Value-Based Purchasing Program Integrity Considerations

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Texas Health and Human Services

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Executive Summary

Value-based purchasing (VBP) models are utilized in government health insurance programs to shift payments from volume to value.[i] Several terms are used, sometimes interchangeably, to describe efforts to tie payments for care delivery to the quality and efficiency of care provision, including value-based purchasing, programs or payments, as well as alternative payment models (APMs). This informational report explores how VBP has evolved nationally, Texas' implementation and a discussion of potential program integrity challenges and considerations related to the OIG's future work in this space.

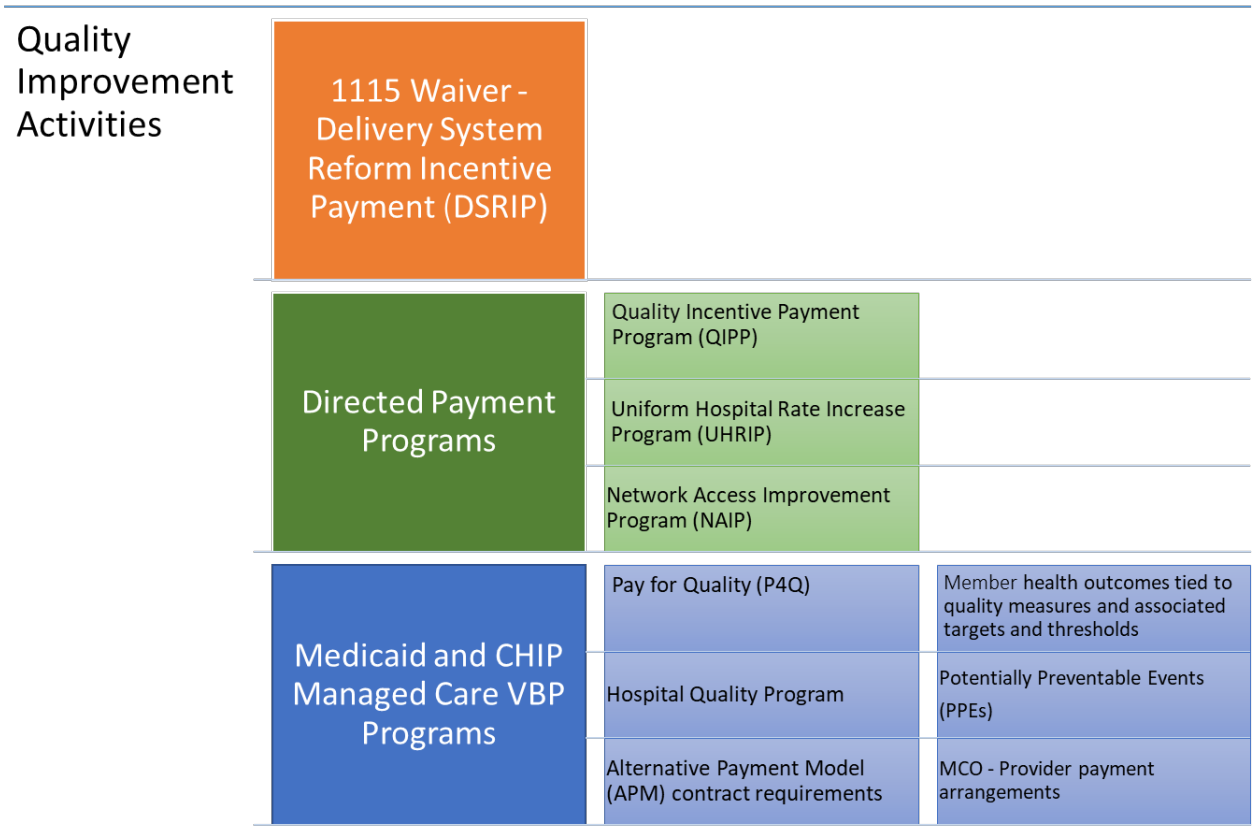
National Landscape

Over the last decade, the federal government has prioritized the use of VBP in the provision of health-care services by enacting and implementing key legislation requiring VBP. Since 2010, there have been several federal requirements, as well as guidance from the Centers for Medicare & Medicaid Services (CMS), to prioritize VBP in Medicare, Medicaid and the Children's Health Insurance Program (CHIP). Federal requirements allow states flexibility to develop and implement their own requirements, measures and programs to promote value in provider reimbursement models in Medicaid and CHIP.

VBPs and APMs in Texas Medicaid and CHIP

The shift to paying for value versus volume in state health-care programs is a priority in Texas. Texas has followed national trends to link Medicaid and CHIP health-care payments to quality and efficiency by enacting legislation and implementing VBP programs and APM requirements.[ii] The Texas Health and Human Services Commission (HHSC) administers various programs to improve health-care quality and outcomes while containing costs. These activities are shown in Figure 1.

Figure 1: HHSC Quality Improvement Activities



Source: Developed by OIG[iii]

The primary vehicle in Texas for associating health-care payments to measures of quality and/or efficiency has been through managed care. In Texas Medicaid and CHIP managed care, VBP and APM initiatives financially reward managed care organizations (MCOs)[1] and providers to improve health outcomes for members by providing high-quality health care. All Medicaid and CHIP MCO contracts include policies and programs to align financial incentives with member health outcomes. For state fiscal year (SFY) 2021, MCO contracts target payments tied to APMs constitute 50 percent, and payments tied specifically to risk-based APMs 25 percent, of all MCO-reported medical and pharmacy expenditures.[iv]

[1] For the purposes of this report, the term 'MCOs' is inclusive of Dental Maintenance Organizations (DMOs) unless otherwise noted.

Program Integrity Challenges and Considerations

Program integrity refers to ensuring taxpayer dollars are spent appropriately on quality, necessary care and preventing fraud, waste, and abuse (FWA). With the introduction of VBP and associated complex contractual arrangements, there are new program integrity considerations for both MCOs and regulators to examine. Nationally and in Texas, regulators are working to understand the complexities of these contracting methods and the resultant program integrity considerations in this space. Based on targeted research and programmatic observations, the OIG outlines two areas of operational challenge and related program integrity considerations within value-based contracting:

1. **Data Sharing and Integrity** – The impacts and program integrity considerations tied to accurate and complete data and timely sharing between providers, MCOs and the state.
2. **Payment Integrity** – Behaviors or schemes that may result from VBPs and APMs and the potential integrity issues tied to the complexity of these models.

Federal Input Related to Program Integrity and VBP

In response to the expansion of VBP models in the United States health-care system and related program integrity considerations, federal agencies have issued guidance and solicited information on efforts to combat FWA in this space.

- **2018 Federal OIG Advisory Opinion on VBP** - The federal OIG has examined specific value-based arrangements and issued guidance through an advisory opinion, indicating compliance (or not) with program integrity federal laws.[v]
- **2019 CMS Request for Information on the Future of Program Integrity in VBP** – The CMS Center for Program Integrity sent out a request for information (RFI) on the future of program integrity with a focus on VBP programs.[vi]
- **2020 CMS Roadmap for States to Accelerate VBP –** CMS issued guidance to state Medicaid directors designed to advance the adoption of VBP strategies across their health-care systems and align provider incentives across payors.[vii]
- **2020 Revisions to Federal Regulations Implementing Stark Law, Federal Anti-Kickback Statute, and Civil Monetary Penalties** – United

States Health and Human Services (U.S. HHS) changes to federal regulations provide greater flexibility to providers engaging in VBP arrangements.[viii]

OIG Work in VBP

To prevent, detect and deter FWA in managed care VBP and APM arrangements, the OIG is working to address these program integrity considerations to ensure taxpayer dollars are spent appropriately on quality and necessary services for Texas Medicaid and CHIP managed care members.

VBP and APM payment arrangements are designed to improve member health outcomes while containing costs, and it is the OIG's responsibility to independently validate payments and if the stated outcomes were achieved in compliance with federal and state statutes, regulations, and contract requirements. These payment arrangements continue to become more numerous and complex, presenting new program integrity challenges for the OIG to consider in its VBP-related work.

