



Draft DSRIP Transition Plan

**As Required by
1115 Waiver Special Terms and
Conditions #37**

Health and Human Services

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1. Executive Summary

The Delivery System Reform Incentive Payment (DSRIP) pool in the Texas Healthcare Transformation and Quality Improvement Program Medicaid 1115 Demonstration (Waiver) benefits Texans and the Texas healthcare delivery system. Texas providers earned over \$15 billion in DSRIP funds from 2012 to January 2019, and served 11.7 million people and provided 29.4 million encounters from October 1, 2013 to September 30, 2017.¹ In the initial phase of the Waiver, most providers succeeded in achieving their outcome goals, including goals related to diabetes and high blood pressure control, reducing emergency department visits for ambulatory care sensitive conditions, and reducing the risk-adjusted congestive heart failure hospital readmission rate.

DSRIP is locally driven, based on community needs, and as an incentive payment program, offers flexibility to: 1) innovate to deliver better care and improve health outcomes; and 2) deliver services not traditionally billable to insurance but that can improve health. Major DSRIP focus areas include:

- Behavioral health;
- Primary care;
- Patient navigation, care coordination, and care transitions, especially for complex populations;
- Chronic care management; and
- Health promotion and disease prevention.

When the Centers for Medicare and Medicaid Services (CMS) renewed the Waiver in December 2017, it authorized DSRIP through September 30, 2021 with a Waiver end date of September 2022. Special Terms and Conditions (STCs) 37 of the Waiver requires Texas to submit a draft DSRIP Transition Plan to CMS no later than October 1, 2019 (Appendix A).

The Texas Health and Human Services Commission (HHSC) and CMS agreed upon certain assumptions for the DSRIP Transition Plan during the Waiver renewal negotiations in 2017.

- CMS is not prescribing the content of the Transition Plan except that it may relate to the use of alternative payment models (APMs), the state's adoption of managed care payment models that support providers' delivery system reform efforts, and other opportunities.
- The Transition Plan does not require Texas to sustain specific DSRIP projects or core activities.

¹ The numbers of people served and encounters provided are for demonstration years (DYs) 3-6 and are not unduplicated counts.

- The Transition Plan does not require Texas to sustain a certain level of funding to support ongoing transformation efforts.
- The Transition Plan will describe how the Texas DSRIP program will hand off to other Texas initiatives such as those in the Value-Based Purchasing (VBP) Roadmap.
- Texas will define the milestones for DY 9-10, which will relate to Texas' planned progress in advancing initiatives such as those outlined in the VBP Roadmap or other state or federal initiatives.

HHSC asked stakeholders to submit initial program ideas for DSRIP transition that used existing funding sources by November 30, 2018, to share with Texas state leadership and help inform the development of the DSRIP Transition Plan. HHSC received responses from more than 30 entities. Proposals focused on broad systems of care, community-based and hospital care, rural health, behavioral health, public health, and academic medicine. They ranged from statewide to regional to individual provider level. A high-level summary of these stakeholder proposals is included as Appendix B.

Using the initial proposals as a starting point, HHSC will work with Texas stakeholders and leadership to develop and propose to CMS new programs, policies, and other Medicaid strategies in key areas to build on successful DSRIP work and advance delivery system reform, while leveraging existing resources and financing structures. These key areas include some issues that have gained attention both in Texas and nationally since the initial Texas Waiver, such as maternal morbidity and mortality, the opioid epidemic, and social drivers of health. DSRIP afforded Texas the opportunity to address social drivers of health, such as through care navigation for individuals with complex conditions, housing supports, and transportation assistance. An increased knowledge base nationally, along with the early work in DSRIP, offers opportunities for next steps.

The milestones included in this transition plan lay the groundwork to develop strategies, programs, and policies to sustain successful DSRIP activities and for emerging areas of innovation in health care. The following are key focus areas for the state (listed in no particular order).

- Behavioral health;
- Primary care;
- Patient navigation, care coordination, and care transitions, especially for patients with high costs and high utilization;
- Chronic care management;
- Health promotion and disease prevention;
- Maternal health and birth outcomes, including in rural areas of the state;
- Pediatric care;
- Rural health care;
- Telemedicine and telehealth; and
- Social drivers of health.

The DSRIP Transition Plan contains specific goals for next steps in delivery system transformation. Milestones are categorized by the following broad goals:

- Advance APMs that target specific quality improvements.
- Support further delivery system reform that builds on the successes of the Waiver and includes current priorities in health care.
- Explore innovative financing models.
- Develop cross-focus areas such as social drivers of health that use the latest national data and analysis to continue to innovate in Texas.
- Strengthen supporting infrastructure for increased access to health care and improved health for Texans.

These goals represent the work that Texas will undertake during the last two years of the DSRIP program to enhance the state Medicaid program and inform the next 1115 Waiver renewal submission to CMS. Milestones linked to these goals are listed below.

In addition to the DSRIP Transition Plan, there is also a requirement in the Waiver renewal STCs for a Health Information Technology (Health IT) Strategic Plan. Texas is developing both plans in concert with one another, and the work undertaken for the plans will inform each other. It is necessary for the state to continue to improve health information data sharing so that Medicaid and CHIP managed care organizations (MCOs) and providers have access to timely data for VBP and advancing delivery system transformation.

Proposed Milestones for DY 9-10

Advance APMs to Promote Healthcare Quality

- HHSC updates the Texas VBP Roadmap to address strategies to sustain key DSRIP initiative areas. [September 30, 2020]
- HHSC updates the Texas Medicaid quality strategy to address program and stakeholder goals. HHSC will:
 - ▶ To advance potential APMs for Medicaid recipients with high needs and high costs, identify measurement approaches for services and populations that traditionally have been challenging to measure. Potential areas for refined measurement approaches: severe mental illness/severe emotional disturbance; pediatric populations; and community integration for people with disabilities.
 - ▶ Improve alignment and standardization of APMs in Medicaid managed care. Maternal and newborn health is an initial focus area. [December 31, 2020]

Support Further Delivery System Reform

- HHSC identifies and submits to CMS any proposals for new programs, including state-directed payment programs, to sustain key DSRIP initiative areas. This would include programs that require an amendment to the Waiver to begin in DY 11. [September 30, 2020]
- HHSC conducts a preliminary analysis of DY 7-8 (October 1, 2017 - September 30, 2019) DSRIP quality data and related core activities to outline lessons learned on health system performance measurement and improvement. This analysis will help inform HHSC strategies for quality improvement and proposals for new programs or policy changes. [December 31, 2020]
- HHSC reviews DSRIP activities as possible Medicaid state plan benefits and policy changes, and submits to CMS review results or approval requests, as necessary. Potential examples include community health workers and Medicare benefits such as: chronic care management, comprehensive care codes for integration of behavioral and physical health, and the Diabetes Prevention Program. [December 31, 2020]
- HHSC identifies and submits to CMS any proposals for new programs to sustain key DSRIP initiative areas that would start in the next Waiver renewal period. [September 30, 2021]

Explore Innovative Financing Models

- HHSC assesses Texas' current financial incentives for Medicaid MCOs and providers to enter into meaningful quality-based alternative payment models and identifies potential opportunities to strengthen or align incentives. This work includes providing additional guidance to Medicaid MCOs and providers for allowable Quality Improvement costs² to help sustain certain successful DSRIP strategies. [March 31, 2021]

Cross-Focus Areas

- HHSC completes an assessment of which social factors are correlated with Texas Medicaid health outcomes, including pediatric health outcomes. This analysis will help inform HHSC strategies for quality improvement and proposals for new programs or policy changes. [March 31, 2021]

Strengthen Supporting Infrastructure to Improve Health

- HHSC assesses the current capacity and use of telemedicine and telehealth, particularly in rural areas of Texas, to inform next steps to address access gaps. [December 31, 2020]

² Quality improvement costs are Texas MCO expenditures for "Activities that improve health care quality" (45 CFR §158.150) and "Expenditures related to Health Information Technology and meaningful use requirements" (45 CFR §158.151).

- HHSC identifies options for the Regional Healthcare Partnership structure post-DSRIP. [March 31, 2021]

DSRIP has increased the infrastructure and capacity of Texas' health care delivery system, including for meaningful stakeholder collaboration and quality measurement, reporting, and improvement. It is also testing models and services to promote appropriate access and value-based care. Under the waiver, Texas' Medicaid managed care model has expanded with an enhanced focus on measuring and paying for value. Through the development and implementation of the DSRIP Transition Plan, Texas will identify opportunities to further integrate the work occurring under the waiver in DSRIP and Medicaid managed care to continue to reform the health care delivery system.

The milestones, specifically, represent the work that HHSC plans to complete in DY 9-10 for changes in the Medicaid program to support DSRIP sustainability and other innovations. In addition, new programs and policies that leverage existing resources and financing structures will be explored to build on DSRIP's successes in increasing access to care and delivering cost-effective care for Texans. HHSC looks forward to working with CMS, Texas leadership, and stakeholders on next steps to transform health care and improve health in Texas.

2. Introduction

The Centers for Medicare and Medicaid Services (CMS) initially approved the Texas Healthcare Transformation and Quality Improvement Program Medicaid 1115 Demonstration (Waiver) in December 2011. A key component of the Waiver is the Delivery System Reform Incentive Payment (DSRIP) program.

Texas received CMS approval of a five-year Waiver renewal on December 21, 2017. Under the renewal, the DSRIP pool is \$3.1 billion each year in federal fiscal years 2018 and 2019, \$2.91 billion in 2020, \$2.49 billion in 2021, and \$0 in 2022. As shown in the table below and described in more detail later in this plan, there was a shift in the focus of DSRIP beginning in demonstration year (DY) 7 from the original Texas DSRIP program (DSRIP 1.0) to the current DSRIP program (DSRIP 2.0) to evolve from project-level reporting to provider system-level reporting on health quality measures.

DSRIP	Demonstration Year (DY)	Pool Amount (All Funds)
DSRIP 1.0	DY1	\$0.50B
	DY2 (10/1/12 – 9/30/13)	\$2.30B
	DY3 (10/1/13 – 9/30/14)	\$2.67B
	DY4 (10/1/14 – 9/30/15)	\$2.85B
	DY5 (10/1/15 – 9/30/16)	\$3.10B
	DY6 (10/1/16 – 9/30/17)	\$3.10B
DSRIP 2.0	DY7 (10/1/17 – 9/30/18)	\$3.10B
	DY8 (10/1/18 – 9/30/19)	\$3.10B
	DY9 (10/1/19 – 9/30/20)	\$2.91B
	DY10 (10/1/20 – 9/30/21)	\$2.49B
	DY11 (10/1/21 – 9/30/22)	\$0

The Special Terms and Conditions (STCs) of the Waiver require Texas to submit a draft DSRIP Transition Plan to CMS no later than October 1, 2019 (the beginning of DY 9). STC 37 includes the following:

- The plan will describe how the state will further develop its delivery system reform efforts without DSRIP funding and/or phase out DSRIP funded activities.
- The plan will be finalized within six months of submission to CMS (April 1, 2020).
- Texas will propose milestones by which it will be accountable for measuring sustainability of its delivery system reform efforts absent DSRIP funding.
- Milestones may relate to use of alternative payment models, the state's adoption of managed care payment models, payment mechanisms that support providers' delivery system reform efforts, and other opportunities.
- Portions of overall Federal Financial Participation (FFP) for DSRIP will be at-risk for the state's achievement on achievement milestones.

