Sustainability Planning Template Companion Document, October DY6

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General Reporting Guidance

The sustainability milestone is designed for DSRIP participating providers to report what efforts, if any, the provider has taken to evaluate or move toward the sustainability of DY2-6 project activities. The data will provide HHSC with a better picture of sustainability work to date, including any value-based purchasing (VBP) initiatives, and where there are gaps that HHSC may help facilitate provider readiness for sustaining system transformation. In order to receive approval for payment for the milestone, the provider must respond to each question in the template. HHSC is looking for thorough and thoughtful responses to each question. Although an answer of "No" is generally acceptable, it may trigger follow-up question(s) in which the provider should provide a description or explanation as to why they are not participating in certain sustainability efforts. Please answer each question to the best of your ability.

Semi-Annual Reporting (SAR) Requirement

The provider is not required to complete the Progress Update field in the DSRIP Online Reporting System for metric M-4 as the template itself acts as a progress update. During the October DY6 reporting period, HHSC will post the instructions as to where to download and upload the Sustainability Template in the Progress Update field, similar to what is done for Cat 3 milestones that are reported only using the Category 3 Reporting Template.

Template Submission and Naming Convention

The Sustainability Template should be saved as a **macro-enabled excel file (.xlsm)** and use the standard naming convention: **RHPXX_ProviderTPI_M4_OctDY6.xlsm** (e.g., RHP08_123456789_M4_OctDY6.xlsm). Completed Sustainability Templates should be uploaded to your first projects M-4.1 metric for the specific RHP. Providers must save the template as a macro-enabled file (.xlsm); HHSC will not accept as complete templates that are not saved as macro-enabled.

Since this is a provider level template, only one template needs to be uploaded during the October DY6 reporting period. Providers who participate in multiple regions and have active projects in those regions will need to complete a template for each region, as the projects are broken up at the regional level.

Please note that carryforward is not allowed for metric M-4.1, so October DY6 will be the only reporting in which the provider may submit the Sustainability template to earn payment for this metric.

The Sustainability Template

To ensure the Sustainability Template's interactive features work properly, please be sure that workbook calculations are set to Automatic. To check that automatic calculations are enabled, go to the File tab in Excel, click Options, followed by Formulas. Under Calculation Options, "Automatic" should be selected for Workbook Calculation.

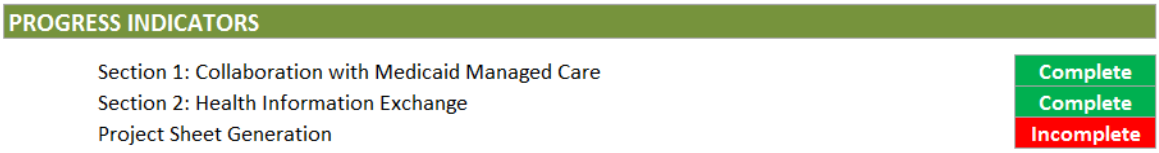
Data entry fields that the provider will need to complete are highlighted in yellow. As the provider makes selections for questions that involve checklists or dropdown menus, additional questions may open up. This is detailed in the instructions below.

Please note: Because the template involves hidden fields that open up depending on a provider's answer, please allow time for the template to run.

Provider Level Tab

PROGRESS INDICATORS

The progress indicators at the top of the Provider Level Questions tab will indicate the provider's progress on responding to the questions on the Provider Level Questions tab. There are two sections on the Provider Level tab, and each section has multiple questions. Once the provider has completed all open questions and has generated their project level tabs, all three progress indicators on the Provider Level Questions tab should display as a green "**Complete**."



Please note that the provider will need to complete data entry for Section 1: Collaboration with Medicaid Managed Care and Section 2: Health Information Exchange before the "Create Project-Specific Worksheets" button appears at the bottom of the Provider Level Questions tab.

PROVIDER SELECTION

The provider will select their region and TPI - provider name from the dropdown menus provided.

Due to macros and hidden rows, you may experience a small delay in the display of the provider level questions once you select your Region and Provider Name.

SECTION 1: COLLABORATION WITH MEDICAID MANAGED CARE

For the first question, the provider should select the Medicaid or CHIP MCO(s), DMO(s), and program(s) in which the provider is enrolled as a network provider from the check list (example shown below). The list may vary by region. If the provider is enrolled in a MCO/DMO and program that is not included on the list, please select "**[Enter MCO/DMO and program if not listed above]**" and click on cell **D46** to enter their MCO/DMO and program name.

