Health and Human Services Healthcare Quality Plan

As Required by

S.B. 200, 84th Legislature,

Regular Session, 2015

Health and Human Services

November 2017

TEXAS
Health and Human Services

Table of Contents

List of Tables and Figures

1. Executive Summary

Based on recommendations in the Sunset Advisory Commission Staff report for the Health and Human Services Commission (HHSC), Senate Bill (S.B.) 200, 84th Texas Legislature, Regular Session, 2015, directs HHSC to develop a comprehensive plan to improve the coordination and transparency of state healthcare quality initiatives.

The resulting Health and Human Services (HHS) Healthcare Quality Plan provides a broad strategy for healthcare quality improvement across all HHS system agencies. The plan establishes six priorities to guide HHS system policy making and program activities over the next five years:

1. Keeping Texans healthy at every stage of life through prevention and by engaging individuals, families, communities, and the healthcare system to address root causes of poor health;
2. Providing the right care in the right place at the right time to ensure people receive timely services in the least intensive or restrictive setting appropriate;
3. Keeping patients free from harm by building a safer healthcare system that limits human error;
4. Promoting effective practices for chronic disease to better manage this leading driver of healthcare costs;
5. Supporting patients and families facing serious illness to meet physical, emotional, and other needs; and
6. Attracting and retaining high-performing providers and other healthcare professionals to participate in team based, collaborative, and coordinated care.

Leveraging HHSC's existing operational planning process, programs and stakeholders will collaborate to implement initiatives to address priorities. A more robust, data-driven method will be used to evaluate healthcare quality improvement

to increase accountability and ensure established milestones are met and progress is regularly reported to agency leadership and the public.

2. Introduction

S.B. 200 directs HHSC to develop a comprehensive plan for healthcare quality. This HHS Healthcare Quality Plan is required to:

1. Include broad goals for improving healthcare quality and efficiency in Texas, prioritizing Medicaid and the Children's Health Insurance Program (CHIP);
2. Lead to consistent approaches across major quality initiatives; and
3. Improve the evaluation of quality initiatives' statewide impact.

The legislative requirement responds to the Sunset Advisory Commission Staff report for HHSC. The Commission found quality initiatives, particularly major ones, did not consistently work together, “creating missed opportunities for synergy, potentially duplicating effort, and impeding the broad change in healthcare delivery intended to improve the overall healthcare system."[1]

In requiring the plan, the Legislature anticipated HHS agencies and programs would revise quality initiatives to align with the plan’s priorities and would develop and report outcome measures and other analytics to help policy makers and stakeholders better understand notable trends for healthcare quality and efficiency.

The plan, as presented, provides a coordinated approach for improving the effectiveness of healthcare quality initiatives across HHS system agencies, emphasizing accountability by

[1] Sunset Advisory Commission, "Sunset Advisory Commission Staff Report with Final Results: Health and Human Services Commission and System Issues," (July 2015), 89.

individuals, payers, providers, and health related public programs. Broadly speaking, the plan aims to promote better care and services, healthier people and communities, and smarter spending. This Triple Aim framework will target improvement efforts on value rather than on quality or cost containment alone.

To achieve these aims, the plan builds on existing initiatives that support the transformation of healthcare from a volume to a value based system, establishes six priorities to guide policy making and program activities, and identifies desired outcomes through which to monitor progress on each priority.

3. Background

S.B. 200 provided an opportunity to implement new strategies for promoting value in Texas healthcare. This bill restructured the HHS system to improve service delivery, coordination, and accountability. One benefit of the restructuring, referred to as "transformation," was the consolidation of programs and units from different areas of the HHS system with responsibility for improving healthcare quality and efficiency into a single section of the Medicaid and CHIP Services (MCS) Department within HHSC's new Medical and Social Services Division.[2]

S.B. 200 also granted the HHS Executive Commissioner authority to establish the Value Based Payment and Quality Improvement Advisory Committee (Quality Committee). Committee members representing diverse sectors of the healthcare system are tasked with providing input on quality improvement initiatives, including the HHS Healthcare Quality Plan, and will recommend consensus actions to help Texas achieve the highest value for healthcare in the nation.

HHS system transformation, and the resulting increase in coordination between HHS programs and stakeholder groups like the Quality Committee, will help ensure tools and strategies are in place to improve Texas healthcare. Generally, according to the Institute of Medicine (IOM), value based improvement strategies should target the elimination of waste stemming from:

- low value or unnecessary services,
- inefficiently delivered services,
- complex administrative processes,
- services priced beyond competitive benchmarks,

[2] This new section is known as Quality and Program Improvement.

- missed prevention opportunities, and
- fraud. [3] These categories of waste in healthcare not only increase costs but can compromise quality and patient safety.

Table 1 represents major HHS value based initiatives and how they function to improve the quality and efficiency of state healthcare services.

Table 1. Ongoing or Planned HHS Value Based Initiatives

Initiative	Description	Quality and/or Efficiency Measures
Transition from Fee-for-Service to Managed Care	Over 90 percent of Medicaid and CHIP clients receive services through risk bearing Managed Care Organizations (MCOs) and Dental Maintenance Organizations (DMOs). The transition to managed care has occurred in carefully planned stages over a 24 year period.	Federal and state law require a number of quality related activities including routine reporting on evidence based measures of MCO and DMO performance.
Delivery System Reform Incentive Payment (DSRIP) Program	Incentive payments to hospitals and other providers for strategies to enhance access to healthcare, increase the quality and cost-effectiveness of care, and improve the health of patients and families.	Menu of measures developed/approved by HHSC (with stakeholder input) and the Centers for Medicare and Medicaid Services (CMS).

[3] Institute of Medicine, "Best Care at Lower Cost: The Path to Continuously Learning Health Care in America," (Washington: IOM, 2013), 103.

Initiative	Description	Quality and/or Efficiency Measures
MCO and DMO Pay for Quality (P4Q)	Budget neutral programs that create incentives and disincentives for MCOs and DMOs. Health plans that excel on specified quality metrics are eligible for additional funds above their existing premium payments; health plans that don't meet their measures can lose funds.	P4Q includes industry recognized process and outcome measures within a model that: 1) is easy to understand; 2) allows health plans to track performance and improvement; 3) rewards both high performance and improvement; and 4) promotes transformation and innovation.
Hospital Quality Based Payment Program for Potentially Preventable Readmissions and Complications	Provides incentives and disincentives to hospitals to reduce potentially preventable readmissions and complications.	Potentially Preventable Readmissions and Potentially Preventable Complications.
MCO Performance Improvement Projects (PIPs)	Projects must be designed to demonstrate significant improvement sustained over time in clinical and non-clinical care that has a favorable effect on health outcomes and enrollee satisfaction.	HHSC, with the External Quality Review Organization (EQRO), determines topics for PIPs based on improvement goals. MCOs create a PIP plan, report on progress annually, and provide a final report.

Initiative	Description	Quality and/or Efficiency Measures
Quality Incentive Payment Program (QIPP)	Incentivizes nursing facilities to improve quality and innovation in the provision of services using the CMS five-star rating system as a basis.	Performance measures include: 1) high-risk residents with pressure ulcers; 2) percent of residents who received an antipsychotic medication; 3) residents experiencing one or more falls with major injury; 4) residents who were physically restrained.
MCO Value Based Contracting with Providers	HHSC contractual requirement for MCOs to develop value based payment models with providers.	HHSC is establishing overall and risk based targets for the level of MCO and DMO reimbursement to providers through value based payments relative to a plan's total medical expenses.

The most significant value based initiative has been the introduction of managed care into Medicaid, the largest state funded health program. For the past 24 years, HHSC has transitioned Medicaid away from fee-for-service reimbursement to a managed care system that holds health plans accountable for controlling costs and improving quality. As of January 2017, over 90 percent of the state's 4.5 million Medicaid and CHIP clients received services through risk bearing MCOs and DMOs, making Texas a national leader in delivering healthcare through a value based model to people with low income or disabilities.

Unlike traditional fee-for-service, Medicaid managed care provides policy makers, administrators, and clients with

systematic feedback on health plan and program performance. Federal law requires an annual, external, and independent review of state Medicaid managed care programs' quality outcomes, covering access to services, timeliness of services, clients' experiences within the care system, analysis of healthcare claims and encounter data, and reporting on evidence based performance measures.

Chapter 536 of the Texas Health and Safety Code extends on these accountability provisions by creating a comprehensive framework for promoting value in public medical assistance programs, including requirements that provider payments and MCO premiums be linked to outcomes. Chapter 536 also requires HHSC to develop outcome measures to support performance based initiatives for high quality and efficient healthcare, with emphasis on reducing preventable events such as emergency department visits and avoidable hospital admissions and readmissions.

