



Report on Pay-for- Quality Measures

As Required by

**Senate Bill 1, Article II, Rider
20, 85th Legislature, Regular
Session**

Health and Human Services

Commission

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Executive Summary

The *Report on Pay-for-Quality Measures* for fiscal year 2018 is submitted in compliance with [the 2018-19 General Appropriations Act \(GAA\), Senate Bill \(S.B.\) 1, 85th Legislature, Regular Session, 2017 \(Article II, HHSC, Rider 20\)](#).

Rider 20 directs the Health and Human Services Commission (HHSC) to evaluate how Texas Medicaid providers and managed care organizations (MCOs) use existing Pay-for-Quality (P4Q) measures to improve healthcare delivery and whether these initiatives result in a higher quality of care and improved health outcomes. Pursuant to Rider 20, HHSC must report recommendations to improve current P4Q measures, areas requiring additional study, and how HHSC could potentially use study findings if it expands the use of P4Q measures into outpatient settings.

HHSC first implemented medical and dental P4Q programs in 2014. Based on the experience from 2014 through 2016, HHSC used 2017 to redesign the medical and dental P4Q programs with the goals of simplification, greater predictability, rewards for high performance and improvement, and achieving better health outcomes. The redesigned medical and dental P4Q programs were implemented beginning calendar year 2018.

This report presents the results for the dental P4Q programs for Medicaid and CHIP for 2014 through 2016. The medical P4Q program was suspended for 2014 through 2016 due to issues with the methodology. Therefore, there is no data to report on for medical P4Q for this timeframe.

Given the recent redesign, it is too soon to determine the impact of the current P4Q programs on quality of care and health outcomes. For 2018 measures, HHSC will have results in fall 2019 and recoupments and distributions will occur in early 2020.

The redesigned P4Q program, implemented January 1, 2018, measures services and outcomes of care provided in inpatient and outpatient settings. While the program includes measures of potentially preventable events in inpatient settings (admissions, readmissions, and complications), most P4Q measures evaluate care provided in outpatient settings. The specific P4Q measures were selected to focus on state priorities and the needs of Texas Medicaid members, such as prevention, chronic disease management, and maternal and infant health.

HHSC continues to consider opportunities to improve and expand the P4Q programs. For example, HHSC plans to include STAR Kids in the P4Q program beginning in calendar year 2020. HHSC will also explore options for further alignment across HHSC quality programs. Some MCOs use the P4Q measures as part of payment arrangements with providers to advance value-based care. HHSC will continue its work with MCOs, DMOs, and providers to promote alignment, innovation, and transparency in value-based care efforts.

1. Introduction

Rider 20 requires HHSC to submit, by October 1, 2018, an initial report to the Governor, the Legislative Budget Board, and the appropriate standing committees of the Legislature. The report must include the following elements:

- An evaluation of how Texas Medicaid providers and MCOs use existing P4Q measures to improve health care delivery;
- Whether these MCO and provider initiatives result in a higher quality of care and improved health outcomes;
- Recommendations to improve current P4Q measures and areas requiring additional study; and
- Information on how HHSC could use the findings of this analysis if it expands the use of P4Q measures into outpatient settings.

The 2016-17 General Appropriations Act, H.B. 1, 84th Legislature, Regular Session, 2015 (Article II, Health And Human Services Commission, Rider 67) contained this same requirement and the [Combined Report on Quality-Based Payment and Delivery Reforms in Medicaid and the Children's Health Insurance Program](#) was submitted February 22, 2017.

2. Background

From 2009 to 2013, HHSC administered an incentive/disincentive program called the At-Risk and Quality Challenge (ARQC). Under ARQC, a percentage of the MCOs' capitation was at-risk, and their performance on certain quality metrics was measured against fixed benchmarks. However, the program did not account for the MCOs' individual quality improvement over time.

To comply with S.B. 7, 83rd Legislature, Regular Session, 2013 and to consider MCO improvement over time, HHSC developed its first P4Q model in January 2014. Texas Government Code, Section 536.051, requires HHSC to base a percentage of the premiums paid to organizations participating in Texas Medicaid or the Children's Health Insurance Program (CHIP) on the organization's performance with respect to outcome and process measures developed under Section 536.003. This statute was the basis for the medical and dental P4Q programs for MCOs and dental contractors implemented in 2014.