This DSRIP Transition Plan outlines milestones that lay the groundwork for further development of delivery system reform efforts without DSRIP funding and/or phase out of DSRIP-funded activities. To provide necessary context and foundation for the milestones, this plan also:

- Provides background information on the initial Waiver period and on the Waiver renewal that Texas is currently implementing.
- Describes quality efforts in Texas Medicaid, including DSRIP.
- Summarizes health care priorities in Texas, including legislation from the 86th Legislature, Regular Session, 2019, and CMS focus areas.

The milestones are categorized by goals and represent next steps for Texas' health care delivery transformation. They do not focus on DSRIP in isolation, but rather on the overall Texas Medicaid program and improving the health of Texans.

3. Overview of Texas Medicaid in Relation to DSRIP

Who's Covered By Texas Medicaid - Texas Medicaid and the Children's Health Insurance Program (CHIP) serve about 4.5 million people each month, primarily through the managed care delivery system. Over three million of these enrollees are children, and most of the others are low-income adults with disabilities, aged and Medicare-related adults (dual eligibles), and pregnant women.

Managed Care Delivery System - A key component of the Waiver is roll out of Medicaid managed care statewide, in addition to bringing additional Medicaid populations and benefits into managed care. Texas now has 92 percent of its Medicaid-enrolled population served through managed care organizations (MCOs), which HHSC pays a fixed amount per member, per month.³ MCOs provide a medical home to their members through primary care providers and have incentives to improve quality of care.

How Texas Medicaid is Financed - In Texas, for most Medicaid costs, the federal fiscal year (FFY) 2019 federal matching rate is 58.19 percent, which means that for every one dollar spent on Medicaid services, federal funds pay 58.19 cents and non-federal funds pay 41.81 cents. State General Revenue (GR) funds are the non-federal funds source for the monthly capitation payments Texas Medicaid makes to MCOs (other than for the specific programs referenced below). However, Texas also uses intergovernmental transfers (IGT) from local government entities and other public entities as the non-federal share for certain supplemental payments and directed payment programs.⁴ The following Texas Medicaid programs currently rely on IGT:

- Disproportionate Share Hospital (DSH);
- Uncompensated Care (UC);
- DSRIP;
- Network Access Improvement Program (NAIP);
- Nursing Facility Quality Incentive Payment Program (QIPP);
- Uniform Hospital Rate Increase Program (UHRIP); and
- Graduate Medical Education (GME) for eligible non-state hospitals.

³ Ibid, p. 4.

⁴ The IGTs are comprised of local property, sales, and health care-related taxes, and other allowable public sources of funds.

Some of the supplemental payments (DSH, UC, DSRIP, and GME) go directly to providers, while others (NAIP, QIPP, and UHRIP) flow through the MCOs. In fiscal year 2017, 32 percent of Texas Medicaid payments to hospitals (\$4.2 billion) was from the federal share of supplemental payment programs.⁵

Texas Geography and Medicaid - Texas is the second largest state in the U.S. both in terms of area and population, with wide variation in population and healthcare infrastructure across its 254 counties. According to the Rural Health Information Hub, almost 11 percent of Texas' over 28 million people (about 3 million) live in rural Texas.⁶ While Texas has some of the largest cities in the country (Houston, San Antonio, Dallas, and Austin), it also has many rural, frontier, and border communities with varying health care needs.

As of April 2019, Texas had:

- 85 Critical Access Hospitals
- 302 Rural Health Clinics
- 179 Federally Qualified Health Center sites located outside of Urbanized Areas.⁷

According to the Texas Department of State Health Services (DSHS) Office of Border Health, the Texas border region currently has a population of three million residents. The border is disproportionately affected by higher rates of obesity, diabetes, cervical cancer, caesarian section deliveries, and certain contagious diseases, including tuberculosis. Like other parts of Texas, rapid growth on the border poses multiple challenges, including the development of a sufficient health workforce and access to primary, preventive, and specialty care.⁸

Texas' experience both with Medicaid managed care and DSRIP underscores the importance of thinking about distinct geographical needs and issues in program development and implementation. One of the strengths of DSRIP is that provider initiatives have been based on regional community needs assessments and supported by the Regional Healthcare Partnership (RHP) structure to foster provider collaboration at the local and regional level.

⁵ Information provided by HHSC Rate Analysis Department, June 2019.

⁶ <https://www.ruralhealthinfo.org/states/texas>. (Accessed June 4, 2019)

⁷ Ibid.

⁸ <https://www.dshs.texas.gov/borderhealth/>. (Accessed June 4, 2019)

4. Texas 1115 Transformation and Quality Improvement Program Accomplishments

The initial five-year Waiver was approved December 12, 2011, with an end date of September 30, 2016. CMS approved the Waiver with a two-fold purpose: “to expand the existing Medicaid managed care programs, STAR and STAR+PLUS, statewide, and to establish two funding pools, that will assist providers with uncompensated care costs and promote health system transformation.” CMS also stated:

The Demonstration also takes an important step forward by redirecting the supplemental payments that currently exist under the Medicaid State plan [Upper Payment Limit, or UPL programs] to the Demonstration in order to improve care delivery systems and capacity, while emphasizing accountability and transparency, and requiring demonstrated improvements at the provider level for the receipt of such payments.⁹

HHSC distributed the supplemental funds through two pools: Uncompensated Care (UC) and DSRIP. The non-federal share of payments for both pools is financed by IGT, primarily from hospital districts and other local public entities.

The goals in the initial Waiver period were as follows:

- Expand risk-based managed care statewide;
- Support the development and maintenance of a coordinated care delivery system;
- Improve outcomes while containing cost growth;
- Protect and leverage financing to improve Texas' health care infrastructure; and
- Transition to quality-based payment systems across managed care and hospitals.

Texas was the second state to implement a DSRIP program as part of an 1115 Demonstration. A key feature of Texas' DSRIP program was the ability of providers to focus on quality initiatives without regard to payer and that could benefit all patients.

The first five years of DSRIP initiated statewide transformation through more than 1,400 projects delivered by 300 performing providers to improve access to care, test innovative care models, and address regional needs. DSRIP performing

⁹ www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Downloads/TexasHealthcareTransformationandQualityImprovementProgramCurrentApprovalDocuments.pdf. (Accessed June 4, 2019)

providers included hospitals (public and private), community mental health centers, physician practices (largely academic health science centers), and local health departments. After a necessary startup period to develop the program protocols, conduct regional community needs assessments, and develop DSRIP projects based on community needs, CMS approved DSRIP projects to move forward from mid-2013 through mid-2014.

Initial key areas of transformation included:

- Behavioral Health;
- Primary Care;
- Patient Navigation, Care Coordination, Care Transitions;
- Chronic Care Management; and
- Health Promotion and Disease Prevention.

Performing providers earned incentive payments for achievement of goals, including serving greater numbers of Medicaid and LIU individuals, and achievement of process milestones and outcome metrics.

One of the early successes of the DSRIP program was the establishment of 20 RHPs covering the state, which led to increased local and regional collaboration to identify and address priority community healthcare needs. RHPs help support the development and maintenance of a coordinated delivery system. Many of the DSRIP projects by their nature involved coordinating care delivery, including projects related to integrated physical and behavioral healthcare, patient-centered medical homes, chronic care management, and patient care navigation. To achieve metrics, the performing providers were often dependent on coordinating with other providers and other community-based organizations.

In addition, Texas Medicaid MCOs must have performance improvement projects (PIPs), some of which have goals in common with one or more DSRIP projects in a given geographic area. Learning collaboratives in many regions were designed to connect MCOs and DSRIP providers to better coordinate their efforts.

DSRIP enabled groundbreaking work, including increased regional and cross-regional collaboration between diverse healthcare providers and stakeholders and investments in infrastructure and innovation to improve systems of care. Texas' DSRIP projects resulted in increased access to primary and preventive care, emergency department (ED) diversion, and enhanced services for individuals with behavioral health needs. Over a four-year period, DSRIP projects provided 29.4 million encounters and served 11.7 million people (cumulative totals from DY3-6 reporting, not unduplicated counts).

DSRIP 1.0 required reporting for each project, including reporting on outcome measures. Each DSRIP project in the initial phase of the Waiver reported on at least one associated outcome measure, which they selected from the options provided in Category 3 of the RHP Planning Protocol. Each selected Category 3 outcome was

related to a DSRIP project, but generally outcomes measured improvement at a level broader than the DSRIP project intervention. Providers earned partial payment for achieving at least 25 percent of the goal for a given performance year.

The table below shows a sample of outcome achievement in DSRIP 1.0.¹⁰

Measure	Projects with Selected P4P Outcome	Projects Reporting 100% Achievement of DY6 Goal	Projects Reporting 25% - 75% Achievement of DY6 Goal	Median Improvement
IT-1.10: Diabetes care: A1c Control >9.0%	103	83%	5%	23%
IT-1.7: Controlling high blood pressure	72	89%	0%	23%
IT-3.3: Risk Adjusted Congestive Heart Failure (CHF) 30-day Readmission Rate	48	90%	0%	21%
IT-12.1 Breast Cancer Screening	28	84%	8%	41%
IT-8.19: Post-Partum Follow-Up and Care Coordination	13	100%	0%	75%
IT-1.18: Follow-Up After Hospitalization for Mental Illness	25	84%	8%	42%

¹⁰ From HHSC presentation at Children’s Hospital Association of Texas DSRIP learning collaborative event, June 5, 2019 (Noelle Gaughen).

Texas submitted a companion document to the Waiver evaluation to CMS in May 2017 that provides more detailed information on Category 3 outcome measures that show Texas' progress in improving the health of Texans in the first five years of the Waiver.¹¹

DSRIP facilitated a significant expansion of healthcare quality measurement in Texas. Both DSRIP and Medicaid managed care have focused on cost-effective care delivery. The impact of DSRIP cannot be measured in isolation due to the number of quality initiatives employed in Medicaid and other healthcare programs. DSRIP and other initiatives in Texas have shown progress in cost-effective care, as explained in the Evaluation Companion referenced above:

"In the broader sense, data from [Texas'] External Quality Review Organization, the Institute for Child Health Policy (ICHP) at the University of Florida, shows that there has been a reduction in Potentially Preventable Admissions expenditures for the Texas Medicaid/CHIP population, which decreased from a total of \$6,966 per 1,000 member months in calendar year 2013 to \$5,831 in calendar year 2015. This represents a decrease in Potentially Preventable Admissions (PPAs) expenditures of 16% per member month over two years. While not directly attributable to DSRIP, many DSRIP projects have focused on this area. ICHP has urged HHSC to use caution in interpreting the state level data. For example, the sample sizes are very large so even if something is statistically significant, the issue of practical significance can be raised. In other words, is the difference observed practically meaningful, which can be challenging to answer."¹²

The UC and DSRIP pools have been complementary programs to provide financing to improve Texas' health care infrastructure. Funding from the UC pool is a major contributor to the active participation of both public and private hospitals in Medicaid, giving Medicaid enrollees access to hospital care. For DY 7 (October 2017 - September 2018), 367 hospitals and public physician groups earned UC pool funds. Of the almost \$3.1 billion earned by these providers for DY 7, almost 68 percent went to private and not-for-profit hospitals, 26 percent went to public hospitals, and about 3.4 percent went to state-owned hospitals and physician groups. Public ambulance providers earned 2.8 percent.¹³

To further improve Texas' health care safety net, the DSRIP program enabled hospitals, other healthcare providers, and community partners to improve Texas' healthcare infrastructure through innovative care delivery models and increased access to care. These improvements in care benefit not only Medicaid and LIU

¹¹ <https://hhs.texas.gov/sites/default/files/documents/laws-regulations/policies-rules/1115-docs/Evaluation-Companion-Document.pdf>. (Accessed June 5, 2019)

¹² <https://hhs.texas.gov/sites/default/files/documents/laws-regulations/policies-rules/1115-docs/Evaluation-Companion-Document.pdf>. (Accessed June 5, 2019)

¹³ Information provided by HHSC Rate Analysis Department, May 2019.

patients, but all Texans in need of care, including Medicare patients and those insured via their employers or the marketplace.

