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Rider 20: MCO Benchmarks

May 26, 2022

Rider 20

Rider 20 (2022-23 General Appropriations Act)

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

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Proposal

High-Value Plan

Cost Efficiency	Quality of Care	Experience of Care		
Medical Cost	Administrative Cost	Health-Related Measures	Member Experience	MCO Operational Performance	Provider Experience

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Rider 20 Requirements: Guiding Principles

- Select measures that:
  - Are established and can be built upon, where feasible;
  - Align with other managed care oversight efforts;
  - Can be calculated at the plan level, and as needed at the service area level; and
  - Capture the unique nature of different programs.
- Establish benchmarks based on national or other relevant standards, not just current performance, to the extent possible.
- Continue to evolve measurement once foundation is built.

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High-Value Plan | Cost Efficiency | Medical Cost

- **Proposed Measure:** Risk-Adjusted Spending Ratio that is one dimension of the value-based enrollment algorithm (VBEA).
  - VBEA has undergone substantial internal and external review.
  - Calculation is straightforward.
  - Transparent (information related to the ratio is available in annual managed care rate-setting actuarial analysis reports).
  - Already excludes directed/supplemental payments.
  - Includes medical and pharmacy costs but excludes administrative expenditures.
  - Excludes most long-term services and supports, which may be a future consideration for STAR+PLUS and STAR Kids.

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High-Value Plan | Cost Efficiency | Medical Cost

- Spending Ratio = Actual Expenditures/Expected Expenditures
- Expected Expenditures are calculated by the state's External Quality Review Organization using the Chronic Illness and Disability Payment System (CDPS), a diagnostic classification system designed to be used for Medicaid programs, and actual Texas Medicaid data.
- Spending Ratio can be calculated for each program, plan, and service area combination.

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High-Value Plan | Cost Efficiency | Medical Cost

- Benchmarks
  - Will need to consider possible regional variation.
  - Focus on developing methodology to set benchmarks because actual benchmark values may change from year to year.

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High-Value Plan | Cost Efficiency | Administrative Cost

- MCOs have some flexibility in how they manage spending and may elect to spend more administratively in order to control medical costs or spend less administratively with the potential that medical costs will be higher.
- Relying solely on medical cost may not reflect an MCO's overall cost efficiency.

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High-Value Plan | Cost Efficiency | Administrative Cost

- **Proposal:** Develop a Spending Ratio for allowable administrative costs similar to what is proposed for Medical Cost.
  - Actual Administrative Expenditures would come from Financial Statistical Reports
  - Expected Expenditures would be based on the administrative components of premiums and may include the following:
    - Fixed and variable administrative components
    - Premium Tax
    - Maintenance Tax

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High-Value Plan | Cost Efficiency | Administrative Cost

- **Proposal:** Develop a Spending Ratio for allowable administrative costs similar to what is proposed for Medical Cost.
  - Additionally, the ratio may include expenditures for the following:
    - Service Coordination
    - Quality Improvement
  - Consideration would need to be given to the magnitude of medical cost relative to administrative cost when comparing or combining the two ratios.

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High-Value Plan

Quality of Care

Health-Related Measures

- **Proposed Measure:** Performance Indicator Dashboard that is used to promote quality improvement and MCO accountability.
  - Program-specific measures align with state and federal healthcare quality initiatives.
  - Publicly available on thlcportal.com.
    - 2022 measures can be downloaded under Resources, HHSC Performance Standards, Measurement Year 2022.
  - Reflects a broader range of quality measures than VBEA, which should prevent plans from being advantaged or disadvantaged by selection of a narrow set of measures.
  - Performance is comparable across years.

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- Dashboard includes measures that can be grouped into the following categories:
  - Prevention
  - Chronic Disease Management
  - Behavioral Health
  - Maternal Health
  - Avoidable Hospitalizations
  - Member Experience

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High-Value Plan

Quality of Care

Health-Related Measures

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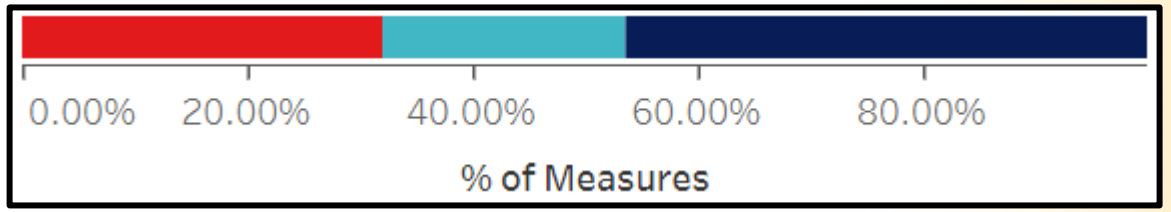
Number of Measures by Program and Category (2022)