The 2014 medical P4Q model provided financial incentives and disincentives to MCOs based on year-to-year incremental improvement on a single set of quality measures. The model set minimum performance levels and attainment goals. The attainment goals indicated optimal performance and were multi-year targets. Each MCO was expected to close the gap between its prior year performance and the measure's attainment goal by 15 percent each year. Points were assigned to each MCO based on their year-to-year improvement on each quality measure. Positive points were assigned for year-to-year improvements in performance, and negative points were assigned for year-to-year declines. The rewards and penalties were based on the total positive and negative points. Four percent of the MCO's capitation was at risk for recoupment, and conversely, the MCO could earn up to four percent above its capitation as a reward.

When the medical 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, in June 2016 HHSC decided to suspend the medical P4Q program — 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 dental P4Q program was implemented in 2014 using a model similar to the 2014 medical P4Q model. Two percent of the dental plan's capitation was at-risk and plans could earn some or all of their at-risk premium based on year-to-year incremental improvement on a set of quality measures. HHSC recouped payments based on dental plan performance for calendar years 2014, 2015, and 2016. In alignment with the medical program, HHSC did not administer a dental P4Q program in calendar year 2017, as staff used this time to develop and formalize a new program for calendar year 2018.

HHSC revised the methodology and measures for both P4Q programs beginning in calendar year 2018 to simplify the programs, provide more predictability for MCOs to track their own performance and estimate losses, reward high performance and improvement, and promote transformation and innovation in an effort to achieve better health outcomes.

3. Dental Pay-for-Quality Results 2014-2016

This section contains dental P4Q results for calendar years 2014, 2015, and 2016.

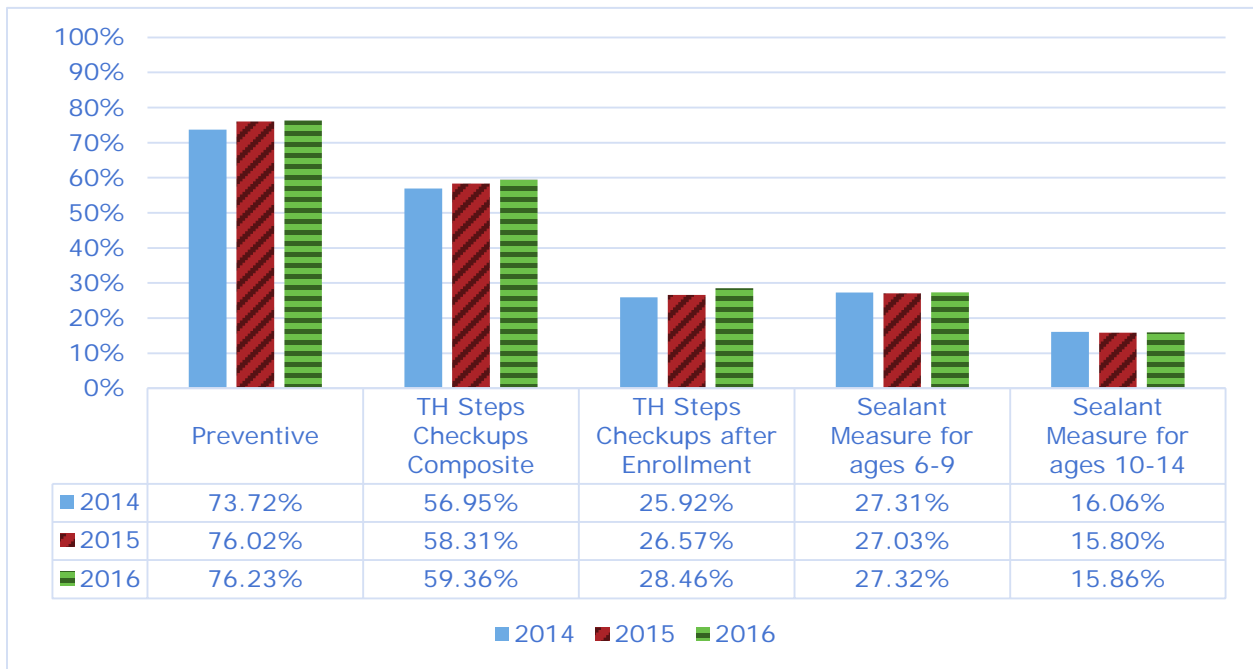
Medicaid

Figure 1 outlines results for the Medicaid dental P4Q measures:

- **Preventive**
 - Percent of members aged 1-20 years enrolled for at least 11 of the past 12 months who had at least one preventative dental service during the measurement year
- **Texas Health Steps (TH Steps)**
 - Percent of members aged 1-20 years receiving a checkup within 90 days of enrollment
 - A composite score including the percent of members aged 1-20 years receiving at least two check-up visits plus half of the percent of members receiving exactly one check-up visit during the measurement year
- **Sealant**
 - Percent of members aged 6-9 years enrolled for at least six continuous months who had at least one dental sealant during the measurement year
 - Percent of members aged 10-14 years enrolled for at least six continuous months who had at least one dental sealant during the measurement year

Figure 1 shows Medicaid dental performance remained fairly constant across all years with some improvement in preventive and THSteps measures.

Figure 1: 2014-2016 Medicaid Rates, Dental P4Q Measures



CHIP

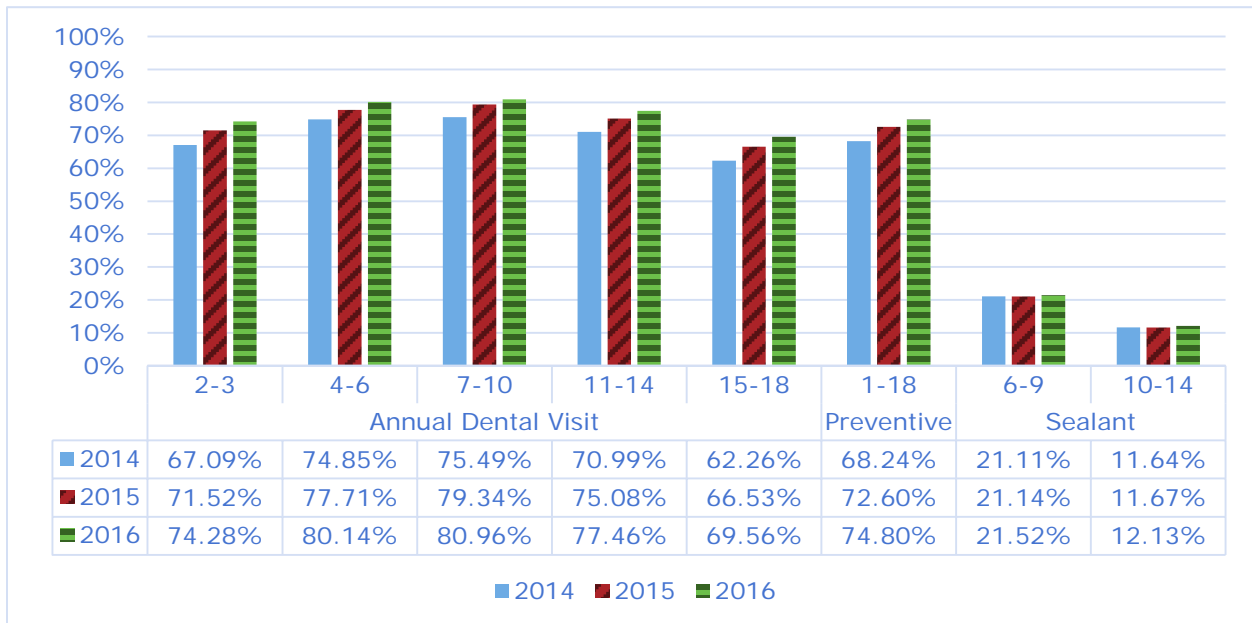
Figure 2 outlines results for the CHIP Dental P4Q measures:

- **Annual Dental Visit:** Percent of members enrolled for at least 11 of the past 12 months who had at least one annual dental visit (ADV) during the measurement year for the following age groups:
 - 2-3
 - 4-6
 - 7-10
 - 11-14
 - 15-18
- **Preventive:** Percent of members aged 1-18 years enrolled for at least 11 of the last 12 months who had at least one preventative dental service during the measurement year.
- **Sealant:** Percent of members aged 6-14 continuously enrolled for at least 180 days who had at least one sealant during the measurement year for the following age groups:
 - 6-9
 - 10-14

For CHIP, statewide performance improved on all of the dental P4Q program measures except for the rate of dental sealants, which remained relatively constant across all years. The measure with the greatest amount of improvement from 2014

to 2016 was the annual dental visit for CHIP members aged 15-18 which increased by almost eight percentage points.