Texas made progress in the initial Waiver period toward transitioning to quality-based payment systems across managed care and hospitals, and this continues to be a major goal of the Medicaid program. The initial Waiver enabled providers to undertake initiatives to improve care delivery and to earn incentive funds based on achieving project milestones and related outcomes. In that sense, DSRIP has been an incubator for value based payment (VBP) in Medicaid managed care, as the findings from DSRIP demonstrate which types of initiatives may be promising for value-based reimbursement arrangements between MCOs and providers in their networks. In 2014, HHSC began requiring MCOs to develop and submit a written plan for expansion of value-based provider payment structures that includes an inventory of different payment models being deployed, provider types involved, performance metrics and evaluation methods used, and payment models planned for the future. This laid the groundwork for the requirement HHSC implemented in 2018 for a certain percentage of MCO payments to providers to be value-based, with increased requirements over time.

5. Waiver Renewal

In May 2016, CMS granted Texas a 15-month extension to the Waiver through December 31, 2017. In December 2017, CMS approved a five-year renewal for DY 7-11. In the Waiver renewal application, Texas proposed to focus the renewal period on:

- Strengthening the Waiver programs and the connections between them.
- Further aligning the Medicaid managed care programs within the Waiver with DSRIP projects to support systems of care for Medicaid enrollees and LIU individuals and support sustainability of the innovative work underway in DSRIP.
- Developing a quality roadmap that includes both managed care and DSRIP and actively engage health plans to coordinate with the DSRIP initiatives that benefit their members.
- Partnering with clinical and quality experts from around the state to identify best practices and lessons learned from DSRIP to help inform Medicaid benefits and VBP arrangements in managed care.
- Promoting increased data sharing across providers and publish data to show whether Texas, the RHPs, and the managed care service areas are making progress on key quality indicators.

The Waiver renewal also noted the UC pool would continue to be essential to ensure access to quality care for low-income Texans and enable hospitals and other providers to undertake initiatives to improve how care is delivered.

Texas Medicaid has met its initial goal of expanding risk-based managed care statewide through the STAR, STAR+PLUS, and Children's Medicaid Dental Services programs. HHSC expanded all three of these capitated managed care programs statewide, including carving into managed care inpatient hospital services and pharmacy services. Texas Medicaid managed care programs cover over 3.6 million Medicaid enrollees per month (February 2019).¹⁴ HHSC successfully implemented several other major managed care expansions and initiatives during the demonstration period, including adding eligible persons with intellectual and developmental disabilities (IDD) into STAR+PLUS for their acute care (September 2014), carving mental health targeted case management and rehabilitation services into managed care (September 2014), implementing the Texas Dual Eligible Integrated Care project (March 2015), carving nursing facility services into managed care (March 2015), and implementing the Community First Choice program (June 2015). STAR Kids is a Medicaid managed care program that provides Medicaid benefits to children and adults 20 and younger who have disabilities

¹⁴ [https://hhs.texas.gov/about-hhs/records-statistics/data-statistics/healthcare-statistics - Medicaid and CHIP MCO Enrollment by SDA, Preliminary](https://hhs.texas.gov/about-hhs/records-statistics/data-statistics/healthcare-statistics-Medicaid-and-CHIP-MCO-Enrollment-by-SDA-Preliminary) (February 2019, Updated Quarterly), (Accessed June 4, 2019)

(November 2016). In addition to these newer programs, for many years the STAR Health program has provided primary, acute, and behavioral health care, as well as dental, vision, and pharmacy services to children in Texas state conservatorship through the Department of Family and Protective Services (DFPS).

DSRIP 2.0

A significant transition occurred between the initial Waiver period and the renewal period. During the 15-month extension, new DSRIP program protocols were developed to evolve from project-level reporting to provider system-level reporting (DSRIP 2.0).

The DSRIP program is designed to provide incentive payments to Texas hospitals, physician practices, community mental health centers, and local health departments for investments in delivery system reforms that increase access to health care, improve the quality of care, and enhance the health of patients and families they serve. Program parameters for DSRIP are outlined in two protocols.

- Measure Bundle Protocol - Defines the performing provider system-level measures that are bundled to align closely with transformative DSRIP project areas from the initial demonstration period and includes an appendix for measure specifications.
- Program Funding and Mechanics Protocol - Describes the State review process for RHP Plans and RHP Plan updates, incentive payment methodologies, RHP and state reporting requirements, and penalties for missed milestones.¹⁵

The Measure Bundle Protocol for DSRIP 2.0 reflects the evolution of the DSRIP program from project-level reporting to provider-level quality measure reporting to assess the continued transformation of the Texas healthcare system. In DSRIP 2.0, performing providers report on required reporting categories (A, B, C, and D) at their provider system level.¹⁶

Category A includes progress on core activities, APM arrangements, costs and savings, and collaborative activities. The Category A requirements were developed to serve as an opportunity for DSRIP performing providers to move further towards sustainability of their transformed systems, including development of APMs to continue services for Medicaid and LIU individuals after DSRIP ends. The listing of core activities in the Measure Bundle Protocol reflects those project areas that have been determined to be the most transformational and will support continuation of the work begun by performing providers during the first years of DSRIP. These core

¹⁵ <https://hhs.texas.gov/sites/default/files/documents/laws-regulations/policies-rules/1115-waiver/waiver-renewal/AttachmentJ-PFM-DY7-8-05.21.18.pdf>, p.2. (Accessed June 4, 2019)

¹⁶ https://hhs.texas.gov/sites/default/files/documents/laws-regulations/policies-rules/1115-waiver/waiver-renewal/MeasureBundleProtocol_05.21.18.pdf. (Accessed June 4, 2019)

activities are continued or implemented by a performing provider to support achievement of its Category C measure goals.

Category B defines the provider system. As DSRIP shifts from project-level reporting to system-level reporting, HHSC wants to ensure that providers maintain a focus on serving Medicaid and LIU individuals. To that end, Category B requires each performing provider to report the total number of individuals and the number of Medicaid and LIU individuals served by its system during each DY. The Measure Bundle Protocol sets out parameters for a performing provider to define its “system” to reflect the provider’s current care landscape in which they are striving to advance the Triple Aim: improving the patient experience of care; improving the health of populations; and reducing the per capita cost of health care.

The shift to DSRIP 2.0 focusing on provider systems rather than specific projects allowed for:

- Transition from “DSRIP clients” to all patients in the system measured for health care quality achievement as applicable.
- Increased focus on health care quality measures over outputs to know not just how many individuals were seen but how many individuals’ health has changed or improved.
- Increased focus on quality measures laying the foundation for value-based care.

For Category C, targeted measure bundles were developed for hospitals and physician practices, and lists of measures are available for community mental health centers and local health departments. Measure bundles consist of measures that share a unified theme, apply to a similar population, and are impacted by similar activities. Bundling measures allowed for ease in measure selection and approval, increases standardization of measures across the state for hospitals and physician practices with similar activities, facilitates the use of regional networks to identify best practices and share innovative ideas, and continues to build on the foundation set in the initial Waiver period while providing additional opportunities for transforming the health care system and bending the cost curve.

Category D represents a population health perspective for all DSRIP performing providers. Whereas the initial Waiver period included Category 4 statewide reporting for hospitals, Category D includes measures for all DSRIP performing provider types. This reporting is designed to assist providers, MCOs, RHPs, and state and federal agencies to have regional and statewide views of important health care trends. The Category D reporting measure bundles are:

- Aligned with Medicaid and LIU populations;
- Identified as high priority given the health care needs and issues of the patient population served; and
- Viewed as valid health care indicators to inform and identify areas for improvement in population health within the health care system.

DSRIP 2.0 was designed to strengthen the programs within the Waiver and the connections between them. Introducing “measure bundles” to measure the provider system was designed to further align the Medicaid managed care programs with DSRIP to support systems of care for Medicaid enrollees and LIU individuals and support sustainability of the innovative work underway in DSRIP. There is also considerable crossover between the Category C quality measures and the MCO Pay-for-Quality (P4Q) program measures, which is discussed in more detail later in this plan.

Measure Development Process

HHSC formed a DSRIP Clinical Champions stakeholder group in 2015 to provide clinical expertise for next steps in the development of DSRIP. The Clinical Champions consisted of clinical, health quality, and operational professionals in Texas. In 2015, the Clinical Champions reviewed provider-submitted Transformational Impact Summaries—brief, structured project descriptions and evaluations—and identified DSRIP projects’ high impact practices. HHSC used these high impact practices to inform the initial selection of the DSRIP 2.0 Category C measure bundle topics. The Clinical Champions also helped HHSC refine the DSRIP project menu to include only the most transformational project areas.

In 2017, Texas HHSC began a new process with the Clinical Champions to seek their input on the meaningfulness, improvability, and clinical appropriateness of proposed measures to include in the hospital and physician practice measure bundles, as well identify any gaps in measurement. HHSC implemented a multi-round process with the Clinical Champions to choose the draft measures for each of the Category C measure bundles. The Bundle Advisory Teams rated each potential measure based on the measure’s importance according to the member’s clinical judgement. Additionally, Bundle Advisory Team members had the opportunity to suggest new and innovative measures. Community mental health centers and the Texas Council of Community Centers provided recommendations for measures related to behavioral health. Local health departments were engaged in the development of measures for those providers. Some measure bundles were designated as “high state priority” or “state priority”. These designations were focused on the most pressing health needs in Texas. HHSC incentivized providers to select these measure bundles by assigning them a higher point value.

High state priority measure bundles:

- Maternal Care
- Chronic Non-Malignant Pain Management

State priority measure bundles:

- Chronic Disease Management: Diabetes
- Chronic Disease Management: Heart Disease
- Healthy Texans
- Pediatric Primary Care

- Pediatric Chronic Disease Management: Asthma
- Behavioral Health in a Primary Care Setting
- Behavioral Health & Appropriate Utilization
- Integrated Care for People with Serious Mental Illness

Promoting Data Exchange

DSRIP has been a significant catalyst for various forms of data sharing. The RHP structure is designed to respond to the needs and characteristics of the populations and communities of each region. The foundation for developing DSRIP regional goals was data sources describing local demographics and key health challenges. Providers then built projects around these shared goals, focusing on objectives such as care coordination, patient care navigation, and physical and behavioral health integration, for which the level of success is partially driven by the ability to share timely and accurate data with other providers. As DSRIP has shifted to more strategic systemic efforts under the renewal, it has also intensified the need for providers to build relationships that enable health system performance measurement and improvement. The renewal has also prompted increased emphasis on MCO and DSRIP provider collaboration to determine ways to incorporate DSRIP models under managed care and conduct meaningful quality measurement for these efforts.

