Annual Report on Quality Measures and Value-Based Payments

As Required by

Section 536.008 of the Texas Government Code

TEXAS
Health and Human Services

Health and Human Services

December 2018

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Executive Summary

Texas Government Code, Section 536.008, directs the Health and Human Services Commission (HHSC) to publicly report annually on its efforts toward development of quality measures and quality-based (or value-based) payment models.

Additionally, House Bill (H.B.) 1629, 85th Legislature, Regular Session, 2017, requires HHSC to add to the report data collected using a quality-based outcome measure regarding Medicaid and CHIP enrollees with human immunodeficiency virus (HIV) infection.

HHSC administers various programs and measures through the Medicaid managed care system to improve health care quality and outcomes while containing costs:

- Medical and dental Pay-for-Quality (P4Q) programs[1]
- Requirements[2] for managed care organizations (MCOs) and dental contractors (DCs) to expand value-based payment (VBP) models with providers
- Hospital quality-based payment program[3] targeting reductions in potentially preventable events
- Programs that make additional payments for nursing facilities[4] and hospitals[5], some of which are linked to measures of quality
- Monitors health plans' performance using the HIV viral load suppression measure (HIV measure) from CMS

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[1] P4Q information available at: https://hhs.texas.gov/about-hhs/process-improvement/medicaid-chip-quality-efficiency-improvement/pay-quality-p4q-program
[2] MCO value-based contracting information available at: https://hhs.texas.gov/about-hhs/process-improvement/medicaid-chip-quality-efficiency-improvement/value-based-contracting
[3] Hospital quality based payment program available at: https://hhs.texas.gov/about-hhs/process-improvement/medicaid-chip-quality-efficiency-improvement/potentially-preventable-events
[4] QIPP information available at: https://hhs.texas.gov/services/health/medicaid-chip/provider-information/quality-incentive-payment-program-nursing-homes
[5] Uniform Hospital Rate Increase Program (UHRIP) - information available at: https://rad.hhs.texas.gov/hospitals-clinic/hospital-services/uniform-hospital-rate-increase-program

Furthermore, HHSC maintains a performance indicator dashboard to measure performance of these programs. HHSC added the HIV measure to the dashboard available on the Texas Healthcare Learning Collaborative (THLC) portal[6].

[6] https://thlcportal.com/home

1. Introduction

Over 90 percent of Texas Medicaid and 100 percent of Children's Health Insurance Program (CHIP) recipients are enrolled in a managed care organization (MCO). HHSC contracts with 19 MCOs and two Managed Care dental contractors (DC), who oversee networks of healthcare providers in their respective service delivery areas. As Texas has transitioned from fee-for-service (FFS) to managed care, the state is also transitioning the Medicaid and CHIP programs from paying for volume to paying for value.

HHSC administers various programs through the Medicaid managed care system to improve health care quality and outcomes while containing costs. Furthermore, the Delivery System Reform Incentive Payment Program (DSRIP)[7] continues under the approval of the Medicaid 1115 Transformation waiver. These dollars, which are not passed through the MCOs, fund locally-developed, innovative, and value-based solutions for uninsured and Medicaid populations.

During the first six years of the waiver, providers that were involved in DSRIP reported on metrics and outcome measures for specific projects that were selected through regional assessments of community needs performed for each region. Beginning in Demonstration Year 7 (state fiscal year 2018), DSRIP providers are reporting on achievement of outcomes at their system level to measure the continued transformation of the Texas healthcare system.

HHSC has observed progress on various key indicators of healthcare quality and efficiency at the program level (e.g., STAR, STAR+PLUS), hospital level, MCO level, service area level, and overall in Medicaid and CHIP. A large set of Healthcare Effectiveness Data and Information Set (HEDIS) measures and Agency for Healthcare Research and Quality (AHRQ) measures show improvements. Progress on the frequency and associated costs for potentially preventable inpatient complications, potentially preventable hospital admissions, potentially preventable emergency room visits, potentially preventable hospital readmissions is mixed. This report includes information on trends in key quality metrics by program.

[7] Information on DSRIP available at: https://hhs.texas.gov/laws-regulations/policies-rules/waivers/medicaid-1115-waiver

2. Background

The shift in Texas towards a managed care system created conditions for effective value-based payments (VBP). In VBP, MCOs, DCs, and providers enter into new payment models in which portions of healthcare payments are linked to metrics of quality and efficiency. Several legislative sessions have provided HHSC with the direction and tools to promote VBP.

A comprehensive approach to VBP incentivizes MCOs, DCs, and providers to achieve high quality, efficient healthcare. The VBP initiatives implemented in the Medicaid and CHIP managed care systems are outlined in this report.

Successful implementation of VBP requires that HHSC examine its role in relation to MCOs, DCs, and providers. HHSC must evaluate existing tools and processes, identify new strategies to support VBP, and explore ways to align Medicaid and CHIP VBP efforts within the programs and the larger healthcare system (i.e., Medicare, commercial health plans).

Data sharing, whether by an MCO, DC, or a provider, is essential in a VBP environment. Public performance reporting can be an effective strategy to accelerate improvement and establish a transparent and accountable system. HHSC is exploring additional ways it can leverage the Texas Healthcare Learning Collaborative (THLC) portal[8] to support MCOs, DCs, and providers to pursue improved outcomes and efficiency. Additionally, because timely access to clinical data is critical to coordination of care, HHSC is exploring ways to promote greater sharing of electronic health records among providers, and between providers and MCOs and DCs.

As HHSC pursues VBP, it will strive to adhere to the guiding principles, as outlined in the VBP Roadmap, including:

- Continuous Engagement of Stakeholders
- Harmonize Efforts
- Administrative Simplification
- Data Driven Decision-Making

[8] THLC portal accessed at: https://thlcportal.com/home

- Movement through the VBP continuum
- Reward Success

3. Managed Care Value-Based Payments Programs

Three primary interconnected activities are considered VBP within managed care, including:

- MCO Pay for Quality (P4Q) Program[9]
- MCO Contractual Requirements for Value-Based Contracting with Providers[10]
- Hospital Quality Based Payment Program[11]

MCO Pay-for-Quality Program

The P4Q program is required for all MCOs and DCs. The program uses financial risks and rewards, coupled with performance metrics, to catalyze performance improvement.

For the medical P4Q program, each MCO has up to three percent of its capitation at-risk. MCOs not meeting target performance thresholds for the P4Q measures could lose capitation dollars that are at risk. Performance is measured against benchmarks (performance within the year relative to state and national norms or established standards) and performance against self (year-to-year improvement over self). Recouped capitation dollars from low performing MCOs for at-risk measures are redistributed to high performing plans. If there are any remaining funds after the collection and redistribution process, they are collected to form a performance bonus pool to reward the highest performing MCOs on specific measures. Because there are significant capitation dollars for an MCO to lose or gain, this program incentivizes MCOs to collaborate with providers to develop VBP models that can help ensure their success.

