setting functions were consolidated as a result of a 2015 Sunset recommendation to promote consistency in rates across the HHS System
- The Provider Finance Department (PFD) develops fee-for-service (FFS) reimbursement rates for most HHS programs (primarily Medicaid) and coordinates with program staff and other state agencies
- PFD coordinates with Actuarial Analysis (AA) as FFS rates and rate changes are incorporated into the calculation of managed care capitation rates
- FFS rates are also used by managed care organizations (MCOs) and providers as benchmarks in their contract negotiations
- PFD also administers the financial components of several supplemental and directed-payment programs



# Rates Overview

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## PFD is responsible for:

- Developing Texas Administrative Code rules, state plan amendments, and waiver applications
- Conducting rate and rule hearings
- Reviewing all rates at least once every two years
- Preparing requests for approval by the Office of the Governor and Legislative Budget Board (LBB) of rate increases that meet a certain cost threshold
- Processing of supplemental payments and collection of intergovernmental transfers (IGT)
- Supporting the Department of Family and Protective Services (DFPS) via interagency contract by providing subject matter expertise and technical support for various rates
  - The authority to determine such rates is held by the Commissioner of DFPS



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# Medicaid Shortfall and Factors that Impact Rates

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**Costs not covered by Medicaid rates constitute the Medicaid shortfall**

Factors that impact rates include:

- Legislative Direction – appropriations or cost containment
- Revolutionary advancements in medical technology or treatments
- Changes in clinical standards
- Access-to-care issues
- Attempts to change provider/consumer behavior through rate methodologies
- Medicare changes
- Litigation
- Federal policy changes



# Rate Hearing and Rule Hearing Public Process

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## Hearing Required:

- State law requires HHSC to hold a public rate hearing prior to adopting any Medicaid rate change regardless of whether the rate is increased or decreased
- Notice of the public rate hearing is published in the Texas Register, posted on HHSC's website, and e-mailed to stakeholder lists at least 10 days prior to the public rate hearing

## Opportunity to Comment:

- Any interested parties are given the opportunity to comment on the proposed rate changes at the public rate hearing or via U.S. mail or e-mail

## Presentation to Committees:

- If rate changes require changes to agency rules, the proposed rules are presented to the Medical Care Advisory Committee, Hospital Payment Advisory Committee (if related to hospital reimbursement), and the agency's Council for input
- All of these meetings have additional opportunity for public comment



# Section 16 Reporting Requirements

## Article II, Sec. 16 – Rate Limitations and Reporting Requirements (as applies to FFS rates):

- Requires LBB and the Office of the Governor approval for any rate that would result in expenditures that exceed, in any fiscal year, the amounts appropriated to a strategy for the services to which the rate applies
- Exceptions to required approval, include:
  - Rates for new procedure codes required to conform to Federal Healthcare Common Procedure Coding System updates
  - Revised rates occurring as a result of a biennial calendar fee review
  - Any rate change estimated to have an annual fiscal impact of less than \$500,000 in General Revenue-related Funds or Temporary Assistance for Needy Families Federal Funds
- Requires quarterly reporting of all exceptions
- Requests for approval are considered to be approved unless the LBB or the Office of the Governor issues a written disapproval within 15 business days of the date on which LBB staff concludes its review of the request for authorization of the rate



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# Managed Care Capitation Rates

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## Medicaid/CHIP Managed Care Payments

- Risk-based payment model
- Rates are developed prospectively on a State Fiscal Year, per member per month basis
- MCOs receive monthly payments based on their enrollment and capitation rates

## Federal Requirements – Actuarial Soundness

- Generally accepted actuarial principles and practices
- Certified by a qualified actuary as appropriate for the populations being covered and the services being furnished under the contract



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# Rate Setting Methodology: Overview

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**Rates include provision for all reasonable and appropriate costs necessary to serve clients and administer the Medicaid and CHIP benefits**

- Client Services
- Quality Improvement
- Administrative Costs
- Net Reinsurance
- State Premium and Maintenance Taxes
- Risk Margin

## **Community Based Rate with Risk Adjustment**

- A consistent methodology is used across managed care programs
- Community rate (average cost)
  - Managed Care Program
  - Geographical Service Area
  - Risk Group
- MCOs receive community rate with risk adjustment to reflect their unique membership acuity





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# Rate Setting Methodology: Overview

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## Managed Care Data Collection and Rate Development

### Historical Texas Medicaid and CHIP Managed Care Data:

- Enrollment
- Claims data
- Financial Statistical Reports
- Supplemental Requests

### Adjustments:

- Cost Containment initiatives
- Provider reimbursement changes
- Related party
- Other benefit and policy changes