The transition of Medicaid to a more accountable and innovative managed care model, coupled with the program's focus on quality has contributed to improved performance. Between calendar years 2012 and 2015, the overall frequency of potentially preventable hospital admissions related to conditions such as asthma, diabetes, and urinary tract infection, adjusted for changes in case mix and enrollment, fell by eight percent.[4]

Medicaid's transition to managed care has been complemented by other system initiatives, such as the 1115 Healthcare Transformation and Quality Improvement Waiver, to promote improved quality and efficiency in state healthcare services, as described in Table 1.

[4] Unpublished analysis provided by the state's EQRO: Institute for Child Health Policy (ICHP), University of Florida, December 2016.

4. Better Care at Lower Cost: Aims and Priorities for Improving Health

The HHS Healthcare Quality Plan aims to simultaneously improve outcomes of care for individuals, improve the health of the state's population, and lower the trend in healthcare cost growth. This Triple Aim strategy, first proposed by the Institute for Healthcare Improvement in 2008, provides a value oriented framework for raising quality and lowering cost. The Triple Aim has been adopted as the foundation for many quality initiatives around the world, including by CMS and the U.S. Department of Health and Human Services for its National Quality Strategy.[5]

To advance the Triple Aim in Texas, this plan identifies six priorities for action, each with broad desired outcomes (see Table 2). The priorities, selected after an extensive environmental scan (see Appendix A) of emerging healthcare trends and expert recommendations for increasing healthcare value reflect a consensus of lead staff in the MCS Department's Quality and Program Improvement Section. Four external stakeholder groups reviewed and were given opportunity to comment on draft versions of the priorities.[6]

Although the priorities are particularly important to the state's Medicaid and CHIP programs, they have broader relevance. These priorities promote health and disease prevention throughout the lifespan; focus on better care coordination to

[5] The U.S. Department of Health and Human Services reframes the Triple Aim as: "Better Care, Smarter Spending, and Healthier People and Communities."
[6] Advisory committee meetings where draft plan priorities were presented include HHSC Managed Care Semiannual Meeting (January 5, 2017), Value Based Payment and Quality Improvement Advisory Committee (January 23, 2017), Texas Medical Association Medicaid Committee (January 27, 2017), and Managed Care Advisory Committee (February 8, 2017).

maximize the number of people served in the least intensive[7] or restrictive[8] setting, especially for individuals with chronic or serious illness; and emphasize safety in hospital inpatient, emergency department, nursing home, and other care settings. Achieving these priorities requires a strong partnership between the state's public health and healthcare systems along with the efforts of well trained and motivated interdisciplinary health professionals.

Table 2. Healthcare Quality Plan Priorities and Desired Outcomes

Priority	Desired Outcomes
Keeping Texans healthy	• Reduced rate of health risk behaviors such as tobacco use, obesity, and substance use • Increased rate of preconception, early prenatal, and postpartum care and other preventive health utilization • Reduced infant, postneonatal, maternal, and other premature mortality
Providing the right care in the right place at the right time	• Reduced rate of avoidable hospital admissions • Reduced rate of avoidable emergency department visits • Reduced rate of people needing crisis interventions • Increased proportion of individuals with a disability living in the community

[7] Intensity or level of care refers to a continuum ranging at the lower level from self-management or office based care through higher levels of care such as acute inpatient hospital services.

[8] Least restrictive setting refers to the qualified right of individuals with a disability, established by the 1999 U.S. Supreme Court decision in Olmstead v. LC, to receive state funded supports and services in the community (least restrictive setting) rather than institutions.

Priority	Desired Outcomes
Keeping patients free from harm	• Reduced rate of avoidable readmissions • Reduced rate of avoidable complications • Reduced rate of adverse healthcare events
Promoting effective practices for chronic disease	• Slower progression of chronic disease • Reduced rate of avoidable hospital and emergency department visits for individuals with medical complexity, including with co-occurring behavioral health diagnoses • Higher rate of self-management • Increased satisfaction with care
Supporting patients and families facing serious illness	• Reduced inpatient days in last six months of life • Reduced percent of deaths for serious illness occurring in a hospital
Attracting and retaining high-performing providers and other healthcare professionals	• Increased number of individuals, particularly individuals with complex medical needs, served in integrated, accountable care models • Reduced proportion of population reporting difficulties accessing care • Reduced rate of avoidable emergency department visits

Keeping Texans healthy

This priority focuses on the primary goal for health policy in Texas—to keep people healthy at every stage of life—through a combination of clinical and nonclinical health related

interventions. The healthcare system is crucial for advancing wellness through preventive services such as immunizations and medical and dental checkups, but what happens in homes and communities matters at least as much as healthcare alone.

For example, researchers note a significant gap between the U.S. and peer nations on the infant mortality rate (the number of deaths per 1,000 births for infants under age one year).[9] This finding is noteworthy because during the first days and weeks of life when skilled medical interventions and technology can be decisive for a good outcome, especially for low birthweight newborns, the infant mortality gap between the U.S. and peer nations is “quantitatively small" or even nonexistent.[10] It is only as newborns age during the first year of life and family and community-level factors become more prominent that the U.S. disadvantage becomes "substantial."[11] One implication from this pattern of infant mortality in the U.S. is that non-clinical interventions, such as public awareness campaigns to prevent sudden infant death syndrome and accidents or nurse visitation programs to support first-time low income families, have a vital role to play as part of a comprehensive strategy to improve newborn outcomes.

For another example, diabetes, the most expensive chronic disease to treat in the U.S. and likely Texas,[12] has evidence based, non-medical interventions to prevent or delay onset. Interventions include promoting evidence based wellness

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[9] At 5.7 deaths per 1,000 live births, the Texas infant mortality rate is comparable to the U.S. average of 5.8 deaths but above the rate for the European Union of 4.4 deaths per 1,000 births.

[10] A. Chen, E. Oster, and H. Williams, "Why is Infant Mortality Higher in the United States than in Europe?" Am Econ J Econ Policy, May 4, 2016, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4856058/ (accessed February 15, 2017).

[11] Ibid.

[12] J. Dieleman et al, "US Spending on Personal Health Care and Public Health, 1996-2013," JAMA, December 27, 2016, http://jamanetwork.com/journals/jama/fullarticle/2594716 (accessed February 15, 2017).

education and activities to modify risk factors for poor nutrition, low physical activity, and tobacco and substance use, as well as improving access within communities to best practices for healthy living.

Effective strategies to reduce the incidence of preventable conditions require partnerships between the healthcare and public health systems to identify and address root causes at an individual and community level. The ability of public health to implement protective interventions and change the decision making context has the potential to reduce healthcare costs and improve the health of individuals and the population through prevention.

Providing the right care in the right place at the right time

This priority focuses on increasing healthcare value by ensuring the right care is delivered in the right place, at the right time, by the right professionals. Misuse, underuse, and overuse of care, including receiving care in a more intensive or restrictive setting than needed, can lead to poor outcomes and high cost. Some examples include an expensive emergency department or inpatient stay that could have been prevented with coordinated, person centered primary care, or a person with a disability residing in a long term care facility instead of at home because appropriate community-based services weren't available.

Effective health policy maximizes the number of individuals receiving services in higher value, non-institutional settings. Objectives for this priority include reducing admissions to hospitals, emergency departments, and long term care facilities that may have been prevented with better outpatient care, care coordination, home and community supports, or individual health practices.

Keeping patients free from harm

This priority focuses on minimizing preventable injuries, complications, and deaths in all healthcare settings. Since the publication of IOM's landmark consensus report in 2000, To Err is Human: Building a Safer Health System, patient safety initiatives have been an area of national attention.[13] However, room for improvement still exists. For example, obstetric hemorrhage is a leading cause of severe maternal morbidity and preventable maternal mortality in the U.S. Recent work in California indicates that a patient safety approach involving more precise monitoring of blood loss and other indicators during and after delivery may significantly improve maternal outcomes. In the California pilot, hospitals that implemented the national hemorrhage safety bundle experienced a 20.8 percent reduction in severe maternal morbidity, compared to a 1.2 percent reduction for hospitals that did not implement the bundle.[14]

Key areas for improving patient safety include minimizing adverse medication events, strengthening infection control, and reducing other preventable complications that can occur during a hospital stay. Adverse medication events, many of which are preventable, account for up to 770,000 injuries and deaths each year.[15] The Centers for Disease Control and Prevention (CDC) estimates that at least 1.7 million healthcare associated infections occur nationwide in hospitals each year, contributing to 99,000 deaths.[16] In Texas, the Medicaid and CHIP programs reported about 14,000 potentially preventable complications

[13] Institute of Medicine, "To Err Is Human: Building a Safer Health System," Washington, DC: The National Academies Press (2000).
[14] E. Main, et.al, "Reduction of Severe Maternal Morbidity from Hemorrhage Using a state Perinatal Quality Collaborative," American Journal of Obstetrical Gynecology, March 2017, 216.
[15] U.S. Department of Health and Human Services, "National Strategy for Quality Improvement in Health Care," March 2011, 9.
[16] Ibid.

related to inpatient care for 2015 at a cost of about $60 million.[17]

Promoting effective practices for chronic disease

This priority focuses on minimizing the progression of and complications from chronic disease by increasing the appropriate use of screening services, increasing health literacy and self-management among patients and families, improving care coordination, and increasing access to behavioral healthcare and social support services.