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[9] P4Q information available at: https://hhs.texas.gov/about-hhs/process-improvement/medicaid-chip-quality-efficiency-improvement/pay-quality-p4q-program

[10] Information on MCO VBP requirements available at: https://hhs.texas.gov/sites/default/files/documents/about-hhs/process-improvement/quality-efficiency-improvement/FY18-MCO-UMCC-UMCM-APM-providers-042117.pdf

[11] Information on Hospital Quality Based Payment program available at: https://hhs.texas.gov/about-hhs/process-improvement/medicaid-chip-quality-efficiency-improvement/potentially-preventable-events

The at-risk measures for the medical P4Q program[12] are shown in Table 1.

Table 1. At-Risk Measures for the Medical Pay-for-Quality (P4Q) Program

At-risk Measures	STAR	STAR+ PLUS	CHIP
Potentially Preventable Emergency Room Visits (PPVs)	√	√	√
Appropriate Treatment for Children with Upper Respiratory Infection (URI)	√		√
Prenatal and Postpartum Care (PPC)	√		
Well Child Visits in the First 15 months of Life (W15)	√		
Diabetes Control - HbA1c < 8% (CDC)		√	
High Blood Pressure Controlled (CBP)		√	
Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are using antipsychotics (SSD)		√	
Cervical Cancer Screening (CCS)		√	
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (WCC) - Sub measures counseling for nutrition and counseling for physical activity			√
Adolescent Well Care (AWC)			√

[12] Measures and associated benchmarks along with detailed methodology available at: https://hhs.texas.gov/sites/default/files//documents/laws-regulations/handbooks/umcm/6-2-14.pdf

The bonus pool measures for the medical P4Q program are listed in Table 2.

Table 2: Bonus Pool Measures for the Medical P4Q Program

Bonus Pool Measures	STAR	STAR+ PLUS	CHIP
Potentially Preventable Admissions (PPA)	√		
Low Birth Weight (LBW)	√		
Good Access to Urgent Care (CAHPS[13])	√	√	√
Rating their Health Plan a 9 or 10 (CAHPS)	√	√	√
Potentially Preventable Readmissions (PPR)		√	
Potentially Preventable Complications (PPC)		√	
Prevention Quality Indicator Composite (PQI)		√	
Childhood Immunization Status (CIS) Combination 10			√

For the dental P4Q program, each DC has a total of 1.5 percent of its capitation at-risk for 2018. Performance is calculated for each plan separately based on its own performance compared to past years. DCs that decline in performance overall could lose some of their at-risk capitation. Recouped capitation dollars from a DC that declines overall may be redistributed to a DC that improved. The measures in the dental P4Q program assess the extent to which members receive regular oral evaluations and primary prevention services for dental caries.

The first year of the redesigned medical and dental P4Q programs began January 1, 2018. Results for the medical and dental P4Q programs will be available in fall 2019.

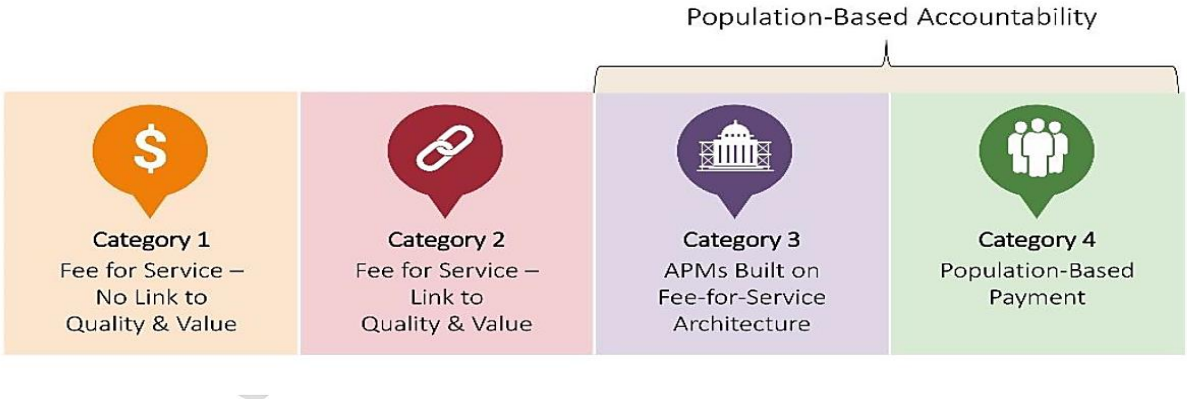
[13] Consumer Assessment of Healthcare Providers and Systems. Available at: https://www.ahrq.gov/cahps/index.html

MCO Value-Based Payment Models with Providers

A strong medical P4Q program creates the conditions for MCOs to pursue VBP models with providers to achieve quality outcomes. In addition, MCO contractual requirements help ensure MCOs are pursuing VBP in managed care programs in all service areas.

HHSC uses the Healthcare Payment Learning and Action Network (LAN) Alternative Payment Model (APM) Framework[14] (Figure 1) to help guide this effort. This framework provides a menu of payment models from which MCOs could choose to develop VBP contracts with their providers. Moving from one category to the next adds a level of complexity on the payment model. MCOs can choose any of these models in their transition to a payment transformation based on value.

Figure 1: Healthcare Payment LAN APM Framework



In 2018, HHSC introduced contractual requirements for MCOs and DCs to promote VBP, as follows:

- *Establishment of MCO and DC VBP targets:* overall *and* risk-based VBP contractual targets are based on MCO expenditures on VBP contracts relative to all medical expenses. For MCOs for calendar year 2018, targets start at 25 percent of provider payments in any type of VBP and 10 percent of provider payments in risk-based VBP. These targets increase over four years to 50 percent overall VBP and 25 percent risk-based VBP in calendar year 2021. For DCs, these targets are set at 25 percent overall VBP and 2 percent risk-

[14] LAN Framework available at: https://hcp-lan.org/groups/apm-fpt-work-products/apm-framework/

based VBP in 2018. The targets increase to 50 percent VBP and 10 percent risk-based VBP in 2021.

- *Requirements for MCOs and DCs to adequately resource this activity:* MCOs and DCs must dedicate sufficient resources for provider outreach and negotiation, assistance with data and/or report interpretation, and other collaborative activities to support VBP and provider improvement.

- *Requirements for MCOs and DCs to establish and maintain data sharing processes with providers:* MCOs and DCs must share data and reports with providers and collaborate on common formats, if possible.

- *Requirements for MCOs and DCs to have a process in place to evaluate VBP models:* MCOs and DCs are required to evaluate the impact of VBP models on utilization, quality, cost, and return on investment.

The introduction of VBP targets, as well as a newly redesigned P4Q programs, may accelerate progress MCOs are making with provider VBP efforts. HHSC has refined its data collection instruments for tracking progress of VBP contractual arrangements, and will be collecting MCO and DC reports on their VBP initiatives on an annual basis.

MCOs and DCs have VBP contracts with providers, or are collaborating with providers that are ready to enter into VBP arrangements. Most of the VBP initiatives involve primary care providers, are incentive-based, and built on a FFS payment approach with financial distributions for achievement of established quality measures or lowering total cost of enrollee care. Additionally, there are VBP models with specialists (including obstetricians/gynecologists), behavioral health providers, hospitals, nursing facilities, and long-term services and supports providers.