Figure 2: 2014-2016 CHIP Rates, Dental P4Q Measures



Recoupments and Distributions

Neither of the state’s two dental contractors received distributions under the dental P4Q methodology in place from 2014 through 2106. Although the performance of each individual dental contractor varied, total recoupments decreased each year under that program, as shown in Table 1.

Table 1: Dental Pay-for-Quality Recoupments for 2014-2016

Measurement Year	2014	2015	2016
Total Recoupment (Medicaid and CHIP)	\$8,226,572.97	\$8,152,723.55	Not yet finalized

4. Redesigned 2018 Medical and Dental P4Q Programs

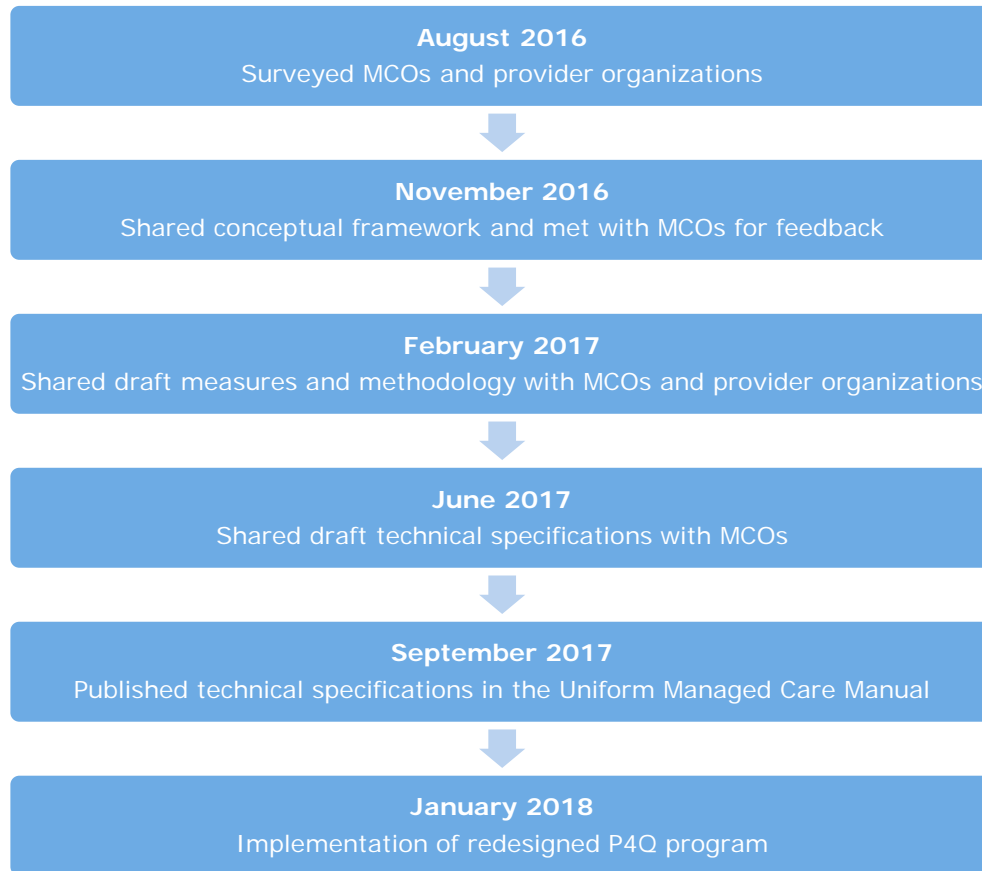
HHSC developed processes and procedures for P4Q (see Appendix A. P4Q Process and Procedures), which it followed in redesigning the medical and dental P4Q program. HHSC included MCOs, dental contractors, and provider organizations in the development of the redesigned P4Q programs. In addition, HHSC worked with the Department of State Health Services in an effort to align priorities and initiatives. These collaborations were critical to developing a program that meets all federal and state requirements, can be implemented within existing resources, and is coordinated with other quality initiatives.

HHSC will receive calendar year 2018 measure results in the fall of 2019 with recoupments and distributions occurring in early 2020.

Medical P4Q

HHSC solicited MCO, provider, and other stakeholder feedback throughout the medical P4Q redesign process. This included conducting surveys, meeting and communicating with stakeholders, making presentations, and soliciting comments at each stage of the redesign process. All materials including the conceptual framework, recorded webinars and slides, a question and answer document, and simulations were provided to the MCOs. In August 2017, all MCOs signed letters acknowledging their support of the program and the many opportunities to provide input into its design.

Figure 3: Medical P4Q Redesign Timeline



In the redesigned medical P4Q program, three percent of the MCOs' capitation is at-risk. MCO performance is evaluated in three ways:

- Performance against self (comparison of an MCO's performance to its prior year performance)
- Performance against benchmarks (comparison of an MCO's performance against Texas and national peers)
- Bonus pool measures

Utilizing performance against self and performance against benchmarks allows HHSC to reward high performing plans while still incentivizing plans to improve regardless of their current level of performance. Plans can earn or lose money based on their performance against self and performance against benchmarks. A portion of the at-risk capitation is assigned to each selected quality measure with half allotted to performance against self and half allotted to performance against

benchmarks. Rewards and penalties are tiered, so the better or worse a plan performs, the more they can earn or lose.

Table 2: Example of How MCO Performance is Calculated by Measure

Prior Year Rate	Measurement Year Rate	Percentage Point Change	Performance Against Benchmarks Percent Capitation lost/ gained	Performance Against Self Percent Capitation lost/ gained	Total Percent Capitation earned/ lost for measure
31.03%	45.60%	14.57%	-.375	.375	0
Performance Against Benchmarks				Percent Capitation Earned/Lost	
Above HEDIS 66.67th percentile (>64.91%)				0.375	
HEDIS 50th percentile through HEDIS 66.67th percentile (59.58% through 64.91%)				0.1875	
State mean through HEDIS 50th percentile (54.67% through 59.57%)				0	
HEDIS 25th percentile through state mean (53.49% through 54.66%)				-0.1875	
Below HEDIS 25th percentile (<53.49%)				-0.375	
Performance Against Self				Percent Capitation Earned/Lost	
>6.00%				0.375	
3.00% through 6.00%				0.1875	
2.99% through -2.99%				0	
-3.00% through -6.00%				-0.1875	
<-6.00%				-0.375	

The capitation percentages earned or lost are summed across all measures to determine the MCO's recoupment or distribution. The program is budget neutral to the state and distributions cannot exceed recoupments at the program level. If more money is earned than recouped, distributions will be reduced to match the total dollars available from recoupments. If any money remains after recoupments and distributions it is placed in a bonus pool where MCOs can earn rewards if they meet a separate set of bonus pool measures. Bonus pool measures allow HHSC to encourage improvement in new areas with no financial risk to the health plans.

The 2018 medical P4Q program measures were selected to focus on prevention, chronic disease management, including behavioral health, and maternal and infant health. HHSC selected measures using the following criteria:

- State and federal regulations and healthcare priorities
- Standardized and nationally recognized measures
- Alignment with other state initiatives (e.g., Department of State Health Services, Delivery System Reform Incentive Payment program, hospital incentive/disincentive program)
- Number of members affected
- Areas where improvement is needed
- Severity of the problem
- Feasibility of measurement (e.g., limitations in data, resources, timeframes, etc.)

Table 3: Medical P4Q At-Risk Measures

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

Table 4: Medical P4Q Bonus Pool Measures

Measure	Program
Potentially Preventable Admissions (PPAs)	STAR
Low Birth Weight	STAR
Access to Urgent Care on the CAHPS Survey	STAR, STAR+PLUS, CHIP
Rating the Health Plan a 9 or 10 on the CAHPS Survey	STAR, STAR+PLUS, CHIP
Potentially Preventable Readmissions (PPRs)	STAR+PLUS
Potentially Preventable Complications (PPCs)	STAR+PLUS
Prevention Quality Indicator Composite	STAR+PLUS
Childhood Immunization Status (CIS) Combination 10	CHIP

The detailed methodology for the redesigned program was published as [Chapter 6.2.14 of the Uniform Managed Care Manual](#) on September 1, 2017.

Dental P4Q

The dental P4Q redesign followed a similar process with HHSC sharing information and soliciting stakeholder feedback along the way. In August 2017, both dental contractors signed letters acknowledging their support of the program and the many opportunities to provide input in its design.

