



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

As Required By

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

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

**2016-17 General Appropriations Act, H.B. 1, 84th
Legislature, Regular Session, 2015 (Article II, Health And
Human Services Commission, Rider 46 And Rider 67)**

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1. EXECUTIVE SUMMARY

This annual report builds on the previous annual report¹, submitted in February 2016, which provided information about Health and Human Services Commission (HHSC) quality-based measures, outcomes, and systems for Medicaid and the Children's Health Insurance Program (CHIP). Data and observations demonstrate continued improvements across key measures of quality and efficiency. For example, Medicaid clients experienced fewer potentially preventable events (PPEs) and managed care organizations (MCOs) avoided expenditures on those events.

With the implementation of STAR Kids², HHSC continues to migrate the Medicaid program and CHIP to a managed care delivery system model. Under this model, the state contracts with MCOs that provide customer service, clinical oversight, care coordination, and oversee payments to contracted medical care providers.

HHSC and contracted MCOs use a wide array of measures to assess quality of care and efficiency. These measures are often used to support quality-based payment systems or incentive and disincentive programs, either between HHSC and contracted MCOs, or between MCOs and their contracted health care providers.

HHSC requires all Medicaid and CHIP MCOs and dental maintenance organizations (DMOs) to submit an annual update to HHSC detailing their various value-based contracting (VBC) initiatives. As of the last deliverable in December 2015, all of Texas' 19 Medicaid and CHIP MCOs and both DMOs offer some form of VBC for their providers.

Some MCOs have several years of experience with VBC and have rolled out programs across larger geographic regions based on their successes, while other plans have chosen to start small with pilot programs. The number of providers participating in different MCO incentive programs varies depending on whether the providers are engaged individually or in group practices. In general, the larger the size of the physician practice or group, the more advanced the VBC approaches.

MCOs continue to expand value-based payment contracts with network providers. With support from and coordination with HHSC, MCOs also actively evaluate projects implemented under the Delivery System Reform Incentive Payment (DSRIP) program for possible inclusion as a VBC model for their providers.

To better understand how or if VBC achieves HHSC's goals, such as improved quality and lower cost, staff will study the cost and quality impacts of different MCO value-based payment models. However, due to the numerous initiatives underway at the state, national, and commercial levels focused on similar areas of health care quality and efficiency improvement, it will be challenging to attribute improvement to any single initiative.

¹ February 2016 Report accessed at: <https://hhs.texas.gov/sites/hhs/files/sb7-rider-46.pdf>

² Information on STAR Kids accessed at: <https://hhs.texas.gov/services/health/medicaid-and-chip/programs/star-kids>

HHSC also continues to evaluate and refine the different quality initiatives underway at the state and federal level to ensure they are well-coordinated and administrative burdens are minimized. HHSC recently organized separate internal units that had previously overseen different aspects of quality into one larger section within the Medicaid and CHIP Services Department. Pursuant to S.B. 200, 84th Legislature, Regular Session, 2015, this section is developing a coordinated quality roadmap that is responsive to the population health priorities of the state as well as from a national perspective. This coordinated quality strategy will be inclusive of internal stakeholder input, including other agencies such as the Department of State Health Services (DSHS), as well as external stakeholder groups. Quality initiatives will work in tandem to support these priorities.

Finally, HHSC recently selected members for the new Value-Based Payment and Quality Improvement Advisory Committee³. This committee will serve in an advisory role to HHSC in the areas of value-based payment approaches, metrics and analytics, and strategic direction.

2. INTRODUCTION

The 2016-17 General Appropriations Act (GAA), H.B. 1, 84th Legislature, Regular Session, 2015 (Article II, HHSC, Rider 46), directs HHSC to implement the following quality-based payment and delivery reforms in Medicaid and CHIP:

- Develop quality-based outcome and process measures that promote the provision of efficient, quality health care and can be used to implement quality-based payments for acute and long-term care services across delivery models and payment systems.
- Implement quality-based payment systems for compensating a health care provider or facility participating in Medicaid and CHIP.
- Implement quality-based payment initiatives to reduce potentially preventable readmissions (PPRs) and potentially preventable complications (PPCs).
- Implement a bundled payment initiative in the Medicaid program, including a shared savings component for providers that meet quality-based outcomes (high-cost and/or high-volume services may be selected for bundling, and HHSC may consider the experiences of other payers and other state of Texas programs that purchase health care services in making the selection).

Additionally, per Rider 46, HHSC may implement a special reimbursement class for nursing facilities commonly referred to as "small house facilities." Such a class may include a rate reimbursement model that is cost neutral and adequately addresses the cost differences that exist in a nursing facility constructed and operated as a small house facility. The payment increment may be based upon a provider incentive payment rate.

Rider 46 requires HHSC to provide annual reports on the following:

- The quality-based outcome and process measures developed
- The progress of the implementation of quality-based payment systems and other related initiatives

³ Information on the Value-Based Payment and Quality Improvement Advisory Committee accessed at: <https://hhs.texas.gov/about-hhs/leadership/advisory-committees/value-based-payment-and-quality-improvement-advisory-committee>

- Outcome and process measures by health service region
- Cost-effectiveness of quality-based payment systems and other related initiatives

S.B. 7, 82nd Legislature, First Called Session, 2011, requires HHSC to annually report on quality-based outcome and process measures developed, the progress of the implementation of quality-based payment systems and other payment initiatives, and outcome and process measures by health care service region and service delivery model.

S.B. 7, 83rd Legislature, Regular Session, 2013, expanded the annual reporting requirement on outcome and process measures to include, as appropriate:

- Geographic location, which may require reporting by county, health care service region or other appropriately defined geographic area
- Recipient population or eligibility group served
- Type of health care provider, such as acute care or long-term care provider
- Number of recipients who relocated to a community-based setting from a less integrated setting
- Quality-based payment system
- Service delivery model

The 2016-17 GAA (Article II, HHSC, Rider 67) also requires HHSC to evaluate and report on how Texas Medicaid providers and MCOs use pay-for-quality (P4Q) measures to improve health care delivery, whether these initiatives result in a higher quality of care and improved health outcomes, efforts undertaken to make the current P4Q measures more effective, and how HHSC will use those findings if it expands the use of P4Q measures into outpatient settings.

This report fulfills S.B. 7 (2011 and 2013), Rider 46, and Rider 67 requirements and provides a comprehensive update on HHSC's efforts to promote the provision of efficient, quality health care in Medicaid and CHIP.

3. BACKGROUND

HHSC continues to advance quality and efficiency in the Medicaid and CHIP programs, and has consolidated quality functions in one section, Quality and Program Improvement, within the Medicaid and CHIP Services Department. By organizing previously separate units focused on different aspects of quality into one larger section, HHSC is positioned to improve the coordination, harmonization, and administration of initiatives focused on quality and efficiency improvement. Pursuant to S.B. 200, HHSC is developing a quality operational plan to ensure optimal coordination of quality initiatives and better communication of strategic direction to stakeholders.

The newly appointed Value-Based Payment and Quality Improvement Advisory Committee will serve in an advisory role to HHSC on:

- Value-based payment and quality improvement initiatives to promote better care, better outcomes, and lower costs for publicly funded health care services
- Core metrics and a data analytics framework to support VBP and quality improvement in Medicaid and CHIP

- HHSC and MCO incentive and disincentive programs based on health care value
- The strategic direction for Medicaid and CHIP value-based programs

As with the previous annual report, strong signals of progress on several key measures of quality and efficiency are being observed. Furthermore, MCOs are steadily increasing and diversifying their value-based payment models with providers.

4. UPDATE ON QUALITY MEASURES AND IMPLEMENTATION OF QUALITY-BASED PAYMENT SYSTEMS

Updates on quality-based measures and payment systems outlined in the previous annual report are described below.

4.1 Medical Pay-for-Quality Program

Background

In 2014, HHSC implemented a Medicaid and CHIP Medical P4Q Program⁴ for MCOs in the STAR, STAR+PLUS and CHIP programs. The medical P4Q program used an incremental improvement approach, providing financial incentives and disincentives to MCOs based on year-to-year incremental improvement on pre-specified quality goals. The quality of care measures used in this initiative were a combination of process and outcome measures including select PPEs and other measures specific to the program's populations.

Rewards and penalties were based on rates of improvement or decline from the baseline level of performance. MCOs that excelled in meeting the improvement targets were eligible for an incentive payment of up to four percent of their capitation payments. MCOs that declined in performance could lose up to four percent of their capitation rate. The medical P4Q program also set minimum baseline performance levels for the measures so low-performing MCOs were not rewarded for marginal gains if their performance remained substandard. All funds recouped from lower performing MCOs (up to four percent) were to be used to create a reward pool, which is redistributed to higher performing MCOs. No funds would be returned to the state.