The Texas Healthcare Learning Collaborative (THLC) portal serves as a public reporting platform, contract oversight tool, and a tool for Medicaid and CHIP MCO quality improvement efforts.¹⁷ The website was developed for use by HHSC, MCOs, providers, and the public to obtain up-to-date MCO and hospital performance data on key quality of care measures, including potentially preventable events (PPEs), Healthcare Effectiveness Data and Information Set (HEDIS®), and other quality of care information. Providers also have the ability to see performance data by MCO within a service area over time. These data may serve as an important tool for providers, including DSRIP providers, to engage MCOs on value-based contracting. The THLC portal is updated and expanded on an ongoing basis. For example, in 2017, in-depth data visualizations of key quality measures were added.

The Portal also enables increased data sharing across providers and publishes data to show whether Texas, the RHPs, and the managed care service areas are making progress on key quality indicators.

¹⁷ <https://thlcportal.com/home>. (Accessed June 5, 2019)

6. Texas Medicaid Quality Initiatives and Value-Based Care

Value-Based Purchasing Roadmap

HHSC released its draft Value-Based Purchasing Roadmap (Roadmap) in August 2017 as part of its Waiver renewal submission to CMS.¹⁸ The Roadmap described the quality initiatives in Texas Medicaid, including DSRIP, and goals to further value-based care in Texas. The Roadmap noted:

Healthcare payment transformation (also referred to as value-based purchasing or alternative payment models) is essential to advancing HHSC's healthcare quality plan priorities:¹⁹

1. Keeping Texans healthy
2. Providing the right care in the right place
3. Keeping patients free from harm
4. Promoting effective practices for chronic disease
5. Supporting patients and families facing serious illness
6. Attracting high performing providers.²⁰

The Roadmap also noted:

"Through its managed care contracting model, HHSC is making progress on a multiyear transformation of provider reimbursement models that have been historically volume based (i.e., fee-for-service) toward models that are structured to reward patient access, care coordination and/or integration, and improved health care outcomes and efficiency. In concert with other policy levers, VBP has the strong potential to accelerate improvement in health care outcomes and increase efficiency. The Texas Medicaid program is one of the largest Medicaid programs in the country, with almost \$40 billion in expenditures annually. Because it is such a significant payer, the Medicaid program can be a driving force behind payment transformation".²¹

¹⁸ <https://hhs.texas.gov/sites/default/files/documents/about-hhs/process-improvement/quality-efficiency-improvement/draft-texas-vbp-apm-roadmap-august-2017.pdf>. (Accessed June 5, 2019)

¹⁹ Ibid, page 1.

²⁰ *HHS Healthcare Quality Plan*, November 2017. Available at <https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2017/HHS-Healthcare-Quality-Plan-2017.pdf>. (Accessed June 5, 2019)

²¹ <https://hhs.texas.gov/sites/default/files/documents/about-hhs/process-improvement/quality-efficiency-improvement/draft-texas-vbp-apm-roadmap-august-2017.pdf>, pp. 1-2.

The Roadmap broadly defined value-based purchasing (VBP) as linking health care payments to measures of quality and/or efficiency (i.e., "value") rather than only paying based on service volume. In its guidance to the Medicaid and CHIP MCOs regarding the new VBP contract requirements for state fiscal year 2018, HHSC defined value "as either a measure of quality or a composite measure of quality (outcomes) and efficiency (cost)."²² The Roadmap includes guiding principles, anticipated outcomes, and descriptions of HHSC's major initiatives related to VBP.

Roadmap guiding principles of VBP:

- Continuous engagement of stakeholders
- Harmonize efforts
- Administrative simplification
- Data driven decision-making
- Movement through the VBP continuum
- Reward success

Roadmap anticipated outcomes of VBP:

- Aligned incentives between State, MCOs and providers
- Optimal health care outcomes and patient experience
- Improved health care efficiency

Included in the Roadmap are the major initiatives focused on improving access, quality and efficiency in Texas Medicaid. Summaries of these initiatives follow.

Medical and Dental Pay-for-Quality (P4Q) Programs²³

Effective January 1, 2018, HHSC replaced its managed care At-Risk and Quality Challenge program with the Medical Pay for Quality (P4Q) program. In the redesigned program, three percent of each MCO's capitation is at risk based on their performance on designated outcome measures (improvement over self, performance against benchmarks, and performance on bonus pool measures). The 2018 program measures were selected to focus on prevention, chronic disease management (including behavioral health), and maternal and infant health.²⁴ The

²² Email from HHSC (Matt Ferrara), December 2017, regarding guidance (entitled VBP_APM Overview) sent to MCOs and Dental Contractors (DCs) regarding contract APMs targets effective January 1, 2018.

²³ <https://hhs.texas.gov/about-hhs/process-improvement/medicaid-chip-quality-efficiency-improvement/pay-quality-p4q-program>

²⁴ HHSC Presentation, November 13, 2017, Quality Forum. For more information: Overview of the program on HHSC main quality webpage: <https://hhs.texas.gov/about-hhs/process-improvement/medicaid-chip-quality-efficiency-improvement>. (Accessed June 5, 2019) Detailed methodology and benchmarks in UMCM, Ch. 6.2.14 available at: <https://hhs.texas.gov/sites/default/files/documents/laws-regulations/handbooks/umcm/6-2-14.pdf>. (Accessed June 5, 2019). Additional information on Texas Healthcare Learning Collaborative (THLC) Portal: <https://thlcportal.com/>.

medical care P4Q measures follow. A similar P4Q program is in place for the two dental contractors that serve children in Medicaid.

DSRIP activity, both in the initial phase of the Waiver and in DSRIP 2.0, relates closely to Medicaid managed care P4Q focus areas, including primary and preventive care, chronic care management, behavioral health care, and reducing unnecessary ED use. Since DSRIP payments are incentive-based (rather than service-based), DSRIP providers have had flexibility to deliver care that currently is not a Texas Medicaid billable service, including some services that Medicare now reimburses, such as chronic care management, integration of behavioral and physical health services, and diabetes prevention. There may be opportunities to add some of these types of services as Texas Medicaid benefits to enable this work to continue.

P4Q At-Risk and Bonus Pool Measures for STAR Effective January 1, 2018

STAR At-Risk Measures	STAR Bonus Pool
Potentially Preventable Emergency Room Visits (PPVs)	Potentially Preventable Admissions (PPAs)
Appropriate Treatment for Children with Upper Respiratory Infection (URI)	Low Birth Weight (LBW)
Prenatal and Postpartum Care (PPC) <ul style="list-style-type: none"> ● Timeliness of Prenatal Care ● Postpartum care 	CAHPS Children with Good Access to Urgent Care (child)
Six or more Well Child Visits in the First 15 months of Life (W15)	CAHPS Adults Rating their MCO a 9 or 10 (adult)

P4Q At-Risk and Bonus Pool Measures for STAR Effective January 1, 2018

STAR+PLUS At-Risk Measures	STAR+PLUS Bonus Pool
Potentially Preventable Emergency Room Visits (PPVs)	Potentially Preventable Readmissions (PPRs)
Diabetes Control - HbA1c < 8% (CDC)	Potentially Preventable Complications (PPCs)
High Blood Pressure Controlled (CBP)	Prevention Quality Indicator (PQI) Composite
Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are Using Antipsychotics (SSD)	CAHPS Adults with Good Access to Urgent Care
Cervical Cancer Screening (CCS)	CAHPS Adults Rating their MCO a 9 or 10

P4Q At-Risk and Bonus Pool Measures for CHIP Effective January 1, 2018

CHIP At-Risk Measures	CHIP Bonus Pool
Potentially Preventable Emergency Room Visits (PPVs)	CAHPS Children with Good Access to Urgent Care
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (WCC) <ul style="list-style-type: none"> • Counseling for nutrition. • Counseling for physical activity 	CAHPS Caregivers Rating their Child's MCO a 9 or 10
Appropriate Treatment for Children with Upper Respiratory Infection (URI)	Childhood Immunization Status (CIS) Combination 10
Adolescent Well Care (AWC)	

MCO VBP Targets with Contracted Providers²⁵

Since 2012, HHSC has required that each MCO and dental contractor (DC) submit an annual report on its VBP activities with providers for HHSC information and planning purposes. HHSC instituted a significant change for calendar year 2018, when it added to the managed care contracts two types of VBP targets that the MCOs must meet.²⁶

For 2018, for each MCO by program type (STAR, STAR+PLUS, CHIP), 25 percent of the MCO's and DC's payments to providers must be value-based, increasing to 50 percent in 2021, with certain exceptions.²⁷ A portion of these value-based models are required to include downside financial risk for providers: 10 percent of MCO payments in 2018, increasing to 25 percent by 2021, with certain exceptions. HHSC uses the nationally recognized [Healthcare Payment Learning and Action Network \(HCP LAN\) Alternative Payment Model \(APM\) Framework](#) 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.

HHSC also included contractual requirements that the MCOs and DCs adequately resource their VBP activities, including by establishing and maintaining data sharing processes with providers, and dedicating resources to evaluating the impact of APMs on utilization, quality, and cost.

Examples of the types of programs that count as value-based:

- incentive-only programs built on fee-for-service payments,
- alternative payment models in which the MCO and provider agree to incentives and/or disincentives based on performance on agreed upon metrics,
- "gold carding" high-value providers defined as conditional relief from a prior authorization or other administrative requirement, or
- other arrangements that link some of the overall payment to quality or value measure(s).

Examples of the types of programs that will count as value-based with provider financial risk:

- partial or full capitation with a linkage to quality metrics,
- episode-based payments with a linkage to quality metrics,

²⁵ <https://hhs.texas.gov/about-hhs/process-improvement/medicaid-chip-quality-efficiency-improvement/value-based-contracting>

²⁶ HHSC *Uniform Managed Care Contract*, sec. 8.1.7.8.2. Available at: <https://hhs.texas.gov/sites/default/files/documents/services/health/medicaid-chip/programs/contracts/uniform-managed-care-contract.pdf>. (Accessed June 4, 2019)

²⁷ These percentage targets could be lower for an MCO based on exceptions, such as achieving a higher than expected level of performance on both potentially preventable hospital admissions and potentially preventable ED visits (PPVs) as defined in the contract.

- bundled payments with a linkage to quality metrics, or
- arrangements based on enrollee total cost of care with a linkage to quality metrics, etc.