Caring for a growing population of patients with one or more chronic conditions is a challenge for the healthcare system. Chronic diseases are now the leading cause of premature mortality and account for the fastest growing share of healthcare expenditures for nearly all payers and demographics, including the Medicaid program.[18] The CDC reports about half of adults living in the U.S. have at least one chronic illness and many have several. [19] According to the Agency for Healthcare Research and Quality, 86 cents of every healthcare dollar are spent treating individuals with a chronic disease, with 71 cents spent treating individuals with multiple chronic conditions.[20] Medicare and Medicaid often serve individuals with expensive, complex conditions. Individuals with co-occurring chronic and behavioral health conditions may face social barriers such as isolation,

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[17] From an unpublished analysis provided by the state's EQRO: ICHP, University of Florida, October 2016. Potentially preventable complications are harmful events such as accidental laceration during a procedure or negative outcomes such as hospital acquired pneumonia that may result from the process of care rather than from a natural progression of underlying disease.
[18] G. Hegar, "Texas Health Care Spending Report Fiscal 2015, Publication #96-1796," Texas Comptroller of Public Accounts, January 2017, 39-41.
[19] Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention, "Chronic Disease Overview," February 23, 2016, https://www.cdc.gov/chronicdisease/overview/ (accessed February 16, 2017).
[20] J. Gerteis, D. Izrael, D. Deitz, L. LeRoy, R. Ricciardi, T Miller, and J Basu (2014), "Multiple Chronic Conditions Chartbook," AHRQ, no. Q14-0038, Rockville, MD: Agency for Healthcare Research and Quality (April 2014): 7.

unemployment, and homelessness which exacerbate their chronic medical illnesses.[21]

Supporting patients and families facing serious illness

This priority focuses on meeting a range of needs for patients and families facing a serious illness. A majority of people with a serious illness wish to spend as much time as possible in a non-hospital setting, among loved ones, free from pain, and not being a burden to their family. Despite these preferences, three issues persist in the care of seriously ill patients:

- severe, poorly treated pain in approximately half of hospitalized patients with a serious illness (50 percent 6-month mortality rate), as well as general confusion between patients and physicians about patient goals of care;[22]
- high variability in intensity of treatment in the last months to years of life, with some patients subjected to three to six times as much medical intervention as others without better outcome;[23] and
- extremely high costs, with personal bankruptcy for 25 percent of Medicare patients in the last five years of life[24] and 25 to 30 percent of annual Medicare spending for the five percent of Medicare patients who die each year.[25]

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[21] J. Turner and B. Kelly (2000), "Emotional Dimensions of Chronic Disease," Western Journal of Medicine, 2000 Feb; 172(2), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1070773/ (accessed March 21, 2017).
[22] A. Connors, N. Dawson, and N. Desbiens, "A Controlled Trial to Improve Care for Seriously Ill Hospitalized Patients: The SUPPORT Study," JAMA 274, (1995):1591-98 565-576.
[23] Multiple periodically updated reports and analysis available at www.dartmouthatlas.org.
[24] A.S. Kelley et al., "Out-of-Pocket Spending in the Last Five Years of Life," J Gen Intern Med. 28, no. 2, (February 2013): 304-9.
[25] G.F. Riley and J.D. Lubitz, "Long-Term Trends in Medicare Payments in the Last Year of Life," Health Serv Res 45, no. 2 (2010): 565-76.

Improving these outcomes in Texas will require investment in the palliative care workforce and infrastructure, as well as increased awareness of what palliative care is and is not.[26]

Palliative care offers an additional layer of specialized, multidisciplinary support to relieve the pain, symptoms, and stress of serious illness. Palliative care is not just for the end of life. While hospice palliative care addresses the terminal stage of serious illness, supportive palliative care (SPC) can be beneficial regardless of prognosis, be combined with treatments to cure illness or extend life, and is most effective if started in the early stages of disease.[27] Over the last decade, peer reviewed studies have demonstrated timely SPC services improve quality of life, reduce patient and caregiver burden, and increase longevity for some patients, all while lowering total healthcare costs.[28] As the need for greater access to SPC becomes better understood, more states, including Texas, are creating initiatives to enhance its quality and availability.[29]

Attracting and retaining high-performing providers and other healthcare professionals

This priority focuses on promoting access to high value healthcare for all Texans by attracting and retaining well trained and motivated healthcare professionals and increasing their participation in healthcare programs such as Medicaid.

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[26] Health and Human Services Commission, "Texas Palliative Care Interdisciplinary Advisory Council Recommendations to the 85th Texas Legislature," November 2016, https://hhs.texas.gov/reports/2016/12/texas-palliative-care-interdisciplinary-advisory-council-recommendations-85th-texas-legislature (accessed February 16, 2017).
[27] A. Sinclair and D. Meier, "How States Can Expand Access to Palliative Care," Health Affairs Blog, January 30, 2017, http://healthaffairs.org/blog/2017/01/30/how-states-can-expand-access-to-palliative-care/ (accessed February 16, 2017).
[28] Ibid, Health and Human Services Commission (2016).
[29] See H.B. 1874, Sess. of 2015 (Texas 2015), http://www.capitol.state.tx.us/BillLookup/Text.aspx?LegSess=84R&Bill=HB1874.

The most recently available survey data (2016) from the Texas Medical Association (TMA) indicates about 45 percent of the state's physicians currently treat Medicaid MCO patients.[30] Among physicians not participating in Medicaid, significant numbers cite low reimbursement (60 percent) and administrative complexity (43 percent) as reasons.[31]

The Statewide Health Coordinating Council (SHCC), in conjunction with the Health Professions Resource Center and the Texas Center for Nursing Workforce Studies (all at the Department of State Health Services [DSHS]), analyzes workforce trends in the health professions and provides input and planning recommendations to state policymakers. Recommendations have included ensuring the availability of adequate educational opportunities and training for physicians, nurses, physician assistants, and others. Recently, SHCC identified the need to address shortages in the primary care and behavioral health workforce and encouraged the formation of innovative, team-based primary care models, such as patient-centered health homes that provide integrated and coordinated physical, behavioral, and community services.[32]

[30] Texas Medical Association, "TMA 2016 Physician Survey Findings and Results," (2016), 66, https://www.texmed.org/uploadedFiles/Current/2016_Advocacy/2016_Physician_Survey_Findings.pdf (accessed February 28, 2017).
[31] Ibid, 67.
[32]Statewide Health Coordinating Council, Texas Department of State Health Services, "2017-2022 Texas State Health Plan: A Proposal for Ensuring High Quality Health Care for All Texans," November 1, 2016, http://www.dshs.texas.gov/chs/shcc/ (accessed February 16, 2017).

5. Tools for Improving Value

Achieving progress on plan priorities will require private and public sector stakeholders to align quality improvement projects, public health initiatives, delivery system restructuring, and payment reforms to support value in healthcare. State government plays an important role by using policy levers to manage public programs more effectively and promote cooperation. HHSC's value based toolkit supports quality plan priorities and the transformation of healthcare into a value based system (see Table 3).

Table 3. HHS Value Based Toolkit

Tool	Role in Promoting Healthcare Value/Quality Plan Priorities	Initiatives to Build on
Contracting for Value	The HHS system delivers the vast majority of services through contracts, including with MCOs and DMOs. HHSC's policy is to contract for performance and work through these contracts to promote quality improvement. All priorities in this plan depend, at least in part, on effective contract development, management, and oversight strategies.	The HHS system is taking proactive steps to fully support its new orientation as an entity focused on contract development, monitoring, and oversight, offering a comprehensive approach for assessing contractor performance and pursuing appropriate compliance actions. HHSC has changed its organizational structure to better support contract management, is revamping its contract management system, and has credentialed about 1,100 employees through the Certified Texas Contract Manager (CTCM) program.

Tool	Role in Promoting Healthcare Value/Quality Plan Priorities	Initiatives to Build on
Aligning Payments with Value	While fee-for-service incentivizes volume in healthcare, payments aligned with value encourage evidence-based practice, choice of highest value services whether medical or non-medical, and care coordination. Value based payment is an important tool for incentivizing care and service models, such as patient centered health homes, that emphasize prevention, wellness, and care coordination.	HHSC places a portion of MCO and DMO payments at risk based on performance on key quality metrics through the MCO and DMO P4Q programs and encourages MCOs to engage their provider networks through alternative payment models. Texas Medicaid also incentivizes hospitals to improve performance on preventable readmissions and complications.
Empowering Individuals	Value based payment models function best when patients have the information, skills, and incentives to practice positive health behaviors and seek out the highest value services. Health literacy supports clients to use the emergency department less, have more success with self-management, and achieve lower rates of smoking and obesity.	HHSC provides clients with MCO report cards to assist in the choice of health plans. Some MCOs offer value added services to incentivize healthier living. HHSC strives to maximize client choice and accountability to the extent feasible under the law. A possible future step for HHSC and its MCO partners is to develop tools to help clients select high value providers.