	STAR	STAR+PLUS	STAR Kids	STAR Health	CHIP
Prevention	13	8	13	8	12
Chronic Disease Management	7	20	4	0	2
Behavioral Health	21	20	10	8	4
Maternal Health	5	2	0	0	0
Avoidable Hospitalizations	9	8	6	2	5
Member Experience	13	10	12	7	4
TOTAL	**68**	**68**	**45**	**25**	**27**

Note: MCOs will not be evaluated on measures that have been retired or undergone specification changes; therefore, MCOs may be evaluated on fewer measures than identified in the table.

High-Value Plan | Quality of Care | Health-Related Measures

- Each underlying measure has its own standard for high performance and minimum performance.
  - The methodology for setting dashboard standards is published in the Uniform Managed Care Manual, Chapter 10.1.14.
- Dashboard identifies
  - Percentage of measures where the high-performance standard is exceeded (dark blue in sample)
  - Percentage of measures where the minimum performance standard is met or exceeded but the high-performance standard is not met (turquoise in the sample)
  - Percentage of measures where the minimum performance standard is not met (red in the sample)
  - Sample Performance:



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High-Value Plan

Quality of Care

Health-Related Measures

- Benchmarks
  - Require meeting or exceeding the high-performance standard for a minimum number or percentage of measures
  - Require meeting or exceeding the minimum performance standard for a minimum number or percentage of measures

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High-Value Plan | Experience of Care | Member Experience

- Member experience is an important indicator of a plan's value.
- Member experience measures are included in the Performance Indicator Dashboard.
- In addition to the overall benchmarks related to the Performance Indicator Dashboard, a minimum level of performance on measures of member experience may be required.

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High-Value Plan

Experience of Care

Member Experience

Member Experience Measures	STAR	STAR+PLUS	STAR Kids	STAR Health	CHIP
% Good Access to Routine Care	Adult/Child	Adult		Child	
% Rating Personal Doctor a "9" or "10"	Adult/Child	Adult	Child	Child	Child
% Rating Their Health Plan a "9" or "10"	Adult/Child	Adult	Child	Child	Child
Getting Care Quickly Composite	Adult		Child		Child
Getting Needed Care Composite	Adult		Child		
% How Well Doctors Communicate Composite	Adult/Child	Adult	Child	Child	Child
% Good Access to Specialist Appointment	Child			Child	
% Good Access to Urgent Care	Child	Adult		Child	
% Advised to Quit Smoking	Adult	Adult			
% Good Access to Behavioral Health Treatment or Counseling		Adult	Child	Child	
% Good Access to Service Coordination		Adult			
% Good Access to Special Therapies		Adult			
% Good Access to Specialist Appointment		Adult			
% Receiving Help Coordinating Child's Care			Child		
% Very Satisfied with Communicating Among Child's Providers			Child		
Access to Specialized Services			Child		
Customer Service			Child		
Doctors Discuss Eventual Transition to Adult Care for Adolescents			Child		
Personal Doctor Who Knows Child			Child		

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High-Value Plan | Experience of Care | MCO Operational Performance

- Measures of MCO operational performance are included in contracts and monitored by HHSC.
- Areas being considered include the following:
  - Claims Processing Timeliness
  - Accurate and Timely Encounters Submission
  - Appeals/Grievances Resolution Timeliness
  - Network adequacy
- How to benchmark those measures is an area for additional work.

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High-Value Plan | Experience of Care | Provider Experience

- Previous efforts by HHSC to assess provider experience through surveys have resulted in low response rates.
- HHSC will review existing measures to see if there are any that can be considered a proxy for provider experience.

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High-Value Plan

Use of Definition

- HHSC uses the following tools to drive MCO performance:
  - Technical assistance and training
  - Plans of action and corrective action plans
  - Liquidated damages
  - Enrollment methodology (e.g., value-based enrollment, suspension of enrollment)
  - Incentives (e.g., Pay-for-Quality program)

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Proposal

- Work completed to satisfy the requirements of Rider 20 would become the building blocks for further defining high-value plans.
- Work on the high-value plan definition would continue beyond September 1, 2022 and incorporate additional areas, including provider experience for which measures do not currently exist.
- Additionally, benchmarks and uses may require continued refinement.

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Thank You