Hospital Quality-based Potentially Preventable Readmissions and Complications Program²⁸

HHSC administers the Hospital Quality-based Potentially Preventable Readmissions and Complications Program for all hospitals in Medicaid and CHIP. All hospitals are measured on their performance for risk-adjusted rates of potentially preventable readmissions (PPR) and potentially preventable complications (PPC) across all Medicaid and CHIP programs. Hospitals can experience up to a 4 percent reduction to their payments for inpatient stays for high rates of PPR and 4.5 percent reduction for high rates of PPC. Safety net hospitals can meet certain criteria and receive bonus payments above their base payments for low risk-adjusted rates of PPRs and/or PPCs. Measurement, reporting, and application of disincentives and incentives occurs on an annual cycle.

MCO Performance Improvement Projects (PIPs)

PIPs are required in Medicaid managed care to achieve, through ongoing measurements and interventions, significant improvement sustained over time in clinical or non-clinical care areas that are expected to have a favorable effect on health outcomes. HHSC, in consultation with its External Quality Review Organization (EQRO), determines topics for PIPs based on historical MCO performance. MCOs create a PIP plan, report on their progress annually, and provide a final report on their PIP, which the EQRO also evaluates.

HHSC requires each MCO and DC to conduct two PIPs per program. Each PIP is two years and they are implemented on a staggered schedule so that one PIP per program is being implemented each calendar year. One PIP must be a collaborative with another Medicaid/CHIP MCO, DC, or DSRIP project. Ideally, over time, PIPs should incorporate VBP approaches between MCOs and providers, and leverage measures identified in the medical P4Q program.

The STAR PIPs for 2016-2018 related to reducing potentially preventable ED visits for upper respiratory tract infections, well child visits in the first 15 months of life, prenatal and postpartum care, asthma, diabetes, and behavioral health. The STAR+PLUS PIPs for 2016-2018 focused on care transitions and care coordination to reduce behavioral health-related admissions and readmissions, mental health

²⁸<https://hhs.texas.gov/about-hhs/process-improvement/medicaid-chip-quality-efficiency-improvement/potentially-preventable-events>. (Accessed June 5, 2019)

self-direction, chronic obstructive pulmonary disease (COPD) management, breast and cervical cancer screening, and diabetes control.²⁹

For 2019, HHSC and the EQRO worked with the health plans to develop PIPs related to Medicaid enrollees with complex needs (high costs/high utilization). This is a statewide PIP initiative for all managed care programs (STAR, STAR+PLUS, CHIP, STAR Health, and STAR Kids) and may be in collaboration with DSRIP providers. While outcome measures may vary by program and MCO, a consistent goal is to reduce potentially preventable ED visits (PPVs) and PPAs among members with anxiety or depression through improved treatment for these conditions.

Texas Dual-Eligibles Integrated Care Demonstration Project (The Dual Demonstration)³⁰

The Dual Demonstration is a CMS and HHSC joint project designed to test whether an innovative and coordinated payment and service delivery model can improve coordination of services for recipients who have Medicare and Medicaid benefits (dual eligible enrollees), enhance quality of care, and reduce costs for both the state and the federal government. By having one Medicare-Medicaid plan (MMP), Medicare and Medicaid benefits work together to better meet the member's healthcare needs.

The key objectives of the Dual Demonstration are:

1. Make it easier for clients to get care.
2. Promote independence in the community.
3. Eliminate cost shifting between Medicare and Medicaid.
4. Achieve cost savings for the state and federal government through improvements in care and coordination.

The Dual Demonstration is in six urban counties – Bexar, Dallas, El Paso, Harris, Hidalgo, and Tarrant.

Nursing Facility Quality Incentive Payment Program (QIPP)³¹

QIPP is a Medicaid managed care delivery system and provider payment initiative under 42 Code of Federal Regulations §438.6(c). QIPP payments to nursing facilities flow through the STAR+PLUS MCOs.

²⁹<https://hhs.texas.gov/about-hhs/process-improvement/medicaid-chip-quality-efficiency-improvement/performance-improvement-projects>. (Accessed June 5, 2019)

³⁰ <https://hhs.texas.gov/services/health/medicaid-chip/programs/dual-eligible-project-mmp>. (Accessed June 5, 2019)

³¹ <https://hhs.texas.gov/services/health/provider-information/quality-incentive-payment-program-nursing-homes>. (Accessed June 5, 2019)

CMS has indicated to HHSC that directed payment programs are a potential model for Texas to consider as it transitions the DSRIP program. The nursing facility program, which has been approved by CMS, features some elements familiar to HHSC and DSRIP providers, including the requirement for inter-governmental transfers as the state share and a mix of pay-for-reporting and pay-for-performance measurements for quality.

Under QIPP, incentive payments are based on improvements in quality and innovation in the provision of nursing facility services. This includes payment incentives to improve the quality of care for residents. Facilities are able to achieve this goal by showing improvement over baselines as they relate to specified quality measures.

QIPP operates on a state fiscal year basis and is currently in its second year of implementation. HHSC is making significant changes to QIPP for year three beginning September 1, 2019.³²

Beginning September 1, 2019, QIPP will include 10 measures across four domains:

- Quality Assurance and Performance Improvement Meetings
- Workforce Development (registered nurse staffing levels, staff recruitment and retention program)
- Minimum Data Set CMS Five-Star Quality Measures (pressure ulcers, antipsychotic medication use, ability to move independently)
- Infection Control (urinary tract infections, pneumococcal vaccine, antibiotic stewardship)

DSRIP

HHSC's VBP Roadmap includes DSRIP because it has been effectively testing how alternative VBP models can support patient-centered care and clinical innovation. HHSC continues to work closely with MCOs and DSRIP providers on ways to incorporate promising clinical models into the MCO provider payment stream in the form of a VBP model.

There are a number of challenges to incorporating DSRIP into the MCO model, including payments directly to providers, the broader population served by DSRIP, and the timelines for MCO premium setting and incentive payment structures. Nevertheless, DSRIP is building capacity for providers to participate in VBP models with MCOs through better use of health information technology and better measurement processes. HHSC anticipates the transition from specific projects and discrete measures to broader measure bundles will promote greater coordination

³²[https://hhs.texas.gov/services/health/medicaid-chip/provider-information/quality-incentive-payment-program/qipp-resources_QIPP_Year_Three_Quality_Metrics_\(PDF\).pdf](https://hhs.texas.gov/services/health/medicaid-chip/provider-information/quality-incentive-payment-program/qipp-resources_QIPP_Year_Three_Quality_Metrics_(PDF).pdf). (Accessed June 4, 2019)

among DSRIP providers, improved population health, and negotiation of VBP arrangements between DSRIP providers and MCOs.

Quality Improvement (QI) Costs

Effective September 1, 2016, HHSC added a new quality improvement (QI) cost provision in managed care contracts to allow certain MCO quality-related costs that previously had been counted as administrative expenses to instead count as medical expenses. As medical expenses, QI costs count toward each MCO's medical loss ratio and are not subject to administrative caps. This change was enabled by federal regulation ([45 CFR §§158.150-151](#)), which recognized increasing evidence that targeted non-clinical interventions can have a substantial impact on improving health outcomes and lowering medical spending, particularly for low-income populations and individuals with serious mental illness and other complex health risks.

The HHSC *Uniform Managed Care Manual* provides some guidance on how MCOs should count QI expenditures.³³ In general, the types of expenses that qualify as QI costs are activities that improve health quality and health outcomes or increase the likelihood of good health outcomes and are grounded in evidence-based medicine or widely accepted best clinical practices. Examples include effective case management, patient education and counseling, discharge planning, wellness assessments, and health information technology to support these activities.

In its November 2018 report, HHSC's Value-Based Payment and Quality Improvement Advisory Committee recommended that HHSC provide additional guidance for MCOs and providers on how to leverage the QI cost strategy to provide patient navigation services to patients with high needs and high utilization patterns. Some of the activities supported by DSRIP likely could be counted as QI costs, including patient navigation for complex patients, chronic care management activities, and community health worker services, whether handled directly by an MCO or delegated to a provider.³⁴

Managed Care Capitation and Rates

HHSC develops its managed care capitation rates from historical claims experience, trended forward with a number of adjustments. A challenge for all payers, including Medicaid managed care programs, is how to reward successful VBP programs in the long term. When a health plan invests in a VBP strategy that reduces high cost services such as emergency department care or hospitalization, associated savings

³³ HHSC *Uniform Managed Care Manual*, Ch. 5.3.1.62 available at:

<https://hhs.texas.gov/sites/default/files/documents/laws-regulations/handbooks/umcm/5-3-1-62.pdf>. (Accessed June 4, 2019)

³⁴ <https://hhs.texas.gov/sites/default/files/documents/about-hhs/communications-events/meetings-events/vbpqi/jan-2019-vbpqi-agenda-item-6.pdf>, Report pages 19-20. (Accessed June 4, 2019)

may be removed from the plan's future funding base through the capitation rate-setting process. This challenge is not unique to Texas. In early 2018, the California Health Care Foundation commissioned a report on precisely this topic - how to encourage through the rate setting process sustained Medicaid health plan investments in health-related benefits and services that improve care and lower costs.³⁵

Texas Medicaid's capitation rate setting process encourages cost-effective, high quality care in various ways, including through mechanisms such as experience rebates, capped administrative expenditures, and quality programs. As HHSC requires its contracted MCOs to increase their VBP arrangements with providers, it will explore how to reward MCOs and providers that implement VBP arrangements that improve health quality while reducing costs.

Value-Based Payment and Quality Improvement Advisory Committee (VBPQI)

Established by the Texas Legislature in 2016, the VBPQI includes healthcare experts and provides a forum to promote public-private, multi-stakeholder collaboration in support of quality improvement and VBP initiatives for Medicaid, other publicly-funded health services, and the wider health care system. The VBPQI released its first report in November 2018 with recommendations related to enhanced data analytics and data sharing; pursuing VBP models related to maternity and newborn care and mental health and substance use disorders (SUD); providing additional guidance on Medicaid-allowable quality improvement costs; and working to standardize HHSC's managed care VBP efforts to reduce administrative burden and encourage provider participation. The VBPQI's work plan for 2019-2020 will focus on standardized measures for maternal and newborn care and behavioral health, use cases for quality improvement costs, and continued engagement of stakeholders regarding HHSC's VBP initiatives to increase awareness and participation of different types of providers.

Emerging Initiatives to Advance VBP Currently Underway in Texas

Accountable Health Communities (AHC): Three healthcare organizations in Texas received CMS AHC grant awards. HHSC, as the state Medicaid agency, is a partner to this project. This grant tests whether identification of and/or linkages to the health-related social needs of enrollees impacts total health care costs and

³⁵ *Intended Consequences: Modernizing Medi-Cal Rate-Setting to Improve Health and Manage Costs*, March 2018, Prepared by Manatt Health for the California Health Care Foundation. Accessed at <https://www.manatt.com/Insights/White-Papers/2018/Modernizing-Medi-Cal-Rate-Setting-to-Improve-Health>

improves health and quality of care. This grant will inform HHSC on ways to structure and support effective VBP approaches related to social drivers of health.

Certified Community Behavioral Health Clinics (CCBHC): HHSC received a CMS and Substance Abuse and Mental Health Services Administration (SAMHSA) planning grant for CCBHC, and this supported the development of the clinic certification process and payment model for patient-centered, integrated care. HHSC applied for, but did not receive, a demonstration grant award for model implementation. However, HHSC now requires its STAR and STAR+PLUS MCOs that have CCBHC-certified providers in their areas to enter into some type of VBP arrangement with each CCBHC to continue to support this care model.

