



## Frequently Asked Questions: Value-Based Purchasing

1. What is a value-based payment (VBP)?
  - VBP is a general term used to describe new payment models where providers are paid for improving health care quality rather than for the volume of services delivered. VBP arrangements can span from pay-for-performance contracts built on fee-for-service architecture to full capitation contracts with comprehensive population-based payments paid on a per member per month basis.
2. What are Alternative Payment Models (APMs)?
  - An Alternative Payment Model (APM) is a payment approach that gives added incentive payments to provide high-quality and cost-efficient care. APMs can apply to a specific clinical condition, a care episode, or a population. The term often is used synonymously with VBP (as is the case in Texas Medicaid), but may also refer to a more systematic approach to VBP where APMs exist along a continuum with progressively greater emphasis on the management of a population (e.g. shared savings, bundled payments, and capitation). In Medicare, Advanced APMs are a subset of APMs that let practices earn more rewards in exchange for taking on risk related to patient outcomes.
3. How is Texas HHSC defining APM for managed care organization (MCO) and dental contractor (DC) contract requirements?
  - HHSC is using the terms alternative payment model (APM) and value-based payment (VBP) interchangeably.
  - APM/VBP is a shift from payment for volume (fee for service) to payment tied to quality and/or value (where value = quality/cost). Texas Medicaid is predominantly a managed care model in which HHSC pays health plans a per member per month rate to cover care for their enrollees. However, MCOs and DCs historically have paid their contracted providers on a fee for service basis. This is gradually changing as in the past several years HHSC instituted incentives and then requirements **for some of health plans' payments to providers to be through VBP/APMs rather than fee for service.**
  - HHSC uses the nationally recognized Healthcare Payment Learning and Action Network (HCP LAN) Alternative Payment Model (APM) Framework (<https://hcp-lan.org/about-us/>) to help guide this effort and to align definitions. This framework describes a range of payment model concepts, encompassing varying degrees of risk on providers. Additional information on the HCP LAN is provided in the **"Resources" section below.**

4. What APM targets did HHSC put in place for Medicaid and CHIP MCOs and DCs beginning in 2018?
  - The provision related to APMs is outlined in the [HHSC Uniform Managed Care Contract \(PDF\)](#), Section 8.1.7.8.2 MCO Alternative Payment Models with Providers. The plans must include incentive payments to doctors, hospitals and other providers for quality care.
  - Each health plan (and dental contractor) has overall and risk based VBP contractual targets based on MCO expenditures on VBP contracts relative to all medical expense.
  - The targets began for the FY18 contract year (September 1, 2017 – August 31, 2018).
  - For MCOs, these targets are 25% overall VBP and 10% risk based VBP in FY2018 and increase over 4 years to 50% overall VBP and 25% Risk Based VBP in FY2021. For dental contractors, the targets are 25% overall VBP and 2% risk based VBP in 2018, increasing to 50% overall VBP and 10% risk based VBP in 2021.
  
5. How are the targets calculated?
  - The target APM ratios (e.g. 25% and 10% in 2018) are expressions of APM-based provider payments relative to total provider payments.
  - The targets are statewide targets for each MCO by managed care program (STAR, STAR+PLUS, etc.).
  - Each year, each MCO/DC self-reports its APM activity to HHSC on the template found on this link: [Value-Based Contracting Data Collection Tool](#)
  - HHSC uses this information to calculate whether the MCO met the target percentages.
  
6. **What happens if an MCO or DC doesn't hit the required target?**
  - If an MCO does not meet the targets or certain allowed exceptions, the MCO will be required to submit a corrective action plan and HHSC may impose contractual remedies, including liquidated damages.
  - One exception is if an MCO achieves better than expected performance on both potentially preventable hospital admissions and emergency department visits [PPAs and PPVs]) as defined in the contract, any penalty or corrective action is waived.
  
7. If there is a dispute with payment between a provider and MCO, including on the accuracy of data, metrics, or panel size what is the course of action to resolve the issue?
  - Payment disputes for APMs would be adjudicated based on contractual provisions between an MCO and a provider.
  
8. Is there a dispute resolution appeal process directly with HHSC after all avenues are exhausted with an MCO?
  - Dispute resolution involving an appeal to HHSC related to an APM payment would go through the same process as any other appeal regarding an MCO payment.

9. What requirements does HHSC have for MCOs for the APMs they engage in with providers?

- MCOs are required to:
- Share data and performance reports with APM providers on a regular basis.
- Provide outreach and negotiation, assistance with data and/or report interpretation, and other activities to support provider's improvement.
- Dedicate resources to evaluate the impact of APMs on utilization, quality and cost, as well as return on investment.
- MCOs are encouraged to the extent possible, within service areas collaborate on development of standardized formats for the provider performance reports and data requested from providers.

10. Can "gold carding" a provider (waiving pre-authorization, other administrative relief) qualify as VBP/APM?

- Yes, we recognize that providers value these arrangements in lieu of financial incentives, and so these can be included as an incentive in an APM. We also recognize that "gold carding" may include different types of performance measurement than standard value/quality metrics.

11. Do MCOs have to have APMs with all their providers?

- No. HHSC encourages collaborative efforts between MCOs and providers and believes that enhanced collaboration will be essential for success in a value-based environment, particularly if MCOs are to meet the risk-based targets in the APM initiative. However, MCOs are not required to have APMs with all their providers.

12. **I'm a Medicaid provider, but no MCO/DC has approached me about APMs.**

Why not and how do I get involved?

- Given the administrative work required for an MCO and provider to participate in an APM, it makes sense that the MCOs are starting with providers that represent a larger share of their business and who are most ready to engage in APMs.
- MCOs will focus APM efforts on providers that can help them:
- avoid unnecessary costs through appropriate primary, preventive and specialty care and care coordination, and
- succeed with the Pay for Quality measures for which 3% of the MCO payments are at risk.

13. Where can I find the Pay for Quality measures?

- The redesigned medical P4Q program, effective January 1, 2018, including measures and further description of the program is at this link: <https://hhs.texas.gov/about-hhs/process-improvement/medicaid-chip-quality-efficiency-improvement/pay-quality-p4q-program>

14. What is the most common type of APM in Texas Medicaid?

- For calendar year 2017, most of the APMs in Texas Medicaid were upside incentives only, with no downside financial risk for the provider. The most common type of arrangement was pay for performance, with fee for service base payments and bonuses for quality performance.
- HHSC has posted the summaries of APMs by year from Texas Medicaid MCOs and dental contractors on this web page in the section above.

15. Does HHSC have APM contractual targets for APMs with different types of providers (e.g. physicians, hospitals, behavioral health, home health, pharmacy, etc.)?

- No, the APM requirements in the managed care contracts are across all provider types, so a health plan has flexibility in which providers to engage in APMs. In 2017, more than half of APMs were with physician groups (primary care, OB/GYN, urgent care), followed by hospitals and specialists.

16. How big are the incentives health plans pay through APMs to providers?

- For 2017, the health plans paid out over \$75 million in net incentives, representing just under one (1) percent of total payments. Over \$8 million of these incentives were to Primary Care, OB/GYN, and over \$42 million to Urgent Care providers, followed by over \$17 million to specialists and behavioral health providers.

17. As a provider, how do I prepare to engage in APMs?

- **Information is provided below in “Resources” section on this web page. For example, “Provider Competencies to Succeed in APMs” includes technical assistance on:**
  - Governance & Culture
  - Financial Readiness
  - Health IT
  - Patient Risk Assessment
  - Care Coordination
  - Quality
  - Patient Centeredness

18. **What if a provider isn’t ready to engage in an APM, and especially one with downside risk?**

- **Other than HHSC’s required hospital programs related to Potentially Preventable Readmissions (PPRs) and Potentially Preventable Complications (PPCs), HHSC does not require any particular provider to enter into an APM with a managed care organization or dental contractor. Provider participation in APMs is voluntary.**

19. What is Upside Risk (i.e. Upside Gainsharing)?

- In an upside risk contract, providers share in the savings but not the risk of loss. When the cost of care is lower than the projected budgeted cost, providers receive a defined percentage of the difference between actual costs and budgeted costs (shared savings). However, if the actual cost of care exceeds the projected budgeted cost, providers are not responsible for the difference.

20. What is Downside Risk?

- In a downside risk contract, providers share in savings and potential losses. Providers may earn upside gains, but when the total cost of care is greater than the projected budgeted cost, providers are responsible for a defined percentage of the excess costs. Typically, providers assume downside risk for an opportunity for greater financial rewards (e.g. a higher defined percentage of shared savings).

21. What does total cost of care (TCOC) mean?

- A broad indicator of spending for a given population for a care episode or period of time (i.e., payments from payer to provider organizations). In the context of VBP models, in which provider accountability spans the full continuum of care, TCOC includes all spending associated with caring for a defined population, including provider and facility fees, inpatient and ambulatory care, pharmacy, behavioral health, laboratory, imaging, and other ancillary services.

22. What are Shared Savings?

- Reimbursement methodology that evaluates providers on quality and cost of care. Shared savings contracts often include quality targets that must be achieved to be eligible for shared savings. When the actual total cost of care is lower than the projected budgeted cost of care, shared savings are achieved. Providers receive a defined percentage of the savings as defined in the contract. Shared savings contracts give providers an opportunity to share in the savings they generate. In contrast, if savings were achieved within a fee-for service contract, all savings would accrue to the payer.

23. How can I provide feedback or input?

- You can contact HHSC staff directly. Jimmy Blanton serves as lead staff for the initiative: [Jimmy.Blanton@hpsc.state.tx.us](mailto:Jimmy.Blanton@hpsc.state.tx.us), 512-380-4372.