☐	**Amerigroup Texas, Inc. - STAR/CHIP**
☐	**Molina Healthcare of Texas - STAR/CHIP**
☐	**Parkland HEALTH First - STAR/CHIP**
☐	**Amerigroup Texas, Inc. - STAR/CHIP MRSA**
☐	**Superior Health Plan - STAR/CHIP MRSA**
☐	**Superior Health Plan - STAR Health**
☐	**DentaQuest - Dental - Medicaid/CHIP**
☐	**MCNA Dental - Dental - Medicaid/CHIP**
☐	**Molina Texas Community Plus - STAR+PLUS**
☐	**Superior Health Plan Plus - STAR+PLUS**
☐	**HealthSpring - STAR+PLUS MRSA**
☐	**United HealthCare - STAR+PLUS MRSA**
☐	**Amerigroup Texas, Inc. - STAR Kids**
☐	**Children's Medical Center - STAR Kids**
☐	**Texas Children's Health Plan - STAR Kids**
☐	**United Healthcare Texas - STAR Kids**
☐	**[Enter MCO/DMO and program if not listed above]**
☐	**None of the Above**

If the provider is not enrolled as a network provider with any Medicaid MCOs or DMOs, they should select "**None of the Above**." Doing so will open up an additional question (shown below) that requests an explanation as to why the provider is not enrolled in any Medicaid MCOs or DMOs.

b) Please explain why the provider is not enrolled as a network provider with any of these Medicaid MCOs or DMOs.

As you select your MCO(s), DMO(s), and program(s), additional questions will open up for each MCO/DMO and program. You'll find a list of your projects (by the last two indicators in their project ID - the category number and project number). An example is shown in the picture below. The provider should select which projects the MCO/DMO refers its members to (if known) and provide a description of the services to which the MCO is referring in the adjacent field that will open when the project is selected.

Amerigroup Texas, Inc. - STAR/CHIP

a) Please select the project(s) below to which this MCO/DMO refers its clients, if known. In the field next to the selected project, **please describe the services in this project for which the MCO refers its members, if known**.

☐	**1.1**
☐	**1.2**
☐	**1.3**
☐	**1.4**
☐	**2.1**
☐	**2.2**
☐	**2.3**
☐	**None of the Above**

If they do not refer members to any of the projects for services, then please select "**None of the Above**." Once selected, another text box (shown below) will open up requesting why the MCO(s)/DMO(s) do not participate in the DSRIP projects.

i) Please provide any information the provider has about why MCOs and/or DMOs may not refer their members to receive services through a DSRIP project.

For the second question, the provider is asked if they are paid by an MCO or DMO through an alternative payment model (APM) or value-based payment (VBP) methodology.

2) Is the provider paid by an MCO or DMO through an alternative payment model (APM)/ value-based payment (VBP) methodology? An APM/VBP methodology is a payment arrangement in which a payer reimburses a provider through a method other than, or in addition to, the traditional fee-for-service (FFS) reimbursement (through incentive bonus payments, or bundled payments around an episode of care, for example).

Selecting "**Yes**" will open up a list of applicable APM and VBP methodologies (shown below). The provider should indicate each of the VBP methodologies they are engaged in with a Medicaid MCO. The provider is not required to indicate which MCO they are contracted with for VBP purposes; this is at the discretion of the provider and contractual agreements between the MCO and the provider. Please refer to Appendix A in this companion document for HHSC's definition of the APM/VBP methodologies listed below.

☐	**FFS + Incentive and/or Disincentive Component**
☐	**DRG + Incentive and/or Disincentive Component**
☐	**Partial Capitation**
☐	**Full Capitation**
☐	**Bundled Payment**
☐	**Episode Payment**
☐	**"Non-financial Incentive (i.e. administrative relief, preferential provider status)"**
☐	**Supplemental Payments**
☐	**Shared Savings/Risk**

For each APM and/or VBP methodology selected, three additional questions will open up asking the provider to describe the APM/VBP methodology, if the provider is submitting encounter-based claims under the methodology, and to provide feedback on the methodology (e.g., what works, what doesn't work, etc.). Please see below.

☑ **FFS + Incentive and/or Disincentive Component**

i) Please describe.

ii) Does the provider continue to submit encounter-based claims under this APM/VBP methodology?

iii) Please provide any feedback on this APM/VBP methodology. What is working? What is not working?

If the provider selects "**No**" for Question 2, the template asks why the provider is not participating in an AMP/VBP methodology payment agreement with an MCO or DMO.

SECTION 2: HEALTH INFORMATION EXCHANGE

For the first question in this section, the provider will indicate if they participate in the exchange of health-related information with other providers or organizations (MCO, community partners, etc.). These questions are not specific to a Health Information Exchange (HIE) entity, and providers can answer based on any level of exchange of health-related information or data. Selecting "**Yes**" will open up seven additional questions (shown below).

a) Which individuals/organizations are exchanging the health-related information?

b) Please indicate the type(s) of health-related information being exchanged.

- ☐ Claims data
- ☐ Clinical data
- ☐ Case notes (i.e., clinician observations, client responses to questions, etc.)
- ☐ Other

c) Provide a detailed description of the type(s) of health-related information being exchanged and how the information is used by both parties.

d) What systems are being used to exchange the health-related information?

e) Is the health-related information exchanged in "real time"?

f) What are the obstacles to the exchange of health-related information between/among providers/organizations?

- ☐ Contract agreement too burdensome
- ☐ Do not have the technology in place
- ☐ The technology is too costly
- ☐ The project does not require additional data
- ☐ Other

g) Please describe any actions being taken to overcome these obstacles.