VBP to Support Interventions for Populations with Complex Needs and High Cost: All HHSC-contracted MCOs are required to have targeting, outreach, and intervention strategies in place for enrollees with complex needs and high cost (sometimes referred to as “superutilizers”). In 2019, HHSC is requiring MCO PIPs to focus on the needs and outcomes of this population, specifically for members with anxiety or depression. A flexible VBP model could support patient-centered care for complex populations like these.

Innovation Accelerator Programs: CMS began offering technical assistance to states through its Innovation Accelerator Program (IAP) in 2014, and Texas has participated in a number of CMS’ IAP initiatives, including related to SUD services, beneficiaries with complex care needs and high costs, and promoting community integration through long-term services and supports.³⁶

From February 2016 through June 2018, Texas participated in two CMS-sponsored IAPs to promote community integration for Medicaid beneficiaries through improved partnerships between state Medicaid and housing agencies. The first developed an inventory of tenancy supports available under Medicaid waivers, non-waiver supports, and general revenue funded DSHS programs and Texas Department of Housing and Community Affairs programs. The second included development of a Medicaid crosswalk, which identified current Medicaid services that support people with disabilities in housing, and a housing gaps analysis, which identified key resources for expanding housing opportunities in Texas. The Housing IAP also resulted in an improved partnership with the Texas State Affordable Housing Corporation, which has the potential to create additional housing for Medicaid enrollees in the future.

Texas is furthering the work of the IAP through participation in the National Academy for State Health Policy (NASHP) Housing and Health Institute. Texas is one of five states chosen to participate in the NASHP technical assistance project, and many Texas stakeholders are involved. HHSC has identified the NASHP work group as an opportunity to further explore ways to expand community integration

³⁶ <https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/index.html>. (Accessed June 5, 2019)

for all individuals with disabilities receiving Medicaid, including those with IDD and behavioral health issues.

In Spring 2018, Texas HHSC was selected by CMS to participate in the “Value-Based Payment for Home and Community-Based Services” IAP.³⁷ The overall goal of this initiative is to expand Medicaid VBP, now focused mainly on acute care, to include home and community-based services (HCBS). The specific aim is to determine whether and how to structure VBP for HCBS programs between MCOs and HCBS providers, by developing measures of community integration outcomes (opportunity, community participation, well-being, and recovery). The target population is adults and children receiving long-term services and supports (LTSS) through two managed LTSS (MLTSS) programs, STAR+PLUS (adults) and STAR Kids (children). Most Medicaid LTSS are provided through these two programs.

HHSC’s main areas of interest for the VBP for HCBS IAP include:

- Identifying standardized measures for a VBP strategy and appropriate data sources to support VBP for an HCBS initiative;
- Designing VBP for HCBS strategies that offer both financial and non-financial incentives;
- Learning about successful VBP strategies in other MLTSS states; and
- Aligning HCBS VBP with the HHSC VBP Roadmap to the maximum extent possible.

HHSC is working to develop a detailed project plan for implementation of HCBS VBP over several years.

Health IT Strategic Plan

STC 39 of the Waiver renewal requires HHSC to use Health Information Technology (Health IT) within the demonstration to link services and core providers across the continuum of care to the greatest extent possible. The state is expected to achieve minimum standards in foundational areas of Health IT and to develop goals for the transformational areas of Health IT use. The state must report semi-annually on how it has met or plans to meet required health IT goals/milestones.

Specifically, STC 39 directs HHSC to use the CMS “1115 Health IT Toolkit” for Health IT considerations in conducting an assessment and developing a Health IT Strategic Plan.³⁸ HHSC is targeting to submit the plan on October 1, 2019. The strategic plan must support a number of goals, including:

- exchange of clinical health information to coordinate care;

³⁷ <https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/program-areas/community-integration-ltss/index.html>

³⁸ *1115 Health IT Toolkit* available at: <https://www.healthit.gov/topic/advancing-interoperability-medicaid>. (Accessed June 5, 2019)

- a comprehensive Medicaid enterprise master patient index;
- a comprehensive Medicaid provider directory;
- improved coordination and integration between Medicaid behavioral health, physical health, home and community-based, and community-level collaborators for improved care coordination; and
- a quality measurement strategy that supports appropriate data collection to monitor and evaluate the objectives of the demonstration.

Further, the Health IT Strategic Plan must have milestones that are achievable for Health IT adoption by Medicaid service providers both eligible and ineligible for Medicaid Electronic Health Record (EHR) Incentive Programs, plan for the exchange of clinical health information related to Medicaid beneficiaries statewide, and advance the standards identified in the “Interoperability Standards Advisory—Best Available Standards and Implementation Specifications” (ISA) in developing and implementing state policies.

Health IT, and health information exchange (HIE), in particular, is a critical component of expanding upon the successes of DSRIP. The exchange of timely and accurate data facilitates key areas of transformation under DSRIP, such as chronic care management, patient care navigation, and integration of physical and behavioral health care. The activities that will be conducted under the Health IT Strategic Plan will be crucial to furthering transformation efforts, including as MCOs and DSRIP providers collaborate on ways to incorporate DSRIP models under managed care and conduct meaningful quality measurement for these efforts.

Medicaid-CHIP IAPD for HIE Connectivity

Health Information Technology for Economic and Clinical Health Act (HITECH) funding is available through 2020. In late 2017, Texas received federal approval for a Medicaid HIE Implementation Advanced Planning Document (IAPD) to receive enhanced federal funding to take next steps to advance HIE to support the Medicaid program. The HIE Connectivity Project is the current Texas Medicaid HIE initiative funded by CMS through the HIE IAPD. The primary objectives of this project are to increase HIE use and adoption by Texas Medicaid providers and create additional capacity in Texas that can support that use and adoption.

The HIE Connectivity Project will accomplish its primary objectives by implementing the following three strategies.³⁹ Successful implementation of the three strategies will result in increased HIE adoption and use by Medicaid providers, creation of new HIE capacity in the state, and bring clinical information into the Texas Medicaid program via HIE.

- *Strategy 1: Medicaid Provider HIE Connectivity* - This strategy will help Medicaid providers connect to HHSC-approved local HIE organizations. These

³⁹ <https://hhs.texas.gov/about-hhs/process-improvement/health-informatics-services-quality/local-hie-grant-program>. (Accessed June 5, 2019)

connections will facilitate electronic reporting and data exchange between providers and Texas Medicaid.

- *Strategy 2: HIE Infrastructure* - This strategy includes enhancing the state's HIE infrastructure to support connectivity with the state's Medicaid system and assisting local HIEs in implementing connections to HIETexas, which is a set of state-level shared services managed by the Texas Health Services Authority.
- *Strategy 3: Emergency Department Encounter Notifications (EDEN)* - This strategy will help Texas Medicaid reduce emergency department (ED) utilization and hospital readmissions by enabling better follow-up care through the electronic receipt of Health Level Seven (HL7) Admission, Discharge, and Transfer (ADT) data from hospital EDs and publishing alerts to MCOs or DCs when a patient in their network is admitted to the ED, facilitating timely care coordination.

7. Next Steps in Delivery System Reform

As Texas works on planning for post-DSRIP and next steps to advance delivery system reform, it will be mindful of CMS and state policy context and priorities.

CMS Health Policy Priorities

CMS's mission is to transform the health care delivery system to focus on value for patients – to provide high quality, accessible care, at the lowest cost. In a May 2018 speech on Medicare, CMS Administrator Seema Verma explained that CMS seeks to do this by:

- empowering patients (e.g., giving them better access to their own health care data);
- increasing competition (e.g., giving Medicare Advantage health plans more flexibility to cover and compete on supplemental benefits that go beyond traditional Medicare benefits, such as home modifications and respite care for caregivers);
- realigning incentives (e.g. testing out new ways of paying for care through the CMS Innovation Center, including for patients with complex conditions) and
- reducing regulatory and other barriers to value driven care.⁴⁰

In 2019, CMS also noted as priorities advancing the use of technology in Medicare and special consideration for rural providers to improve systems of care and focus on quality improvements (Rethinking Rural Health strategy).⁴¹

Specific to Medicaid, when Administrator Verma spoke at the 2018 Medicaid Managed Care Summit in September 2018, she emphasized three key pillars of CMS' strategy around Medicaid.⁴²

- Flexibility – Empower states to best serve the citizens in their community by giving them flexibility to innovate in Medicaid policy.
- Accountability – Standardize waiver evaluation and increase transparency for stronger accountability, including through tools such as the CMS Medicaid & CHIP Scorecard.
- Integrity – Strengthen the regulatory framework around Medicaid supplemental payments, in particular to promote integrity by ensuring that

⁴⁰ <https://www.cms.gov/newsroom/press-releases/speech-medicare-remarks-cms-administrator-seema-verma-commonwealth-club-california>. (Accessed June 3, 2019)

⁴¹ <https://aasm.org/verma-identifies-several-cms-priorities-for-2019/>. (Accessed June 3, 2019)

⁴² <https://www.cms.gov/newsroom/press-releases/speech-remarks-administrator-seema-verma-2018-medicaid-managed-care-summit>. (Accessed June 3, 2019)

states put up their fair share of state matching funds only from permissible sources.

Both for Medicare and Medicaid, CMS has acknowledged the role social drivers of health play in health outcomes. In a recent speech, Health and Human Services Secretary Alex Azar said the current federal administration is deeply interested in this question, and thinking about how to improve health and human services through greater integration.⁴³ He noted that the CMS is allowing its Medicare Advantage health plans to pay for a wider array of health-related benefits beginning in 2019 (transportation, home health visits) and 2020 (home modifications, home delivered meals, and more). CMS recently approved new Medicaid pilots for North Carolina through which Medicaid health plans similarly will be able to pay for enhanced services for high needs enrollees who have risk factors related to food, housing, transportation, and interpersonal violence.

In approving North Carolina's 1115 waiver proposal in October 2018, CMS strongly emphasized health outcomes:

- whether the demonstration was likely to assist in improving health outcomes,
- whether it would address health drivers that influence health outcomes, and
- whether it would incentivize beneficiaries to engage in their own health care and achieve better health outcomes.⁴⁴

HHSC will build on DSRIP's emphasis on health outcomes, particularly in DSRIP 2.0, to better care for Texans after the DSRIP pool ends.

Key Health Priorities in Texas

During Texas' 86th Legislature, Regular Session, 2019, state policymakers and stakeholders discussed major health priorities, including improving Medicaid managed care oversight, behavioral health, maternal and newborn health, and telemedicine and telehealth. These high priority areas for the state align with Texas' DSRIP work and Medicaid managed care VBP strategies.

MCO Oversight

Texas has evolved its MCO oversight continually since the state began implementing Medicaid managed care. The State Medicaid Managed Care Advisory Committee provides recommendations and ongoing input to HHSC on the statewide implementation and operation of Medicaid managed care. The STAR Kids Managed Care Advisory Committee was established to advise specifically on the

⁴³ *The Root of the Problem: America's Social Determinants of Health*, Alex M. Azar II, Hatch Foundation for Civility and Solutions, November 14, 2018, Washington, D.C., <https://www.hhs.gov/about/leadership/secretary/speeches/2018-speeches/the-root-of-the-problem-americas-social-determinants-of-health.html>. (Accessed June 3, 2019)

⁴⁴ <https://files.nc.gov/ncdhhs/CMS-1115-DemonstrationWaiver-Approval-Letter.pdf>. (Accessed June 3, 2019)

implementation of the STAR Kids Medicaid managed care program for children and youth with disabilities.