1. Introduction

Value-based purchasing (VBP) models are utilized in government health insurance programs to shift payments from volume to value.[ix] Medicare, Medicaid, the Children's Health Insurance Program (CHIP) and commercial payors apply VBP reimbursement models to health outcomes achieved through prevention and better care.

Texas' consolidated state budget for the health and human services system is approximately $80 billion (All Funds) in the SFY 2020 – 2021 biennium.[x] Of that total, approximately $32 billion annually is dedicated to Medicaid, and of that amount $24 billion is for Medicaid managed care,[xi] which provides 4 million Texans (94 percent of Medicaid clients) access to health-care services.[xii] An additional $1 billion (All Funds)[xiii] is dedicated to CHIP to provide health-care services through managed care to more than 400 thousand children in Texas.[xiv]

The Texas Health and Human Services Commission (HHSC) administers various programs to improve health-care quality and outcomes while containing costs. In Texas Medicaid and CHIP managed care, VBP and APM initiatives incentivize MCOs and providers to improve health outcomes for members by providing high quality health care. All Medicaid and CHIP managed care organization (MCO) contracts include policies and programs to align financial incentives with member health outcomes.[xv]

Several terms are used, sometimes interchangeably, to describe efforts to tie payments for care delivery to the quality and efficiency of care provision, including value-based purchasing, programs or payments, as well as alternative payment models (APM). The following Key Concepts section (p.7) provides more detail on the use of these terms. The adoption of VBP provides Texas, MCOs, and providers opportunities to contain costs while improving members' health outcomes; however, with the introduction of VBPs there are also new program integrity considerations and challenges. Program integrity refers to ensuring taxpayer dollars are spent appropriately on quality, necessary care and preventing fraud, waste, and abuse (FWA).[xvi] Nationally and in Texas, regulators are working to understand the complexities of these contracting methods and the resultant program integrity considerations.

This informational report explores how VBP has evolved nationally, Texas' implementation and a discussion of potential program integrity challenges and considerations related to the OIG's future work in this space.

2. Key Concepts

Following are some terms used nationally among different payors to tie value to improved health outcomes.

Value-based purchasing is considered a business strategy aimed at maximizing benefits received when buying goods or services to improve performance in specific areas.[xvii] In Medicaid and CHIP managed care, value-based purchasing refers to "any activity that a state undertakes to hold providers or contracted MCOs accountable for the costs and quality of the care they provide or pay for."[xviii] Value-based purchasing is focused on changing payor behaviors, including that of MCOs, to improve performance on behalf of their members.[xix] In Texas, all Medicaid and CHIP managed care contracts have performance incentives and disincentives related to HHSC's value-based purchasing approach.[xx] As described below, value-based purchasing is broader than value-based payment.

Value-based programs refers to programs developed by payors to incentivize providers to improve quality of care for target populations or services. For example, the Medicare End Stage Renal Disease (ESRD) Quality Incentive Program focuses on outpatient dialysis facilities treating patients with ESRD.[xxi]

Value-based payments provide financial rewards for desired behaviors.[xxii] This may include payments made by the state to MCOs for achieving quality measures or MCO payments to providers. Value-based payments are a component of value-based purchasing.[xxiii]

Alternative payment model refers to "a payment model that links a portion of the full health-care payment to a measure or measures of quality, access, and/or efficiency (outcomes + patient experience / cost = value), or other behavior that is determined to advance quality, outcomes or efficiency."[xxiv]

- *Quality* refers to patients receiving appropriate and timely care consistent with evidence-based guidelines and patient goals, resulting in optimal patient outcomes and patient experience."[xxv]
- *Access* refers to members' ability to obtain covered services, as per accepted standards.[xxvi]

- *Efficiency* refers to the degree to which services, care delivery models, and payment arrangements achieve the core outcome goals in relation to their costs.[xxvii]

APMs can apply to a specific clinical condition, a care episode, or a population. APMs typically are MCO payments to providers. All value-based purchasing models are APMs, but not all APMs are value-based purchasing models.[xxviii]

The Health Care Payment Learning & Action Network (HCP LAN) standardized this term and established a framework for providers and payors. Detail on this framework is in Appendix A [p. A-1]. Many state Medicaid programs, including Texas Medicaid and CHIP, have adopted this framework.

3. National Landscape

Over the last decade, the federal government has prioritized the use of VBP in the provision of health-care services by enacting and implementing key legislation requiring VBP programs. Since 2010, there have been several legislative requirements, as well as guidance from CMS, to prioritize VBP in Medicare, Medicaid and CHIP.

Patient Protection and Affordable Care Act (PPACA)

The PPACA is a comprehensive health-care reform law enacted in March 2010 that includes provisions to target how health care is delivered and paid for in the United States.[xxix] PPACA established several payment reforms aimed at improving quality and constraining costs in both public health programs and the commercial insurance market.[xxx] Some key reforms include the expansion of the use of Patient Centered Medical Homes (PCMH),[xxxi] the establishment of the Medicare Shared Savings Program (MSSP)[xxxii] and the CMS Innovation Center.[xxxiii]

Medicare

In 2018, Medicare covered more than 59.6 million Americans at a cost of more than $740.6 billion.[xxxiv] Since 2008, CMS has shifted the focus of payments from volume to quality, as part of its strategy to improve the delivery of health care in Medicare.[xxxv]

The Medicare Improvements for Patients and Providers Act (MIPPA) of 2008, which required CMS to develop a plan to implement certain VBPs[xxxvi], and the Medicare Access and Children's Health Insurance Program (CHIP) Reauthorization Act of 2015 (MACRA) tied Medicare reimbursement to quality improvements and cost efficiency by setting up two tracks for provider incentives under the Quality Payment Program (QPP):

- Streamlining quality programs under the new Merit-Based Incentive Payments System (MIPS).
- Giving bonus payments for participation in eligible APMs.[xxxvii]

While VBP and APM can mean slightly different things by payor and program, Medicare paved the way for how other payors implement VBPs and APMs to incentivize quality and outcomes.[xxxviii]

4. Medicaid and CHIP Managed Care Landscape

Federal requirements at 42 Code of Federal Regulations (CFR) 438.340 require states to develop and implement a managed care quality strategy that must be reviewed and updated at least every three years. The initial strategy and any significant changes are submitted to CMS for review and feedback. Several specific elements must be included as part of this strategy, including measurable goals and objectives for the state to evaluate continuous quality improvements. To obtain CMS approval, payment arrangements must be based on the utilization and delivery of services to Medicaid clients.

Federal requirements allow states flexibility to develop and implement their own requirements, measures, and programs to promote value in provider reimbursement models. States are using various methodologies to implement VBP in their Medicaid and CHIP programs. The three primary approaches are:

- Traditional fee-for-service (FFS) payments with APMs.
- MCO contract requirements to design and implement APMs, including guidance on what the models must include, or APM percentage thresholds based on MCO expenditures.
- MCOs implement state-designed APMs.[xxxix]

Based on a 2016 survey of MCOs nationwide, surveyed MCOs reported most APMs focused on acute care services and the early stages of specialized services, such as behavioral health and long-term care.[xl] Additional information on state implementation of VBPs and APMs is included in Appendix B [p. B-1].

2020 MACPAC Report

In March 2020, the Medicaid and CHIP Payment and Access Commission (MACPAC) published a report on state strategies to promote the use of VBP in Medicaid managed care. Key findings include:

1. States and MCOs are adapting VBP models to local circumstances.
2. While states have multiple tools to promote VBP in managed care, implementation requires substantial state effort.
3. States face trade-offs between more prescriptive and flexible approaches.

4. Contract requirements do not address challenges with provider participation in VBP models.
5. States monitor MCO compliance; however, limited formal VBP monitoring exists, particularly in states with less prescriptive approaches.[xli]

5. VBP and APMs in Texas Medicaid and CHIP

The shift to paying for value versus volume in state health-care programs is a priority in Texas. Texas has followed national trends to link Medicaid and CHIP health-care payments to quality and efficiency by enacting legislation and implementing VBP programs prioritizing value-based care.[xlii]

Texas Legislative Requirements

Over the last decade Texas legislation has placed an emphasis on programs, contractual requirements, and reporting to prioritize value-based care. Below are key highlights related to VBP requirements and legislation in Texas:

Hospital PPR and PPC Program: Senate Bill (S.B) 7, 82nd Legislature, First Called Session, 2011 established the hospital-based Potentially Preventable Readmissions (PPR) and Potentially Preventable Complications (PPC) Program.[xliii]

Pay for Quality Program: S.B. 7, 83rd Legislature, Regular Session, 2013 required HHSC to base a portion of Medicaid and CHIP managed care premiums on outcome and process measures.[xliv] HHSC established the first Pay-for-Quality (P4Q) Program in January 2014.