If a provider selects "**No**" for question 1)**e) Is the health-related information exchanged in "real time"?**, two additional questions (shown below) will open up for the provider to complete.

i) What is the time lag?

ii) What actions, if any, are being taken to reduce this time lag?

If the provider selects "**Other**" for question 1)**f)** an additional field will open up for the provider to enter other types of obstacles that the provider has encountered.

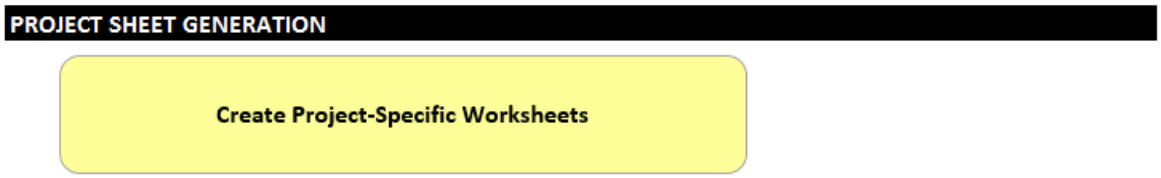
i) Please describe any other obstacles.

For the second question under the Health and Information Exchange section, the provider should list any HIEs in which they participate, if any. If the provider does not participate in a formal HIE, a response of "None" is sufficient.

2) Please list any Health Information Exchange(s) (HIE[s]) to which health-related information is being provided or from which health-related information is being received for the purposes of any of the provider's DSRIP projects.

PROJECT SHEET GENERATION

The "**Create Project-Specific Worksheets**" button (shown below) will appear at the bottom of the Provider Level Questions tab when the progress indicators for Section 1 and Section 2 show as "**Complete**." If the progress indicators for Section 1 or Section 2 are still incomplete, go back through the sections to ensure that you have answered each question. Click the "**Create Project-Specific Worksheets**" button to create the project specific tabs for all DY6 active projects belonging to the provider within a region. *Please note that the projects are populated in the template based on the region the provider selected in the Provider Selection section. The project data is for DY6 only, so if projects combined into one region in DY6, they will all be under the RHP for the DY6 project. If the provider has active projects in multiple regions, they will need to complete one template per region in order to submit responses to ALL of their projects' M-4.1 metrics.*



Please be patient as the template creates your project level tabs, especially for those providers who have many projects.

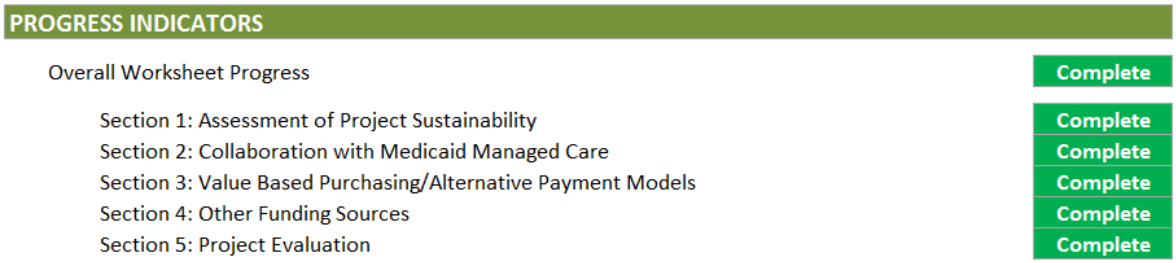
Clicking the "Create Project-Specific Worksheets" button will also generate a "Template Progress" Tab. This should be used by the provider to help track completion of the project-specific tabs and to indicate when the template is complete and ready for submission to HHSC.

Project Specific Tabs

A project tab will be created for each active DY6 Category 1 and 2 project. They are labeled with the last two numbers in the Project ID (e.g., 1.1, 1.2, 2.3, etc.). There are five sections with multiple questions on each project tab. Providers should fill out each project tab completely.

PROGRESS INDICATORS

The progress indicators at the top of the Project Specific tabs will indicate the provider's progress on responding to the questions on the selected Project Specific tab (e.g., 1.1, 1.2, 2.3, etc.). Once the provider has completed all questions within each section, the progress indicators on the Project Specific tab should display as a green "**Complete**." This progress is also shown on the Template Progress tab, under the last two numbers of the project ID.



SECTION 1: ASSESSMENT OF PROJECT SUSTAINABILITY

The first section is for the provider to describe any activities undertaken to assess and/or implement the project's sustainability. This section allows for a free-form, narrative response. HHSC is looking for providers to address any of their project-specific evaluation or sustainability efforts, especially those that are not addressed by specific questions in the template.

1) Please describe the activities the provider conducted in DY6A to assess the project's sustainability potential, including evaluating if the project is providing better care and/or cost containment/savings, and based on that assessment, as appropriate, sustain the project. If the project/activity is not continuing, please explain the reasoning. Please make sure to describe any activities that are not addressed by the questions below.

SECTION 2: COLLABORATION WITH MEDICAID MANAGED CARE

In this section, the provider should describe any collaboration with managed care that is occurring specifically at the project level. These responses should be limited to the services and activities that are occurring in the project.