Hospital Quality Based Payment Program

HHSC administers the Hospital Quality Based Payment program for all hospitals in Medicaid and CHIP in both managed care and FFS delivery systems.[15] Hospitals are measured on their performance for risk-adjusted rates of potentially preventable hospital readmissions within 15 days of discharge (PPR) and potentially preventable

[15] Hospital Quality Based Payment program information available at: https://hhs.texas.gov/about-hhs/process-improvement/medicaid-chip-quality-efficiency-improvement/potentially-preventable-events

inpatient hospital-acquired complications (PPC) across all Medicaid and CHIP programs, as these measures have been determined to be reasonably within hospitals' control. Hospitals can experience up to a 4.5 percent reduction to their payments for inpatient stays for high rates of PPRs and PPCs, and if they are safety net hospitals, can receive additional payments above their base payments for low risk-adjusted rates of PPRs and/or PPCs. Measurement, reporting, and application of disincentives/incentives is on an annual cycle.

Changes in hospital performance on PPRs and PPCs during the 2014-2016 time period are outlined in Table 3. For these measures, increases in rates indicate worsening performance, while a decrease means improvement. Trends in potentially preventable events are included later in this report (page 25).

Table 3. Changes in hospital performance during 2014 - 2016 period

Performance Measure	Fiscal Year 2014-2016* change in performance
PPR weights per Admission at risk for PPR**	increase of 0.6%
PPC weights per Admission at risk for PPC**	decrease of 5.7%

**The fiscal years 2014-2016 period was used because 2014 was the first year weights were tracked for this program and 2016 is the most current complete year.*

***PPR and PPC weights: Calculated based on the anticipated resource use resulting from the actual PPRs and PPCs. In this sense, they are an approximation of costs associated with the PPR or PPC. An Admission at risk for PPR or PPC is an admission that could result in a PPR or PPC.*

4. Delivery System Reform Incentive Payment (DSRIP) Program

The Centers for Medicare and Medicaid Services (CMS) originally approved the Texas Healthcare Transformation and Quality Improvement Program 1115 Waiver[16], known as the 1115 Transformation Waiver, as a five-year demonstration program from December 2011 to September 2016 (Demonstration Years [DY]1-5). A subsequent extension took the waiver through DY6 (October 2016 to September 2017). On December 21, 2017, CMS approved an additional five-year extension from October 2017 to September 2022 (DY7-11).

The Texas 1115 Transformation Waiver extension continues Medicaid managed care statewide and maintains funding pools for Uncompensated Care and the DSRIP program. The DSRIP funding pool was extended for four years, through September 30, 2021.

The DSRIP program provides incentive payments to Texas hospitals, physician practices, community mental health centers, and local health departments for investments in delivery system reforms. During DY2-6 (October 2012 to September 2017), approximately 300 DSRIP providers implemented over 1,450 locally-driven projects to increase access to healthcare, improve the quality of care, and enhance the health of patients and families served.

Beginning with DY7 (October 2017 to September 2018), the DSRIP program structure evolved from project-level reporting to provider-level outcome reporting. HHSC worked with clinical experts and stakeholders throughout the state to develop a menu of measures that align with Medicaid program goals and state priorities. State priority measure bundles include those related to chronic disease management for diabetes and heart disease; preventive care and chronic disease screening; pediatric primary care and chronic disease management; improved maternal care and maternal safety; and behavioral health care.

[16] 1115 waiver information available at: https://hhs.texas.gov/laws-regulations/policies-rules/waivers/medicaid-1115-waiver

DSRIP Success in Achieving Performance Goals

During DY2-6, DSRIP providers were required to report on at least one outcome measure for each of their DSRIP projects in the reporting domain called Category 3, a pay-for-performance (P4P). The following information summarizes the achievement of DSRIP providers to date on Category 3 outcomes, both overall and for some of the most frequently reported measures.

In the P4P component of DSRIP, providers that demonstrated improved performance on selected outcome measures for DSRIP projects qualified for a partial incentive payment if they achieved at least 25 percent of the associated improvement goal. The full incentive payment was earned if they met or exceeded 100 percent of the associated improvement goal. The number of P4P outcome measures for which performance was reported and the number of outcomes that earned a partial or full incentive payment based on the results are shown in Tables 4 and 5. As noted in the table, most reported outcomes achieved at least 25 percent of their goal, and a high percentage achieved 100 percent of their goal, which is evidence of quality improvements being made across the state through DSRIP.

Table 4. DSRIP Category 3 Achievement for All Outcomes

Demonstration Year (DY)	No of Outcomes* with P4P in DY	No of P4P Outcomes Reporting Performance	≥25% Goal Achievement	100% Goal Achievement
DY4	1,552	1,542	91%	83%
DY5	1,851	1,819	91%	83%
DY6**	*1,792*	*1,592*	*87%*	*76%*

** This is the total number of pay-for-performance outcomes eligible to be reported per DY. There are approximately 300 DSRIP providers, however the number of outcomes with pay-for-performance milestones varies for each DY.*

*** The October DY7 reporting period (October 2018) is the last opportunity to report achievement of DY6 goals and additional data is expected.*

Table 5. DSRIP Category 3 Achievement for Selected Clinical Outcomes

Outcome Measure	DY	No of P4P Out-comes in DY	No of P4P Repor ting Perfor mance	≥25% Achiev ement [17]	100% Achiev ement [18]	Median Improve ment over Baseline [19]
Diabetes care: HbA1c poor control (>9.0%) (blood glucose not controlled)	DY4	97	95	87%	87%	15%
	DY5	104	100	89%	87%	23%
	*DY6**	*103*	*93*	*88%*	*85%*	*23%*
Controlling high blood pressure	DY4	64	64	91%	88%	16%
	DY5	73	73	95%	88%	20%
	*DY6**	*72*	*66*	*89%*	*86%*	*24%*
Risk Adjusted All-Cause 30-Day Readmissions	DY4	53	53	87%	79%	10%
	DY5	53	53	89%	72%	15%
	*DY6**	*53*	*40*	*85%*	*75%*	*19%*
Risk Adjusted 30-Day Readmissions for Congestive Heart Failure	DY4	48	48	90%	90%	24%
	DY5	48	48	79%	73%	21%
	*DY6**	*48*	*37*	*86%*	*81%*	*19%*
Reduce Emergency Department Visits for Behavioral Health/Substance Abuse	DY4	23	23	87%	78%	11%
	DY5	23	23	87%	74%	18%
	*DY6**	*22*	*14*	*93%*	*71%*	*22%*

**The October DY7 reporting period (October 2018) is the last opportunity to report achievement of DY6 goals and additional data is expected.*

[17] The percent of outcomes that received payment for reporting at least 25 percent achievement of the DY goal and 100 percent achievement of the DY goal, out of all P4P outcomes that reported a baseline and the applicable performance year data.
[18] Supra, note 19.
[19] Median improvement is measured as the median percentage of gap closed between baseline and best possible rate (0 percent or 100 percent depending on the outcome) for successful outcomes. Gap closed is calculated as performance rate minus baseline divided by best possible rate minus baseline. For example, a measure with a baseline of 50% and a DY6 performance rate of 75% has closed the gap between baseline and the best possible outcome of 100% by 50%; the median improvement over baseline of 50% is calculated as performance minus baseline divided by the best possible rate minus baseline.