Each MCO's performance is measured using nationally recognized performance measures, including Health Effectiveness Data Information Set (HEDIS) quality of care measures and PPEs. The quality measures used in P4Q are a combination of process and outcome measures relevant to each program's enrolled populations and identified as important targets for desired improvement. The STAR program provides acute care services and serves largely children and pregnant women. The STAR P4Q program focused on measures that cover preventive care, healthy pregnancies, and avoidance of PPEs. The STAR+PLUS Medicaid program provides coverage for a much more medically complex and generally older population. The P4Q measures in STAR+PLUS also focused on avoidance of PPEs as well as management of chronic diseases.

⁴ Pay-for-Quality information accessed at: <https://hhs.texas.gov/about-hhs/process-improvement/medicaid-and-chip-quality-and-efficiency-improvement/pay-quality-p4q-program>

Serving a pediatric population, CHIP used similar measures to the STAR program except for the measures relating to pregnant women and PPR (due to low volume of events).

Table 1 shows the specific measures used in the 2014 P4Q program in STAR, STAR+PLUS, and CHIP.

Table 1. Measures Used in 2014 Medical P4Q by Program Type

Measure	Measure Description	STAR	CHIP	STAR+PLUS
Well-Child Visits at 3, 4, 5, and 6 Years	The percentage of members 3–6 years of age who had one or more well-child visits with a primary care provider (PCP) during the measurement year.	X	X	
Adolescent Well-Care Visits	The percentage of enrolled members 12–21 years of age who had at least one comprehensive well-care visit with a PCP or an obstetrics/gynecology (OB/GYN) practitioner during the measurement year.	X	X	
Timeliness of Prenatal Care and Postpartum Care	Of the live births in the measurement period: <ul style="list-style-type: none"> • Timeliness of Prenatal Care: The percentage of deliveries that received a prenatal care visit as a member of the organization in the first trimester or within 42 days of enrollment in the MCO. • Postpartum Care: The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery. 	X		
PPA	Risk-adjusted expenditures for hospital or long-term care facility admission that may have been prevented with access to ambulatory care or health care coordination.	X	X	X
PPR	Risk-adjusted expenditures for return hospitalizations resulting from care or treatment deficiencies provided during a previous hospital stay or from post-hospital discharge follow-up.	X		X
PPV	Risk-adjusted expenditures for hospital emergency room or freestanding emergency medical care facility treatment provided for a condition that could be provided in a nonemergency setting.	X	X	X

Measure	Measure Description	STAR	CHIP	STAR+PLUS
Antidepressant Medication Management	Of members 18 and older diagnosed with major depression: <ul style="list-style-type: none"> • Effective Acute Phase Treatment: The percentage of newly diagnosed and treated members who remained on an antidepressant medication for at least 84 days (12 weeks). • Effective Continuation Phase Treatment: The percentage of newly diagnosed and treated members who remained on an antidepressant medication for at least 180 days (6 months). 			X
HbA1c Control <8	The percentage of members 18-75 years of age with diabetes (type 1 and type 2) who had HbA1c control (<8.0%).			X

Medical P4Q Results

While Texas saw varied results in statewide performance on P4Q measures, many of the MCOs met their quality improvement goal on the measures as indicated in Table 2 below.

Table 2. Number of MCOs Meeting 2014 Medical P4Q Expected Quality Improvement Goals

Medical Measures	STAR (18 MCOs)	STAR+PLUS (5 MCOs)	CHIP (17 MCOs)
PPA	7	1	8
PPR	4	3	N/A
PPV	4	0	5
Well-Child Visits at 3, 4, 5, and 6 years	9	N/A	11
Adolescent Well-Care Visits	11	N/A	15
Prenatal Care	12	N/A	N/A
Postpartum Care	11	N/A	N/A
Antidepressant Medication Management - Acute	N/A	0	N/A
Antidepressant Medication Management - Continuation	N/A	2	N/A
HbA1c Control <8	N/A	4	N/A

Following is a comparison of P4Q measure results by program for 2013 and 2014 (the first year of P4Q implementation).

STAR

For the STAR program, statewide performance improved on four out of the six P4Q measures: adolescent well-care visits, prenatal and postpartum care, PPAs, and PPRs (the results of the sub-measures for prenatal and postpartum care are presented separately in Figure 1). The rate of well-child visits in the third, fourth, fifth, and sixth years of life decreased by 1.34 percent between 2013 and 2014. While the PPV expenditures per 1,000 member months decreased by 4.17 percent, the actual number of PPVs per 1,000 member months increased by 0.2 percent. There could be a number of reasons why the number of events per 1,000 member months changed in the opposite direction from the expenditures per 1,000 member months. For example, the types of events may be more or less costly, the MCO may have changed their rates or contracted with different providers, or the patients coming through the door may be more or less complicated. See Figure 1 and Table 3 for these results.

Figure 1. 2013-2014 Weighted STAR Rates, HEDIS P4Q Measures

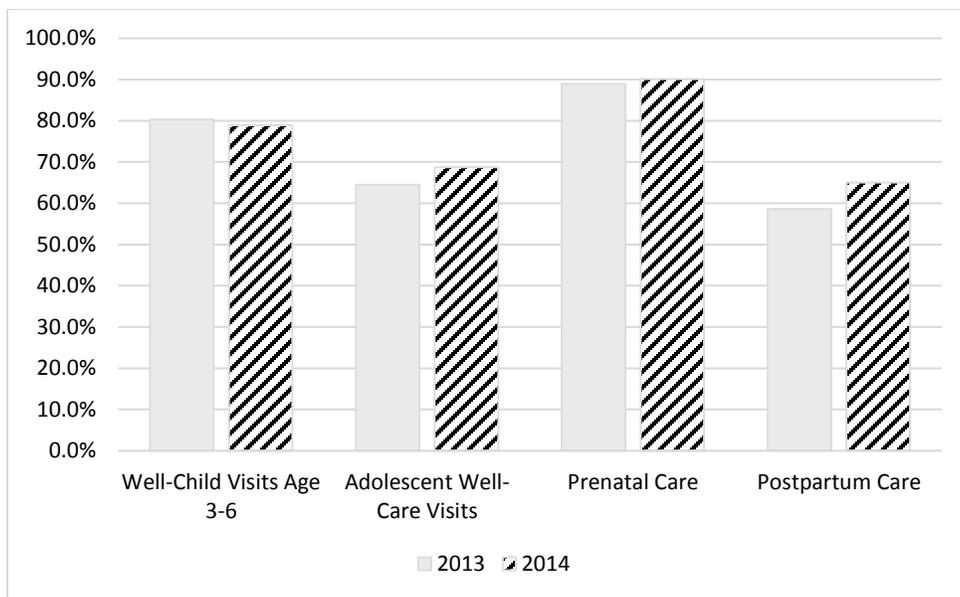


Table 3. STAR PPE P4Q Measures

Events	Actual Number of Events Per 1,000 Member Months 2013	Actual Number of Events Per 1,000 Member Months 2014	Actual Expenditures Per 1,000 Member Months 2013	Actual Expenditures Per 1,000 Member Months 2014
PPAs	0.80	0.72	\$3,536	\$3,403
PPRs*	0.20	0.19	\$1,519	\$1,404
PPVs	39.38	39.46	\$10,306	\$9,876

* Number of PPR chains per 1,000 member months. A PPR chain is defined as one or more PPRs within the 30-day readmission period.

STAR+PLUS

For STAR+PLUS, statewide performance improved on four out of the five P4Q measures: diabetes control, PPAs, PPRs, and PPVs. However, the rate of antidepressant medication management declined, with acute phase treatment decreasing by 1.2 percent and continuation phase treatment decreasing by 0.48 percent between 2013 and 2014 (the results of the sub-measures for antidepressant medication management are presented separately in Figure 2). See Figure 2 and Table 4 for these results.