Tool	Role in Promoting Healthcare Value/Quality Plan Priorities	Initiatives to Build on
Simplifying Administrative Processes	Administrative complexity reduces provider productivity and satisfaction and diverts energy and resources that otherwise could go toward improving patient care. Administrative simplification is a key tool for Medicaid and CHIP to recruit high-performing providers.	HHSC supports the Texas Association of Health Plans' (TAHP) efforts to consolidate provider credentialing and has launched its own initiative to simplify provider enrollment. This healthcare quality plan is also a step toward streamlining performance measurement.
Improving Business Intelligence	Successful organizations routinely transform data into actionable information for decision making. The need for a comprehensive approach to strategically use data was a major HHSC issue identified by the Sunset Advisory Commission and is a prerequisite for pursuing quality plan priorities.	HHSC is working to address four pivotal business intelligence activities: data inventory, data sharing, data integration, and information dissemination. HHS programs are developing dashboards, linked datasets, and other business intelligence tools to support data driven decision making.

Tool	Role in Promoting Healthcare Value/Quality Plan Priorities	Initiatives to Build on
Increasing Health Information Technology (HIT) and Exchange (HIE)	HIT and HIE enable routine, near real time collaboration among providers, health plans, and individuals. HIT and HIE projects cut across all priorities. As an example, electronic prescribing, which can flag potentially dangerous drug interactions and prevent problems with handwriting, similar drug names, and dosage specifications has been shown to significantly reduce medication errors that sometimes can be harmful to patients.	HHSC spearheads major initiatives to promote HIT and HIE in Texas, including administering incentives to Medicaid providers for adopting electronic health records and pursuing innovative ideas to expand HIE.
Expanding Public Reporting	Public reporting is essential to drive accountability and transparency in healthcare and is a cornerstone of market oriented healthcare reform efforts to better support decision making by patients, payers, and health professionals.	HHS programs post significant amounts of health system performance data to their public facing webpages, covering Medicaid and CHIP, all payers, and public health.

Contracting for Value

The Medicaid and CHIP programs account for about 16 percent of healthcare spending in Texas, and certain essential healthcare services are particularly reliant on Medicaid/CHIP dollars:

- Medicaid pays for over half of all births in the state.
- Medicaid is the primary payer of healthcare services for children and adults under the age of 65 with disabilities.
- Medicaid assists the majority of Texans in nursing homes.

Most services provided for more than 4.5 million Medicaid and CHIP clients monthly, as well as for many other clients served by HHS programs, are administered and delivered through contractual arrangements with MCOs and other parties. HHSC's fundamental commitment is to contract for performance and to leverage these contracts to maximize value. As HHSC carves more programs and services into a managed care model that favors value over volume, the agency is taking proactive steps to support its new orientation as an entity focused on contract development, monitoring, and oversight, offering a comprehensive approach for assessing contractor performance and appropriate compliance actions. As a result of transformation, the HHS system has consolidated procurement and contracting services, is updating its contract administration system to allow better tracking and management of all general administration and client services contracts, and has trained and credentialed about 1,100 employees through the Certified Texas Contract Manager program.[33]

Aligning Payments with Value

Efficient healthcare delivery models reward caregivers who provide value, that is, better outcomes at lower cost. In most cases, the elimination of wasteful activities reduces spending and improves the quality of care patients receive. While the fee-for-service approach compensates providers for the volume of services they deliver, payments aligned with value encourage providers to engage in evidence-based practices, collaborate and

[33] Texas Comptroller, "Directory of Certified Individuals," https://www.comptroller.texas.gov/purchasing/training/certified-individuals.php (accessed February 21, 2017).

coordinate with peers, and connect people to appropriate clinical and nonclinical services. Alternative payment models (APMs) with the greatest potential to transform the healthcare system shift more accountability directly to providers and promote population-wide strategies to improve outcomes. HHSC supports the formation of APMs within MCO networks and is working with Medicaid MCOs on approaches to advance this practice, including the incorporation of specific language and incentives for APMs into MCO contracts. These new contract provisions[34] will establish a minimum percent of an MCO's medical spending that must be paid to providers through an APM. The thresholds are proposed to increase over a four-year period until they meet a goal of 50 percent overall and 25 percent risk based.

Empowering Individuals

Value based or alternative payment models achieve maximum success when coupled with efforts to increase the knowledge, skills, and incentives for patients to practice positive health behaviors and seek the highest value health services. Health literacy can help individuals use the emergency department less, have more success with self-management, quit smoking, and maintain a healthy weight, among other benefits. However, a large percentage of adults[35] have difficulty understanding and applying health information available in healthcare facilities, retail outlets, media, and communities. Since health literate patients are more likely to use high value preventive services and screenings and are less likely to use expensive services such as emergency departments, this deficiency is estimated to cost the nation $106-$236 billion annually.[36] Health literacy related

[34] The APM contract provisions will be effective September 1, 2017.
[35] U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion, "National Action Plan to Improve Health Literacy," 2010, 1.
[36] National Institute of Health, "Clear Communication: Health Literacy", 2014, http://www.nih.gov/clearcommunication/healthliteracy.htm (accessed February 16, 2017).

problems are particularly pronounced among lower income clients served through state Medicaid programs.[37]

HHSC strives to maximize client choice and accountability to the extent feasible under the law. At enrollment, Medicaid clients receive a report card on MCO performance to help inform their choice of health plan. Some MCOs offer value added services to promote healthier living, which may also influence member plan selection. To date, state Medicaid and CHIP programs typically have not been allowed to adopt client accountability provisions common in commercial healthcare plans. Examples are consumer-directed medical accounts (in the case of Medicaid and CHIP programs, these could be funded primarily with public dollars), penalties for smoking if a client does not participate in a smoking cessation program, or copayment requirements for inappropriate emergency room use. Recently, CMS has signaled an openness to provide states with enhanced flexibility.[38] As federal policy evolves, HHSC will closely monitor opportunities to incorporate client empowerment and accountability reforms into the Texas Medicaid and CHIP programs.

Simplifying Administrative Processes

The power to appropriately monitor, oversee, license, and regulate activity is an important tool at the state's disposal for maintaining safe and effective products and services and for promoting competitive and efficient markets. However, experts recognize that many differing, sometimes conflicting, rules and

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[37] M. Kutner, E. Greenberg, Y. Jin, and C. Paulsen, "The Health Literacy of America's Adults: Results From the 2003 National Assessment of Adult Literacy (NCES 2006–483)," U.S. Department of Education, Washington, DC: National Center for Education Statistics, (2006), 18, https://nces.ed.gov/pubsearch/pubsinfo.asp?pubid=2006483 (accessed February 16, 2017).

[38] U.S. Department of Health and Human Services, "Secretary Price and CMS Administrator Verma take First Joint Action: Affirm Partnership of HHS, CMS, and States to Improve Medicaid Program," March 14, 2017, https://www.hhs.gov/about/news/2017/03/14/secretary-price-and-cms-administrator-verma-take-first-joint-action.html (accessed April 7, 2017).

standards imposed by public and private entities related to billing, payment, provider credentialing, quality measurement, and other business transactions have led to excessive complexity in healthcare administration. This administrative complexity raises overall healthcare costs and diminishes quality. For example, compared to non-healthcare sectors in the U.S. economy, which typically operate 100 full-time equivalents (FTEs) or fewer to collect and process $1 billion in revenue, healthcare practices maintain median administrative staff levels of 770 FTEs per $1 billion collected.[39] The IOM estimates excess administrative costs at 7.6 percent of healthcare spending, making it a leading source of waste in healthcare.[40] Physicians report that to retain and recruit providers, simplifying administrative processes in the Medicaid program could prove just as important as increasing compensation.[41]

The 83rd Texas Legislature[42] and Sunset Advisory Commission[43] have both identified opportunities to streamline the state's medical assistance programs with the goal of shifting a greater portion of the healthcare dollar to the direct care of patients and away from complex, redundant, low value administrative processes, procedures, and documentation. To this end, HHSC is participating in efforts led by TAHP to streamline the MCO provider credentialing process. HHSC also launched its own initiative to simplify provider enrollment.

The authorization of this healthcare quality plan provides an opportunity to reduce and align the metrics used across the state's healthcare system. As HHSC advances APMs within the

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[39] J. Blanchfield et al., "Saving Billions of Dollars -- and Physician's Time -- by Streamlining Billing Practices," Health Affairs 29, no. 6 (2010), 1249.
[40] Ibid, Institute of Medicine (2013), 229.
[41] S. Long, "Physicians May Need More than Higher Reimbursements to Expand Medicaid Participation: Findings from Washington State," Health Affairs 32, no. 9, (2013): 1560-1567.
[42] S.B. 1150, 83rd Legislature, Regular Session, 2013 http://www.capitol.state.tx.us/tlodocs/83R/billtext/pdf/SB01150F.pdf#navpanes=0 (accessed November 6, 2014).
[43] Ibid, Sunset Advisory Commission (2015), 85.