5. Quality Incentive Payment Program (QIPP)

QIPP is designed to incentivize nursing facilities to improve quality and innovation in the provision of nursing facility services[20]. QIPP Year One began on September 1, 2017.

QIPP Elements

HHSC selected four measures from the CMS 5-star rating system for nursing facilities as the basis for evaluating improved quality of care for residents:

- High-risk long-stay residents with pressure ulcers;
- Residents who received an antipsychotic medication (long-stay);
- Residents experiencing one or more falls with major injury; and
- Residents who were physically restrained.

MCOs receive QIPP funds through three components of the STAR+PLUS nursing facility (NF) MCO per member per month (PMPM) capitation rates. MCOs distribute the funds to enrolled NFs based on each NFs performance on the quality metrics.

The three components follow:

- Component One (Pay-for-Reporting)
  - Payments are only available to the non-state governmental owned NFs.
  - Payments are based on the NF's submission of an attestation of a monthly Quality Assurance Performance Improvement (QAPI) Validation Report. Federal law requires NFs to develop QAPI programs and review them quarterly. This attestation is a signed statement that signifies that the NF conducted this comprehensive review monthly.

- Component Two (Pay-for-Performance)
  - All participating facilities are eligible to earn Component Two payments.
  - Payment is based on NF improved performance on the four metrics listed above. Initial quarterly goals are based on a 1.7 percent increase over baseline and increase each quarter up to a 7 percent increase by the end

[20] https://hhs.texas.gov/services/health/medicaid-chip/provider-information/quality-incentive-payment-program-nursing-homes

of the year. Alternatively, the facility can achieve payment by meeting or exceeding the national benchmark.

- Component Three (Pay-for-Performance)
  - All participating facilities are eligible to earn Component Three payments.
  - Payment is based on NF improved performance on four metrics listed above. Initial quarterly goals are based on a 5.0 percent increase over baseline and increase each quarter up to a 20.0 percent increase over baseline by the end of the year. Alternatively, the facility can achieve payment by meeting or exceeding the national benchmark.

QIPP Year One Performance to Date

For year one, 514 NFs participated in QIPP, including 430 non-state governmental owned nursing facilities and 84 private nursing facilities.

HHSC evaluates NFs performance on the quality measures on a quarterly basis. Results are available for quarter one (September 2017 through November 2017), quarter two (December 2017 through February 2018) and quarter three (March through May 2018).

Although HHSC does not yet have a full year's worth of data for QIPP, a high percentage of NFs are meeting the program's quality metrics. Early next year (2019) when a full year of data is available, the state will compare performance of QIPP facilities against non-QIPP facilities of similar size and location to evaluate the impact of the program.

Component One results: All eligible nursing facilities met the reporting requirements for Component One.

Table 6. Component Two results

Number of Measures Met	Number of NFs Quarter 1	Number of NFs Quarter 2	Number of NFs Quarter 3
0 Measures	4 (0.78%)	5 (0.97%)	5 (0.97%)
1 Measures	11 (2.14%)	12 (2.33%)	7 (1.36%)
2 Measures	68 (13.23%)	80 (15.56%)	68 (13.23%)

Number of Measures Met	Number of NFs Quarter 1	Number of NFs Quarter 2	Number of NFs Quarter 3
3 Measures	216 (42.02%)	186 (36.19%)	193 (37.55%)
4 Measures	215 (41.83%)	231 (44.94%)	237 (46.11%)

The four facilities marked as meeting 0 measures in Quarter 1 and the five facilities marked as meeting 0 measures in Quarter 2 and 3 reflect facilities that became ineligible for the program due to closure and ceased participating.

Table 7. Component Three results

Number of Measures Met	Number of NFs Quarter 1	Number of NFs Quarter 2	Number of NFs Quarter 3
0 Measures	4 (0.78%)	5 (0.97%)	5 (0.97%)
1 Measures	13 (2.53%)	18 (3.50%)	8 (1.56%)
2 Measures	74 (14.40%)	82 (15.95%)	75 (14.59%)
3 Measures	217 (42.22%)	191 (37.16%)	203 (39.49%)
4 Measures	206 (40.08%)	218 (42.41%)	215 (41.83%)

The four facilities marked as meeting 0 measures in Quarter 1 and the five facilities marked as meeting 0 measures in Quarter 2 and 3 reflect facilities that became ineligible for the program due to closure and ceased participating.

Table 8. Total Payments

Component	Payments Quarter 1	Payments Quarter 2	Payments Quarter 3
Component One	$ 44,912,142	$ 46,852,193	$ 46,009,185
Component Two	$ 12,207,209	$ 12,856,634	$ 12,770,347
Component Three	$ 22,413,277	$ 23,499,853	$ 23,162,746
Lapsed Funds	$ 8,463,751	$ 9,082,229	$ 8,799,801

To continue incentivizing NFs to improve quality and innovation in the provision of NF services, HHSC is proposing new quality metrics, eligibility requirements, and financing components for QIPP to begin in program year 3 (i.e., September 1, 2019, through August 31, 2020).

6. HHSC Directed-Payment Programs

Uniform Hospital Rate Increase Program (UHRIP)

The UHRIP program[21] is a HHSC directed-payment program in which local taxpayer funds are used to match federal Medicaid funds to increase payments to hospitals. Funds are built into the MCO capitation payments and are then paid out to eligible hospitals. While not considered a VBP, MCOs are exploring ways that portions of UHRIP funds can be linked to measures of quality related to HHSC priority areas.

Network Access Improvement Program (NAIP)

NAIP is also a HHSC directed-payment program in which local taxpayer funds are used to match federal Medicaid funds. These funds are built into MCO capitation rates, and are designed to increase the availability and effectiveness of primary care for Medicaid beneficiaries by incentivizing health-related institutions (HRIs) and public hospitals to provide quality, well-coordinated, and continuous care. Through this program, some MCOs utilize quality metrics to trigger payments to providers.

[21] Information on the UHRIP program available at: https://rad.hhs.texas.gov/hospitals-clinic/hospital-services/uniform-hospital-rate-increase-program

7. HHS Quality Webpage and Texas Healthcare Learning Collaborative (THLC) Portal

Public reporting of measurement results can be an effective strategy to advance quality and efficiency in healthcare. HHSC continues to increase the information about quality initiatives and data available to MCOs, DCs, providers, and other stakeholders through the HHS Quality webpage[22] and the THLC portal.[23]

THLC Portal

HHSC's external quality review organization (EQRO)[24] developed the THLC originally as a tool to support and inform MCOs and DCs on quality improvement activities. In collaboration with HHSC, the EQRO modified the THLC portal to serve as a public reporting platform that enables users to compare performance of programs, MCOs, DCs, and regions across process and outcome measures and multiple time periods[25]. Through expanded analytics and enhanced data visualizations, the portal allows the user to better understand and compare performance, and download data for customized analytics. The portal also helps providers understand opportunity areas for value-based contracting with MCOs and DCs.