Figure 2. 2013-2014 Weighted STAR+PLUS Rates, HEDIS P4Q Measures

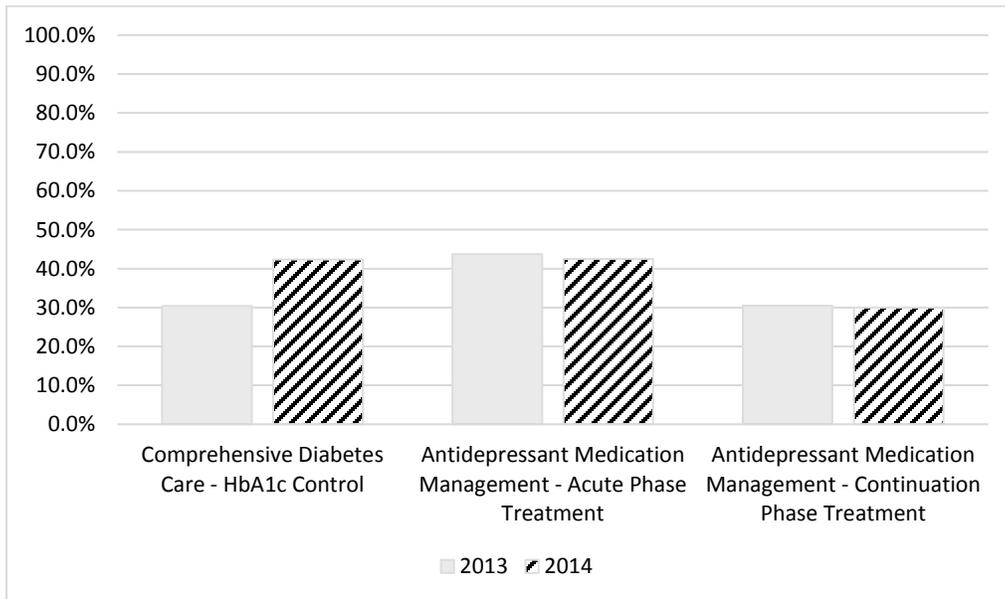


Table 4. STAR+PLUS PPE P4Q Measures

Event	Actual Number of Events Per 1,000 Member Months 2013	Actual Number of Events Per 1,000 Member Months 2014	Actual Expenditures Per 1,000 Member Months 2013	Actual Expenditures Per 1,000 Member Months 2014
PPAs	7.54	6.92	\$38,411	\$34,845
PPRs*	3.04	2.66	\$25,788	\$17,732
PPVs	90.25	90.02	\$40,899	\$40,013

* Number of PPR chains per 1,000 member months. A PPR chain is defined as one or more PPRs within the 30-day readmission period.

CHIP

For CHIP, statewide performance improved on two out of the four P4Q measures: well-child visits in the third, fourth, fifth, and sixth years of life⁵ and adolescent well-care visits. PPAs per 1,000 member months increased by 5.26 percent and expenditures per 1,000 member months increased by 16.15 percent. While the PPV expenditures per 1,000 member months decreased by 0.89 percent, the actual number of PPVs per 1,000 member months increased by 1.82 percent. There could be a number of reasons why the number of events per 1,000 member months changed in the opposite direction from the expenditures per 1,000 member months. For example, the types of events may be more or less costly, the MCO may have changed their rates or contracted with different providers, or the patients coming through the door may be more or less complicated. See Figure 3 and Table 5 for these results.

⁵ In 2014, NCQA allowed for measure rotation, meaning certain measures that were calculated using a hybrid methodology could be run every other year. Two MCOs opted to rotate the measure Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life in 2014, so the CHIP rate presented in this report includes the 2013 rate for those two MCOs.

Figure 3. 2013-2014 Weighted CHIP Rates, HEDIS P4Q Measures

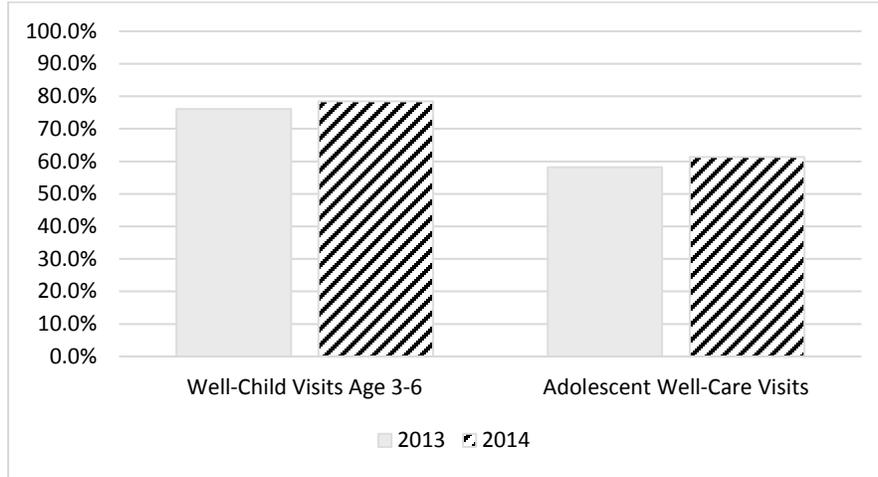


Table 5. CHIP PPE P4Q Measures

Event	Actual Number of Events Per 1,000 Member Months 2013	Actual Number of Events Per 1,000 Member Months 2014	Actual Expenditures Per 1,000 Member Months 2013	Actual Expenditures Per 1,000 Member Months 2014
PPAs	0.38	0.40	\$1,979	\$2,299
PPVs	15.91	16.20	\$5,842	\$5,790

HHSC found mixed results in 2013 (pre-implementation) and 2014 (post-implementation) program-wide performance on medical P4Q measures. Many MCOs did demonstrate improvement on the P4Q measures in 2014; however, the 2014 results should be viewed cautiously as one year is an insufficient period of time to draw valid conclusions. Results for 2015 are not scheduled for release until after the date of this report.

Additionally, outcome changes cannot be attributed to any particular program because many federal and state initiatives have targeted quality at the same time. HHSC has many overlapping quality initiatives and aligns these initiatives to the degree possible. While this alignment improves the coordination, harmonization, and administration of these various initiatives, it makes it difficult to understand what is causing change and attribute change to any single initiative. For example, in 2014, 14 MCOs implemented performance improvement projects (PIPs) focused on improving adolescent well-care, and 8 MCOs implemented PIPs addressing well-child visits in the third, fourth, fifth, and sixth years of life. Two MCOs had PIPs focused on PPAs, and two MCOs had PIPs on PPVs. One STAR+PLUS plan implemented a PIP to address antidepressant medication management. Some MCOs also focus on PPEs as part of DSRIP projects.

In addition to P4Q, since 2013, MCOs and hospitals have been financially accountable for PPCs and PPRs based on hospital-level performance for these measures. Under the Hospital Quality-

Based Payment Program, adjustments are made to fee-for-service hospital inpatient claims and similar adjustments are also made in each MCO's experience data, which affects MCO capitation rates. The Hospital Quality-Based Payment Program is discussed in more detail in Section 4.3 of this report.

The P4Q program also replaced the MCO At-Risk and Quality Challenge (ARQC) program that ran through 2013. The ARQC program had a similar focus and used some of the same measures, so much change would not be expected in the measure results between 2013 and 2014 because MCOs already had interventions in place to improve quality in 2013.

Finally, the P4Q results should be viewed with caution because improvements and declines may not be statistically significant and were further affected by changes in population, health status, or programs. For example:

- In September 2011, STAR and STAR+PLUS expanded to 28 counties contiguous to the existing service areas.
- On September 1, 2014, STAR+PLUS expanded to the Medicaid Rural Service Area.
- On September 1, 2014, mental health rehabilitation and mental health targeted case management services were added into managed care.

Update on Medical Pay-for-Quality Program

When the P4Q financial incentive model was applied to the 2014 results, issues with the methodology were identified which could have resulted in a negative impact to some plans with demonstrated positive performance. For this reason, HHSC decided to hold the health plans harmless – to not recoup or distribute any of the at-risk amount for calendar years 2014, 2015, or 2016 – and use 2017 to redesign the program. The first measurement year of the redesigned P4Q program will be calendar year 2018. HHSC's goal is to simplify the program, allow plans to track their performance and predict losses, reward high performance and improvement, and promote transformation and innovation, ultimately leading to better health outcomes.

On November 1, 2016, HHSC launched the STAR Kids program for children with complex health care needs. Quality measures for this program are under development. HHSC will include STAR Kids in the medical P4Q program, with calendar year 2019 as the first measurement year.

Rider 67 requires HHSC to address expansion of P4Q measures into outpatient settings. Several of the 2014 P4Q HEDIS measures evaluate care provided in an outpatient setting:

- Well-Child Visits at 3, 4, 5, and 6 Years
- Adolescent Well-Care Visits
- Timeliness of Prenatal Care
- Postpartum Care
- Antidepressant Medication Management (Effective Acute Phase Treatment and Effective Continuation Phase Treatment)
- HbA1c Control (<8.0%)

The HEDIS measures look at services provided or outcomes of care regardless of the location. For example, services that occur in ambulatory surgical centers (ASCs) and PCP offices are

outpatient services. If a member were to receive a qualifying service in these or other outpatient settings, it could be counted in the HEDIS measure. Additionally, ASC services may be counted in the PPV measure depending on the procedure performed. ASC-provided services would not be captured in the PPA, PPR, or PPC measures because those measures only look at inpatient settings. HHSC is continuing to review the potentially preventable ancillary services (PPS) measure, which includes services provided in both inpatient and outpatient settings.

It is also worth noting that PPAs and PPVs, while measured in inpatient settings, are measures that may be driven in part by outpatient care. For example, if a member's diabetes is not well-controlled in the community through outpatient care, this may lead to a potentially preventable hospitalization. MCOs have the unique ability to address health care of their members across care settings at the network level.

4.2 Dental Pay-for-Quality Program

Background

The dental P4Q program, which was initiated in 2014, holds DMOs responsible for their performance on quality measures by putting two percent of each DMO's capitation at-risk. Each DMO is measured based on its incremental performance on each quality measure and is eligible to earn back the funds placed at-risk. In the 2014 model, the most each DMO was eligible to earn was its plan specific two percent at-risk, but in 2015, the model was changed to allow funds recouped from one DMO to be earned by another DMO based on performance. The dental P4Q program model sets minimum performance levels for each of the measures.

In the dental P4Q program for 2014-2016, the measures used in Medicaid dental related to the proportion of members who received preventive dental services, Texas Health Steps (THSteps) dental checkups (both regular checkups and first checkup within 90 days of enrollment), and dental sealants. The dental P4Q measures for CHIP dental are related to the proportion of members who received annual dental visits, preventive dental measures, and dental sealants.

The following presents the state average of both DMOs on Medicaid and CHIP dental P4Q program measures for calendar years 2013 and 2014. For all measures, a year-to-year increase indicates improvement.

Dental P4Q Results

Medicaid

Figure 4 outlines results for the four Medicaid dental P4Q measures:

- Percent of members aged 1-20 years enrolled for at least 11 of the past 12 months who had at least one preventive dental service
- Percent of members who received THSteps dental checkups
- Percent of members receiving a THSteps checkup within 90 days
- Percent of members enrolled for at least six continuous months who had at least one sealant on one of the permanent first molars, ages 6-9 and ages 10-14

For the Medicaid program, statewide performance improved most noticeably on the percent of members enrolled for at least six continuous months who had at least one sealant on one of the permanent first molars. The 6-9 age group increased by 0.87 percent and the 10-14 age group increased by 1.09 percent.

CHIP

Figure 5 outlines results for the three CHIP dental P4Q measures:

- Percent of members aged 1-18 years enrolled for at least 11 of the past 12 months who had at least one preventive dental service
- Percent of members enrolled for at least 11 of the past 12 months who had at least one annual dental visit (ADV), multiple age brackets

- Percent of members enrolled for at least six continuous months who had at least one dental sealant, ages 6-9 and ages 10-14

For CHIP, statewide performance improved on all of the dental P4Q program measures except for the rate of dental sealants for 6-9 years old. This sub-measure decreased by 0.49 percent between 2013 and 2014. The majority of the measures increased by less than one percent. The measure with the greatest amount of improvement from 2013 to 2014 was the preventive dental service measure which increased by 1.21 percent.

Figure 4. 2013-2014 Medicaid Rates, Dental P4Q Measures

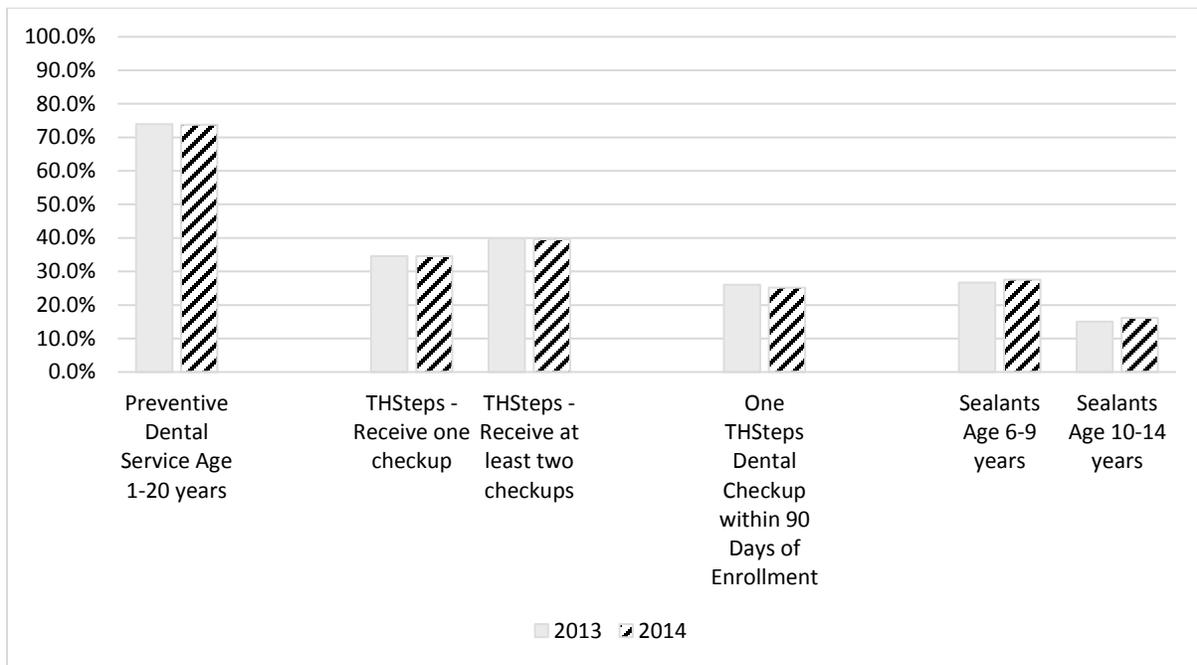
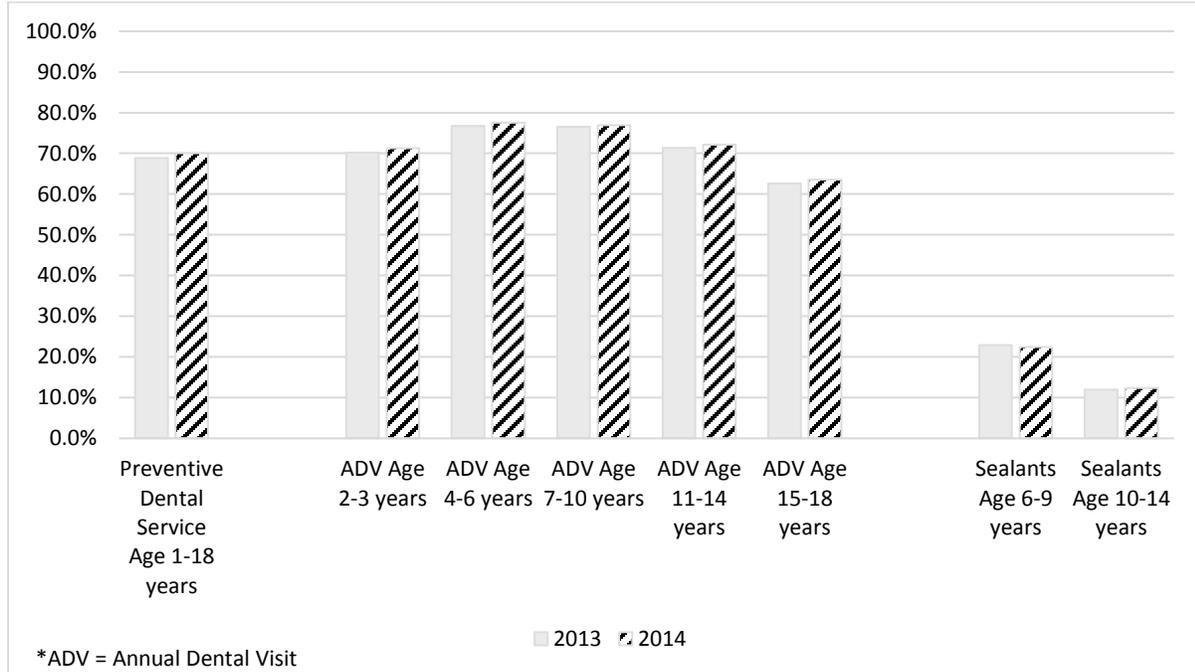


Figure 5. 2013-2014 CHIP Rates, Dental P4Q Measures



Update on Dental Pay-for-Quality Program

As with medical P4Q, HHSC will not administer a dental P4Q program in calendar year 2017 as staff will use this time to develop and formalize a new program for calendar year 2018. HHSC will use the existing dental P4Q model to award or recoup payments based on dental plan performance for calendar years 2014, 2015, and 2016.

4.3 Hospital Quality-Based Payment Program

HHSC continues to oversee the Hospital Quality-Based Payment Program⁶, which utilizes payment disincentives for high rates of PPRs and PPCs. In 2016, HHSC introduced payment incentives to safety-net hospitals for lower rates of PPRs and PPCs pursuant to the 2016-17 GAA (Article II, Special Provisions Relating to All Health and Human Services Agencies, Section 59). This was an important addition to the Hospital Quality-Based Payment Program in that it helped to create a sustainable quality improvement program consistent with value-based payment principles that involve risks and rewards.

Table 6 below shows rates of PPRs and PPCs for a four-year period (fiscal years 2012-2015) for the Hospital Quality-Based Payment Program. While the PPR rates show a significant decline, the PPC rates appear flat. It should be noted the PPR rates in Table 6 are calculated using a 15-

⁶ Hospital Quality-Based PPR PPC Program information accessed at: <https://hhs.texas.gov/about-hhs/process-improvement/medicaid-and-chip-quality-and-efficiency-improvement/potentially-preventable-events>

day period between discharge and readmission, whereas the PPR rates shown in Table 3 and Table 4 for the medical P4Q program are calculated using a 30-day period between discharge and readmission. Furthermore, the periods used below for PPR and PPC calculation are fiscal year, and the periods used for PPEs Tables 1 through 4 are calendar year.

Table 6. Statewide Hospital Quality-Based Payment Program*

Fiscal Year	Medicaid PPR [†] Rate	Medicaid PPC Rate
2012	3.74%	‡
2013	3.74%	3.60%
2014	2.69%	3.59%
2015	2.56%	3.60%

* Note: These data have some small corrections to data represented in the previous annual report.

[†] PPR counts represent chains, which could be multiple PPRs within the 15-day readmission period. A PPR chain is defined as one or more PPRs within the readmission period.

[‡] Due to changes in PPC measurement methodology and populations included, comparisons of fiscal year 2012 to 2013, 2014 and 2015 are not valid.

4.4 Managed Care Organization Payment Reform Efforts with Providers

There are multiple initiatives at the national and state levels to move health care payments away from the customary volume-based fee-for-service reimbursement model toward models that incentivize improved health care outcomes and increased efficiencies. In January 2015, the U.S. Department of Health and Human Services (HHS) set a goal of tying 30 percent of all traditional (fee-for-service) Medicare provider payments to quality or value through alternative payment models, such as Accountable Care Organizations (ACOs), Patient Centered Medical Homes (PCMH) or "bundled payment" arrangements by the end of 2016, and tying 50 percent of payments to these models by the end of 2018.⁷ The U.S. Department of HHS also set a goal of tying at least 85 percent of all traditional (fee-for-service) Medicare payments to quality and value by 2016 and 90 percent by 2018 through programs such as the Hospital Value-Based Purchasing and the Hospital Readmissions Reduction Programs.^{8,9}

These efforts go by various names, such as pay-for-performance (P4P), pay-for-quality (P4Q), value-based payments/purchasing (VBP), alternate payment model (APM), or value-based contracting (VBC). As Texas Medicaid and CHIP moves from volume-based payments to value-

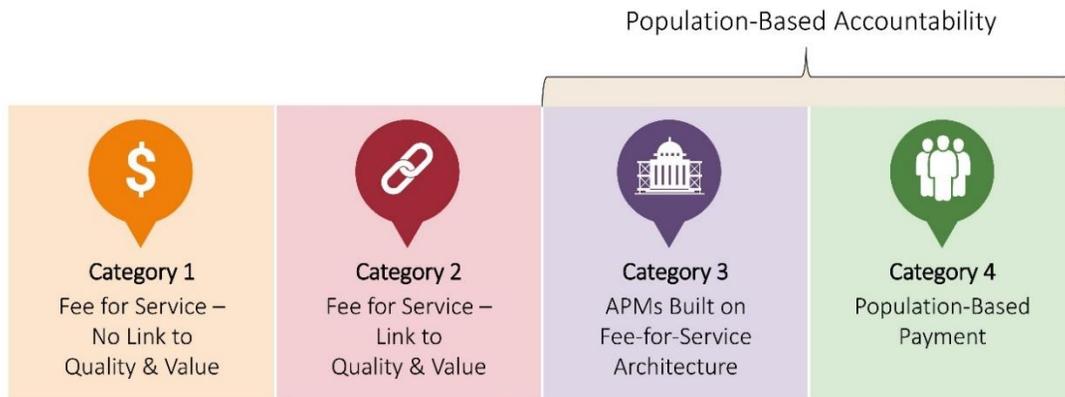
⁷ "Progress Towards Achieving Better Care, Smarter Spending, Healthier People" accessed at: <http://www.hhs.gov/blog/2015/01/26/progress-towards-better-care-smarter-spending-healthier-people.html>

⁸ Information on the Hospital Value Based Purchasing program accessed at: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/HVBP/Hospital-Value-Based-Purchasing.html>

⁹ Information on the Hospital Readmissions Reduction Program accessed at: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/HRRP/Hospital-Readmission-Reduction-Program.html>

based payments, HHSC expects to see a gradual transition of payment models over the next few years following the APM Framework (Figure 6).

Figure 6: APM Framework (At-a-Glance)



Source: Alternative Payment Model Framework and Progress Tracking Work Group

This framework was created at the request of the Centers for Medicare & Medicaid Services (CMS) by the Health Care Payment Learning & Action Network¹⁰, which created a more detailed view of the APM framework and white paper¹¹ that explore the topic fully.

HHSC requires all Medicaid and CHIP MCOs and DMOs to submit an annual update to HHSC detailing their various VBC initiatives. As of the last deliverable in December 2015, all of Texas' 19 Medicaid and CHIP MCOs and both DMOs offer some form of VBC. VBC approaches differ according to MCO/DMO size and level of VBC sophistication, composition/characteristics of provider network, geographic diversity, and beneficiaries' needs. The following is a summary of the reports received from the MCOs and DMOs.

Geographic Diversity

In general, the VBC structures the MCOs have implemented for their providers include all service delivery areas and programs they serve. The extent of geographic coverage depends on a plan's experience with APMs. Some MCOs have several years of experience and have rolled out programs across larger geographic regions based on their successes, while other plans chose to start small with pilot programs. A smaller number of MCOs chose to include their entire provider network within a service area and program. Local provider culture may also play a role in which VBC models expand within a region. Because high quality and accessible primary care are considered to be critical in advancing quality outcomes, some MCOs are modifying the way physicians are paid and valuing primary care in a way that improves access and quality. This model incentivizes appropriate, patient-centered primary care for members assigned to these providers.

¹⁰Information on the Health Care Payment and Learning and Action Network access at: <https://hcp-lan.org/>

¹¹ Alternative Payment Model Framework white paper accessed at: <https://hcp-lan.org/workproducts/apm-whitepaper-onepager.pdf>

Provider Types

The types of providers engaged in alternative payment structures proposed by MCOs vary. Some MCOs include all provider types in the network, while others target specific providers that serve a certain size of panel/membership. Minimum patient panel size is also a factor in participation in more sophisticated or risk-based VBC models. Examples include using a fee-for-service base payment with a bonus or a partial capitation model for small-to-medium size providers, and a fully capitated medical home or shared-savings ACO type of model for large multi-specialty practices. For one health plan, qualifying providers must meet the threshold of providing services to at least 30 of the plan's members. Another plan uses an incentive arrangement that encourages quality care available to all physicians with a significant panel size and membership. Other plans offer their physicians a fixed amount per-member per-month (PMPM) based on their panel size as an incentive for care coordination and management.

In addition to primary care providers, such as family practice and general practice, specialist providers, such as internal medicine, OB/GYN, pediatrics, surgery, therapy services, durable medical equipment, and pharmacies, were involved in the reported VBC arrangements.

The number of providers participating in different MCO incentive programs often varied depending on whether the providers were engaged individually or in group practices. The number of participating providers ranged from several practitioners to entire provider groups with hundreds of physicians. In general, the larger the size of the physician practice or group, the more advanced the VBC approaches. Some sophisticated forms of VBC arranged with large medical providers may serve hundreds or even thousands of members. VBC approaches involving sophisticated population health management infrastructure to facilitate shared savings and/or shared risk tend to require large patient panel sizes.

Members Impacted and Provider Payments Relative to MCO Capitation

There is an ongoing effort to estimate the number of members who are served under a VBC payment model (relative to the total MCO membership in the respective plan) as well as the amount of MCO expenditures that are considered VBC (relative to the total premiums paid by HHSC and to the total MCO payments to their providers). Such information can be calculated only when the MCO calculates provider performance and the overall membership and capitation amount of each MCO is known. HHSC is contemplating various evaluation methodologies for calculating VBC penetration rates. One way is to look at the number of MCO members associated with the new types of payment structures. Another way is to analyze the funding spent in VBC out of the MCO's total payments to providers. These are complicated endeavors as the financial contractual agreements between MCOs and providers are confidential.

Care must also be taken to choose measures that do not inadvertently mislead rather than inform. For example, one type of VBC can give the impression of a very high rate of VBC penetration with a small bonus on top of a standard fee-for-service arrangement. However, this may result in little positive change. Alternatively, a more robust program targeting a smaller population may have greater overall impact in enhancing the quality of care provided to members and driving down cost.

Common Measures Used

The MCOs generally used recognized quality indicators for determining triggers for incentives, including:

- HEDIS measures such as well-child visits, asthma care, HbA1c (blood sugar) level, prenatal/postpartum care and breast cancer screening
- PPE measures (PPV, PPA, PPR, PPC, PPS)
- Other administrative-related and accessibility-based measures

A majority of the MCOs focused on P4Q measures. Rider 67 requires HHSC to evaluate and report on how Texas Medicaid providers and MCOs use existing P4Q measures to improve health care delivery. To complete this analysis, HHSC staff reviewed the MCOs' 2014 Quality Assessment and Performance Improvement (QAPI) plan reports and MCO administrative interviews to evaluate actions MCOs take to improve quality of care.

MCOs report on their CMS-required QAPI programs annually to HHSC. These reports outline the effectiveness of each MCO's QAPI program for the previous calendar year, supported by presentation of results, analysis, and actions taken in the measurement period related to their performance improvement structure and the effectiveness of their program. Each year, the Texas external quality review organization (EQRO) also conducts an administrative interview with each MCO to assess elements important to the provision of quality care and service to members in these programs, including the health plan structure and provision of care.

The QAPI reports and administrative interviews supply a significant degree of insight into the management of quality goals by each MCO. Efforts undertaken in response to examination of underlying causes of low performance yield a variety of approaches for improving processes. For example, one MCO uses face-to-face contact with members to reduce PPEs by developing personal relationships with members. Another MCO conducts appointment availability calls to all providers to ensure members have adequate access to after-hours care and are thus more likely to seek care in an appropriate setting. Although different, both MCOs' efforts are designed to reduce PPEs by ensuring members receive adequate interaction with points of contact who can limit the chance of a preventable event.

HHSC's Rider 67 review focused on MCO projects that affected P4Q measures (either HEDIS or PPE). HHSC identified six categories of projects that frequently emerged from the QAPIs and interviews. These six categories are:

- **Provider Outreach and Training:** Includes MCO efforts to improve data analytics on utilization; enhance reporting to providers; promote collaboration between pharmacies and prescribers; provide one-on-one education with providers; visit PCPs after new member enrollment; include provider input in the development of best practices; and create and disseminate training materials.
- **Member Outreach and Education:** Includes MCO efforts to distribute member education materials such as newsletters and guidance on disease prevention; attend school health fairs; follow-up with members who have not received their checkups and screenings; and outreach to members after hospital admissions or emergency department visits.

- **Reward or Incentive Programs:** Includes MCO efforts to entice members to complete testing/checkups with a gift card upon completion; provide bonus payments to providers when members are seen by their prescribing physician after hospital discharge; and physician recognition programs with a bonus tied to chronic care management.
- **Service Coordination or Case Management:** Includes MCO efforts to conduct early identification of high-risk members for eligibility into case management; use of predictive modeling software that incorporates inpatient/outpatient, medical, behavioral health, pharmacy, and claims data; monthly member questionnaires; discharge planning; hospital transition programs; and home visits.
- **Health/Disease Management Programs:** Includes MCO efforts to implement disease management programs; provide in-home behavioral health management; partner with PCPs to provide Saturday clinics; and provide health care toolkits for pregnant members and members with chronic conditions.
- **Miscellaneous Interventions:** Includes MCO efforts to utilize software applications to review timely filling of asthma controller medications and responsive interventions; collaborate with law enforcement to reduce PPEs and locate high utilizers; work with providers to offer after-hours care.

Table 7 provides the number of MCOs with projects in each of these categories. Of note, each MCO typically has projects in multiple categories.

Table 7. Counts of MCOs with Projects Targeting Measures Used in the P4Q Program

Category of MCO Project	Number of MCOs Targeting HEDIS Measures	Number of MCOs Targeting PPE Measures
Provider Outreach and Training	11	14
Member Outreach and Education	18	11
Reward or Incentive Programs	13	5
Service Coordination or Case Management	6	14
Health/Disease Management Programs	5	10
Miscellaneous Interventions	5	5

In each case, interventions were implemented to address specific issues. For example, after assessing its performance on the HEDIS Prenatal Care and Postpartum Care measure, one MCO found it had an inefficient process for contacting and conducting health risk questionnaires for newly enrolled pregnant members. The MCO's inability to accurately track and report the number of pregnant members prevented it from identifying and contacting members with high-risk pregnancies. To remedy the problem, the MCO contracted with a member outreach center to assume the task of contacting every pregnant member on a monthly basis to perform health risk questionnaires. This allowed the MCO to more effectively target high-risk members for case management.

Among preventable events, polypharmacy risk, the simultaneous use of multiple drugs to treat a single patient for one or more conditions, was an issue identified in the 2014 QAPI reports. One MCO cited polypharmacy as a main cause of overdosing and drug interactions and was responsible for increased use of emergency room visits and hospitalization. Physicians were not aware of members seeing multiple prescribers and pharmacies and obtaining multiple controlled substances. To counter this situation, the MCO provided communication to prescribers on members who saw multiple prescribers and obtained multiple controlled substances from various pharmacies. Together, the MCO medical director, case management supervisor, and the pharmacist director determined if these members should be referred to the Inspector General (IG) and placed in its Lock-in Program, which restricts an individual's access to a single designated pharmacy. In 2014, the seven members the MCO referred to the IG were no longer on the polypharmacy listing at the end of the year.

Payment Structures

As described by the MCOs, the types of alternative payment structures varied, but generally represented the following major combinations:

- Fee-for-service with bonus payments for achievement of a specific measure or measures, either for desired administrative activities (e.g., use of electronic health records), quality outcomes (e.g., HEDIS scores, lower emergency department use), or access to care (e.g., the practice accepts new Medicaid patients, offers same-day appointment options and/or expanded after-hours/weekend access)
- Partial capitation with or without bonuses for quality improvement and/or bundling of various medical episodes (e.g., pregnancy, cardiac care) and various medical home models
- Shared savings approaches based on lowering patient population total cost of care, reductions/avoidance in emergency room visits, hospital admissions/readmissions, or pharmaceutical spending

A combination of different payment models is often employed. For example, the same MCO may have a provider receiving a capitated rate with a shared savings element. Various strengths and weaknesses of these VBC categories are described below.

Fee-for-Service with Bonus Payments

The purpose of fee-for-service with bonus payments is to compensate for achievement of a specific measure or measures, either for better administrative or quality outcomes, or increased access (e.g., well-child visits or other timely visits, expanded after-hours access).

An example is when one MCO pays (among several items) \$10 for each adolescent well-child visit, \$20 for each prenatal and postpartum visit, and \$25 for members with diabetes whose HbA1c (blood sugar level) is kept under control.

This approach has several strengths and benefits:

- Relatively easy to implement for both the MCO and the provider
- Can generally be done with administrative data

- Minimal provider resistance, especially if done with few provider time, labor, and other resources required
- Can be done with providers with smaller member panel sizes
- Can be used to target a measure with special need for improvement, often with a focus on the measures used in the Medicaid and CHIP P4Q program, and could include measures like PPEs that could have been avoided through better care

This approach has several weaknesses and challenges:

- Payment incentives may not be big enough to change behavior (a minimum tipping point may be needed)
- Still rooted in fee-for-service and continues the volume-based model
- May not lead to notable practice management changes or population health management
- Providers with very small panel sizes may not have a large enough numerator to calculate some measures accurately

Considerations for implementation include:

- While a straightforward approach is relatively easy to implement, the gains may be minimal without a lot of MCO work with the providers (practice transformation assistance is important no matter which VBC model is implemented).
- The MCO may place requirements for providers to participate in their incentive program, such as having an open panel (accepting new Medicaid patients) or extended clinic hours, and a provider would have to agree to these items as a pre-condition to access the bonus payment program.

This approach is already commonly used by MCOs, and at least 10 MCOs have adopted this model. This approach may be used as a first effort or as part of a suite of incentive programs.

Partial Capitation with or without Bonuses

The purpose of partial capitation with or without bonuses is to incentivize quality and/or bundling of various medical episodes (e.g., pregnancy, cardiac care) and various medical home models

This approach has several strengths and benefits:

- Can generally be implemented with administrative data, but electronic health records and health information exchange are often used as leverage
- Can be done with providers with somewhat smaller member panel sizes; however, the benefits of the model increase as panel size gets larger
- Creates incentives for improved practice management changes and population health management
- If done properly, provides an incentive to manage a population efficiently
- Can be scaled from relatively small PMPM bonus amounts for simple improvements to advanced models where capitation covers a large portion of the provider's revenue
- Moves away from being rooted in fee-for-service and continues the evolution toward a more complex value-based model

This approach has several weaknesses and challenges:

- PMPM payment incentives must be significant enough to change behavior.
- The provider must commit to the work involved in implementing the model (major change in how their practice operates).
- Providers with a very small panel size of members may not have large enough numerators to calculate some measures accurately.
- MCOs may have difficulty doing the practice transformation work with providers with small panel sizes (the MCOs need a certain critical mass of members to justify the resources involved).
- The approach can require much more involvement to implement from both the MCO and the provider and may be faced with more provider resistance as it requires much more provider time, labor, and other resources to do effectively.