### Trend:

- Necessary to recognize changes in case mix, acuity, medical innovations

### Acuity:

- Based on each MCO's population



# Rate Setting Timeline

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## **Capitation rate development begins 10 months prior to the beginning of the fiscal year**

- Collect and validate data and information
- Review assumptions and current developments with various HHSC and Office of Inspector General (OIG) departments and staff
- Provide opportunity for MCO comment
- Receive approval from the HHSC Executive Commissioner
- Finalize capitation rates and execute contracts

**Rates are submitted to state and federal offices 45 days prior to implementation for review and approval**



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# Accountability through Contract Oversight

## Tools span five key areas

- 1 Access to services**  
Network adequacy, appointment availability, member satisfaction
- 2 Service delivery**  
Utilization reviews (UR), drug URs, electronic visit verification (EVV)
- 3 Quality**  
Improvement projects, pay-for-quality, alternative payment models, custom evaluations, MCO report cards
- 4 Financial**  
Financial statistical reports (FSRs) validation, net profit and experience rebate, independent auditing
- 5 Operations**  
Readiness reviews, biennial operational reviews, targeted reviews

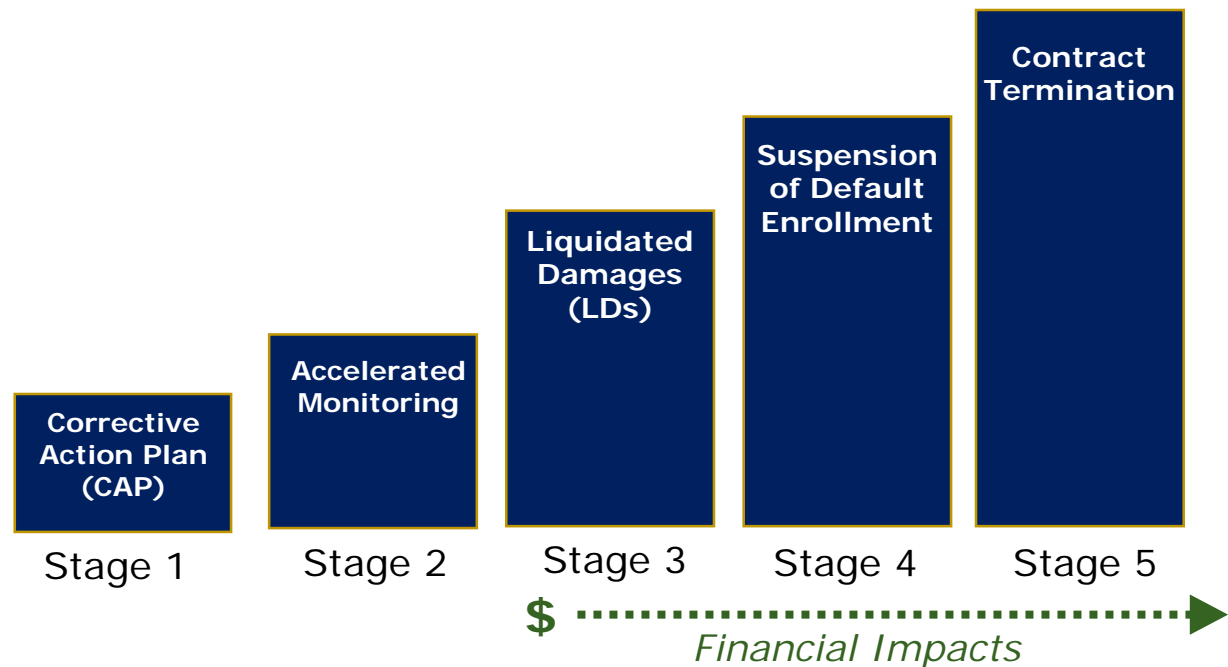


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# Non-Compliance Issues

## Multiple stages of remedies

- Increased levels of impact for MCOs
- Remedy issued is contingent on type of non-compliance and not necessarily sequential