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[22] Quality webpage available at: https://hhs.texas.gov/about-hhs/process-improvement/medicaid-chip-quality-efficiency-improvement
[23] THLC portal accessed at: https://thlcportal.com/home
[24] Information about EQRO is available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html

[25] Per Section 536.003(g) (H.B. 1629, 85R) HIV Viral Suppression Rate (HIV) has recently been added to the suite of measures

8. Trends in Key Quality Metrics

Trends in MCO Medical P4Q Program HEDIS/AHRQ/CMS[26]

The medical P4Q program was redesigned in 2017 creating incentives and disincentives for the STAR, STAR+PLUS, and CHIP Programs. For 2018 P4Q measures, HHSC will have results in Fall 2019, allowing for recoupments and distributions to occur in early 2020.

For all tables below, positive percentage change signifies improving performance and negative percentage change signifies worsening performance, except as indicated. This data is available on the HHSC THLC Portal (https://thlcportal.com).

STAR Measures

The percent change[27] in performance from 2013 through 2016 for quality of care measures in the 2018 STAR medical P4Q program is shown in Table 9.

Table 9. Change in Quality of Care Measures in the STAR Program

STAR Measures	Calendar Year 2013-2016 change in performance
Appropriate Treatment for Children with Upper Respiratory Infection (URI)	5.4%
Timeliness of Prenatal Care (PPC)	-2.6%
Postpartum Care (PPC)	14.8%
Well Child Visits in the First 15 months of Life (W15)	-3.2%

[26] Information is available at: https://www.ncqa.org/hedis/

[27] *The Percent Change is the difference between the final and initial values divided by the initial value*

STAR Measures	Calendar Year 2013-2016 change in performance
Low Birth Weight	4.1%**

***2014-2016 periods used. For this measure, increases in rates = worsening performance.*

STAR+PLUS Measures

The percent change in performance from 2013 through 2016 for quality of care measures in the STAR+PLUS medical P4Q program is shown in Table 10. Control of diabetes improved significantly with an almost 44 percent increase over a period of four years. While the improvement is significant, performance is still below the national average. HHSC will continue to assess performance on this measure, as improvements potentially have a large impact on the secondary prevention of complications usually associated with diabetes.

Table 10. Change in Quality of Care Measures in the STAR+PLUS Program

STAR+PLUS Measures	Calendar Years 2013-2016 change in performance
Diabetes Control - HbA1c < 8% (CDC)	43.7%
High Blood Pressure Controlled (CBP)	-4.6%
Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are Using Antipsychotics (SSD)	3.7%
Cervical Cancer Screening (CCS)	-9.2%

CHIP Measures

The percent change in performance from 2013 through 2016 for quality of care measures in the CHIP medical P4Q program is shown in Table 11. There was an overall improvement in all the quality measures, especially related to children and adolescents weight assessment and counseling for nutrition and physical activity, where there was improvement of almost 30 percent.

Table 11. Change in Quality of Care Measures in the CHIP Program

CHIP Measures	Calendar Years 2013-2016 change in performance
Counseling for Nutrition	29.3%
Counseling for Physical Activity	29.6%
Appropriate Treatment for Children with Upper Respiratory Infection (URI)	8.6%
Adolescent Well Care (AWC)	15.6%
Childhood Immunization Status (CIS) Combination 10	Data not available for all periods

Medicaid and CHIP Dental P4Q Measures

The percent change in performance from 2013 through 2016 for quality of care measures in the Medicaid dental P4Q program is shown in Table 12. There was a positive change in all four measures used to monitor quality performance. Most significant improvement was in the application of Topical Fluoride for Children at Elevated Caries Risk indicating the proportion of children who received the treatment increased by 27 percent during the four-month period.

Table 12. Change in Quality of Care Measures in the Medicaid Dental Program

Medicaid Dental Quality Alliance (DQA) Measures	Calendar Years 2013-2016 change in performance
Oral Evaluation	3%
Sealants for 6–9 Year-Old Children at Elevated Caries Risk	1%
Sealants for 10-14 Year-Old Children at Elevated Caries Risk	7%
Topical Fluoride For Children at Elevated Caries Risk	27%

The positive change in performance was greater in the CHIP dental P4Q program, except for sealants in the 6-9 year-old children, where the change was negative.

Table 13. Change in Quality of Care Measures in the CHIP Dental Program

CHIP Dental Quality Alliance (DQA) Measures	Calendar Years 2013-2016 change in performance
Oral Evaluation	12%
Sealants for 6–9 Year-Old Children at Elevated Caries Risk	-2%
Sealants for 10-14 Year-Old Children at Elevated Caries Risk	9%
Topical Fluoride For Children at Elevated Caries Risk	45%

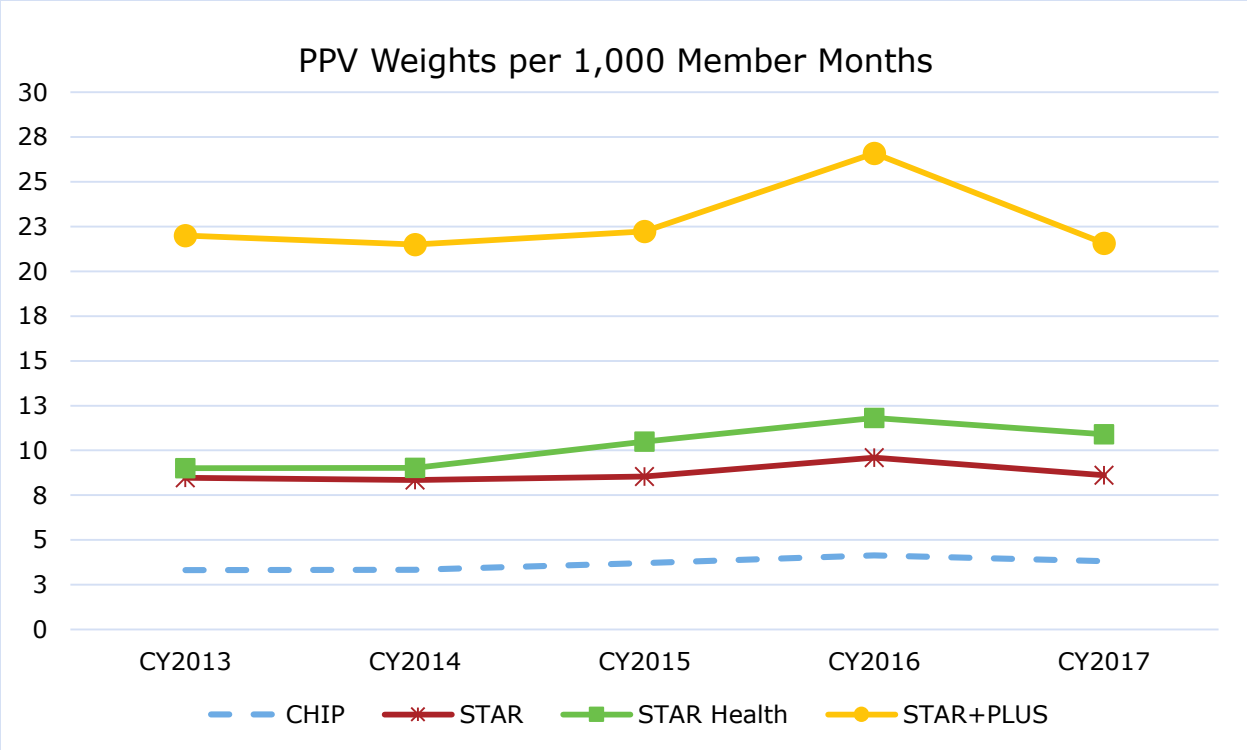
Trends in Potentially Preventable Events, 2013-2017

For all tables included in this section, negative percentage change signifies improving performance and positive percentage change signifies worsening performance, except as indicated. Each table is stratified by managed care program. This data[28] is available on the HHSC THLC Portal (https://thlcportal.com).