Considerations for implementation include:

- Practice transformation assistance from MCOs becomes very important as providers move to capitation.
- MCOs must commit to supporting the model with actionable data for providers to manage a population.
- Capitation can be coupled with shared savings.
- Requires multiple considerations by the MCO when establishing the capitation for providers and the expectations involved for earning it.

This approach is not as common, though growing, with at least six plans having implemented this payment model. There are regions of the state with greater penetration of this model, such as the Nueces (Corpus Christi) area.

Shared Savings Approaches

The purpose of shared savings approaches is to provide compensation based on lowering total cost of care, reductions in and avoidance of emergency room, hospital admissions and readmissions, or pharmaceutical spending.

This approach has several strengths and benefits:

- Can generally be implemented with administrative data, but electronic health records and health information exchange are often used as leverage
 - Hospital admissions-discharge-transfer (ADT) feeds are seen as highly important and this model requires permanent data flow.
- Can be done with providers with somewhat smaller member panel sizes
 - The benefits of the model increase as panel size gets larger.
- May create the strongest incentives for improved practice management changes and population health approach
- When done properly, may create the highest incentive to manage a population efficiently

- Can be customized regarding the amount of shared savings in play and what counts for or against the calculation
 - Customization allows for simple structures all the way to ACO-type arrangements.
- Less rooted in fee-for-service and continues the evolution toward a complex value-based model

This approach has several weaknesses and challenges:

- The shared savings amounts must be significant enough to change provider behavior.
- The provider and the MCO must both commit to the work involved with leveraging this model to maximize the benefits.
- Providers with very small panel sizes may not have large enough numerators to calculate some measures accurately.
- MCOs may have difficulty doing the practice transformation work with providers with small panel sizes (MCOs need a certain critical mass of members to justify the resources involved).
- The approach may be faced with more provider resistance and may require much more provider time, labor, and other resources to do it effectively (the upside of greater revenue has to offset the additional time, labor, and other resources required).

Considerations for implementation include:

- Practice transformation assistance from MCOs becomes very important as providers move to a shared savings model.
- MCOs must commit to supporting the model with actionable data for providers to manage a population.
- Shared savings can be coupled with capitation.
- The approach requires consideration on the part of the MCO when figuring out the shared savings for providers and the expectations involved for earning it.
- HHSC may have a greater role in data sharing through efforts like the ongoing hospital ADT feeds project (timely data is critical to a population-health management model).
- This particular practice only has "upside" incentives through potential shared savings, and is not subject to downside financial risk.

This approach is not as common, though growing, with at least six plans using this payment model. Simple shared savings approaches are more common, though ACO arrangements are also growing. This model lends itself primarily to large multi-specialty practices with substantial panel sizes; however, it may also be used with large single specialty practices, such as OB/GYN.

Summary of Common Considerations for VBC Models and Efforts

- Regardless of the model chosen, there must be a sufficient incentive or disincentive (i.e. tipping point) to change provider practice management and behavior; this may vary by the provider type, region, or other considerations.
- Gains may hinge as much on the support and collaboration between the MCO and the providers as on the specifics of the model.
 - As the MCO and provider's VBC relationship matures, there is a fundamental change in how they do business together because the provider is now the MCO's partner; a trusting relationship and continuous dialogue between payers and providers is critical to success.

- The switch to a value-based model has implications for HHSC, ranging from MCO capitation rate calculation to selection and use of quality improvement measures.
- HHSC may have a role in facilitating data sharing, promoting best practices, researching outcomes, and the development of quality measures that mesh with a health plan system; of particular importance is ensuring that success in payment reform is rewarded and not penalized.
- MCO rate-setting is still built largely on paying for members' medical care (i.e. paying for illness), and the Legislature, stakeholders, and HHSC will have to contemplate what a future Medicaid and CHIP financial system that pays for optimizing “health” looks like when setting MCO payments and moving towards better systems of care.
- As VBC models mature, there is a growing awareness of the interaction between medical care and social services for Medicaid and CHIP beneficiaries.
- An advantage Texas has is a large number of DSRIP projects and a well-organized set of Regional Healthcare Partnerships (RHPs) within the health care transformation initiated by the Texas Healthcare Transformation and Quality Improvement Program 1115 Waiver, known as the 1115 Transformation Waiver.
 - DSRIP helps create a collaborative atmosphere that could help advance VBC; efforts underway in various RHPs to bring MCOs and DSRIP projects together are promising and the RHP infrastructure helps support these efforts.

All MCOs and DMOs providing services to members in Texas Medicaid and CHIP have some level of VBC with their providers. While VBC efforts may vary in size and scope across the MCOs, the evidence is clear the Texas Medicaid and CHIP market is continuously shifting towards outcomes-based payments. This creates changes in how plans and providers work together (payer vs. partner), the mindset (individual patient encounters vs. population health management), and the overall goals of the health care system (largely acute sick care vs. promoting prevention and better overall health).

4.5 Physician Payment Policy Related to Elective Inductions

As required by H.B. 1983, 82nd Legislature, Regular Session, 2011, HHSC implemented a policy prohibiting payment for elective inductions prior to 39 weeks in the Medicaid program. This policy began on October 1, 2011, and has been tracked through reviews of coding on physician health care claims data, coupled with intermittent audits of claims data with corresponding physician medical records. Audits of physician claims by the HHSC IG compared with corresponding medical records largely indicate concordance between the coding on the claims data and medical records documentation.

The 2016-17 General Appropriations Act (Article II, Special Provisions Relating to All Health and Human Services Agencies, Section 45) directed HHSC and DSHS to take steps to improve data and oversight to reduce the rate of early elective deliveries in Texas. Pursuant to Section 45, HHSC is working closely with DSHS on different strategies utilizing various methods and data sets. A separate legislative report on this effort is forthcoming as required by Section 45.

4.6 Delivery System Reform Incentive Payment Program

Background

The 1115 Transformation Waiver is a five-year demonstration waiver through September 2016.¹² Texas submitted a request to CMS in September 2015 to extend the waiver for five years. On May 1, 2016, CMS granted a 15-month temporary extension for the waiver from October 1, 2016, through December 31, 2017, during which HHSC and CMS will continue negotiations on a longer-term extension. In January 2017, HHSC submitted a request to CMS for an additional 21-month extension through September 30, 2019.

The 1115 Transformation Waiver enabled Texas to implement Medicaid managed care statewide, achieving program savings while preserving locally-funded supplemental payments to hospitals. The supplemental funds are distributed through two pools: Uncompensated Care and DSRIP.

Currently, there are over 1,450 active DSRIP projects, involving almost 300 providers. These providers include hospitals (public and private), physician groups (mostly affiliated with academic health science centers), community mental health centers, and local health departments. The major project focus areas are shown in Table 8.

Table 8. Major Categories of Projects in DSRIP*

Focus Area	Percentage of all Projects
Behavioral Health Care	>25%
Access to Primary Care	20%
Chronic Care Management and Helping Patients with Complex Needs Navigate the Health Care System	18%
Access to Specialty Care	9%
Health Promotion and Disease Prevention	8%

* Note: Totals do not add up to 100% as there are miscellaneous categories of projects not included in this table.

Progress Update

As of July 2016, over \$7.9 billion in DSRIP payments have been earned by participating providers in Demonstration Year (DY) 1 through DY 5. The RHP structure, created through DSRIP, has enabled new collaborations and is foundational to strengthen local and regional systems of care. DSRIP projects have collectively provided almost 6.5 million additional encounters and served over 5.2 million additional individuals (cumulative DY 3-5 totals, not

¹² Information on Texas Healthcare Transformation and Quality Improvement Program accessed at: <https://hhs.texas.gov/laws-regulations/policies-and-rules/waivers/medicaid-1115-waiver>

unduplicated counts) compared to the service levels they provided prior to implementing the projects.