# Oversight Tool Highlight

## Financial

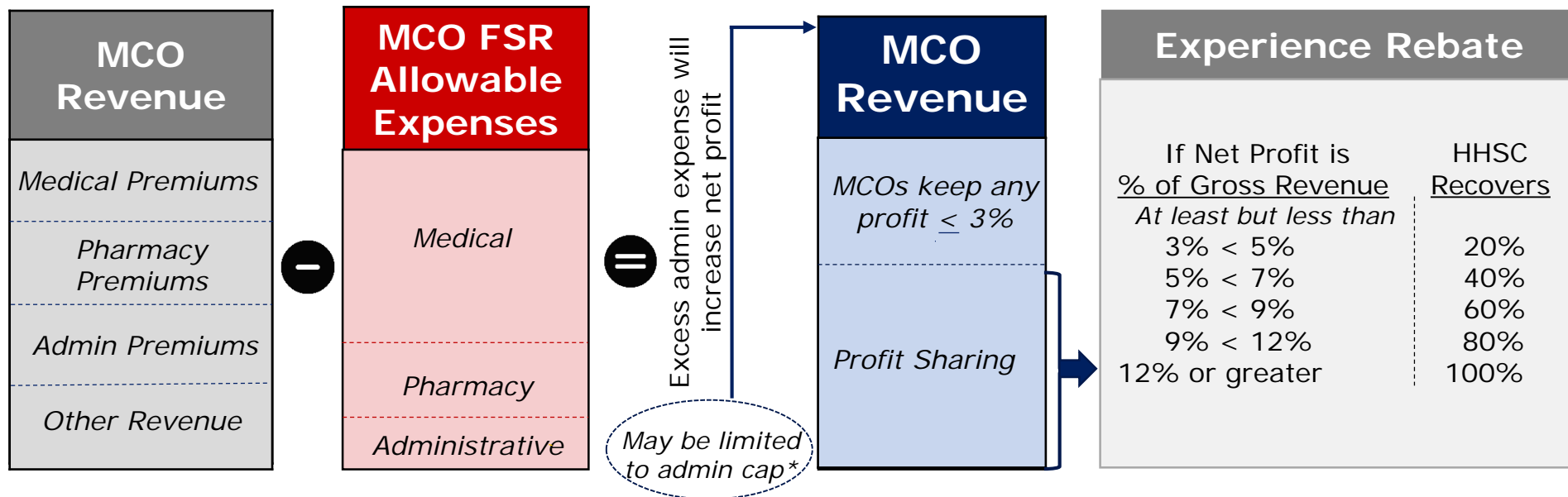


Non-compliance discoveries enforced as established in the contract, including liquidated damages or recovery of the Experience Rebate (i.e. recovery of “excess profit”)

# Net Profit and Experience Rebate

## Fiscal responsibility

Major safeguards through caps on administrative expenses and experience rebates on excessive profit



\*Admin cap is set by program.



# Quality Oversight

## Focused on outcomes

### Overall Quality Performance

- Monitored through a performance indicator dashboard comprised of state and federal measures
- Contracts require MCOs to perform above the minimum standard on more than two-thirds of the dashboard measures

### Performance Improvement Projects (PIPs)

- Topics determined by HHSC and External Quality Review Organization
- Each PIP lasts two years, two PIPs per managed care program, staggered schedule
- Example:
  - *Improve follow-up rate after hospital admission for members with mental illness*

### Managed Care Report Cards

- One- through five-star MCO rating system
- Developed by surveying current members and analyzing claims data
- Key areas looked at:
  - Experience of care
  - Staying healthy
  - Common chronic conditions
  - Overall plan quality
- Provide transparency for members when selecting or changing plans

### Quality Assessment and Performance Improvement (QAPI)

- Ongoing, comprehensive quality-assessment and performance-improvement programs for all the services the MCO provides
- Not time-limited programs targeting a specific aspect of care like PIPs
- Examples:
  - *Foster data-driven decision-making*
  - *Solicit member and provider input on quality activities*



# Incentivizing Quality Care

## Pay-for-Quality (P4Q)

- Evaluates MCOs and DMOs on a set of quality measures
- Plans can earn or lose money based on their level of improvement or decline from the prior year\* and their performance relative to set benchmarks

### Medical P4Q

*Medical focus areas:*

- Prevention
- Chronic disease management (including behavioral health)
- Maternal and infant health

3 percent capitation at risk

Measurement began January 2018

### Dental P4Q

*Dental focus areas:*

- Annual oral evaluations
- Primary prevention against dental caries (cavities)

1.5 percent capitation at risk

Measurement began January 2018

←----- **Alternative Payment Models (APMs)** -----→

*Strong P4Q programs incentivize plans to pursue quality-based APMs with providers. HHSC requires a certain percentage of provider payments to be associated with an APM.*

\*DMO performance compared to performance from two years prior





# Incentivizing Quality Care

## Value-Based Enrollment

Implemented September 1, 2020

### How it works

MCOs with better performance than others on the factors listed below receive a higher share of default enrollments (Medicaid recipients that do not choose a health plan) than under the previous methodology

### Criteria and Weighting

**40%**  
Cost and Efficiency  
*Risk-Adjusted Ratio of  
Actual to Expected  
Spending*

X

**20%**  
Cost and Quality  
*Risk-Adjusted  
Potentially Preventable  
Events (PPE) Ratios*

X

**40%**  
Quality and Member  
Satisfaction  
*Composite MCO Report  
Card Scores*