In question 1, HHSC is looking for examples of services that providers have implemented through DSRIP projects that are provided to Medicaid-enrolled patients, but the services may or may not be Medicaid benefits. Responses may help inform HHSC Medicaid and VBP policies. If the provider lists services in response to this question, the template will open up and request if the provider bills any non-Medicaid payers for the service. It is helpful, if known, for the provider to include the billing code, but it is not required to complete the template.

If the provider does not provide services to Medicaid-enrolled patients that are not billed to Medicaid, please select "None".

1) What services is the provider providing to Medicaid-enrolled patients through this DSRIP project that the provider is <u>not</u> billing to Medicaid (i.e., submitting a claim for reimbursement to a Medicaid MCO or DMO or the Texas Medicaid & Healthcare Partnership [TMHP] for services provided through this project)? Please provide the type of service and procedure code, if available. This question is specific to services provided to Medicaid enrollees.

1	navigation	[Billing Code]

a) Does the provider bill other non-Medicaid payer(s) for this service?

2	[Service]	[Billing Code]
3	[Service]	[Billing

In question 2, HHSC is asking for any shared goals/metrics between the project and Medicaid MCOs/DMOs. The provider is not limited to the shared goals to which the MCOs are held accountable by HHSC; the provider may describe any other common goals. This question also will ask if the provider collaborates with a Performance Improvement Project (PIP) with an MCO. The metrics to which Medicaid MCOs and DMOs are held accountable by HHSC in the Pay-for-Quality program are listed for your reference in Appendix B in this companion document.

2) Does this project share common goals/metrics (i.e., reduction in unnecessary emergency department [ED] utilization or a PIP project) with a Medicaid MCO and/or DMO in in the Medicaid managed care service area(s) overlapping this RHP? Please see the companion document for the goals/metrics to which Medicaid MCOs are held accountable by the state.

If a provider selects "Yes" they will need to complete the following questions.

a) Which goal(s) does this project share with a Medicaid MCO or DMO?

b) Is this project in a collaborative Performance Improvement Project (PIP) with a Medicaid MCO or DMO?

If the provider is participating in the PIP collaboration and answers "yes" to 2) b), the template will open a field for the provider to describe the PIP project and mutual goals with their partnering MCO. PIP topics are included in Appendix C in this companion document for your reference.

Questions 3 and 4 require a yes or no response from the drop down menu. If the provider does have partnerships with other providers or MCOs that have not already been addressed, please answer "yes" and describe the partnership or arrangement in the available field.

3) Is the provider partnering with other DSRIP projects or providers in this RHP to expand the scope and/or impact of this project? For example, has the provider considered or taken further steps in partnering with other providers to increase the size of the provider's Medicaid patient panel to ultimately collaborate with a Medicaid MCO?

4) Is the provider collaborating with an MCO in any capacity not already addressed above?

SECTION 3: VALUE BASED PURCHASING/ALTERNATIVE PAYMENT MODELS

Section 3 is seeking additional information about any VBP or APM arrangements specific to the project listed on the tab. In this section, HHSC is seeking any information about VBP or APM models, if the provider believes the project is a good candidate for VBP or APM models, and if the provider is engaged with any payers (Medicaid or not) regarding VBP arrangements. Dependent on provider's responses, additional space will open up for descriptions of any VBP or APM activities. Providers are not required to name the payers with whom they have engaged in discussion or are contracting.

1) Please select the APM/VBP methodologies that might work for this project. An APM/VBP model is a payment arrangement where a payer reimburses a provider beyond the traditional fee-for-service reimbursement (through incentive bonus payments, or bundled payments around an episode of care, for example).

☐	**FFS + Incentive and/or Disincentive Component**
☐	**DRG + Incentive and/or Disincentive Component**
☐	**Partial Capitation**
☐	**Full Capitation**
☐	**Bundled Payment**
☐	**Episode Payment**
☐	**"Non-financial Incentive (i.e. administrative relief, preferential provider status)"**
☐	**Supplemental Payments**
☐	**Shared Savings/Risk**
☐	**This project would not lend itself to a VBP model**

2) Is the provider for this project discussing with an MCO and/or DMO potential for payment via an APM/ VBP methodology for services provided through this DSRIP project to the plan's Medicaid members?

3) Does the provider have any APM/VBP arrangements with non-Medicaid payers for the services provided through this DSRIP project?

If a provider selects "**Yes**" from question 3, a list of APM/VBP arrangements will open up. For each one the provider selects, they will need to provide an explanation of the arrangement. Again, for reference, the VBP models are defined in Appendix A of this Companion Document.

a) Please select the APM/VBP arrangement(s) the provider has with a non-Medicaid payer.

☐	**FFS + Incentive and/or Disincentive Component**
☐	**DRG + Incentive and/or Disincentive Component**
☐	**Partial Capitation**
☐	**Full Capitation**
☐	**Bundled Payment**
☐	**Episode Payment**
☐	**"Non-financial Incentive (i.e. administrative relief, preferential provider status)"**
☐	**Supplemental Payments**
☐	**Shared Savings/Risk**

SECTION 4: OTHER FUNDING SOURCES

In Section 4, HHSC is seeking any information about any non-Medicaid funding sources the provider has garnered in an effort toward sustaining the specific project listed on the tab. Questions 1 and 2 require a yes or no response from the drop down menu. If the provider answers "yes" additional inputs will open up for the provider to elaborate.