Medicaid and CHIP programs, it will seek to minimize administrative complexity for providers who contract with multiple MCOs.

Leveraging Business Intelligence

The healthcare industry generates approximately 30 percent of all existing health data.[44] Despite the amount of healthcare data available across the U.S., patients, providers, payers, researchers, government officials, and other stakeholders encounter challenges translating these data into action. As the IOM points out, unlike in other successful industries where data are consistently converted into business intelligence, in healthcare significant inefficiencies result in "missed opportunities, waste, and harm to patients."[45] High-performing organizations are more likely to apply business intelligence and analytics when making strategic decisions, compared with their under-performing peers.

Recognizing the low level of healthcare related business intelligence described by the IOM, the 2015 HHSC Sunset review established a goal for the HHS system to improve the strategic management and use of its data resources.[46] In response to recommendations, HHSC has moved to address four pivotal business intelligence activities: data inventory, data sharing, data integration, and information dissemination.

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[44] BridgeHead Software Inc "The BridgeHead Software 2011 International Healthcare Data Management Survey", 2011, http://www.bridgeheadsoftware.com/uploads/BH_2011_Healthcare_Data_Survey_US_-_Web.pdf, (accessed February 16, 2017). Also reported in: Miliard, Mike, "Deluge of data has hospitals swimming upstream." Healthcare IT News, August 2012.

[45] Institute of Medicine, "Best Care at Lower Cost: The Path to Continuously Learning Health Care in America, Report at a Glance," September 2012, http://www.nationalacademies.org/hmd/Reports/2012/Best-Care-at-Lower-Cost-The-Path-to-Continuously-Learning-Health-Care-in-America/Report-Brief.aspx (accessed February 15, 2017).

[46] Ibid, Sunset Advisory Commission (2015), 95.

Clients who account for a majority of HHS system spending tend to suffer from multiple chronic and other health conditions, and specific individuals may receive services provided and/or paid for across a number of agencies and programs. Most transactions related to these services are captured and stored in digital format; however, they often are compiled into separate, unlinked databases scattered across the HHS system.[47] Establishing processes for sharing and integrating this data is a necessary precursor for a state-of-the-art business intelligence platform.

HHSC and DSHS are partners on a variety of projects to improve newborn and maternal outcomes. Analytics for these projects often combine data from birth and death certificates collected by DSHS with data on Medicaid services maintained at HHSC. One such better birth outcomes initiative led to a change in Medicaid medical and reimbursement policy for early elective deliveries.[48] This policy change is credited with lowering the rate of these deliveries by as much as 14 percent, leading to gains of almost five days in gestational age and six ounces in birthweight among impacted newborns.[49] Going forward, the MCS Department, as well as other HHS departments, are developing dashboards, linked datasets, and other analytic tools to inform quality improvement projects and support data driven decision making.

Increasing Health Information Technology and Exchange

HIT and HIE enable near real-time communication and collaboration among healthcare and other service providers,

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[47] Ibid. Sunset staff reported that HHS system data are spread across some 800 underlying data systems decentralized among responsible programs and other state and federal agencies.

[48] Under the early elective delivery policy, payments to physicians for non-medically necessary induction and cesarean procedures prior to 39 weeks gestation are subject to nonpayment or recoupment.

[49] H. M. Dahlen et al., "Texas Medicaid Payment Reform: Fewer Early Elective Deliveries and Increased Gestational Age and Birthweight," Health Affairs 36, no. 3 (2017), 460-467, http://content.healthaffairs.org/content/36/3/460.full (accessed April 6, 2017).

programs, individuals, and families. Improved HIT and HIE capability benefits all priorities identified for this plan. As an example, electronic or e-prescribing systems can flag potentially dangerous drug interactions, assist with reviews of patient prescription histories, and prevent problems caused by handwriting, similar drug names, and dosage specifications. E-prescribing reduces overprescribing and medication errors that can be costly and potentially harmful to patients.[50]

Despite considerable public and private investment in electronic health records (EHRs) and other components of the digital infrastructure, overall progress on the secure exchange of health information has been slow.[51] While the majority of relevant health data is now captured and stored in digital format, and technical challenges for the secure exchange of health information have largely been solved, significant barriers to the formation of robust markets for HIE services remain.[52] In Texas, about 75 percent of doctors report use of an EHR, but only 36 percent participate in a local HIE to share data with other providers or healthcare organizations.[53]

The HHSC Health Informatics Services and Quality (HISQ) office supports initiatives to advance HIE in Texas. These initiatives focus heavily on the Medicaid and CHIP programs. HISQ oversees payments to Medicaid providers for the adoption of EHR systems and is expanding this strategy to help participants connect their EHRs to a local HIE.

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[50] D. Radley et al., "Reduction in Medication Errors in Hospitals due to Adoption of Computerized Provider Order Entry Systems," J Am Med Inform Assoc, 20, No. 3 (2013), 470-476, https://academic.oup.com/jamia/article-lookup/doi/10.1136/amiajnl-2012-001241 (accessed April 6, 2017).
[51] P. Dullabh, J. Adler-Milstein, L. Hovey, and A.K. Jha, "Final Report: Key Challenges to Enabling Health Information Exchange and How States can Help," NORC at the University of Chicago, Chicago, IL, (August 2014), 2, https://www.healthit.gov/sites/default/files/state_hie_evaluation_stakeholder_discussions.pdf (accessed March 21, 2017).
[52] Ibid.
[53] Ibid, TMA (2016), 25 & 30.

HISQ also promotes innovative uses for electronic health data, such as the planned Emergency Department Event Notification (EDEN) system. HHSC has requested enhanced federal matching dollars from CMS to build EDEN.[54] The system would give participating hospitals a tool to route electronic notification to the appropriate MCO when a client presents at its emergency department. This alert, in near real time, would allow MCOs and their primary care networks to quickly intervene to inform medical staff about relevant patient history and ensure a client's post visit care is well coordinated, potentially reducing repeat hospital visits, improving outcomes, and saving dollars.

Expanding Public Reporting

Public reporting on population health and healthcare outcomes, client and patient experience, and health system efficiency motivates and empowers clients, communities, service providers, and policy makers to make informed choices. Public reporting also aligns with the values of a transformed HHS system to be transparent, inclusive, and hold itself accountable for results.[55] HHS programs are posting more performance data to public facing webpages. The MCS Department makes information about MCO performance available through its quality website[56] and the Texas Healthcare Learning Collaborative Portal.[57] In addition, the HHSC Transformation Waiver webpage

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[54] CMS approved an Implementation Advanced Planning Document (IAPD) that included EDEN as one of three strategies for the state's HIE Connectivity project on October 1, 2015. HHSC submitted an IAPD update in May of 2017.
[55] HHSC, "HHS System's New Mission, Vision and Values," The Connection, February 15, 2016. https://theconnection.hhsc.texas.gov/2016/02/15/hhs-system%E2%80%99s-new-mission-vision-and-values (accessed February 16, 2017).
[56] See Medicaid CHIP Quality and Efficiency Improvement Data and Reports web page: https://hhs.texas.gov/about-hhs/process-improvement/medicaid-chip-quality-efficiency-improvement/data-reports (accessed January 31, 2017).
[57] See Texas Healthcare Learning Collaborative web page: https://thlcportal.com/index.php/public (accessed March 21, 2017).

includes all outcomes data on the DSRIP program.[58] DSHS reports hospital specific information for potentially preventable readmissions and complications, along with healthcare associated infections and preventable adverse events for hospitals and ambulatory surgical centers.[59] Expanding these efforts, including through academic partnerships and multi payer initiatives,[60] could benefit consumers, purchasers, providers, and policymakers seeking improved value in healthcare.

[58] See RHP Summary Information web page: https://hhs.texas.gov/laws-regulations/policies-rules/waivers/medicaid-1115-waiver/rhp-summary-information (accessed March 21, 2017).
[59] See for example the DSHS Health Care Safety web page: https://www.dshs.texas.gov/idcu/health/infection_control/hai/ (accessed February 16, 2017).
[60] See for example the CMS Qualified Entity Certification Program. To become a certified Qualified Entity, an organization must have access to state level Medicare claims data and combine it with other claims data, such as from Medicaid and commercial sources (otherwise known as the Medicare Data Sharing for Performance Measurement Program): https://www.qemedicaredata.org/SitePages/background.aspx (accessed February 16, 2017).