Potentially Preventable Emergency Department Visits (PPV)

The graph below shows the five-year trend for weighted rates of potentially preventable emergency department visits (PPVs) relative to how many people are enrolled in the program (member months). PPV is a medical P4Q measure across all programs. Each PPV is assigned a relative weight of anticipated resources needed to provide effective treatment. This is represented by the Y axis in the graph.

Figure 2. Five Year Trend of Potentially Preventable Emergency Department Visits (PPV)



[28] The data for 2017 are over 90 percent complete, but not yet final. STAR Kids trends are not available because it is a new program.

Relative weights are assigned to each ED visit at risk for a PPV based on the amount and type of resources used in the ED visits. National relative weights for CY2017 provided by 3M™ were used to determine resource utilization. The graph shows that while rates of PPVs increase from CY2013 to CY2016 across all programs, a decrease is noted from CY2016 to CY2017. It should also be noted that many MCOs are instituting value based payment models with providers that focus on reductions in emergency department usage. HHSC will continue to assess performance on this key metric. The table below shows the percent change over the same time period, by contrasting the PPV performance in 2017 with that of 2013. [29]

Table 14. Change in Performance of Potentially Preventable Emergency Department Visits

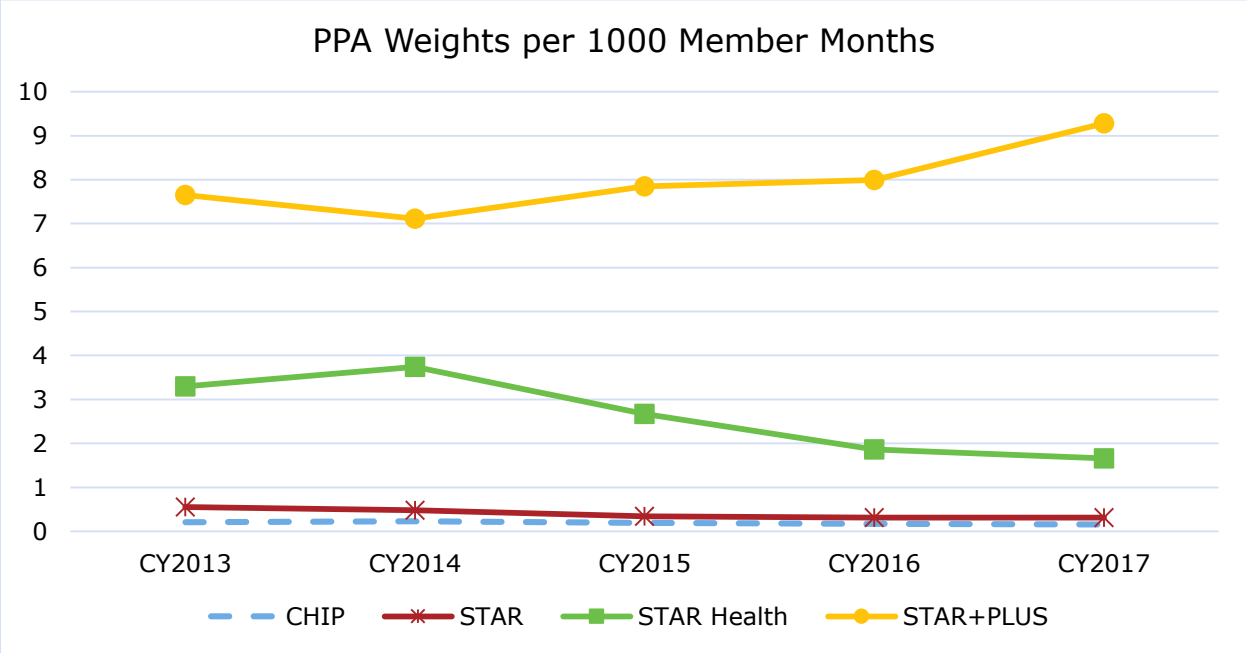
Program	Calendar Years 2013- 2017 change in performance
CHIP	15.2%
STAR	1.7%
STAR+PLUS	-1.9%
STAR Health	21.2%

The performance is represented by the PPV weights per 1,000 member months. As the table indicates, it was a remarkable improvement in performance in the STAR Health program, followed by CHIP, compared with the other two programs.

[29] The Percent Change is the difference between the final and initial values divided by the initial value.

Potentially Preventable Hospital Admissions (PPA)

Figure 3. Five Year Trend of Potentially Preventable Hospital Admissions



The graph above shows the five-year trend in weighted rates of potentially preventable hospital admissions (PPAs) relative to how many people are enrolled (member months). Each PPA is assigned a relative weight of anticipated resources needed to provide effective treatment.

While there was a decrease in PPA in CHIP, STAR, and STAR Health, PPA increased rates in STAR+PLUS. HHSC is analyzing the data to assess the reasons for the increase, particularly from CY2016 to CY2017. The table below shows the percent change for the same period.[30]

Table 15. Change in Performance of Potentially Preventable Hospital Admissions

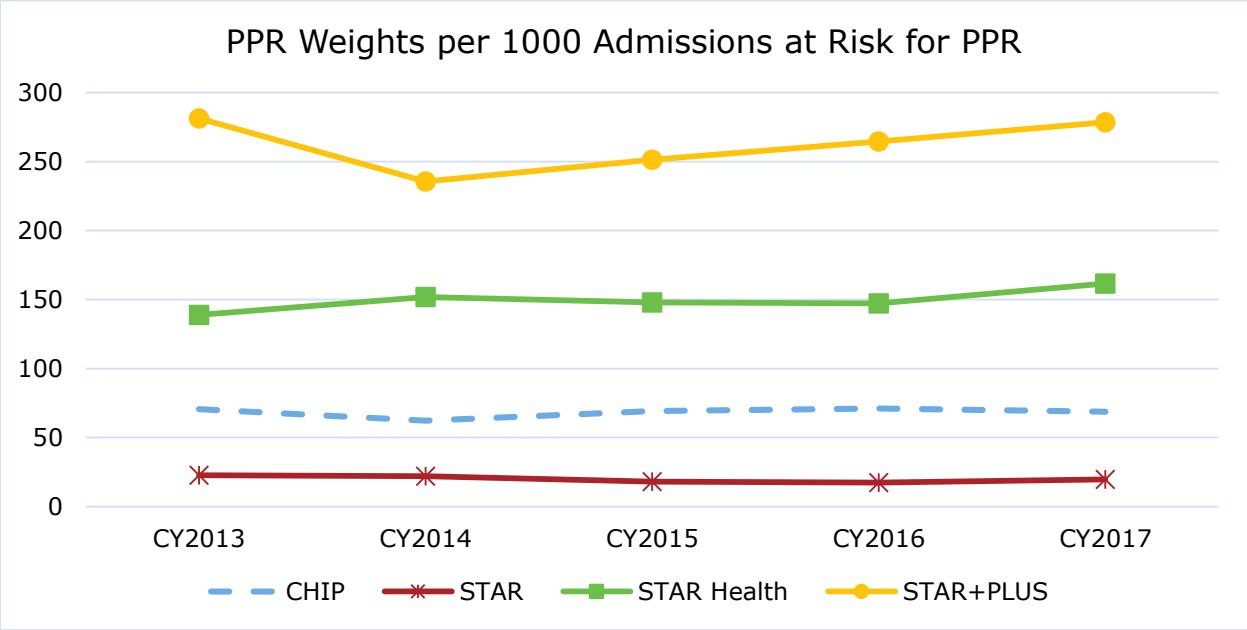
Program	Calendar Years 2013- 2017 change in performance
CHIP	-25.3%
STAR	-43.8%