Quality-Focused MCO Enrollment: S.B. 7, 83rd Legislature, Regular Session, 2013 required HHSC to develop an incentive program that enrolls a greater number of members who did not choose a plan to MCOs based on certain quality criteria.[xlv] To comply with this directive, HHSC has developed MCO report cards to provide enrollees information about MCO performance on specific quality measures[xlvi] and a proposed value-based enrollment methodology for enrolling members who do not actively choose a health plan into Medicaid and CHIP MCOs.[xlvii]

MCO VBPs: S.B. 7, 83rd Legislature, Regular Session, 2013 also required MCOs to establish VBP payment models. "HHSC initiated a contract provision into the managed care contracts that required MCOs to implement with providers and to submit to HHSC annual reports on their VBP activities."[xlviii] S.B. 200, 84th Legislature, Regular Session, 2015 directed HHSC to create and implement a pilot program to further encourage the use and effectiveness of value-based provider payments by MCOs.[xlix]

Quality Plan: S.B. 200, 84th Legislature, Regular Session, 2015 required HHSC to develop a comprehensive plan (Quality Plan) to improve the coordination and transparency of state health-care quality initiatives.[l] The legislative requirement was based on a Sunset Advisory Commission staff report. HHSC published the first Quality Plan in November 2017.[li]

Texas Strategy for VBP

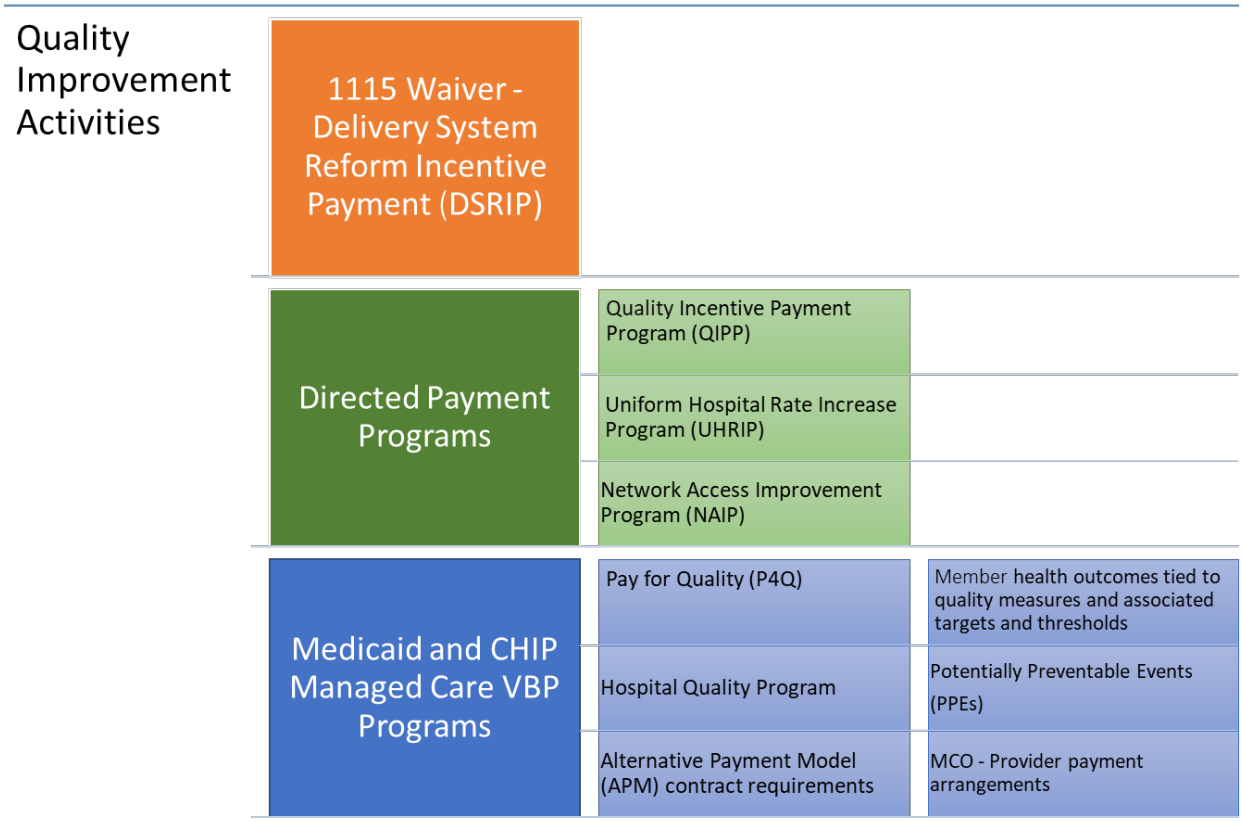
Goals of the current Texas Managed Care Quality Strategy include:

- Transition from paying for volume to a pay-for performance model,
- Improve member satisfaction with care, and
- Reduce payments for low quality care.

The Quality Strategy lays out the mechanisms by which these goals will be achieved, including oversight and monitoring; the implementation of financial incentives and disincentives based on performance; and initiatives that encourage evidence-based clinical and administrative practices by MCOs. The strategy also prioritizes expanding the use of VBP models.[lii]

The value-based care strategy for Texas Medicaid and CHIP[liii] focuses on payment reforms (through medical and dental pay-for-quality programs, the hospital quality-based payment program, Delivery System Reform Incentive Payment (DSRIP) program, directed payment programs, and regular evaluation and reporting of MCO performance on important quality measures).[liv] These can be categorized into the activities denoted in Figure 1 and described further in this section.

Figure 1: HHSC Quality Improvement Activities



Source: Developed by OIG[lv]

HHSC is currently updating the Quality Strategy and Value-based Purchasing Roadmap to support system transformation from volume to value. In March 2020, HHSC presented concepts for the updated VBP Roadmap and Quality Strategy for feedback to the Value-based Purchasing & Quality Improvement Advisory Committee (VBPQIAC). The quarterly VBPQIAC provides a forum to promote public-private, multi-stakeholder collaboration in support of quality improvement and value-based payment initiatives for Medicaid, other publicly funded health services and the wider health-care system. In November 2020, VBPQIAC discussed its final report entitled *Texas Value-Based Payment and Quality Improvement Advisory Committee Recommendations to the 87th Texas Legislature*, which presents several recommendations, including advancing APMs in Medicaid, standardizing certain VBP outcome measures, and leveraging multi-payor data to advance the alignment of VBP efforts across major health-care payors.[lvi] HHSC plans to publish the updated strategy and roadmap in December 2020.

Value-Based Programs in Texas

Over time Texas implemented VBP requirements through several value-based programs. The primary vehicle in Texas for associating health-care payments to measures of quality and/or efficiency has been through managed care.[lvii] CMS approval of Texas' Health Transformation and Quality Improvement Program 1115 Waiver allowed the state to further expand Medicaid managed care and transform the health-care delivery system.

1115 Waiver – Delivery System Reform Incentive Payment Program

The Delivery System Reform Incentive Payment (DSRIP) program provides incentives to hospitals and other providers to focus on achieving health outcomes beyond Medicaid and CHIP members. DSRIP is currently being phased out, and some of these programs may transition to managed care. Goals of the DSRIP Transition Plan include advancing APMs and exploring innovative financing models to incentivize efficient provision of quality care.[lviii]

Directed Payment Programs

Directed payment programs are provider-specific, state-developed programs that allow MCOs to make increased payments through adjustments to provider reimbursement rates or as incentive payments.[lix] HHSC operates three programs within this category as described below.

Uniform Hospital Rate Increase Program

The Uniform Hospital Rate Increase Program (UHRIP) is a voluntary program that uses local taxpayer funds to match federal funds to increase payments to hospitals for uncompensated care costs. All MCOs within a service delivery area (SDA) and the hospitals they contract with must participate for hospitals to receive UHRIP funds.[lx] UHRIP started as a pilot in December 2017 and expanded to other SDAs in March 2018 with participation limited to STAR and STAR+PLUS MCOs.[lxi] In federal fiscal year (FFY) 2018, the program budget was estimated at $600 million in all funds.[lxii]

Network Access Improvement Program

The Network Access Improvement Program (NAIP) increases the availability and effectiveness of primary care for Medicaid clients. NAIP incentivizes health-related institutions and public hospitals to provide quality, well-coordinated, and continuous care.[lxiii] In FFY 2018, funding was an estimated at $427 million in all funds.[lxiv] This program is being phased out.[lxv]

Quality Incentive Payment Program

The Quality Incentive Payment Program (QIPP) targets the improvement of quality and innovation of nursing facility services by compensating facilities in the STAR+PLUS program for meeting or exceeding certain goals. In SFY 2018 and SFY 2019, QIPP provided $400 million (all funds) in annual incentive payments. In SFY 2020, the incentive pool increased to $600 million and will increase to $1.1 billion in SFY 2021.[lxvi] STAR+PLUS MCOs provide participating nursing facilities quarterly payments based on required quality improvement activities and their performance on agreed-upon quality measures including:

- Reducing use of restraints.
- Inappropriate use of anti-psychotic medication.
- Development of pressure ulcers.
- Occurrence of falls with major injury.[lxvii]

Due to the nature of these programs, DSRIP and the Directed Payment Programs are not highlighted further in this report.

Medicaid and CHIP Managed Care Value-Based Programs

HHSC administers various programs and measures through the managed care system to advance quality and efficient care. HHSC's managed care quality strategy focuses on implementing a variety of VBP programs to achieve its goals to improve the quality and efficiency of patient outcomes.

Pay-for-Quality Programs for Medical and Dental

The Pay-for-Quality (P4Q) programs create incentives and disincentives based on performance on certain quality measures and evidence-based practices. All MCOs will participate in SFY 2020, including STAR Kids.

For the medical P4Q Program, MCOs' evaluation on quality measures focuses on prevention, chronic disease management (including behavioral health), and maternal and infant health.[lxviii] Measures are "at-risk" and "bonus pool" measures. MCOs that fail to meet their "at-risk" measures can lose up to 3 percent of their capitation rate, while MCOs that excel at meeting their "at-risk" measures and "bonus" measures may be eligible to receive additional funds.[lxix]

The dental P4Q Program evaluates DMOs based on three defined measures. A total of 1.5 percent of each DMO's capitation payment is at risk for performance in these measures. DMOs that do not improve or decline beyond a set threshold retain their capitation rate. If one DMO declines in performance, the resulting recoupment may be available as an incentive to the other DMO if its performance reflects improvement to earn the incentive payment.[lxx]

Hospital Quality-Based Payment Program

The Hospital Quality-Based Payment program targets reducing potentially preventable readmissions (PPR) and potentially preventable complications (PPC).[lxxi] The program operates in managed care and FFS. HHSC collects data on potentially preventable events to improve quality and efficiency. MCOs and hospitals are financially accountable for PPR and PPCs.[lxxii]

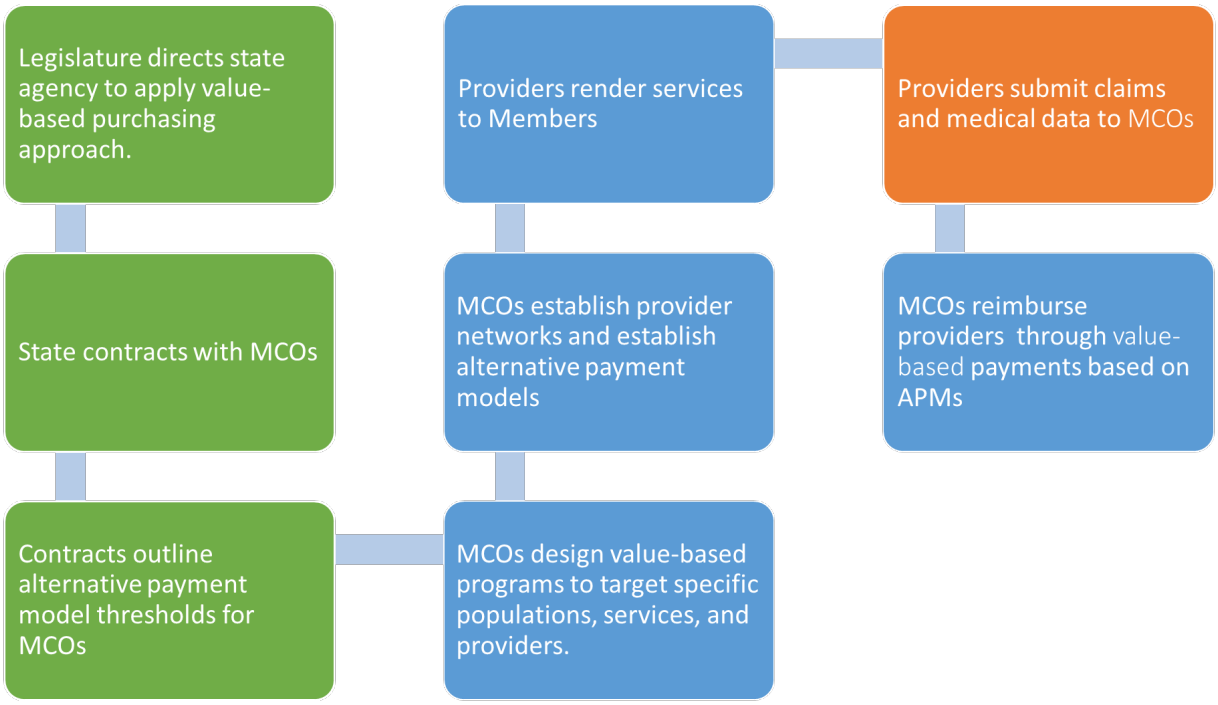
Alternative Payment Model Thresholds

In addition to P4Q programs, MCOs are subject to contractual requirements to increase the number of APM contracts with their providers. Beginning in SFY 2018, MCOs must annually increase the percentage of APM contracts with providers to meet contractual targets. Some MCOs may use APM contracts to help them meet the measure targets required in the P4Q program.[lxxiii]

APMs in Texas Medicaid and CHIP Managed Care

The statutory requirements for managed care within the Texas Government Code provide for outcome-based measures and incentives to MCOs to improve the quality of care for members by providing value-based services.[lxxiv] Resulting language within managed care contracts has emerged over time to drive VBP and the use of APMs in Texas managed care. The following figure provides a simple illustration of the process flow of APMs in Texas managed care.

Figure 2: Process Flow for APMs in Texas



Source: Developed by OIG

Evolution of MCO Contract Requirements

Contract requirements for MCOs have evolved to reflect HHSC's drive towards promoting quality over volume in managed care. Initially, HHSC encouraged MCOs to implement VBP arrangements with their providers. Over time, managed care contract requirements provide measures and metrics for MCOs to meet in their value-based care.

In SFY 2015, the Uniform Managed Care Contract (UMCC) included requirements for MCOs to develop and submit an annual plan for value-based contracting that "encouraged innovation and collaboration and increased quality and efficiency."[lxxv] HHSC retrospectively reviewed the plan, which was required to show a "measurable increase" in the percent of business incentivized from the previous year.[lxxvi] Contract requirements in all Texas managed care contracts[lxxvii] were strengthened in 2018 to require:

- **MCO Reporting -** Submit inventories of APM initiatives developed with providers to calculate compliance with established targets.
- **Provider Data Sharing and Collaboration -** Establish and maintain data sharing processes with providers to promote collaboration on APMs.
- **Staffing and Resources -** Maintain adequate resources to support value-based payment activities such as provider outreach and negotiation.
- **Evaluation -** Assess the impact of APM models on utilization, quality, cost, and return on investment.[lxxviii]

In addition to these requirements, the establishment of APM targets within managed care contracts created metrics for MCOs to include in arrangements with providers. MCOs that are non-compliant with these requirements may be subject to corrective action plans and other remedies.

APM Targets

In calendar year (CY) 2018, Texas managed care contracts required MCOs to achieve established overall and risk based APM targets, which increase over a four-year period as outlined in Appendix C [p.C-1].[lxxix] For state fiscal year (SFY) 2021, MCO contracts target payments tied to APMs constitute 50 percent, and payments tied specifically to risk-based APMs 25 percent, of all MCO-reported medical and pharmacy expenditures.[lxxx]

The APM contract requirement states MCOs' design "should improve health outcomes for members, empower members and improve experience of care, lower health care cost trends, and incentivize providers."[lxxxi] MCOs have the flexibility to establish APMs as they see fit within the requirements to meet these targets.

Managed care contracts include existing APM targets with an added requirement that MCOs must collaborate with other MCOs within the same SDA on APM and VBP models for targeted clinical interventions.[lxxxii]

MCO Reporting

Measuring the progress and impact of VBPs and APMs requires extensive data sources to track and evaluate clinical information, provider claims and MCO encounter data and financial reporting. Key data sources and uses include MCO

encounter data, the MCO annual APM report and the MCO Financial Statistical Report (FSR).

MCO Encounter Data

Providers submit claims to MCOs for reimbursement. MCOs submit information on adjudicated claims to the state through encounter data. Encounter data is a representation of an adjudicated claim for services rendered to a member.[lxxxiii] Currently, MCOs may denote the reimbursement model utilized to pay the underlying claim through a financial arrangement code. HHSC is exploring how to capture additional information to strengthen its ability to track and trend payments in VBP and APM arrangements.[lxxxiv]

MCO Annual APM Report

The UMCC requires MCOs to report VBP data annually using the APM Data Collection Tool.[lxxxv] This deliverable must include "payment models that link payment and a measure of quality of value, which also could be an APM." MCOs must use this tool to provide details regarding VBP programs and the planned initiatives for the following year.

MCOs must include required data elements, such as the SDA, the provider-service type, number of members impacted, and the incentives/disincentives to the provider within the service period. The reporting tool requires narrative descriptions and evaluation methods for each type of APM.

The tool calculates the overall APM percentage and the risk-based APM percentage for the managed care program. Reporting for the previous calendar year is due by July 1 of the subsequent calendar year. HHSC may request supporting data associated with the numbers reported in the tool.[lxxxvi]

Financial Statistical Reporting and Rate Setting

HHSC uses historical data including encounter data and FSRs to determine future capitation rates. As a result, cost savings achieved through APMs may not be reflected in capitation rates until two years later.[lxxxvii] The FSR template that MCOs complete and submit each year does not currently capture specific APM data with providers.[lxxxviii]

March 2020 HHSC Survey of MCOs

HHSC distributed a survey on APMs in March 2020 to all Medicaid and CHIP MCOs in Texas. HHSC received responses from 83 percent of MCOs. All responding MCOs indicated actively pursuing new opportunities to engage in new and more robust quality-based APMs. The most promising opportunities identified by MCOs include shared savings models and APMs in primary care, behavioral health and nursing facilities. The survey also identified barriers to expanding/enhancing quality-based APMs, including:

- Patient churn in Medicaid or patients' ability to change providers limits MCOs' ability to measure outcomes attributable to provider.
- Administrative burden of designing, establishing, and reporting on an APM.
- Lack of provider interest in APMs.[lxxxix]

Other Notable Developments

Value-Based Enrollment Methodology

HHSC has developed a proposed value-based enrollment methodology for the STAR, STAR+PLUS and STAR Kids Medicaid managed care programs that includes value as a factor in HHSC's processes for enrolling members who do not actively choose a health plan into Medicaid and CHIP MCOs.[xc]

Quality Improvement Costs

Contracted Medicaid and CHIP MCOs must report Quality Improvement Costs (defined at 45 CFR § 158.150 and 158.151) on their FSRs to HHSC.[xci] These costs may include efforts to improve quality tied to value-based arrangements and efforts. HHSC continues to monitor how MCOs apply expenses tied to value-based and alternative payment model efforts as Quality Improvement Costs.[xcii]

6. Program Integrity Challenges and Considerations

Program integrity refers to ensuring taxpayer dollars are spent appropriately on quality, necessary care and preventing FWA.[xciii] With the introduction of VBP and associated complex contractual arrangements, there are new program integrity considerations for both MCOs and regulators to examine. Nationally and in Texas, regulators are working to understand the complexities of these contracting methods and the resultant program integrity considerations in this space.

Based on targeted research and programmatic observations, the OIG outlines two areas of operational challenge and related program integrity considerations within value-based contracting:

1. **Data Sharing and Integrity** – The impacts and program integrity considerations tied to accurate and complete data and timely sharing of data between providers, MCOs and the state.
2. **Payment Integrity** – Behaviors or schemes that may result from VBPs and APMs and potential integrity issues tied to the complexity of these models.

Data Sharing and Integrity

The federal OIG noted the importance of monitored financial incentives to ensure, to the extent possible, quality and efficiency goals are achieved and undesirable outcomes avoided. This type of monitoring requires consistent review of encounter, financial and clinical data. As VBPs and APMs increase and mature, timely and accurate data is critical for monitoring and prevention of improper payments. The federal OIG recommends analyzing data systems in value-based payments for timeliness, accuracy and completeness.[xciv] Operational challenges to share and receive data and to promote data integrity pose challenges and potential risks for consideration.

Provider Information Technology (IT) Capabilities: VBPs and APMs are data-driven and rely on the exchange of timely information to ensure appropriate care coordination between MCOs, providers and members.[xcv] There may be several providers participating in a VBP program with different data collection and data sharing programs that may not 'talk' with other data programs. Interoperability between Electronic Health Records (EHR) and other data sharing programs and

providers continues to be a challenge in VBP.[xcvi] These challenges may create data integrity issues compromising reporting and appropriate payments.

***MCO Data Sharing with Providers**:* Based on a 2019 nationwide survey, more than half of surveyed Medicaid MCOs (53 percent) noted that data reporting to providers was the top operational barrier in implementing VBPs/APMs.[xcvii] MCOs may face operational barriers with providing real-time and accurate data to providers to inform day-to-day clinical decisions. Texas managed care contracts require MCOs to share data with providers; however, there are no requirements regarding the frequency or common data elements. These challenges may create data integrity issues, compromising reporting and appropriate payments.

MCO Reporting: To qualify for APMs, most providers need to submit additional data to MCOs or another entity. In Texas, Medicaid and CHIP MCOs also report aggregate APM information to the state in the APM Data Collection Tool.[xcviii] The accuracy of the data in the reporting tool is essential to evaluate performance and determine if MCOs follow state requirements and meet established target percentages.

Data Accuracy: Providers must submit claims to MCOs to receive payment. If a provider submits inaccurate information on a claim, it may lead to inaccurate encounter data. Another scenario is when providers submit accurate claims data, but the MCO reports inaccurate encounter data to the state. Due to the complexity of some VBP models there may be increased potential for challenges with reporting complete and accurate encounter data.[xcix]

Management Information Systems: State Medicaid Management Information Systems (MMIS) and required MCO reports may lack data elements or capacity to capture additional information, such as provider arrangements or accountability structures.[c] Absent the ability to capture these new structures, it may be challenging to determine the appropriateness of the payment(s) within the structure. When recovering payments that are determined to be inappropriate, this may also pose a challenge as the OIG works to determine which part of the payment should be recovered if multiple providers are involved.

Payment Integrity

Payment Integrity captures FWA schemes resulting in improper payments and inherent complexities within VBPs and APMs, which may present new integrity

concerns tied to associated payments to providers. While many FFS FWA schemes extend to managed care, changing financial incentives in VBPs and APMs result in new and different schemes. Each of the following considerations are key as the OIG deploys its tools to promote program integrity in VBP.

***Payment Integrity Requirements**:* Since VBP and APM arrangements are relatively new requirements in state Medicaid and CHIP contracts and are maturing in complexity, identifying methods to improve regulators' ability to track and trend payments tied to VBP and APM arrangements will be imperative to determine the appropriateness of payment(s) and if any overpayments occurred. For the future, HHSC is exploring how to capture the requisite information to strengthen its ability to track and trend payments in VBP and APM arrangements.[ci]

Provider Detection and Investigations: Investigations, audits, inspections, and reviews to prevent, detect, and deter FWA in VBP require access to a variety of data sources, including claims data, encounter data, clinical data and provider credentialing data.[cii] Data affiliated with bundled payments or an episode of care may require multiple data collection points and crosswalks that may present new complexities and extend the level of effort needed to conduct OIG work in this area.

Member Solicitation: Providers may solicit members and/or select healthier members as part of their panel for APMs.[ciii] As a result, members with higher needs may be excluded from participation.[civ] This may lead to access-to-care concerns.

***Bundled Payments**:* APMs that bundle payments to a single provider for a group of services (e.g., global surgery fees, which provide one fee for the surgery and related pre- and post-surgical care) may limit members' participation if they need an individualized set of services.[cv] Bundled payment models may also result in underutilization due to "stinting"[cvi] (providers supplying less services in exchange for a bundled payment) and access-to-care concerns.

Condition-Based Payments and Coding: Some MCO and provider VBP arrangements are directed towards achieving certain condition-based metrics, including diagnosing members with specific chronic medical conditions (e.g., diabetes and asthma) or increasing visits (e.g., well-child). It is important to understand the VBP arrangements and the providers' requirements to receive incentives. In some scenarios, there may be an underlying perverse incentive for providers to provide non-necessary services or inaccurate diagnoses to earn higher

payments.[cvii] Validating condition-based payments requires clinical expertise to determine if members' diagnoses are accurate.[cviii]

***Payment Methodology and Calculation**:* The OIG has the authority to recoup overpayments in Texas Health and Human Services (HHS) programs resulting from FWA.[cix] With VBP arrangements, identifying the potential overpayment amount may be challenging due to several factors. Under an APM, a managed care provider may receive payment from an MCO based on the Medicaid fee schedule along with an incentive payment; however, the payment structure may differ for each MCO within their respective provider contracts. Further, multi-provider arrangements or bundled payments may create additional complexities in identifying the actual overpayment amount. To mitigate such challenges, the federal OIG has stressed evaluation of value-based payments and methodologies to ensure appropriateness and calculation accuracy.[cx]

Vertical Integration and Consolidation: Consolidation of independent physician practices and vertical acquisitions of physician groups and health plans by hospital systems has increased in recent years. To provide robust oversight over the consolidated entities, states are exploring policies to monitor billing practices and ensure the appropriateness of these relationships.[cxi] Vertical integration may pose program integrity risks related to a reduction in patient choice, incomplete or inaccurate information on subcontractor performance and/or lack of access to or falsification of information,[cxii] which may be exacerbated by VBP models.

Federal Input Related to Program Integrity and VBP

In response to the expansion of VBP models in the U.S. health-care system and related program integrity considerations, federal agencies have issued guidance and solicited information on efforts to combat FWA in this space.

2018 Federal OIG Advisory Opinion on VBP

The federal OIG has examined specific value-based arrangements and issued guidance, through advisory opinions, indicating compliance (or not) with federal laws related to program integrity.[cxiii] For example, the federal OIG issued an advisory opinion regarding a VBP arrangement between a provider and a Medicaid MCO. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services provide preventive care to children in Medicaid. Under the arrangement, the MCO would provide an additional incentive payment to the provider to increase utilization

of EPSDT screenings. The federal OIG's interpretation noted that the arrangement met safe harbor requirements, which immunize certain payment and business practices from criminal and civil prosecution and did not violate the Anti-Kickback Statute (AKS).[cxiv]

2019 CMS Request for Information on the Future of Program Integrity in VBP

In fall 2019, a presidential executive order charged CMS with developing changes to combat FWA in Medicare. The CMS Center for Program Integrity sent out a request for information (RFI) on the future of program integrity with a focus on VBP programs. CMS noted potential new approaches may include advanced analytics, the reporting of alternative (e.g. non claims-based) data, or other mechanisms to identify improper payments, beneficiary safety issues, and other program integrity related concerns.[cxv] At the time of this report's preparation, the results of the RFI were not yet known.

2020 CMS Roadmap for States to Accelerate VBP

In September 2020, CMS issued guidance to state Medicaid directors encouraging them to advance the adoption of VBP strategies across their health-care systems and align provider incentives across payors. This guidance lays out the pathways in Medicaid to the adoption of VBP, key considerations for states pursuing VBP and a toolkit of resources for states including lessons learned from early state and federal VBP implementation and examples of innovative payment models. CMS noted the importance for states to consider how program integrity is ensured as part of VBP requirement development for MCOs. This includes a focus on client access to care, provider choice and ensuring medically necessary care is not reduced because of APMs.[cxvi]

2020 Revisions to Federal Regulations Implementing Stark Law, Federal Anti-Kickback Statute, and Civil Monetary Penalties

In November 2020, U.S. HHS finalized changes to federal regulations providing greater flexibility to providers engaging in VBP arrangements. The Stark Law prohibits physicians from referring patients to entities with whom they or immediate family members have a financial relationship.[cxvii] The modified regulations implementing the Stark Law, the Anti-Kickback Statute and related Civil Monetary Penalties (CMP) for inducements to Medicare, Medicaid and CHIP

members to use services, specify permanent exceptions for physicians and other health-care providers participating in value-based arrangements.[cxviii]

7. OIG Work in VBP

To prevent, detect and deter FWA in managed care VBP and APM arrangements, the OIG is working to address these program integrity considerations to ensure taxpayer dollars are spent appropriately on quality and necessary services for Texas Medicaid and CHIP managed care members.

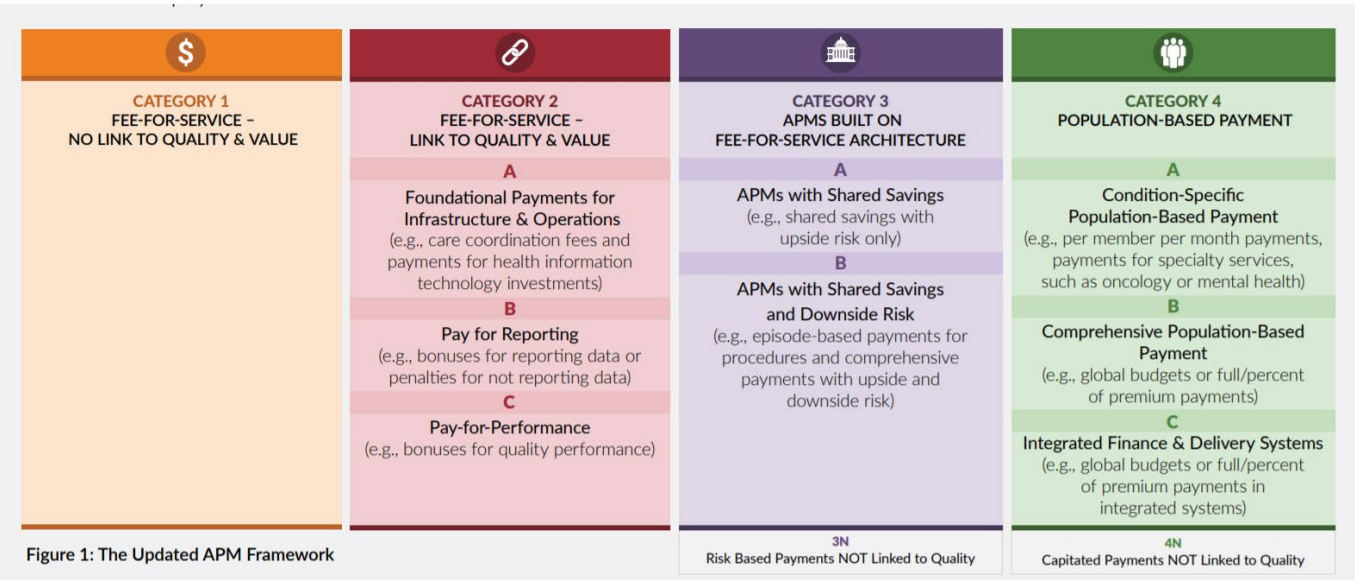
To further understand these arrangements and related program integrity considerations, the OIG Audit and Inspections Division conducted an inspection in 2019 of an APM model at Molina Healthcare of Texas, Inc. (Molina), a Medicaid MCO, to determine the process used to reward nursing facilities for providing quality services. Further details on this inspection are outlined in Appendix D [p. D-1].

VBP and APM payment arrangements are designed to improve member health outcomes while containing costs, and it is the OIG's responsibility to independently validate the basis for payments, and if the stated outcomes were achieved in compliance with federal and state statutes, regulations and contract requirements. These payment arrangements continue to increase and become more complex, presenting new program integrity challenges for the OIG to consider in its VBP-related work.

Appendix A. HCP LAN APM Framework

The Health Care Payment Learning & Action Network (HCP LAN) led efforts to standardize the term "alternative payment model" and established a framework for providers and payors. Figure 3 shows the HCP LAN Framework.

Figure 3: HCP LAN APM Framework



Source: HCP LAN. Factsheet. Alternative Payment Model Framework.[cxix]

Appendix B. State Implementation of VBPs and APMs

Given the flexibility, states are using various methodologies in implementing VBP measures into Medicaid and CHIP managed care. States are implementing VBP models in three primary ways:

- Contracting directly with providers with APMs.
- Requiring MCOs to design and implement APMs, often providing guidance on what the models must include, or APM percentage thresholds based on MCO expenditures.
- Encouraging, requiring, or incentivizing MCOs to implement state designed APMs.[cxx]

States can develop and implement models that work best for populations served and the structure of their Medicaid program. The following chart provides some examples of VBP approaches states are taking.

Figure 4: APMs within State MCO Contracts in Respective SFY 2019

State Approach	Number of States	Examples
Require MCOs to set targets for payments made through APMs	21	• Percentage targets and structure vary between states. • Eleven states noted their targets were linked to the HCP-LAN APM framework.
Have incentives or penalties for meeting or failing to meet APM Requirements	14	• Three states reported plans to add penalties or incentives in FY 2020.
Require MCOs to participate in a State-directed VBP initiative	8	• California requires MCOs to make payments to Designated Public Hospitals on performance measures in four strategic categories. • Virginia is planning to implement bundled payments for maternity and asthma that MCOs will be required to implement.
Require MCOs to develop VBP strategy within state specified guidelines	12	• Oregon requires its MCOs to develop new or expanded VBP efforts in specified care delivery focus areas. • Kansas requires MCOs to implement VBP models that expand service coordination, increase employment, and provide better outcomes for children.

Source: "States Reporting Medicaid Managed Care Requirements for APMs", October 2019, Kaiser Family Foundation[cxxi]

Appendix C: Annual APM Targets Established by HHSC

Ratios reflect the total number of APM-based payments relative to total provider payments by an MCO. The following figures show the annual APM targets established by HHSC for MCOs and DMOs.

Figure 5: Annual APM Targets Established by HHSC for MCOs (not DMOs)

The annual targets established by HHSC began in Calendar Year (CY) 2018		
HHSC will require MCOs to increase their total APM and risk-based APM ratios according to the following schedule.		
Period	**Minimum Overall APM Ratio**	**Minimum Risk-Based APM Ratio**
Year 1 (CY 2018)	>= 25%	>= 10%
Year 2 (CY 2019)	Year 1 Overall APM Ratio +25%	Year 1 Risk-Based APM Ratio +25%
Year 3 (CY 2020)	Year 2 Overall APM % + 25%	Year 2 Risk-Based APM % + 25%
Year 4 (CY 2021)	>= 50%	>= 25%

Source: UMCM Section 8.10, Value-Based Contracting Data Collection Tool, February 2020[cxxii]

Figure 6: Annual APM Targets Established by HHSC for DMOs

The annual targets established by HHSC began in Calendar Year (CY) 2018		
HHSC will require DMOs to increase their total APM and risk-based APM ratios according to the following schedule.		
Period	**Minimum Overall APM Ratio**	**Minimum Risk-Based APM Ratio**
Year 1 (CY 2018)	>= 25%	>= 2%
Year 2 (CY 2019)	Year 1 Overall APM Ratio +25%	Year 1 Risk-Based APM Ratio +25%
Year 3 (CY 2020)	Year 2 Overall APM % + 25%	Year 2 Risk-Based APM % + 25%
Year 4 (CY 2021)	>= 50%	>= 10%

Source: UMCM Section 8.10, Value-Based Contracting Data Collection Tool, February 2020[cxxiii]

Appendix D. OIG Inspection of Molina Quality Living (MQL) Program

Introduction

The Texas Health and Human Services (HHS) Office of Inspector General (OIG) Audit and Inspections Division conducted an inspection of a value-based purchasing model at Molina Healthcare of Texas, Inc. (Molina), a Medicaid managed care organization (MCO), to determine the process used to reward nursing facilities for providing quality services. The inspection covered the period from October 2018 through June 2019, which includes the fourth quarter of calendar year 2018 and the first two quarters of calendar year 2019.

Background

When the Texas Health and Human Services Commission (HHSC) carved nursing facility services into managed care, it required MCOs to develop programs to recognize and encourage quality in nursing facility care.[cxxiv] Molina was the first MCO to implement the required nursing facility incentive program when the Molina Quality Living (MQL) program went into effect on March 1, 2015. Molina has approximately 1,100 nursing facilities in its network, none of which have opted out of participating in the MQL program.

MQL Program Overview

The MQL program uses a pay-for-quality payment model designed to reward the quality and performance of nursing facilities. Through monetary and other incentives, the MQL program encourages nursing facilities to provide or improve quality care to Molina members. Quality and efficient care can improve the health of members and lead to a decrease in health-care costs. From March 2015 through December 2018, Molina awarded approximately $3.6 million in incentive payments to nursing facilities through this program.

MQL Program Qualifications

Each month, CMS determines a star rating for each nursing facility by using (a) the results of annual health-care inspections of the nursing facility, (b) the ratio of nurses to residents, and (c) the results of care assessments, which measure quality of care. A star rating is calculated for each of the three categories and used to calculate an overall star rating. Each month, CMS posts the star ratings for each

nursing facility to help individuals compare nursing facilities and make informed decisions related to nursing facility choices.

Molina reviews MQL program data on a quarterly basis. To qualify for the MQL program, a nursing facility must have:

- At least one Molina member in residence for any month of the quarter
- A rating of four or five stars from CMS for each month of the quarter

Molina downloads the CMS data monthly and identifies qualified nursing facilities. Molina identified the nursing facilities that have Molina members as residents using data from the HHSC Service Authorization System.

Incentive Payment Eligibility

Once Molina identifies a nursing facility qualifies for the MQL program, Molina determines whether the facility met Molina's established quality benchmarks to receive incentive payments. Specifically, Molina bases its determination on whether the nursing facility met or exceeded both the national and Texas average scores on seven select CMS quality measures related to the percentage of residents:

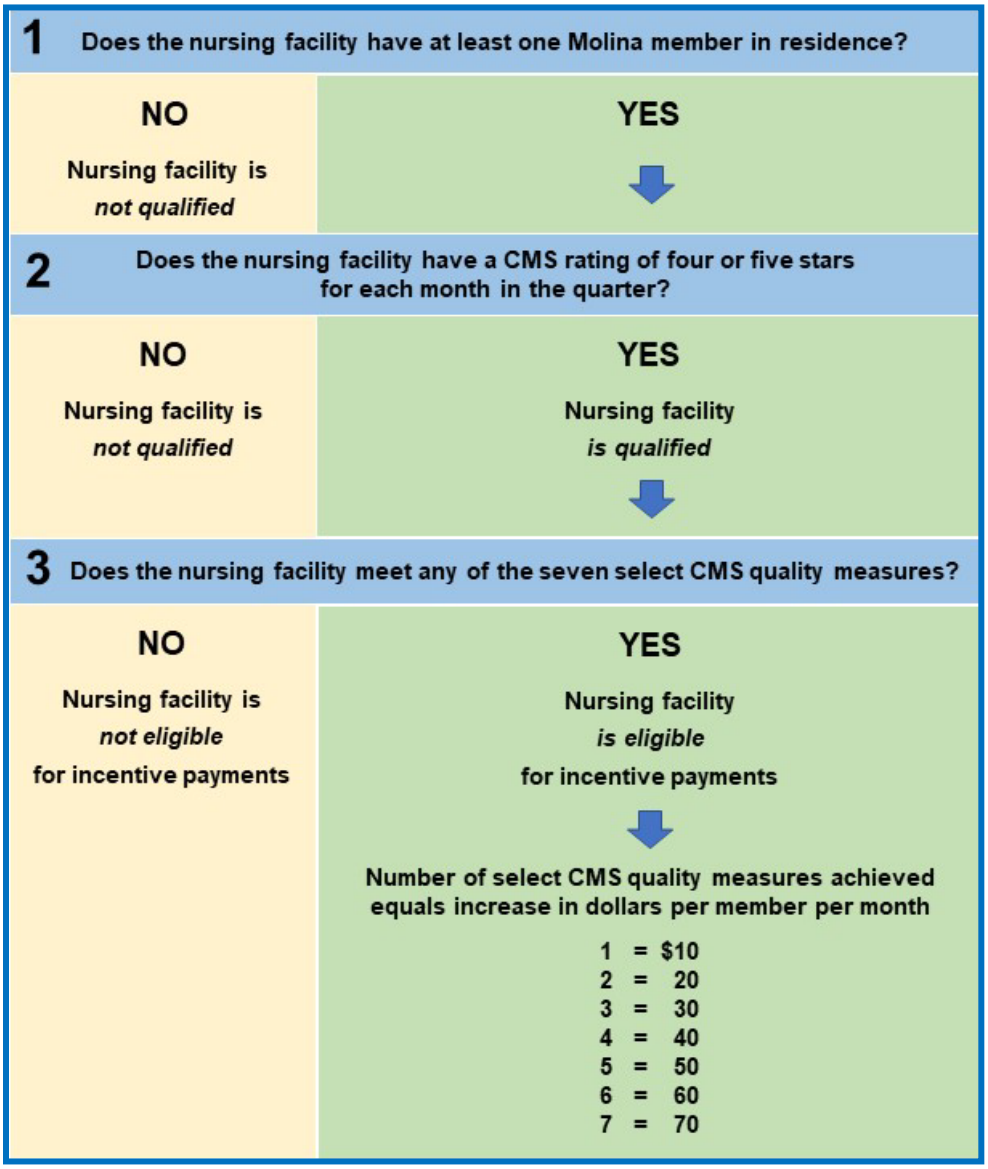
- With pressure ulcers
- Who self-report pain that is moderate to severe
- Whose need for help with daily activities has increased
- Assessed and given, appropriately, the pneumococcal vaccination
- Assessed and given, appropriately, the seasonal influenza vaccine
- Who were re-hospitalized after a nursing facility admission
- Who have had an outpatient emergency department visit

Each nursing facility's scores on the CMS quality measures, along with the national and Texas average scores, are included in the CMS data Molina reviews to determine eligibility. A nursing facility must meet at least one of the seven select CMS quality measures to be eligible for Molina incentive payments. Each CMS quality measure met or exceeded results in incentive payments of $10.00 per member per month. A nursing facility may receive up to $70.00 per member per month if all seven CMS quality measures are met or exceeded. Nursing facilities receive incentive payments from Molina at the end of each quarter.

Figure 7 demonstrates how a nursing facility qualifies for the MQL program and becomes eligible to receive incentive payments. If answers to questions are 'yes,'

the nursing facility is eligible to receive incentive payments based on the number of members residing in the nursing facility and the number of measures achieved.

Figure 7: MQL Program Qualifications and Eligibility for Incentive Payments



Source: OIG Audit and Inspections Division

MQL Advance Payment Program

To encourage nursing facilities to meet or exceed at least three of the seven measures, Molina revised the MQL program, effective January 1, 2019, to include advance payments for qualifying facilities. To qualify for the MQL Advance Payment program, a nursing facility must have:

- At least one Molina member in residence at a nursing facility each month of the quarter
- Achieved a minimum of three quality measures in the previous quarter

MQL Non-Monetary Benefits and Nursing Facility Classifications

All nursing facilities in the MQL program receive non-monetary benefits as part of the program regardless of their eligibility for incentive payments. Each quarter, Molina classifies nursing facilities that qualified for the MQL program as either platinum, gold, or silver to determine which specific benefits are available to the facilities. Figure 8 displays the criteria for each nursing facility classification in place in January 2019.

Figure 8: MQL Nursing Facility Classification Criteria

	Platinum Facility	Gold Facility	Silver Facility
Demonstrated Quality	Rating of 5 stars	Rating of 5 stars	Rating of 4 or 5 stars
Molina Residents	40 or more	20 or more	1 or more

Source: Molina Healthcare of Texas, Inc.

Figure 9 displays the benefits for each nursing facility classification in place in January 2019.

Figure 9: MQL Nursing Facility Classification Benefits

	Platinum Facility	Gold Facility	Silver Facility
Pay-for-Quality	$10.00 per resident per month for each of the seven CMS quality measures achieved and up to an additional $70.00 per resident per month if all seven CMS quality measures are achieved		
Plaque and Molina Website Recognition	"MQL Platinum Facility" plaque and website recognition	"MQL Gold Facility" plaque and website recognition	"MQL Silver Facility" plaque and website recognition
Molina-Sponsored Activities	One every month	One every other month	One every quarter
Molina-Sponsored Employee Appreciation Activities	One per two consecutive quarters of qualifying for MQL	One per two consecutive quarters of qualifying for MQL	None
Exclusive MQL Events	Invitation to attend off-site special events designed for residents of MQL-qualified nursing facilities		
MQL Advance Payment	$30.00 per member per month in anticipation of earning the pay-for-quality funds based upon average membership in the preceding quarter		

Source: OIG Audit and Inspections Division, compiled using information from Molina Healthcare of Texas, Inc.

MQL Scorecard

Molina uses an Excel spreadsheet, referred to as the MQL Scorecard, to calculate incentive payments and determine classifications for nursing facilities in the MQL program on a quarterly basis. The MQL Scorecard lists only the nursing facilities that qualify for the MQL program. For each qualifying nursing facility, the MQL Scorecard includes the:

- Overall CMS star rating for the quarter
- CMS scores for the seven select CMS quality measures
- National and Texas average scores for the seven select CMS quality measures
- Molina membership counts for each month of the quarter
- Previous quarter's advance payment amount

Molina manually populates the fields in the MQL Scorecard with data it obtains from CMS, the HHSC Service Authorization System, and the previous quarter's MQL Scorecard.

MQL Process Development

During the review of Molina's MQL program, opportunities for improvement were identified to strengthen its pay for quality processes.

As a result of the data discrepancies, Molina did not always pay nursing facilities as established by its criteria. Specifically, Molina incorrectly paid the unqualified nursing facilities a total of $14,470 in incentive payments during the inspection period. In addition, Molina did not pay a total of $4,980 in incentive payments that were earned by the nursing facilities but incorrectly excluded from the MQL scorecards.

The MQL Scorecard data inconsistencies occurred as a result of data entry errors that occurred when Molina manually populated the fields in the MQL Scorecard. Molina did not have a quality assurance process in place that could have potentially caught and corrected the errors.

Implementing a review or quality control process could help Molina to identify and resolve data discrepancies prior to assigning classifications and determining whether nursing facilities qualify for incentive payments.

The OIG Audit and Inspections Division presented the inspection results to Molina. In its response, Molina indicated agreement with the results and stated that actions to address the issues are being taken. The OIG Audit and Inspections Division thanks Molina for its cooperation and assistance during this inspection.

Inspection Team

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- Troy Neisen, Director for Inspections
- Xavier Ortiz, Manager for Inspections
- Deborah Wray, R.N. BSN, Team Lead for Inspections
- Pat Krempin, Inspector
- Jill Townsend, Editor
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