6. Counting What Counts

In 2013, the IOM's Roundtable on Value & Science Driven Health Care convened a group of experts to assess current challenges and progress toward developing measurement systems to support the Triple Aim: better care for individuals, better health for populations, and lower costs. The Roundtable found that while measures exist for this purpose, the field lacks "a sense of what's most important among the thousands of measures in use across the nation."[61] The primary need, according to the Roundtable's report, is to "identify a small, practical set of indicators of our progress—how we are doing in achieving better health, better care, lower costs, and in involving people more in their own health and care."[62] These core measures, once identified, should be carefully evaluated and incorporated into accountability initiatives in ways that ensure they are:

- evidence-based;
- adjusted for severity and other confounding factors; and
- simple to administer.

The Roundtable's recommendations are particularly relevant to the design of successful performance based payment frameworks in healthcare. Pay-for-performance programs provide financial rewards or penalties to individual healthcare providers, groups of providers, or institutions according to results on measures of quality and have intuitive appeal as a way to incentivize value over volume.[63] Studies suggest

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[61] Institute of Medicine, "Infographic: Counting What Counts: Measuring Progress Toward Better Health at Lower Cost," http://www.nationalacademies.org/hmd/Reports/2013/Core-Measurement-Needs-for-Better-Care-Better-Health-and-Lower-Costs/Counting-What-Counts-Graphic.aspx (accessed February 16, 2017).

[62] Ibid.

[63] A. Mendelson et al., "The Effects of Pay-for-Performance Programs on Health, Health Care Use, and Processes of Care: A Systematic Review," Annals of Internal Medicine, January 10, 2017,

the choice of measures is crucial for a successful program. A recent RAND Technical Expert panel review of 49 pay-for-performance initiatives concluded outcome measures in lower performing programs were typically relevant for only a small fraction (less than 20 percent) of care, encouraging providers "to narrowly focus improvement efforts on the things that are measured (teaching to test) rather than wholesale improvement."[64] This finding is consistent with Bernt Holmstrom's "informativeness principle," credited with earning him the 2016 Nobel Prize for Economic Sciences. The informativeness principle holds that performance based reimbursement should be linked to all outcomes that can potentially provide information about actions taken.[65] One implication of Holmstrom's work is that value based contracts should be tied to broad performance measures.[66]

Although no complete inventory has been compiled, hundreds of outcome metrics are likely used across Texas healthcare quality initiatives, a situation not unique to this state. CMS has 59

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http://annals.org/aim/article/2596395/effects-pay-performance-programs-health-health-care-use-processes-care (accessed February 16, 2017).

[64] RAND, "Measuring Success in Health Care Value-Based Purchasing Programs: Findings from an Environmental Scan, Literature Review, and Expert Panel Discussions," RAND Corporation, 2014, xxi, http://www.rand.org/content/dam/rand/pubs/research_reports/RR300/RR306/RAND_RR306.pdf (accessed February 16, 2017), XV.

[65] B. Holmstrom, "Nobel Prize Lecture: Pay for Performance and Beyond," Aula Magna, Stockholm University, December 8, 2016, http://www.nobelprize.org/nobel_prizes/economic-sciences/laureates/2016/holmstrom-lecture.html (accessed February 16, 2017).

[66] Advisory Board, "What this Year's Nobel Prize in Economics Means for Health Care," Advisory Board, October 12, 2016, https://www.advisory.com/daily-briefing/2016/10/12/nobel (accessed February 16, 2017). Other implications include that information not related to performance should be filtered, e.g., by adjusting for factors outside the agent's control and/or measuring relative to peers; that incentives should be applied uniformly in a linear model, that is, incentive schemes should avoid cliffs where an incremental change in measurement triggers a significant change in the total amount of an award or penalty; and that overly specified requirements can be counterproductive, encouraging too much attention on provisions that are the most easily quantified.

clinical and patient experience measures in its Hospital Inpatient Quality Reporting Program, 18 measures for its Nursing Home Quality Initiative, 34 measures for accountable care organizations, and 271 measures for its physician focused Merit-based Incentive Payment System. While most quality measures may have a specific, understandable, and necessary purpose for an individual project or initiative, these measures rarely provide information covering the full range of actions connected to producing optimal health and, when viewed together, can appear a messy collection of data points that obscure broad, important trends. The Legislature recognized this challenge when drafting this plan's requirements.

To improve policy makers' ability to evaluate the statewide impact of major quality initiatives, this plan calls for the creation of a dashboard reporting only a small number of high impact measures relevant to the six identified priorities. These measures will convey a broad picture of overall performance. Using the best available data, the dashboard will report performance statewide, by managed care service areas, and by the 20 Regional Healthcare Partnership (RHP) regions that help coordinate local DSRIP projects. The dashboard will focus on outcomes rather than processes. It will also reflect legislative guidance from Chapter 536 of the Texas Health and Safety Code to identify measures with the greatest relevance for quality, efficiency, and expenditure in healthcare. Each year, the dashboard will be updated in time for review by programs and stakeholders and be incorporated into the HHS system's annual program level operational planning process (as described in the next section).

The dashboard will emphasize Medicaid and CHIP measures aligned with the Triple Aim. Where appropriate, results will be stratified for populations receiving services through HHS programs, including the following:

- Newborns and children
- Pregnant women and mothers

- Individuals with mental health and/or substance use disorders
- Individuals with complex healthcare needs
- Individuals age 65 years and over
- Individuals eligible for long term services and supports

In most cases, the dashboard should report the same metrics for the state overall and each population strata; however, in limited instances, population-specific measures may be included.

Texas is a large and diverse state. More than half of the Texas population is Hispanic or non-white. Although 85 percent of Texans reside in an urban location,[67] the nearly four million Texans who live in sparsely populated rural areas exceed the total population of 24 U.S. states and the District of Columbia.[68] An uneven distribution of healthcare and health promotion resources across Texas, especially in rural areas, but also in low income urban areas, affects many children, families, and individuals served by the state's health and human services programs. Of Texas' 254 counties, 189 are at least partially designated as a primary care Health Professions Shortage Area (HPSA), and 207 are at least partially designated as a mental health HPSA. As part of this plan, HHSC will measure health outcomes for these sub-populations, based on race/ethnicity, population density, and low income to identify health disparities across Texas communities and help policy and decision makers target scarce resources to ensure the broadest possible gains from health improvement initiatives.

[67] U.S. Census Bureau, 2010 Census of Population and Housing, Population and Housing Unit Counts, CPH-2-45, Texas, Washington, DC, 2012.
[68] U.S. Census Bureau, 2010 Census of the United States, Resident Population Data, https://www.census.gov/2010census/data/apportionment-dens-text.php (accessed May 16, 2017).

7. Quality Plan Operational Overview

To address the need for better coordination of state healthcare quality initiatives and improve transparency regarding their effectiveness, this quality plan's initiatives must be collaboratively implemented by relevant programs and stakeholders. Because of the high number of HHS system quality improvement initiatives, a decentralized, strategic approach is required to achieve plan priorities.

The existing HHS operational planning process, where executive leadership communicates goals to programs and programs report key activities and milestones, will be leveraged to ensure transparency and accountability. This process will be strengthened by the addition of a robust, ongoing, and data centric evaluation and review component for healthcare quality and efficiency. A small number of core metrics aligned with plan priorities will be identified, tracked, and reported at the state and regional levels. As plan performance data is compiled, the agency will solicit internal and external stakeholder input using a variety of outreach methods and provide feedback to individual programs to use to revise annual operational plans. Key plan milestones, activities, and deadlines are listed in Table 4.

Table 4. Quality Plan Milestones and Activities

Milestone	Activities	Time Frame[i]
Update Statewide Performance Dashboard	• Compile plan dashboard metrics for a rolling five year period	Complete by March 31, with first dashboard report in 2018

Milestone	Activities	Time Frame[i]
Review dashboard results with stakeholders	• Review performance and obtain input from the following entities: 1. Offices within MCS Quality and Program Improvement 2. Other HHS programs with significant responsibility for health quality improvement 3. MCOs and DMOs 4. RHPs 5. Value Based Payment and Quality Improvement Advisory Committee 6. Other interested stakeholders (internal and external) 7. HHS system leadership	Complete by April 30, beginning in 2018
Update the Healthcare Quality Plan	• Note key performance trends • Note emerging industry trends • Incorporate lessons learned • Review and revise plan priorities • Disseminate updated report	Complete by May 31, with first plan revision in 2018

Milestone	Activities	Time Frame[i]
Integrate with annual program level operational plans	• HHS system operational planning requirements will be modified to direct programs involved with health quality improvement to describe how their activities support and align with priorities identified in the Healthcare Quality Plan	June-July, beginning 2017
Implement operational plans	• Individual programs implement their operational plans	September 1, beginning 2017
Report progress to Texas Legislature	• MCS Quality and Program Improvement will lead the drafting of the biennial progress report	October 31, even numbered years

[i] Quality plan activities will be ongoing over each state fiscal year. Plan priorities will be incorporated into the HHS system operational planning process beginning June 2017.