[30] Supra note 29

Program	Calendar Years 2013- 2017 change in performance
STAR+PLUS	21.2%
STAR Health	-49.5%

Potentially Preventable Hospital Readmissions (PPR)

Figure 4. Five Year Trend in Potentially Preventable Hospital Readmissions



The graph above shows the five-year trend in weighted potentially preventable readmissions within 30 days of initial admissions that were at-risk for readmission. In STAR+PLUS, PPR rates track relatively closely with PPA rates. In other words, more PPAs translates to more PPRs. However, the same is not observed with STAR Health. HHSC is analyzing the data to better understand the dynamics between the PPA and PPR trends between these two programs. The table below shows the percent change for the same period.[31]

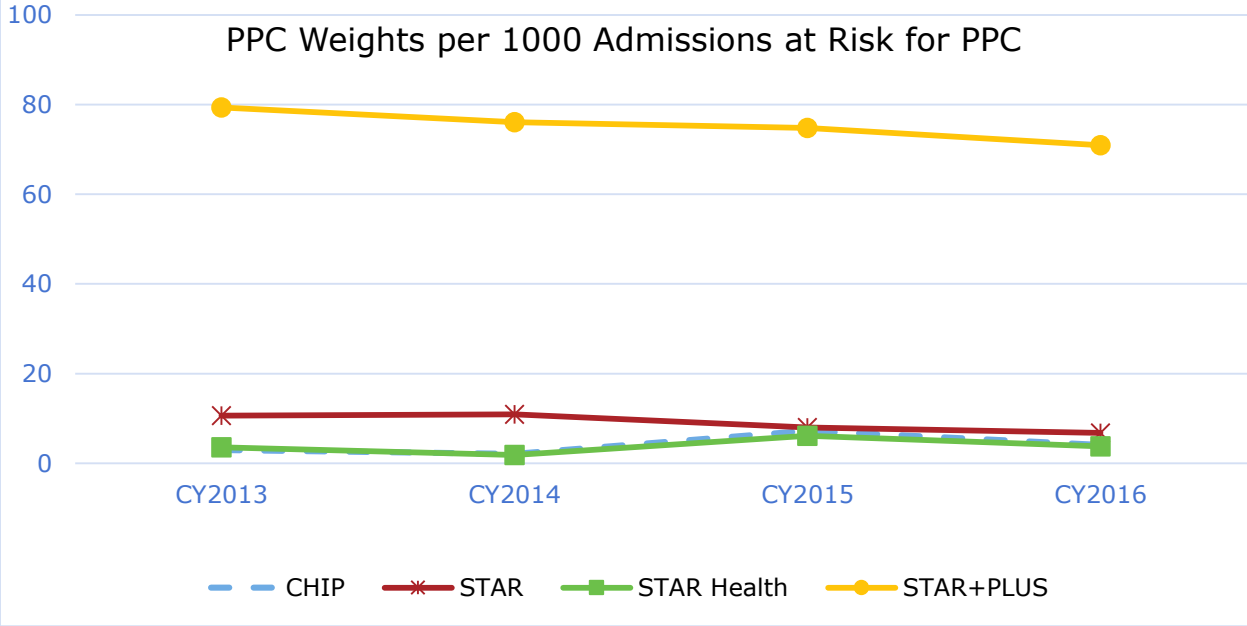
[31] Supra note 29

Table 16. Change in Performance in Potentially Preventable Hospital Readmissions

Program	Calendar Years 2013- 2017 change in performance
CHIP	-2.5%
STAR	-13.4%
STAR+PLUS	-0.9%
STAR Health	16.3%

Potentially Preventable Hospital Complications

Figure 5. Four Year Trend in Potentially Preventable Hospital Complications[32]



The graph above shows the four-year trends in weighted hospital inpatient potentially preventable complications compared to initial admissions that were at-risk for a complication.

As shown in Table 17, improvement was seen in two of the four programs. Of note, there were very few admissions at risk for PPC in STAR Health. Because of the low

[32] Four years were selected for this measure as data corrections were underway for CY2017

numbers, this measure is very volatile. A similar trend and explanation was found in CHIP. The table below shows the percent change for the same period[33].

Table 17. Change in Performance in Potentially Preventable Hospital Complications

Program	Calendar Year 2013- 2016* change in performance
CHIP	38.2%
STAR	-36.3%
STAR+PLUS	-10.6%
STAR Health	5.4%

*Note: 2017 is not included because data are not yet final.

[33] Supra note 29

Additional Measures

HHSC Performance Indicator Dashboard

HHSC expects Medicaid and CHIP MCOs to meet or surpass the HHSC-defined minimum standard on more than two-thirds of the measures on the Performance Indicator Dashboard (numbers of measures range from 26 for STAR, 21 for STAR+PLUS, 16 for CHIP and 8 for STAR Health). Beginning in Fall 2019, an MCO whose per program performance is below the minimum standard on more than 33.33 percent of the measures on the dashboard will be subject to remedies under the contract, such as placement on a corrective action plan (CAP). Calendar year 2018 standards are based on calendar year 2016 data. For more information, please see Chapter 10.1.14 of the Uniform Managed Care Manual[34].

HIV Viral Load Suppression

H.B. 1629, 85th Legislature, Regular Session, 2017, requires HHSC to coordinate with the Texas Department of State Health Services (DSHS) to develop a quality-based outcome measure for individuals with human immunodeficiency virus (HIV) in the CHIP and Medicaid programs. To fulfill this requirement, HHSC is monitoring MCO performance using the HIV viral load suppression measure (HIV measure) from CMS. HHSC added the measure to its dashboard that is available on the THLC portal.

Table 18. Performance standards for the HIV measure by program

Program	Performance Indicator	High Standard	Minimum Standard
STAR	HIV Viral Suppression Rate (HIV)	69%	66%
STAR+PLUS	HIV Viral Suppression Rate (HIV)	70%	67%
CHIP	HIV Viral Suppression Rate (HIV)	85%	81%

[34] https://hhs.texas.gov/sites/default/files/documents/laws-regulations/handbooks/umcm/10-1-14.pdf

The HIV measure's high and minimum performance standards for 2018 are calculated using the following:

- High Performance Standard: 5 percent improvement from 2016 program rate
- Minimum Standard: 2016 program rate

The HIV measure is defined as the percentage of patients, regardless of age, with a diagnosis of HIV, with a HIV viral load less than 200 copies/mL at their last HIV viral load test, during the measurement year.