The 2018-19 General Appropriations Act required HHSC to conduct a review of the agency's contract management and oversight for Medicaid managed care contracts (S.B. 1, 85th Legislature, Regular Session, Article II, HHSC, Rider 61). As a result of Rider 61, HHSC developed the following Medicaid managed care oversight improvement initiatives:

- Administrative Simplification
- Complaints Process and Data Analytics
- Network Adequacy and Access to Care
- Outcome-Focused Performance Management
- Strengthening Clinical Oversight
- Service and Care Coordination

The 86th Legislature, Regular Session, 2019 also provided funding and policy direction in these areas to help strengthen HHSC managed care oversight and operations.

Behavioral Health

Improving mental health and addressing substance use disorders has been and continues to be an area of focus for Texas. In addition to major DSRIP investment in behavioral health since 2012, over the past several legislative sessions, Texas has increased state funding to improve behavioral health services. Like other states, Texas also is leveraging federal funds from the Substance Abuse & Mental Health Services Administration (SAMSHA) to work with local partners to tackle the opioid epidemic. Texas has appropriated about \$7.8 billion in all funds for the 2020-21 biennium for behavioral health services across all state agencies of which \$3.4 billion is appropriated to Medicaid and CHIP.⁴⁵ In addition, legislation from the most recent session (86th Legislature, Regular Session, 2019) increases access to services for substance use disorder and mental health conditions.

The 84th Legislature in 2015 established and the 86th Legislature in 2019 codified into state law the Statewide Behavioral Health Coordinating Council, which includes representatives of 23 state agencies, boards, and higher education entities that expend funds on behavioral health services, to develop a five-year statewide behavioral health strategic plan. The strategic plan, among other objectives, inventories behavioral health programs and services offered by the state, reports statistics on individuals served with BH diagnoses, and details plans to coordinate behavioral health services to eliminate redundancy and ensure optimal service

⁴⁵ 2020-21 General Appropriations Act, H.B. 1, 86th Legislature, Regular Session, 2019 (Article IX, Section 10.04)

delivery. Texas published the Second Edition of the *Texas Statewide Behavioral Health Strategic Plan* in February 2019.⁴⁶

Maternal and Newborn Health

Improving maternal and newborn health continues to be a major focus for Texas leadership and stakeholders. There are several state advisory groups focused on this issue, including the Texas Collaborative for Healthy Mothers and Babies, the Perinatal Advisory Council, and the Texas Maternal Mortality and Morbidity Task Force. Legislation from the 86th Legislature, Regular Session, 2019, aims to enhance prenatal and postpartum services and ensure continuity of care for women transitioning between programs. It also creates pilot programs to establish pregnancy medical homes and deliver prenatal and postpartum care through telehealth or telemedicine.

Telemedicine and Telehealth

Over the course of several legislative sessions, Texas has been expanding the options for Texas providers to engage in telemedicine and telehealth. This expansion has been a key strategy particularly for addressing provider access concerns in rural areas of the state.

During the 85th Legislature, Regular Session, 2017, S.B. 1107 standardized practice requirements for telemedicine and telehealth services by specifying acceptable telemedicine and telehealth service delivery modalities, clarifying necessary physician-patient relationship requirements, and directing Texas Medical Board, Texas Board of Nursing, Texas Physician Assistant Board, and Texas State Board of Pharmacy to jointly develop administrative rules for valid prescriptions generated during a telemedicine visit.

The emphasis on telehealth and telemedicine continued in the 86th Legislature, Regular Session, 2019 and could be seen benefiting other areas of emphasis already discussed in this section, including maternal and newborn health and behavioral health. Other key telehealth and telemedicine legislation this session includes the following:

- H.B. 871: Enables satisfaction of physician requirements for Level IV trauma facility designation in counties with populations less than 30,000 through the use of telemedicine by an on-call physician who has special competence in the care of critically injured patients and provides assessment, diagnosis, consultation, or treatment.

⁴⁶ The 2016-17 General Appropriations Act, H.B. 1, 84th Legislature, Regular Session, 2015 (Article IX, Section 10.04) required Texas to create a statewide BH strategic plan. *Texas Statewide Behavioral Health Strategic Plan Update (February 2019)* available at: <https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2019/hb1-statewide-behv-hlth-idd-plan-feb-2019.pdf>.

- S.B. 670: Allows Federally Qualified Health Centers (FQHCs) to be telemedicine distant and patient site providers, prohibits MCOs from denying reimbursement for covered services and procedures solely on the basis of delivery via telemedicine or telehealth, and prohibits limiting a provider's choice of telemedicine delivery platform or reducing reimbursement on the basis of this choice.

Effectiveness of DSRIP

As the DSRIP pool phases out in the Waiver, the Texas Legislature is interested in better understanding how DSRIP has improved the health and care of Texans. The 2020-21 General Appropriations Act⁴⁷ requires HHSC to report by December 1, 2020, on the cost effectiveness and performance of the DSRIP program in DYs 7-8. The report is to include information on provider performance improving health quality measures and which DSRIP activities were determined to have a positive return on investment based on cost and savings reports.

Planning for Post-DSRIP

Texas will develop the next 1115 Waiver renewal proposal to take further steps in delivery system reform, building on successes and lessons learned from early and current Waiver activities, and mindful of CMS and Texas health priorities. Texas will pursue the following goals as it develops its next renewal proposal:

- Advance APMs that target specific quality improvements.
- Support further delivery system reform that builds on the successes of the Waiver and includes current priorities in health care.
- Explore innovative financing models.
- Develop cross-focus areas such as social drivers of health that use the latest national data and analysis to continue to innovate in Texas.
- Strengthen supporting infrastructure for increased access to health care and improved health for Texans.

Reflected in the milestones are key strategies and areas of innovation that have been described throughout this plan related to Texas Medicaid quality initiatives, including DSRIP. HHSC also has solicited stakeholder input for program ideas.

Stakeholder Input

HHSC asked stakeholders to submit initial program ideas using existing funding sources by November 30, 2018, to share with state leadership and help inform the development of the DSRIP Transition Plan. (Appendix B). HHSC received responses from more than 30 entities, including:

⁴⁷ 2020-21 General Appropriations Act (H.B. 1, 86th Legislature, Regular Session, 2019 (Article II, Rider 38))

- provider associations,
- hospitals,
- academic institutions and providers,
- behavioral health providers,
- local health departments,
- RHPs, and
- Individuals and coalitions.

Proposals focused on broad systems of care, community-based and hospital care, rural health, behavioral health, public health, and academic medicine. They ranged from statewide to regional to individual provider level.

The next steps are to develop and propose to CMS new programs, policies, and other Medicaid strategies in key focus areas (listed below in no particular order) to further delivery system reform. The milestones included in this transition plan lay the groundwork for development of approaches to sustain successful DSRIP initiative areas and address emerging areas of innovation in health care.

- Behavioral health;
- Primary care;
- Patient navigation, care coordination, and care transitions, including for patients with high costs and high utilization;
- Chronic care management;
- Health promotion and disease prevention;
- Maternal health and birth outcomes, including in rural areas of the state;
- Pediatric care;
- Rural health care;
- Telemedicine and telehealth; and
- Social drivers of health.

Any new programs, either to propose for when DSRIP ends in DY 11 or to propose for the next Waiver renewal period, will be further developed through this analysis process.

Proposed Milestones for DY 9-10

Advance APMs to Promote Healthcare Quality

- HHSC updates the Texas VBP Roadmap to address strategies to sustain key DSRIP initiative areas. [September 30, 2020]
- HHSC updates the Texas Medicaid quality strategy to address program and stakeholder goals. HHSC will:
 - ▶ To advance potential APMs for Medicaid recipients with high needs and high costs, identify measurement approaches for services and populations that traditionally have been challenging to measure. Potential areas for refined measurement approaches: severe mental illness/severe emotional

- disturbance; pediatric populations; and community integration for people with disabilities.
- ▶ Improve alignment and standardization of APMs in Medicaid managed care. Maternal and newborn health is an initial focus area. [December 31, 2020]

Support Further Delivery System Reform

- HHSC identifies and submits to CMS any proposals for new programs, including state-directed payment programs, to sustain key DSRIP initiative areas. This would include programs that require an amendment to the Waiver to begin in DY 11. [September 30, 2020]
- HHSC conducts a preliminary analysis of DY 7-8 (October 1, 2017 - September 30, 2019) DSRIP quality data and related core activities to outline lessons learned on health system performance measurement and improvement. This analysis will help inform HHSC strategies for quality improvement and proposals for new programs or policy changes. [December 31, 2020]
- HHSC reviews DSRIP activities as possible Medicaid state plan benefits and policy changes, and submits to CMS review results or approval requests, as necessary. Potential examples include community health workers and Medicare benefits such as: chronic care management, comprehensive care codes for integration of behavioral and physical health, and the Diabetes Prevention Program. [December 31, 2020]
- HHSC identifies and submits to CMS any proposals for new programs to sustain key DSRIP initiative areas that would start in the next Waiver renewal period. [September 30, 2021]

Explore Innovative Financing Models

- HHSC assesses Texas' current financial incentives for Medicaid MCOs and providers to enter into meaningful quality-based alternative payment models and identifies potential opportunities to strengthen or align incentives. Part of this assessment will include review of use cases for the Quality Improvement (QI) cost strategy in Medicaid managed care, after which HHSC will provide additional guidance to Medicaid MCOs and providers for allowable QI costs to help sustain certain successful DSRIP strategies. [March 31, 2021]

Cross-Focus Areas

- HHSC completes an assessment of which social factors are correlated with Texas Medicaid health outcomes, including pediatric health outcomes. This analysis will help inform HHSC strategies for quality improvement and proposals for new programs or policy changes. [March 31, 2021]

Strengthen Supporting Infrastructure to Improve Health

- HHSC assesses the current capacity and use of telemedicine and telehealth, particularly in rural areas of Texas, to inform next steps to address access gaps. [December 31, 2020]
- HHSC identifies options for the Regional Healthcare Partnership structure post-DSRIP. [March 31, 2021]

Conclusion

HHSC looks forward to working with CMS, Texas leadership, and stakeholders on next steps to transform health care and improve health in Texas. Texas will continue to analyze stakeholder proposals using the goals outlined in this Transition Plan. The milestones included in this Transition Plan represent the work that HHSC plans to complete in DY 9-10 for changes in the Medicaid program to support DSRIP sustainability and other innovations. In addition, new programs, policies, and other strategies that leverage existing resources and financing structures will be explored to build on DSRIP's successes in increasing access to care and delivering cost-effective care for Texans.

Appendix A. 1115 Waiver Special Terms and Conditions - STC #37

37. Transition Plan for DSRIP Pool.

- a. Texas will submit a draft transition plan to CMS by October 1, 2019 for CMS review and approval, describing how the state will further develop its delivery system reform efforts without DSRIP funding and/or phase out DSRIP funded activities. The final transition plan will become Attachment Q of the STCs for this demonstration. It must be finalized within 6 months of submission to CMS. As Texas' DSRIP is a time-limited federal investment that will conclude by October 2021, Texas will propose milestones by which it will be accountable for measuring sustainability of its delivery system reform efforts absent DSRIP funding. Milestones may relate to the use of alternative payment models, the state's adoption of managed care payment models, payment mechanisms that support providers' delivery system reform efforts, and other opportunities.
- b. Portions of overall FFP for DSRIP will be at-risk for the state's achievement on achievement milestones, as specified below. If Texas fails to submit a complete sustainability plan by October 1, 2019, CMS will defer 10 percent of FFP for DSRIP funding starting in the next quarter, and an amount in all subsequent quarters indefinitely until the state comes into compliance. Accountability for performance on these milestones will be as follows: an additional 15 percent for FFP for DSRIP will be at risk in demonstration year 9, and additional 20 percent off FFP for DSRIP will be at risk in demonstration year 10.
- c. This deliverable will not be subject to the deferral as described to STC 56; all accountability for the Transition Plan will be applied as per this STC.

Appendix B. Summary of DSRIP Transition Stakeholder Proposals

The Delivery System Reform Incentive Payment (DSRIP) funding pool in the Texas' Medicaid 1115 Transformation Waiver ends on October 1, 2021. The Texas Health and Human Services Commission (HHSC) must submit a transition plan to the Centers for Medicare & Medicaid Services (CMS) by October 1, 2019, describing how the state will further develop its delivery system reform efforts without DSRIP funding when the pool ends.

HHSC asked stakeholders to submit initial program ideas by November 30, 2018, to share with State leadership and help inform the development of the DSRIP Transition Plan. Programs must have a funding source, other than new General Revenue, for the non-federal share of payments.

- HHSC received proposals, letters and comments from 30+ entities, including:
 - ▶ provider associations [6],
 - ▶ hospitals [5],
 - ▶ academic institutions/providers [6],
 - ▶ behavioral health providers [3],
 - ▶ local health departments [7],
 - ▶ regional healthcare partnerships (RHPs) [4], and
 - ▶ individuals/coalitions [2].
- Proposals focused on broad systems of care, community-based and hospital care, rural health, behavioral health, public health, and academic medicine. They ranged from statewide to regional to individual provider level.
- HHSC will analyze all the proposals to share with State leadership and stakeholders, including financing models. Below is a high-level summary of the program themes and geographic/target populations in the proposals. Note the Public Health line reflects proposals from seven (7) separate local health departments.
- The table does not reflect several letters that did not include a specific program proposal.

Multi-Provider/System Proposals

Program Proposal	Target Geography & Population(s)
<p>Texas Community Access and Reform Engagement (Tex-CARE) – a community-based system of care coverage program for adults ages 19-64, anchored by a public hospital system</p>	<p>Optional statewide, locally-driven program targeted to low-income uninsured</p>
<p>Alternative Payment Models with managed care organizations for innovative initiatives and non-traditional services including maternal health; reduce admissions/ED visits; and chronic disease</p>	<p>Statewide – Medicaid (with possible secondary population of low-income and/or uninsured)</p>
<p>Texas Care Connection – allows adults ages 19-64 to participate in the commercial insurance market, which would include value-based purchasing strategies, organized statewide by RHP boundaries</p>	<p>Statewide – Texas citizens and certain legal immigrants under the Federal Poverty Level</p>
<p>DSRIP program replacement focused on affordable access to healthcare, coordination of care, and connecting patients to social safety net programs to improve outcomes</p>	<p>Statewide through current 20 RHPs, targeted to Medicaid and low-income uninsured</p>
<p>Community Health Works! plan – Comprehensive plan to cover social, clinical, and wellness needs. Provide incentive-based supplements to patients to obtain health insurance that is not just catastrophic coverage and that would also help to reimburse providers, limited specialty care funding, funds for social drivers and wrap around services, carve out for mental health.</p>	<p>Statewide -- uninsured and underinsured</p>
<p>Telemedicine program to provide services to all patients in need of inpatient, outpatient, and emergent care services using advanced technology such as</p>	<p>Statewide – pediatric patients</p>

Program Proposal	Target Geography & Population(s)
telemedicine/telehealth and/or digital health services	
Improve the Texas Medical Transportation Program for non-emergency transportation for individuals with chronic conditions at risk for potentially preventable emergency department visits, hospital admissions and readmissions (PPVs, PPAs & PPRs)	Statewide – Medicaid and low-income uninsured

Hospitals

Program Proposal	Target Geography & Population(s)
Children’s hospitals propose programs focused on: behavioral health; medically complex children; special health care needs of children in foster care; well-defined, well-disseminated standards of care for disease-specific care; and improving transitions from pediatric to adult systems of care.	Statewide for pediatric patients; for children in foster care, those enrolled in STAR Health
A hospital managed care value-based purchasing program that would provide enhanced hospital reimbursement to hospitals the meet performance goals on defined measures.	Statewide by Medicaid managed care service delivery areas
A south Texas hospital proposes GME expansion; Care Link service establishment and/or expansion; diabetes comprehensive care and remote tele-monitoring; expansion of urgent and behavioral health emergency care services; and OB/Gyn care coordination	RHP 5, but could be expanded statewide

Rural Health

Program Proposal	Target Geography & Population(s)
Open telehealth network of inpatient clinical and outpatient specialty services focused on rural parts of the state with a rural or community hospital	Statewide (rural parts of the state) for Medicaid and/or low-income/uninsured
Regional payments for quality initiatives proposed to be negotiated with Medicaid Managed Care Organizations (MCOs), providers, and HHSC	Certain rural RHPs
Psychiatric and clinical guidance for the criminal justice system for individuals with behavioral health symptoms	Statewide in rural counties (population less than 100,000)
A rural RHP proposes vital access for essential services	Rural RHP boundaries; Medicaid and low-income uninsured

Behavioral Health

Program Proposal	Target Geography & Population(s)
Coordinated system of care for Medicaid and Low-Income Uninsured adults 18-64 with severe mental illness (SMI)	Could be statewide or certain geographic regions
Partial hospitalization and intensive outpatient services proposed for children and adolescents ages 3-17	Population served by the provider is primarily in Bexar County, but could be applicable in other areas of the state.
Youth Crisis Respite Center to provide brief out-of-home residential services for youth whose psychiatric and/or high-risk behaviors have created significant crisis within the family such that the child may not be able to remain at home. Also provides respite care to prevent such a crisis.	Currently in place in 21 rural counties through DSRIP; could be expanded statewide. Serves youth on Medicaid and low income/uninsured

Public Health

Program Proposal	Target Geography & Population(s)
<p>Seven (7) local health departments proposed the continued inclusion of public health in Medicaid waiver financing and transformation, to continue to support valuable local public health initiatives, including traditional and enhanced services, such as screening/testing, immunizations, oral health, children with asthma, service linkage (some include health information technology), behavior modification intervention, chronic disease such as diabetes, crisis care, and/or health promotion activities to prevent severe and/or disabling preventable conditions. Some are also providing primary care and services to pregnant women & post-partum. Some also focus on certain populations to address health disparities</p>	<p>Could be administered statewide through local health depts. for Medicaid, low-income/uninsured adults & children; some services focus on those with chronic conditions or at risk for them</p>

Academics

Program Proposal	Target Geography & Population(s)
<p>Incentives for physician practices to expand successful DSRIP initiatives, care coordination and community collaboration with MCOs and Anchors forming leadership teams to select quality measures specific to Medicaid managed care regions.</p>	<p>Statewide -- Medicaid and uninsured</p>
<p>Community Wide Campaign & Diabetes Prevention Program – broad structure for healthy living and specific supports for individual change targeted to adults who are pre-diabetic, overweight and/or have elevated blood pressure/hypertension</p>	<p>Medicaid and low-income uninsured adults in RHP 5 (south Texas)</p>
<p>Sustain a particular DSRIP diabetes self-management program (Salud y Vida) that</p>	<p>RHP 5 (scalable to other regions and statewide); Medicaid and low-income uninsured</p>

Program Proposal	Target Geography & Population(s)
focuses on adults with Type 2 diabetes that is poorly controlled or uncontrolled	
Accountable Health Communities (AHC) Alternative Payment Model – screening, referral and patient navigation to community resources to address social drivers of health in coordination with MCOs and RHPs	Statewide – Medicaid and low-income uninsured
Formalize a working relationship or partnership between HHSC and Texas academic medicine to improve programs and contain costs. Academic institutions may have various proposals. One example is a recent article from <i>Academic Medicine</i> titled “A New Community Health Center/Academic Medicine Partnership for Medicaid Cost Control, Powered by the Mega Teaching Health Center.”	Statewide

Appendix C. Abbreviations

ACO – Accountable care organization
AHC – Accountable Health Communities
APM – Alternative payment model
BH – Behavioral health
CCBHC – Certified Community Behavioral Health Clinics
CHIP – Children’s Health Insurance Program
CMS – Centers for Medicare & Medicaid Services
DFPS – Texas Department of Family and Protective Services
DSH – Disproportionate Share Hospital program
DSHS – Texas Department of State Health Services
DSRIP – Delivery System Reform Incentive Payment program
DY – Demonstration year
ED – Emergency department
EQRO – External Quality Review Organization
FFP – Federal financial participation
FFY – Federal Fiscal Year
FY – Fiscal year
GME – Graduate Medical Education
GR – State General Revenue
HEDIS – Healthcare Effectiveness Data and Information Set
HHSC – Texas Health and Human Services Commission
HIE – Health Information Exchange
HITECH – Health Information Technology for Economic and Clinical Health Act
IAP – Innovation Accelerator Program
IAPD – Implementation Advance Planning Document
ICHP – Institute for Child Health Policy, University of Florida
IDD – Intellectual and developmental disabilities
IGT – Intergovernmental transfer
IT – Information technology
LAN – Health Care Payment Learning & Action Network
LIU – Low-Income or Uninsured
MCO – Managed care organization
MMP – Medicare-Medicaid plan
NAIP – Network Access Improvement Program
NASHP – National Academy of State Health Policy
P4Q – Pay For Quality program
PCP – Primary Care Provider
PIP – Performance improvement project
PPA – Potentially Preventable Admission

PPC – Potentially Preventable Complication
PPE – Potentially Preventable Event
PPR – Potentially Preventable Readmission
PPV – Potentially Preventable ED Visit
QI – Quality improvement
QIPP – Nursing Facility Quality Incentive Payment Program
RHP – Regional Healthcare Partnership
Roadmap – Value-Based Purchasing Roadmap
SAMHSA – Substance Abuse and Mental Health Services Administration
SDA – Managed care service delivery area
STC – Special Terms and Conditions
THLC Portal – Texas Healthcare Learning Collaborative Portal
UC – Uncompensated care
UHRIP – Uniform Hospital Rate Increase Program
UPL – Upper Payment Limit
VBP – Value Based Payment/Purchasing
Waiver – Texas Healthcare Transformation and Quality Improvement Program
Medicaid 1115 Demonstration Waiver