As shown in Table 4, priorities established in this plan will guide HHS system policy making and program activities related to healthcare value over the next five years. Reflecting HHS' commitment to continuous improvement, the plan will be refined each fiscal year based on public and private sector experiences, the latest research and evidence, and emerging issues. During even numbered years, staff will conduct a more extensive review, culminating in a progress report to the Texas Legislature.

HHSC's MCS Quality and Program Improvement Section will administer and support the plan.

8. Conclusion

The Texas Healthcare Quality Plan will guide HHS system quality improvement strategies to achieve better care, smarter spending, and healthier people and communities. The plan builds on the foundation provided by the implementation of the managed care model within the state Medicaid and CHIP programs. The plan emphasizes accountability for individuals, payers, providers, and health related public programs, and establishes the following six priorities:

1. Keeping Texans healthy at every stage of life through prevention and by engaging individuals, families, communities, and the healthcare system to address root causes of poor health;
2. Providing the right care in the right place at the right time to ensure people receive timely services in the least intensive or restrictive setting appropriate;
3. Keeping patients free from harm by building a safer healthcare system that limits human error;
4. Promoting effective practices for chronic disease to better manage this leading driver of healthcare costs;
5. Supporting patients and families facing serious illness to meet physical, emotional, and other needs; and
6. Attracting and retaining high-performing providers and other healthcare professionals to participate in team based, collaborative, and coordinated care.

Over the next five years, HHS system policy making and program activities related to healthcare value will align with these priorities. Transforming healthcare into a value based system will be a long term endeavor involving many decisions and coordinated actions by HHS programs and stakeholders. Ongoing efforts will support system-wide change for better care

and health for individuals and populations and lower costs for consumers and payers in Texas.

List of Acronyms

Acronym	Full Name
APM	Alternative Payment Models
CDC	Centers for Disease Control and Prevention
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare and Medicaid Services
DMO	Dental Maintenance Organization
DSRIP	Delivery System Reform Incentive Payments
DSHS	Department of State Health Services
EDEN	Emergency Department Event Notification
EHR	Electronic Health Record
E-prescribing	Electronic Prescribing
EQRO	External Quality Review Organization
FTE	Full-time Equivalents
HHS	Health and Human Services
HHSC	Health and Human Services Commission
HIE	Health Information Exchange
HISQ	Health Informatics Services & Quality (HISQ)
HIT	Health Information Technology
HPSA	Health Professions Shortage Area
IAPD	Implementation Advanced Planning Document
ICHP	Institute for Child Health Policy
IOM	Institute of Medicine
MCO	Managed Care Organization
MCS	Medicaid and CHIP Services
NAM	National Academy of Medicine
NIHCM	National Institute for Health Care Management
P4Q	Pay for Quality
PIP	Performance Improvement Project
QIPP	Quality Incentive Payment Program
RHP	Regional Healthcare Partnership
SFY	State Fiscal Year
SHCC	Statewide Health Coordinating Council
SPC	Supportive Palliative Care
TMA	Texas Medical Association

Appendix A. Environmental Scan: Promoting Value in Healthcare, a State Priority

State government has a strong interest and essential role to play in transforming healthcare. Since 1991, the year the Texas Legislature established HHSC, healthcare spending nationally has risen from 13 percent of gross domestic product to about 18 percent in 2015.[69] At the same time, more responsibility for paying for healthcare has shifted to government at all levels, including state government. Between 1991 and 2015, the portion of total health related expenditures paid by private insurance or directly by individuals fell from 50 to 44 percent, while the portion paid through Medicaid, Medicare, and CHIP increased from 27 to 38 percent nationally.[70] The implications of this shift for public budgets and programs have been greatly discussed at the federal level but are no less profound for the states. As the lead project and research staff for the bipartisan State Health Care Cost Containment Commission wrote, "Forced to pay for escalating healthcare costs, states have neglected investments in education, highways, and infrastructure."[71] In

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[69] U.S. Centers for Medicare and Medicaid Services, "Table 1 National Health Expenditures: Aggregate and Per Capita Amounts, Annual Percent Change and Percent Distribution: Calendar Years 1960-2015," https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/NHEGDP15.zip (accessed February 14, 2017).

[70] Ibid, "National Health Expenditures by Type of Service and Source of Funds: Calendar Years 1960-2015," https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/NHE2015.zip.; "National Health Expenditures; Aggregate and Per Capita Amounts, Annual Percent Change and Percent Distribution: Calendar Years 1960-2015," https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/NHEGDP15.zip. (accessed February 14, 2017).

[71] R. Scheppach and J. Thomasian, "Cracking the Code on Health Care Costs: What the States Can Do," Health Affairs Blog, January 7, 2014. http://healthaffairs.org/blog/2014/01/07/cracking-the-code-on-health-care-costs-what-the-states-can-do/ (accessed February 14, 2017).

Texas specifically, the Legislative Budget Board reports that spending on health and human services (Article II of the Texas budget) increased from 20 percent of general revenue outlays during the 2000-2001 biennium to about 31 percent in 2014-2015.[72]

While the reasons for the high rate of healthcare cost growth and the shifting of a larger portion of healthcare finance to the public sector continue to be debated, policy makers have reached at least a partial consensus on a strategic direction for responding to the challenges posed by these trends. This emerging consensus can be summed up by a single word—accountability—a core value of the transformed HHS system.

State governments are best positioned to lead the transformation of the healthcare system into one that is accountable for managing costs and improving outcomes. State governments collectively pay hundreds of billions of dollars for healthcare through Medicaid, employee health benefits, and other programs while possessing significant regulatory authority, maintaining close relationships with stakeholders, and compiling vast quantities of data generated by the healthcare sector.[73]

As states address the challenge to transform healthcare, one lesson to heed is that more expensive care may not always mean better care. An analysis by researchers at the RAND Corporation identified 61 studies examining the relationship between higher than average spending and improved quality in healthcare. Of these, about one-third found that higher spending was associated with higher quality; one-third found the opposite (higher spending was associated with lower quality); and one-third did not identify an association between higher

[72] Legislative Budget Board, "Fiscal Size Up: 2002-03 Biennium," 5 & Legislative Budget Board, "Fiscal Size Up: 2016-17 Biennium," 3.
[73] State Health Care Cost Containment Commission, "Cracking the Code on Health Care Costs" (The Miller Center, University of Virginia, January 2014), 23.

than average spending and quality at all.[74] In other words, after a point, higher medical spending probably does not lead to better outcomes. Spending trends can be moderated and the health of the population improved simultaneously through better, more integrated care that prevents inpatient and emergency department visits and reduces low value or duplicate procedures or tests that can elevate the risk of harm to patients.

The evidence cited by RAND supports healthcare reform focused on value rather than exclusively on quality or cost. Value oriented strategies target waste in the healthcare system. An expert panel, convened by the IOM in 2013, identified six categories of waste (see Figure 1) associated with enough excess spending in the U.S. healthcare sector to purchase recommended vaccinations for all children born over a 40 year period, fully fund the annual investment needed to provide basic public health services to every U.S. community, and buy a year's worth of groceries for all U.S. households.[75] These six categories include:

- Low value/unnecessary services—the utilization or overutilization of services beyond the current base of evidence, or the choice of higher-cost services when an equally effective and less expensive service is available
- Inefficiently delivered services—medical mistakes, preventable adverse events, and other consequences from care fragmentation
- Administrative complexity—costs related to insurers' administrative inefficiency, fragmented reporting requirements, excessive documentation burdens, and other unnecessary regulatory and compliance costs
- High prices—services and products that may be priced beyond competitive benchmarks in some markets due to atypical cost

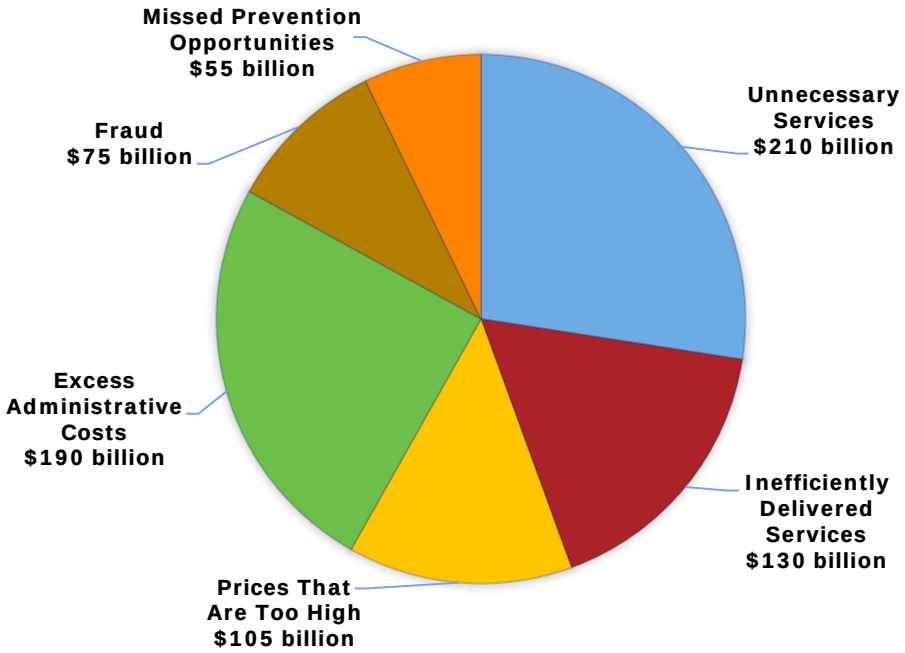
[74] P. Hussey, S. Wertheimer, and A. Mehrotra, "The Association Between Health Care Quality and Cost," Annals of Internal Medicine 158 (2013): 1.
[75] Ibid, Institute of Medicine, "Best Care at Lower Cost: The Path to Continuously Learning Health Care in America," (2013), 103.

and practice incentives, a lack of information on cost and quality, and limited provider competition

- Missed prevention opportunities—costs that could have been avoided, through greater emphasis on evidence-based disease prevention and management and through higher investment in population health strategies
- Fraud—costs imposed by people and organizations who obtain benefits by intentionally engaging in deception such as submitting false healthcare claims or medical histories

About half of the waste identified by the IOM panel results from inefficiently delivered services, unnecessary services, and missed prevention opportunities.