In Section 4, Question 1, if a provider answers "yes", the template will open a table on which the provider should list the funding amount and the source of the payment. If the payments have a specific start and end date, please also enter these in the table. The date range of the other funding source is not required for completion of the template. Providers should include any publicly available information for alternative funding sources. For example, most competitive grants are listed publicly. Listing other

payment arrangements is at the discretion of the provider and contractual agreements between the entity and the provider.

1) Does this project currently have funding sources other than Medicaid (Note: Medicaid includes DSRIP)? For example, does the project receive any grant funding or private insurance payments?

a) Describe the funding source, the total funding amount, and the time period (if applicable).

Number	Funding Amount	Source	Start Date	End Date
Example	$20,000	Grant from County	12/1/2013	1/31/2015
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

For Section 4, Question 2, if the provider answers “yes”, additional space will open for a description of the other agreements.

2) Is the provider pursuing agreements with government agencies (city, county, school district, etc.), foundations, or other organizations to provide funding for this project?

SECTION 5: PROJECT EVALUATION

Section 5 are questions pertaining to any project evaluation that may have been performed for the specific project on the tab. Question 1 asks if the provider has performed an evaluation of the project; the provider may choose yes or no from the drop down menu. If the provider has performed their own project evaluation and answers “yes” to Section 5, Question 1, the provider should upload any report to the M-4.1 metric of the corresponding project.

Regardless of whether or not the provider has previously evaluated this specific project, the provider must continue to answer all questions in this section under Question 2. These are high level questions that request the provider to reflect on the merits or challenges of their project. Again, the more specific the information, the more helpful these responses will be to HHSC. A response of “no” or “none”, when applicable, will be acceptable.

2) Answer the following basic evaluation questions:

a) Briefly describe the project and its goals.

b) What aspects of the program have been evaluated? (Please upload any evaluation reports you have completed under milestone M-4 for this project.)

☐	Access to Services
☐	Data Quality/Infrastructure
☐	Process Improvements
☐	Sustainability
☐	Target Population
☐	Other
☐	None

i) Describe aspects of the program that were evaluated (those checked above, including explanation of "other") and key questions that were asked.

c) Describe program evaluation methodology.

d) What quality outcomes have you utilized to evaluate the project?

e) Describe the positive impact of the project (e.g., assets, successes, outcome, and improvements) based on a formal or informal evaluation.

f) Describe areas for improvement for the project (e.g., barriers, remaining needs, unmet goals).

g) What adjustments to the program have been implemented or are currently being considered (based on a formal or informal evaluation)?

h) How is cost effectiveness being evaluated or explored in the context of continuing this intervention?

i) Do you believe the project is replicable in other areas of the state or by other providers?

j) What has been the key to this project's success?

If the provider selects "**Yes**" for question **i) Do you believe the project is replicable in other areas of the state or by other providers?,** another field will open asking why the provider believes this project is replicable.

Template Progress

The **Template Progress** tab keeps track of the data input progress for all of the provider's projects. Before submitting the Sustainability Template, the provider should confirm that the progress indicators for each project tab display as a green "**Complete**" for each section and the progress message at the top of the tab should change to "**Template is COMPLETE and READY for submission to HHSC!**" (see image below). Please do not submit a Sustainability Template if there are any red "Incomplete" indicators on the Template Progress tab. Providers will receive an NMI if the template is incomplete, as the milestone is P4R and requires complete responses to be eligible for payment.

SUSTAINABILITY MILESTONE TEMPLATE PROGRESS: **Template is COMPLETE and READY for submission to HHSC!**

Please confirm that the Sustainability Milestone template progress shows complete above. If it shows that the template is not ready for submission, please complete any missing steps and correct any outstanding issues before submitting to HHSC.

Provider Level Questions	
Section 1: Collaboration with Medicaid Managed Care	Complete
Section 2: Health Information Exchange	Complete
Project Sheet Generation	Complete
1.1	
Section 1: Assessment of Project Sustainability	Complete
Section 2: Collaboration with Medicaid Managed Care	Complete
Section 3: Value Based Purchasing/Alternative Payment Models	Complete
Section 4: Other Funding Sources	Complete
Section 5: Project Evaluation	Complete

Appendix A: Value Based Purchasing Definitions

Value-based purchasing: Synonymous with terms payment reform, pay for performance (P4P), pay for quality (P4Q), alternate payment models (APM), and value-based contracting (VBC). A term used to describe a (healthcare) payment model that links a portion of the full healthcare payment to a measure or measures of quality, access, value (quality and cost), or other behavior that is determined to advance quality, patient experience or efficiency.

VBC Type	**Description**
Fee-for-service (FFS)	A payment model where services are unbundled and paid for separately.
Diagnosis-Related Group (DRG)	A statistical system of classifying any inpatient stay into groups for the purposes of payment (CMS) and quality performance evaluation (3M).
Financial Arrangement Code	Financial Arrangement code is sent by MCOs in a Note field of Loop 2400 of the 837 encounter transaction. This code denotes the reimbursement model the MCO utilized to pay the underlying claim. Generally, MCOs may pay providers under differing reimbursement arrangements, such as Fee For Service, a delegated arrangement with a subcontractor (such as a Behavioral Health or Vision vendor) or through a capitated arrangement with a provider.
Incentive	Rewards (financial or otherwise) for achievement of desired performance
Disincentive	Consequence (financial or otherwise) for failing to achieve a desired performance
Capitation	A fixed, pre-arranged and prospective payment received by a health plan or provider per patient enrolled in the respective plan or provider
Bundled Payment	A single payment to providers or health care facilities (or jointly to both) for all services to treat a given condition or provide a given treatment.
Episode payment	Payment to a professional for all care associated with an event, such as delivery (includes prenatal, delivery and postpartum care).
Non-financial Incentive	Recognition through awards, report cards, other venues
Supplemental payment	Payment for provider investment in infrastructure such as HIE connectivity, EHR, etc.
Shared savings	A payment strategy that offers providers a percentage of net savings realized as a result of their efforts to reduce health care spending for a defined patient population.
Downside Risk	Risk that costs exceed revenue

Appendix B: 2018 P4Q Measures

Measure	Programs
At-risk Measures	
Potentially Preventable Emergency Room Visits (PPVs)	STAR STAR+PLUS CHIP
Appropriate Treatment for Children with Upper Respiratory Infection (URI)	STAR CHIP
Prenatal and Postpartum Care (PPC)	STAR
Well Child Visits in the First 15 months of Life (W15)	STAR
Diabetes Control - HbA1c < 8% (CDC)	STAR+PLUS
High blood pressure controlled (CBP)	STAR+PLUS
Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are using antipsychotics (SSD)	STAR+PLUS
Cervical cancer screening (CCS)	STAR+PLUS
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (WCC) - Sub measures counseling for nutrition and counseling for physical activity	CHIP
Adolescent Well Care (AWC)	CHIP
Bonus Pool Measures	
Potentially preventable admissions	STAR
Low Birth Weight	STAR
Good access to urgent care	STAR STAR+PLUS CHIP
Rating their health plan a 9 or 10	STAR STAR+PLUS CHIP
Potentially preventable readmissions	STAR+PLUS
Potentially preventable complications	STAR+PLUS
Prevention Quality Indicator Composite	STAR+PLUS
Childhood Immunization Status (CIS) Combination 10	CHIP

Appendix C: 2016 and 2017 Performance Improvement Project (PIP) Topics

Performance Improvement Projects (PIPs) are an integral part of Texas Medicaid's comprehensive quality improvement strategy. The Balanced Budget Act of 1997 requires all states with Medicaid managed care to ensure health plans conduct PIPs. PIPs must be designed to achieve significant and sustainable improvements in both clinical and non-clinical care areas through ongoing measurements and interventions. According to 42 CFR 438.330, projects must be designed to achieve, through ongoing measurements and interventions, significant improvement, sustained over time, in clinical care and nonclinical care areas that have a favorable effect on health outcomes and enrollee satisfaction.

HHSC requires each health plan to conduct two PIPs per program. One PIP must be a collaborative with another Medicaid/CHIP managed care organization, dental maintenance organization, or Delivery System Reform Incentive Payment project.

Program	Health Plan	2016 PIP Topic	2017 PIP Topic
STAR	Aetna Better Health	Increase access to and utilization of outpatient care to reduce PPVs due to respiratory tract infections (URTIs). **Measure:** URTI PPVs	Increase well-child visits in the first 15 months of life W15
CHIP	Aetna Better Health	Increase access to and utilization of outpatient care to reduce PPVs due to respiratory tract infections (URTIs). **Measure:** URTI PPVs	Increase well-child visits in the first 15 months of life W15
STAR Kids	Aetna Better Health	N/A	Provide BH/family support services to caregivers identified by the SAI as experiencing stress/needing support.
STAR+PLUS	Amerigroup	Improve care transitions and care coordination to reduce behavioral health-related admissions and readmissions. **Measures:** FUH 7-day; FUH 30-day; AMM; IET; BH-Related PPAs; BH-Related PPRs; All cause readmissions	Diabetes Control
STAR	Amerigroup	Increase access to and utilization of outpatient care to reduce PPVs due to respiratory tract infections (URTIs). **Measure:** URTI PPVs	Increase well-child visits in the first 15 months of life W15
CHIP	Amerigroup	Increase access to and utilization of outpatient care to reduce PPVs due to respiratory tract infections (URTIs). **Measure:** URTI PPVs	Increase well-child visits in the first 15 months of life W15
STAR Kids	Amerigroup	N/A	Access and continuity of care for MDCP members, using data form monthly check-in calls.
STAR	Blue Cross and Blue Shield of Texas	Increase access to and utilization of outpatient care to reduce PPVs due to respiratory tract infections (URTIs). **Measure:** URTI PPVs	Increase well-child visits in the first 15 months of life W15

CHIP	Blue Cross and Blue Shield of Texas	Increase access to and utilization of outpatient care to reduce PPVs due to respiratory tract infections (URTIs). **Measure:** URTI PPVs	Increase well-child visits in the first 15 months of life W15
STAR Kids	Blue Cross and Blue Shield of Texas	N/A	Timeliness of SAI and develop systems for monitoring and reporting on coordination of care
STAR Kids	Children's Medical Center	N/A	PPVs for members age 6-17 using the SAI to assess risk for ED visits
STAR	CHRISTUS Health Plan	Increase access to and utilization of outpatient care to reduce PPVs due to respiratory tract infections (URTIs). **Measure:** URTI PPVs	Behavioral Health
CHIP	CHRISTUS Health Plan	Increase access to and utilization of outpatient care to reduce PPVs due to respiratory tract infections (URTIs). **Measure:** URTI PPVs	Behavioral Health
STAR+PLUS	Cigna-HealthSpring	Improve care transitions and care coordination to reduce behavioral health-related admissions and readmissions. **Measures:** FUH 7-day; FUH 30-day; AMM; IET; BH-Related PPAs; BH-Related PPRs; All cause readmissions	Diabetes Control
STAR	Community First Health Plans	Increase access to and utilization of outpatient care to reduce PPVs due to respiratory tract infections (URTIs). **Measure:** URTI PPVs	Behavioral Health
CHIP	Community First Health Plans	Increase access to and utilization of outpatient care to reduce PPVs due to respiratory tract infections (URTIs). **Measure:** URTI PPVs	Behavioral Health
STAR Kids	Community First Health Plans	N/A	Evaluate goals of care and gaps in care coordination related to member risk level
STAR	Community Health Choice	Increase access to and utilization of outpatient care to reduce PPVs due to respiratory tract infections (URTIs). **Measure:** URTI PPVs	Increase well-child visits in the first 15 months of life W15
CHIP	Community Health Choice	Increase access to and utilization of outpatient care to reduce PPVs due to respiratory tract infections (URTIs). **Measure:** URTI PPVs	Increase well-child visits in the first 15 months of life W15
STAR	Cook Children's Health Plan	Increase access to and utilization of outpatient care to reduce PPVs due to respiratory tract infections (URTIs). **Measure:** URTI PPVs	Increase well-child visits in the first 15 months of life W15
CHIP	Cook Children's Health Plan	Increase access to and utilization of outpatient care to reduce PPVs due to respiratory tract infections (URTIs). **Measure:** URTI PPVs	Increase well-child visits in the first 15 months of life W15
STAR Kids	Cook Children's Health Plan	N/A	Use the SAI to identify kids needing preventive care and develop systems for improving well visit and immunization rates.

Medicaid Dental	DentaQuest	Increase utilization of preventative services, such as sealants, fluoride treatments, and cleanings* **Measures:** Annual dental visit (HEDIS ADV); Preventive care – fluoride treatments (DQA measure); and Dental sealants on permanent molars (DQA measure)	Increase utilization of oral evaluation for members under 3 targeting an area with historically low utilization
CHIP Dental	DentaQuest	Increase utilization of preventative services, such as sealants, fluoride treatments, and cleanings* **Measures:** Annual dental visit (HEDIS ADV); Preventive care – fluoride treatments (DQA measure); and Dental sealants on permanent molars (DQA measure)	Increase utilization of any preventative code for members age 6-14 in a targeted area of TX with historically low utilization of preventative services for this age group
STAR	Driscoll Children's Health Plan	Increase access to and utilization of outpatient care to reduce PPVs due to respiratory tract infections (URTIs). **Measure:** URTI PPVs	Diabetes Control
CHIP	Driscoll Children's Health Plan	Increase access to and utilization of outpatient care to reduce PPVs due to respiratory tract infections (URTIs). **Measure:** URTI PPVs	Asthma
STAR Kids	Driscoll Children's Health Plan	N/A	Increase the rate of care goal achievement.
STAR	El Paso First	Increase access to and utilization of outpatient care to reduce PPVs due to respiratory tract infections (URTIs). **Measure:** URTI PPVs	Increase well-child visits in the first 15 months of life W15
CHIP	El Paso First	Increase access to and utilization of outpatient care to reduce PPVs due to respiratory tract infections (URTIs). **Measure:** URTI PPVs	Increase well-child visits in the first 15 months of life W15
STAR	FirstCare	Increase access to and utilization of outpatient care to reduce PPVs due to respiratory tract infections (URTIs). **Measure:** URTI PPVs	Behavioral Health
CHIP	FirstCare	Increase access to and utilization of outpatient care to reduce PPVs due to respiratory tract infections (URTIs). **Measure:** URTI PPVs	Behavioral Health
Medicaid Dental	MCNA	Increase utilization of preventative services, such as sealants, fluoride treatments, and cleanings* **Measures:** Annual dental visit (HEDIS ADV); Preventive care – fluoride treatments (DQA measure); and Dental sealants on permanent molars (DQA measure)	Increase number/percent of members who have a dental home with the primary provider providing dental services
CHIP Dental	MCNA	Increase utilization of preventative services, such as sealants, fluoride treatments, and cleanings* **Measures:** Annual dental visit (HEDIS ADV); Preventive care – fluoride treatments (DQA measure); and Dental sealants on permanent molars (DQA measure)	Increase number/percent of members who have a dental home with the primary provider providing dental services

STAR+PLUS	Molina Healthcare of Texas	Increase access to care and improve management of COPD to reduce COPD-related PPAs **Measures:** AAP; COPD-Related PPAs	Diabetes Control
STAR	Molina Healthcare of Texas	Increase access to and utilization of outpatient care to reduce PPVs due to respiratory tract infections (URTIs). **Measure:** URTI PPVs	Behavioral Health
CHIP	Molina Healthcare of Texas	Increase access to and utilization of outpatient care to reduce PPVs due to respiratory tract infections (URTIs). **Measure:** URTI PPVs	Behavioral Health
STAR	Parkland	Increase access to and utilization of outpatient care to reduce PPVs due to respiratory tract infections (URTIs). **Measure:** URTI PPVs	Increase well-child visits in the first 15 months of life W15
CHIP	Parkland	Increase access to and utilization of outpatient care to reduce PPVs due to respiratory tract infections (URTIs). **Measure:** URTI PPVs	Increase well-child visits in the first 15 months of life W15
STAR	Scott and White Health Plans	Increase access to and utilization of outpatient care to reduce PPVs due to respiratory tract infections (URTIs). **Measure:** URTI PPVs	Asthma
STAR	Sendero Health Plans	Increase access to and utilization of outpatient care to reduce PPVs due to respiratory tract infections (URTIs). **Measure:** URTI PPVs	Increase well-child visits in the first 15 months of life W15
CHIP	Sendero Health Plans	Increase access to and utilization of outpatient care to reduce PPVs due to respiratory tract infections (URTIs). **Measure:** URTI PPVs	Increase well-child visits in the first 15 months of life W15
STAR	Seton Health Plan	Increase access to and utilization of outpatient care to reduce PPVs due to respiratory tract infections (URTIs). **Measure:** URTI PPVs	Increase well-child visits in the first 15 months of life W15
CHIP	Seton Health Plan	Increase access to and utilization of outpatient care to reduce PPVs due to respiratory tract infections (URTIs). **Measure:** URTI PPVs	Increase well-child visits in the first 15 months of life W15
STAR+PLUS	Superior HealthPlan	Improve care transitions and care coordination to reduce behavioral health-related admissions and readmissions. **Measures:** FUH 7-day; FUH 30-day; AMM; IET; BH-Related PPAs; BH-Related PPRs; All cause readmissions	Breast and Cervical Cancer Screening
STAR	Superior HealthPlan	Increase access to and utilization of outpatient care to reduce PPVs due to respiratory tract infections (URTIs). **Measure:** URTI PPVs	Increase well-child visits in the first 15 months of life W15
CHIP	Superior HealthPlan	Increase access to and utilization of outpatient care to reduce PPVs due to respiratory tract infections (URTIs). **Measure:** URTI PPVs	Increase well-child visits in the first 15 months of life W15

STAR Health	Superior HealthPlan	Improve care transitions and care coordination to reduce behavioral health-related PPAs and PPRs **Measures:** FUH 7-day; FUH 30-day; AMM; IET; BH-Related PPAs and PPRs	URI PPVs
STAR Kids	Superior HealthPlan	N/A	Reducing PPAs and PPVs
STAR	Texas Children's Health Plan	Increase access to and utilization of outpatient care to reduce PPVs due to respiratory tract infections (URTIs). **Measure:** URTI PPVs	Asthma
CHIP	Texas Children's Health Plan	Increase access to and utilization of outpatient care to reduce PPVs due to respiratory tract infections (URTIs). **Measure:** URTI PPVs	Asthma
STAR Kids	Texas Children's Health Plan	N/A	Ensuring transition planning is done and goals are met
STAR+PLUS	UnitedHealthcare Community Plan	Improve care transitions and care coordination to reduce behavioral health-related admissions and readmissions. **Measures:** FUH 7-day; FUH 30-day; AMM; IET; BH-Related PPAs; BH-Related PPRs; All cause readmissions	Breast and Cervical Cancer Screening
STAR	UnitedHealthcare Community Plan	Increase access to and utilization of outpatient care to reduce PPVs due to respiratory tract infections (URTIs). **Measure:** URTI PPVs	Behavioral Health (ADD)
CHIP	UnitedHealthcare Community Plan	Increase access to and utilization of outpatient care to reduce PPVs due to respiratory tract infections (URTIs). **Measure:** URTI PPVs	Behavioral Health (ADD)
STAR Kids	UnitedHealthcare Community Plan	N/A	Increase utilization of ECI for members younger than 3 yo with developmental concerns