DSRIP providers also have 2,112 active quality outcome measures, with most reporting at least one year of performance. Eighty-one percent of outcomes reported for achievement received payment for improving over their prior year of reporting. These include:

- Pediatric Emergency Department Visits for Ambulatory Care Sensitive Conditions
- Blood Pressure Control
- Diabetes Care Control (HbA1c)
- 30-Day Risk Adjusted All Cause Readmissions
- 30-Day Risk Adjusted Readmissions for Behavioral Health/Substance Abuse

Most DSRIP projects require additional time to demonstrate outcomes and develop sustainability plans. Texas proposes to strengthen the DSRIP program in the CMS waiver extension period to support systems of care for Medicaid enrollees and low-income uninsured individuals. Future actions include:

- Enhanced evaluation of DSRIP activities to identify lessons learned and best practices to sustain and replicate
- Use of DSRIP results to inform Medicaid benefits and VBP in managed care
- Development of a quality roadmap for Medicaid managed care and DSRIP
- Promotion of increased data sharing across providers
- Publication of state-level data to show whether Texas, the RHPs, and managed care service areas are making progress on key quality indicators

Additionally, to ensure different initiatives under HHSC's purview are coordinated, HHSC is developing an operational plan, or roadmap, pursuant to S.B. 200. This roadmap will contain goals of transitioning from volume-based purchasing models to P4P models, improving Medicaid client satisfaction with care, and reducing payments for low quality care.

4.7 Excellence in Mental Health Act

The 2016-17 General Appropriations Act (Article II, HHSC, Rider 79) directed HHSC to develop and submit an application to the Substance Abuse and Mental Health Services Administration (SAMHSA) and CMS for an Excellence in Mental Health planning grant as authorized in the Protecting Access to Medicare Act of 2014.

SAMHSA's Certified Community Behavioral Health Clinic planning grant provided Texas a unique opportunity to partner with MCOs, providers, and stakeholders to certify clinics, develop an integrated service delivery framework, and craft a prospective payment model supporting a robust "integrated behavioral health home" approach for populations for which care is often

fragmented and uncoordinated. Texas was awarded \$982,373 for the planning grant in mid-October 2015.

Through the project, Texas targeted four key populations:

- Children and youth with mental health issues
- Children and youth with substance use disorders
- Adults with mental health issues
- Adults with substance use disorders

Under the planning grant, Texas focused on building the capacity of targeted clinics in select MCO service areas to provide effective, evidence-based, integrated health care, as well as developing a bundled, prospective payment model to support provision of integrated care.

As the final deliverable for the planning grant, Texas was required to submit a demonstration project application in October 2016. In December 2016, Texas was notified it did not receive a grant award. However, HHSC has convened a workgroup to determine how to leverage the work of the planning grant and, if feasible, implement the model without grant funding.

4.8 Small House Facilities

Rider 46 allows HHSC to implement a special reimbursement class for long-term care commonly referred to as "small house facilities." Such a class may include a rate reimbursement model that is cost neutral and adequately addresses the cost differences that exist in a nursing facility constructed and operated as a small house facility. The payment increment may be based upon a provider incentive payment rate.

The previous status update provided in the February 2016 report¹³, which was dependent on CMS approval, was ultimately not supported by CMS. Consequently, HHSC does not believe a small house model can be implemented on a cost neutral basis. HHSC also does not have funding available for the non-federal share of the cost of implementing a special small house model rate.

4.9 Other Ongoing Quality Improvement Initiatives

HHSC continues to engage stakeholder efforts around quality-based payments and overall quality improvement. These efforts include:

- Continual refinement of the HHSC Medicaid and CHIP Quality and Efficiency Improvement website¹⁴ which describes different initiatives and includes performance data related to health care quality
- Regular, data-driven quality improvement meetings or calls with hospital associations and MCOs
- Facilitation of webinars for MCOs and other stakeholders to learn about emerging best practices in targeted areas of quality and value-based payments

¹³ February 2016 Report accessed at: <https://hhs.texas.gov/sites/hhs/files/sb7-rider-46.pdf>

¹⁴ Medicaid and CHIP Quality and Efficiency Improvement website accessed at: <https://hhs.texas.gov/about-hhs/process-improvement/medicaid-and-chip-quality-and-efficiency-improvement/potentially-preventable-events>

Through the webinars, HHSC is creating an active, ongoing "learning collaborative" to help with dissemination of best practices. Examples include webinars related to best practices in neonatal substance abuse treatment, abstinence syndrome, super utilizers, antibiotic overuse, reducing preterm births, and pediatric medical home models. These webinars are ongoing and will continue to identify HHSC priorities and disseminate important information. They are also geared towards MCOs and other stakeholders to showcase innovation in quality. This enables MCOs to share their success stories and for other MCOs to learn about those successes.

5. CONCLUSION

The U.S. health care system is moving increasingly toward a quality-based model and Medicaid and CHIP are part of this trend. This is a major shift in focus for the national health care delivery system and for Texas.

This updated report offers an overview of progress regarding HHSC's efforts related to quality-based payment and delivery reforms as of the close of 2016. It builds upon an earlier review published by HHSC in February 2016. As demonstrated throughout both reports, movement to quality-based payments remains a work in progress for both HHSC and the larger health care ecosystem. There will be continual refinements of existing value-based initiatives and the development of new ones in response to an evolving health care marketplace.

The updated report highlights aspects of three general strategies being leveraged by HHSC in this quality-based effort:

- Leveraging contracts and other agreements to promote value-based efforts, including:
 - Provisions in the managed care contract requiring Medicaid and CHIP MCOs to detail their current quality-based efforts and their work to expand them (MCO reporting requirements are made more detailed for the 2016-2017 contract years)
 - Extensive work with the HHSC Medicaid and CHIP EQRO to collect and analyze data related to quality-based improvements (HHSC is expanding this research through enhancements to existing analysis efforts and a number of planned ad hoc projects)
 - 1115 waiver DSRIP projects, which are by definition value-based payment models
- Increasing use of incentives and disincentives, including:
 - Incentives and disincentives to MCOs and hospitals related to PPEs
 - Incentives and disincentives specific to MCOs related to key health care quality improvement goals
 - MCO expansion of value-based payments with their providers

- Increasing availability of performance data to stakeholders related to quality improvement and value-based payments, including:
 - Regularly updating HHSC's centralized, comprehensive website to share information for stakeholders on all major HHSC quality improvement initiatives
 - Building research partnerships with Texas academic institutions
 - Enhancing the interactive portal that presents detailed Medicaid and CHIP quality performance information from the EQRO, for use by both MCOs and the public
 - The development of detailed reports on PPEs for use by HHSC and MCOs to facilitate shared quality-improvement analysis (HHSC is currently reviewing options for making more performance and quality data available)

While all of these efforts are still relatively new, early results appear positive and this update supports these trends. As of the end of 2016, all Medicaid and CHIP MCOs are increasing their value-based payment models with providers. MCOs have implemented a variety of interventions to meet P4Q goals including provider outreach and training, member outreach and education, reward or incentive programs, service coordination or case management, and health/disease management programs. The data demonstrates a general trend in Medicaid toward lowered rates of PPEs and improved performance on other health care quality metrics (i.e. HEDIS). HHSC's comprehensive quality website and other readily available quality improvement information receive positive feedback from MCOs and stakeholders. HHSC is continuing to build on these collaborative relationships.

The goal remains a Medicaid and CHIP system that provides quality care to its members in a manner that ensures good stewardship of taxpayer dollars. The value-based model transformation embraced by HHSC will be a long-term endeavor. It means a fundamental change for Texas Medicaid and CHIP from paying for health care services to a new mission of better care for individuals, better health for populations, and lower cost.

LIST OF ACRONYMS

Acronym	Full Name
ACO	Accountable Care Organization
ADT	Admissions-Discharge Transfer
APM	Alternative Payment Model
ARQC	At-Risk and Quality Challenge
ASC	Ambulatory Surgical Center
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare & Medicaid Services
DMO	Dental Managed Care Organization
DSHS	Department of State Health Services
DSRIP	Delivery System Reform Incentive Payment
DY	Demonstration Year
EQRO	External Quality Review Organization
HEDIS	Healthcare Effectiveness Data Information Set
HHS	Health and Human Services
HHSC	Health and Human Services Commission
IG	Inspector General
MCO	Managed Care Organization
OB/GYN	Obstetrics/Gynecology
P4P	Pay-for-Performance
P4Q	Pay-for-Quality
PCMH	Patient Centered Medical Home
PCP	Primary Care Provider
PIP	Performance Improvement Plan
PMPM	Per-Member Per-Month
PPA	Potentially Preventable Admission
PPC	Potentially Preventable Complication
PPE	Potentially Preventable Event
PPR	Potentially Preventable Readmission
PPS	Potentially Preventable Ancillary Services
PPV	Potentially Preventable Emergency Department Visit

Acronym	Full Name
QAPI	Quality Assessment and Performance Improvement
RHP	Regional Healthcare Partnership
THSteps	Texas Health Steps
SAMHSA	Substance Abuse and Mental Health Services Administration
VBC	Value-Based Contracting
VBP	Value-Based Purchasing