Healthcare Delivery and Innovation Waivers In Texas

Michelle Apodaca, JD
Haynes and Boone, LLP

Rudy Villarreal
Texas Health and Human Services Commission

Quality-Based Payment and Delivery Reforms in Medicaid and the Children's Health Insurance Program

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As Required By

S.B. 7, 82nd Legislature, First Called Session, 2011

S.B. 7, 83rd Regular Session, 2013

General Appropriations Act, H.B. 1, 84th Legislature, Regular Session, 2015 (Article II, Health and Human Services Commission, Rider 46)

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1. Executive Summary

The Texas Medicaid program has steadily evolved from a fee-for-service (FFS) model whereby the state pays medical care providers directly to a managed care model in which the state contracts with multiple managed care organizations (MCOs).

The Texas Health and Human Services Commission (HHSC) uses a wide array of categories of measures to assess quality. These measures are used to support quality-based payment systems or incentive and disincentive programs in Texas Medicaid and the Children's Health Insurance Program (CHIP). The categories of measures include: process, outcome, composite, utilization, and patient perception of care.

There is a national movement in health care toward paying for value – frequently referred to as value-based purchasing or value-based contracting. While both terms are often used interchangeably with quality-based payments, the general concept is to link a greater share of the health care payment to **value** (health care payments that tend to incentivize quality and efficiency); instead of **volume** (health care payments that tend to incentivize *more care*, rather than *more effective care*).

Value-based payment structures have the potential to accelerate health care quality and efficiency improvements. To this end, HHSC is pursuing a number of quality-based payment strategies at the MCO and provider levels, and in different service delivery models.

Clear evidence is emerging from the numerous quality and value-based payment initiatives underway that progress is occurring in several key measures of health care efficacy, coordination, access, and efficiency. These key measures include potentially preventable emergency department visits, hospital admissions, and readmissions. Between the years 2012-2014, there were reductions in the rates for these measures in different Medicaid and CHIP programs.

Through a new Quality web page, HHSC is also making performance data more readily available. The MCOs can also readily view and assess their performance data through this web page.

Due to the numerous initiatives underway at the state, national, and commercial levels that are focused on similar areas of health care quality and efficiency improvement, it will be challenging to attribute improvement to any single initiative. The HHSC continues to evaluate and refine the different quality initiatives underway to ensure they are well coordinated and administrative burdens are minimized.

2. Introduction

House Bill (H.B.) 1, 84th Legislature, Regular Session, 2015 (Article II, Health and Human Services Commission, Rider 46)[1] directs the Health and Human Services Commission (HHSC) to implement the following quality-based payment and delivery reforms in the Medicaid and Children's Health Insurance Programs (CHIP):

- Develop quality-based outcome and process measures that promote the provision of efficient, quality health care and that can be used to implement quality-based payments for acute and long-term care services across delivery models and payment systems.

- Implement quality-based payment systems for compensating a health care provider or facility participating in Medicaid and CHIP.

- Implement quality-based payment initiatives to reduce potentially preventable readmissions and complications.

- Implement a bundled payment initiative in the Medicaid program, including a shared savings component for providers that meet quality-based outcomes. High-cost and/or high-volume services may be selected for bundling, and HHSC may consider the experiences of other payers and other state of Texas programs that purchase health care services in making the selection.

Additionally, HHSC may implement a Special Reimbursement Class for long-term care commonly referred to as a "small house facilities." Such a class may include a rate reimbursement model that is cost neutral and adequately addresses the cost differences that exist in a nursing facility constructed and operated as a small house facility. The payment increment may be based upon a provider incentive payment rate.

Rider 46 requires HHSC to provide annual reports on the following: (1) the quality-based outcome and process measures developed; (2) the progress of the implementation of quality-based payment systems and other related initiatives; (3) outcome and process measures by health service region; and (4) cost-effectiveness of quality-based payment systems and other related initiatives.

Additionally, Senate Bill (S.B.) 7, 82nd Legislature, First Called Session, 2011,[2] added a requirement that HHSC annually report outcome and process measures by health care service region and service delivery model. Senate Bill 7, 83rd Legislature, Regular

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[1] House Bill 1, 84th Legislature, Regular Session, 2015 (Article II, Health and Human Services Commission, Rider 46), accessed at: http://www.lbb.state.tx.us/Documents/Budget/Session_Code_84/HB1-Conference_Committee_Report_84.pdf on page II-95

[2] Senate Bill 7, 82nd Legislature, First Called Session, 2011, accessed at: http://www.capitol.state.tx.us/tlodocs/821/billtext/doc/SB00007F.doc

Also available as part of the eCourse
Managed Care, Healthcare Delivery and Innovation Waivers in Texas

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