Figure 1. Waste and Excess Cost in Healthcare, 2009[ii]



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Source: "Best Care at Lower Cost: The Path to Continuously Learning Health Care in America". *IOM* (2013), 229.

Costs from waste are amplified by a trend of rising incidence[76] and prevalence[77] of chronic and medically complex conditions. According to the Agency for Healthcare Research and Quality, 86 cents of every healthcare dollar is now spent treating individuals with a chronic disease, with 71 cents spent treating individuals with multiple chronic conditions.[78] Among the Medicare population, which includes a substantial number of individuals with dual coverage through Medicaid, the IOM reports that 48 percent of beneficiaries have at least three chronic conditions, and 21 percent have five or more.[79]

Patients with complex medical needs are often treated through an uncoordinated patchwork of providers who do not consistently communicate with one another or take responsibility for the patient's continuity of care and who are paid through reimbursement mechanisms that favor medical treatments and procedures over prevention, self-management, and community based non-clinical services. The result is lower quality and efficiency, contributing to a higher concentration of spending than optimal on sick care rather than health care.[80]

The National Institute for Health Care Management (NIHCM) Foundation reports that approximately 50 percent of healthcare spending, equivalent to nearly 10 percent of all U.S. economic

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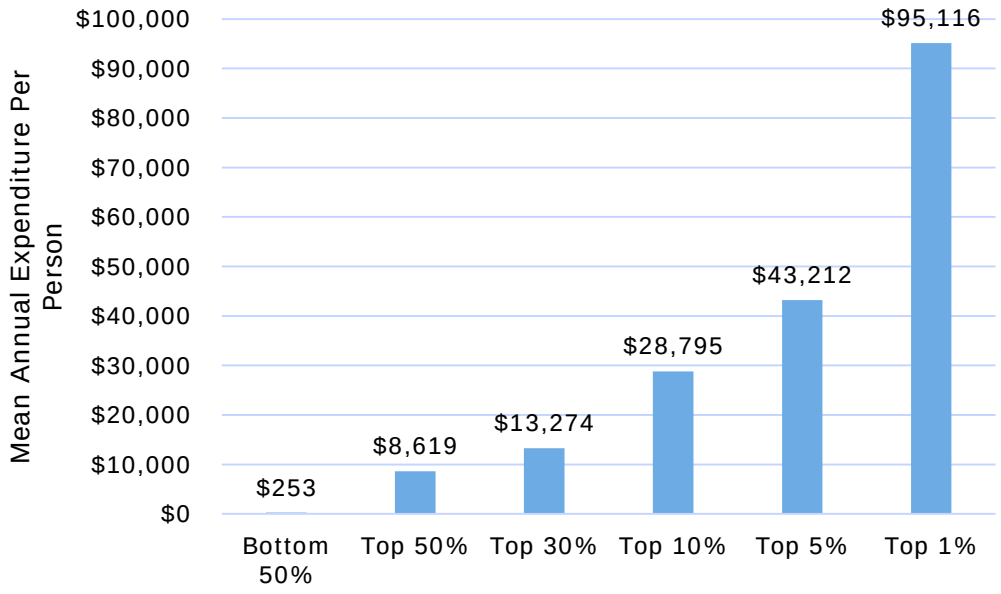
[76] Incidence is the number of new cases of a condition, symptom, death, or injury that develop during a specific time period, such as a year.
[77] Prevalence is the number of existing cases of a condition, symptom, death, or injuring that develops during a specific time period, such as a year.
[78] Ibid, J. Gerteis, D. Izrael, D. Deitz, L. LeRoy, R. Ricciardi, T Miller, and J Basu (2014), 7.
[79] Health Affairs, "Health Policy Brief: Reducing Waste in Health Care," Health Affairs December 13, 2012, http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=82 (accessed February 14, 2017).
[80] F. Marvasti and R. Stafford, "Perspective: From Sick Care to Health Care - Reengineering Prevention into the U.S. System," New England Journal of Medicine, September 6, 2012, http://www.nejm.org/doi/full/10.1056/NEJMp1206230#t=article (accessed May 15, 2017).

activity, goes to pay medical bills for just five percent of the population (see Figure 2). NIHCM notes that individuals with high spending tend to have one or more chronic conditions: "Nearly half of all people in the top five percent of spending reported having hypertension, one-third had lipid disorders, and more than one-quarter had diabetes."[81] Moreover, "chronic conditions are also a likely reason why some people have high spending over a prolonged period, particularly when multiple chronic conditions are present."[82]

Figure 2. Mean Expenditure Per Person from Low to High Spending Group, 2013[iii]



[iii] *Source*: "Health Care's Big Spenders: The Characteristics Behind the Curve" *NIHCM.* Accessed February 28, 21017. https://www.nihcm.org/topics/cost-quality/health-cares-big-spenders-chart-story

[81] J. Schoeman and N. Chockley, "Understanding U.S. Health Care Spending. NIHCM Foundation Data Brief." National Institute for Health Care Management, July 2011, 6, https://www.nihcm.org/awards/5-issue-brief/1313-understanding-u-s-health-care-spending-db (accessed February 14, 2017).
[82] Ibid.

Data from Medicaid programs reflect the overall picture that individuals with multiple chronic conditions are a primary cost driver for healthcare. In fact, it appears that the very same people tend to produce the highest costs for the medical system year after year. The Center for Medicaid and CHIP Services (2013) reports that nationally, nearly 60 percent of Medicaid beneficiaries who were among the most expensive 10 percent of patients in one year remained among the top 10 percent in two subsequent years.[83] These patients, who often suffer from multiple chronic health conditions, may remain high utilizers of care for an extended time in part because they lack access to coordinated, accountable care and may receive fragmented services in expensive acute care settings while in a state of crisis. Many have behavioral health conditions, including mental and substance use disorders. Patients with high utilization of medical services may also face social barriers such as isolation, unemployment, and homelessness, "…which exacerbate their chronic medical illnesses."[84]

A lack of access to coordinated, accountable services can have particularly profound consequences for individuals diagnosed with serious and persistent mental illness[85] and other behavioral health conditions. In Texas, as in the U.S. overall, individuals diagnosed with a serious mental illness have been found to be at elevated risk for premature mortality.[86] Dr. Kenneth Minkoff, a Texas-based expert on integrated, recovery-based models of

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[83] Mann, C, "CMCS Informational Bulletin: Targeting Medicaid Super-Utilizers to Decrease Costs and Improve Quality," Center for Medicaid and CHIP Services, July 24, 2013, 2.
[84] Ibid, Turner and Kelly (2000).
[85] Serious and Persistent Mental Illness includes diagnoses such as schizophrenia, major depression, and bipolar disorder that are both episodic and long-term conditions.
[86] R. Reynolds, E. Becker, A. Shafer, "Causes of Death and Comparative Mortality in Texas Public Mental Health Clients, 2006-2008," Mental Health Clinic 3, no. 1, (2013): 52, http://cpnp.org/resource/mhc/2013/07/causes-death-and-comparative-mortality-texas-public-mental-health-clients-2006 (accessed February 15, 2017).

care, points out that for this population, “co-occurring issues and conditions are an expectation, not an exception.”[87]

Given unsustainable cost trends and a growing number of individuals with complex needs, achieving high quality and efficient healthcare will challenge all participants involved in the promotion and protection of health and wellness to align quality improvement projects, public health initiatives, delivery system restructuring, and payment reforms in ways that are mutually reinforcing. State governments are best prepared, working with their multi sectoral partners, to lead these efforts to transform healthcare to a system that rewards value over volume.

[87] K. Minkoff, "Comprehensive, Continuous, Integrated, System of Care (CCISC) Model," http://kenminkoff.com/ccisc.html (accessed February 15, 2017).