Table 19. Percentage of individuals meeting the HIV viral suppression standard, CY2016

Program	Total number of individuals with HIV	Total number Virally Suppressed	Percentage Suppressed by Medicaid Plan Type
STAR	1,155	766	66%
STAR+PLUS	5,831	3,932	67%
CHIP	122	99	81%

Source: HIV Surveillance Data, Electronic Lab Records linked to Medicaid Claims Data, 2016

Relocation to a Community-Based Setting

Senate Bill 7, 83rd Legislature, Regular Session, 2013, requires HHSC, as appropriate, to report the number of recipients who relocated to a community-based setting from a less integrated setting. The two programs that were included in the analysis were Promoting Independence (PI)[35] and Money Follows the Person (MFP)[36].

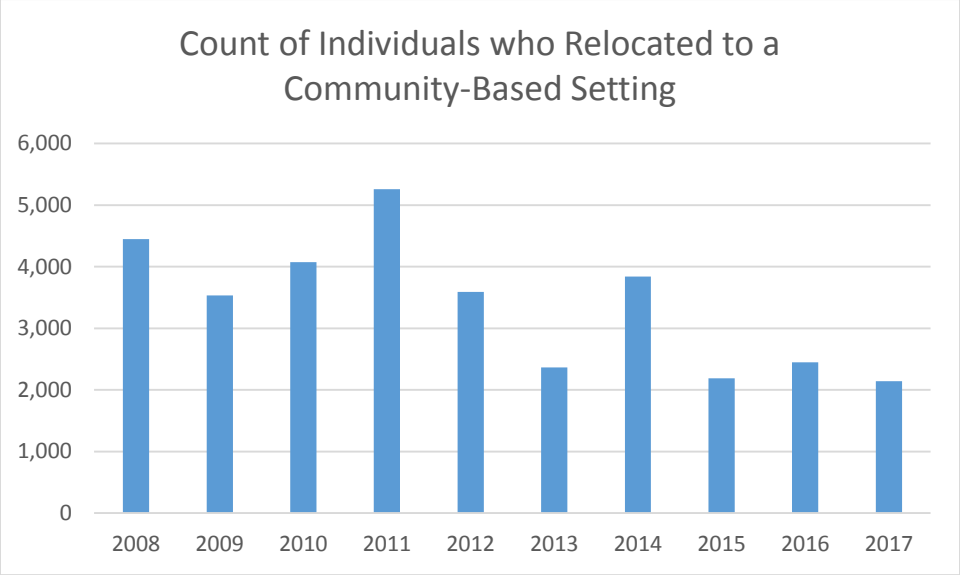
Data on individuals enrolled in PI and MFP that transitioned from less integrated settings to community based settings are shown in Figure 6 below. There were less people transitioning to community based settings. The decline in transitions over

[35] Information regarding Promoting Independence available at https://hhs.texas.gov/doing-business-hhs/provider-portals/resources/promoting-independence-pi

[36] Information regarding Money Follows the Person available at https://hhs.texas.gov/doing-business-hhs/provider-portals/resources/promoting-independence/money-follows-person-demonstration-project

time may be attributed to increased diversion from institutional services and increased community-based services.

Figure 6. Individuals in the Promoting Independence and Money Follows the Person Programs who relocated to a community-based setting from a less integrated setting



Data Source: DADS QAI Data Mart. 10 MFP Demo Semi- Annual Newly Enrolled Participants by Target Population Report. Report Generated January 18, 2018

9. Conclusion

While there has been improvement on many key Medicaid and CHIP quality measures, there is still room for improvement. HHSC will continue to track and address trends in key measures to improve healthcare value.

To support these quality oversight activities, HHSC publicly reports a variety of process and outcome measures related to healthcare quality. HHSC is exploring ways to enhance the public reporting platform as a tool to support data exchange with MCOs, DCs, and providers to advance VBP efforts.

HHSC will also continue to collaborate with MCOs as they expand VBP models with providers. Many of the emerging models are focused on reductions in total cost of enrollee care, which include quality metrics, such as reductions in potentially preventable emergency department visits. As of calendar year 2017, most models incorporate provider incentives for achievement of quality metrics and do not incorporate financial risk to the provider. Some VBP models include opportunities for providers to share in savings with MCOs, if there are cost reductions.

The Texas Medicaid and CHIP programs are in the early stages of the fundamental change from paying for healthcare services to achieving better care for individuals, better health for populations, and lower cost for the state. Over the last year, HHSC has partnered with the University of Texas-Dell Medical School (UT-Dell), and Episcopal Health Foundation for the purpose of identifying areas of opportunity within value based purchasing. Through extensive engagement of stakeholders, UT-Dell has formulated numerous recommendations designed to improve data infrastructure, increase stakeholder awareness of VBP, focus on "high opportunity" VBP models, and reduce administrative burden. HHSC's Value Based Payment and Quality Improvement Advisory Committee has developed a report[37] that incorporates these recommendations. HHSC is committed to engaging stakeholders in a coordinated and sustained effort to advance Medicaid and CHIP VBP initiatives.

[37] This report will be posted on HHSC's website in December 2018

List of Acronyms

Acronym	Full Name
AHRQ	Agency for Healthcare Research and Quality
APM	Alternative Payment Models
AWC	Adolescent Well Care
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CAP	Corrective Action Plan
CBP	Blood Pressure Controlled
CCS	Cervical Cancer Screening
CDC	Center for Disease Control
CHIP	Children Health Insurance Program
CIS	Childhood Immunization Status
CMS	Centers for Medicare and Medicaid Services
DADS	Department of Aging and Disability Services
DC	Dental Contractor
DQA	Dental Quality Alliance
DSHS	Department of State Health Services
DSRIP	Delivery System Reform Incentive Payment

DY	Demonstration Year
ED	Emergency Room
FFS	Fee-For-Service
HB	House Bill
HEDIS	Healthcare Effectiveness Data and Information Set
HHS	Health and Human Services
HHSC	Health and Human Services Commission
HIV	Human Immunodeficiency Virus
LAN	Learning and Action Network
MFP	Money Follows the Person
NAIP	Network Access Improvement Program
NCQA	National Center for Quality Assurance
NF	Nursing Facility
PI	Promoting Independence
PMPM	Per Member Per Month
PPA	Potentially Preventable Hospital Admissions
PPC	Prenatal and Postpartum Care
PPC	Potentially Preventable Hospital Complications
PPR	Potentially Preventable Hospital Readmissions

PPV	Potentially Preventable Emergency Room Visits
QAI	Quality Assurance and Improvement
QIPP	Quality Incentive Payment Program
SSD	Screening for People with Schizophrenia or Bipolar Disorder
STAR	State of Texas Access Reform
STAR+PLUS	State of Texas Access Reform Plus
THLC	Texas Healthcare Learning Collaborative
UHRIP	Uniform Hospital Rate Increase Program
URI	Upper Respiratory Infection
VBP	Value-Based Payments
WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents