Texas Medicaid Managed Care
Capitation At-Risk Program

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Texas History with At-Risk Program

- 19 HMOs currently on contract – big, small, community, national, for-profit, not-for-profit
- Statewide capitated managed care for most populations, even in very rural areas
- 1% of capitation at risk starting in 2007; 5% at risk starting in 2012
- Used measures such as claims payment timeliness and network adequacy standards
- Any recoupment was redistributed based on performance on HEDIS measures
Issues with At-Risk Program

• At-risk measures weren’t tough enough, and health plans almost always earned back their full share of at risk dollars

• Led to few dollars available for the Quality Pool; quality was an after-thought

• At-risk measures represented the minimum standard rather than an achievement goal

• Measures changed every year, and were “all or nothing”; no opportunity for partial reward or partial penalty

• Sometimes included measures that weren’t adequately defined or were inaccurate
Changes to At-Risk Program

- Focused set of measures that will be used for a multi-year period of time
- 4% of premium will really be at risk; a full 4% can be lost or gained (4% statewide equals about $600M/year)
- A baseline is established, above which incentives are possible (generally 50th percentile for HEDIS; state mean for PPEs)
- No “cliffs”
- An attainment goal is established (90th percentile for HEDIS; 25% reduction in PPEs)
- Year-to-year performance improvement goal of 15% for both HEDIS and PPEs
Measures for P4P Program

- **STAR** (for TANF, pregnant women, and children)
  - Well-Child Visits for 3 – 6 year olds
  - Adolescent Well Care
  - Prenatal Care
  - PPA; PPR; PPV

- **STAR+PLUS** (for SSI; aged)
  - Antidepressant Medication Management – acute phase; continuation phase
  - HBA1c control<8
  - PPA; PPR; PPV

- **CHIP**
  - STAR measures minus prenatal care
P4P Program – Early Lessons

• Health Plans resist change, and will always try to derail efforts with concerns about data and methodology
• Meetings with health plans using “blind” data allowed input unbiased by self interest
• Legislature supports new program, which gives backing to efforts
• With so many priorities, holding firm to a few measures may be challenging
Other Key Efforts Related to Quality

- Established internal quality council which includes the quality “brains” in the agency
- Engaged consultant to assess our capitation methodology for opportunities to pay for quality and cost containment
- New HMO contract requirement for HHSC to obtain detailed information on P4P arrangements between health plans and providers
- New workgroup with HMOs to determine flexibilities that may be needed to allow for more flexible payment arrangements between HMOs and providers