Figure 4: Dental P4Q Redesign Timeline



Beginning in calendar year 2018, 1.5 percent of each dental contractor’s capitation is at-risk. Each dental contractor’s performance in the measurement year on selected measures is compared to performance from two years prior. For example, for measurement year 2018 the reference year is calendar year 2016. The two-year comparison of rates is due to the time lag required for data to be complete for analysis.

Financial incentives are tied to performance as follows:

- If a dental contractor’s performance decreases beyond a certain threshold on the dental P4Q measures, HHSC will recoup up to 1.5 percent of the original baseline capitation.
- If a dental contractor’s performance stays roughly the same (within a threshold when performance on multiple measures is compared), the dental contractor will neither have funds recouped nor earn above its baseline.
- If a dental contractor’s performance improves beyond a threshold, it is eligible to earn funds above its own baseline capitation (up to 1.5 percent of its own capitation), but will only receive these funds to the extent that they are available due to being recouped from the other dental contractor in the dental P4Q program.

The 2018 dental P4Q program measures were selected to focus on annual oral evaluations and primary prevention against dental caries. HHSC adopted national measures developed by the Dental Quality Alliance (DQA), an organization convened by the American Dental Association at the request of the Centers for Medicare & Medicaid Services. Both Texas dental contractors are DQA members and have annual opportunities to provide input on the national measures.

Table 5: Dental P4Q Measures

Measure	Description	Medicaid Age	CHIP Age
DQA Oral Evaluation	Percentage of enrolled children: <ul style="list-style-type: none"> who received a comprehensive or periodic oral evaluation within the reporting year 	0-20 years	0-18 years
DQA Topical Fluoride for Children at Elevated Caries Risk	Percentage of enrolled children: <ul style="list-style-type: none"> at “elevated” risk for cavities (i.e., “moderate” or “high”) and received at least two topical fluoride applications within the reporting year 	1-20 years	1-18 years
DQA Sealants for 6-9 year-old Children at Elevated Risk	Percentage of enrolled children: <ul style="list-style-type: none"> at “elevated” risk for cavities (i.e., “moderate” or “high”) and received a sealant on a permanent tooth within the reporting year 	6-9 years	6-9 years
DQA Sealants for 10-14 year-old Children at Elevated Risk	Percentage of enrolled children: <ul style="list-style-type: none"> at “elevated” risk for cavities (i.e., “moderate” or “high”) and received a sealant on a permanent second molar tooth within the reporting year 	10-14 years	10-14 years

The detailed methodology for the redesigned program was published as [Chapter 6.2.15 of the Uniform Managed Care Manual](#) on September 1, 2017.

5. Expansion of P4Q

Rider 20 requires HHSC to address expansion of P4Q measures into outpatient settings. However, most of the current HEDIS measures for the medical P4Q program already evaluate care provided in an outpatient setting:

- Well-Child Visits in the First 15 Months of Life
- Adolescent Well Care
- Blood Pressure Control
- Timeliness of Prenatal Care
- Postpartum Care
- HbA1c Control (<8.0%)
- Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are Using Antipsychotics
- Cervical Cancer Screening
- Counseling for Nutrition and Physical Activity for Children and Adolescents

HHSC expects to be able to incorporate STAR Kids into the P4Q program for calendar year 2020. The first year under the newly redesigned P4Q program, calendar year 2018, will be used to establish the measures for STAR Kids. Additionally, when data is available from the new P4Q measures, HHSC will use those results to identify and evaluate additional outpatient measures to include, if needed.

6. Conclusion

Since the redesigned dental and medical P4Q programs were implemented January 1, 2018, it is still too early to determine the impact on quality of care and health outcomes. The redesigned programs benefit from lessons learned with past models, extensive stakeholder input and feedback, and cross-agency coordination. Texas Medicaid and CHIP MCOs have increasingly incorporated P4Q measures as the quality improvement component of their alternative payment models with providers. The results, available Fall 2019, will assist HHSC in evaluating the redesigned programs' impact.

In redesigning P4Q, HHSC developed a process for the redesign, conducted a literature review on the effectiveness of pay for performance programs, and conducted an environmental scan of other states' programs. HHSC took into consideration the advantages and disadvantages of various approaches and developed a model that aligns best with the agency goals for the program. The redesigned program is simpler and easier to understand, allows plans to better track their performance and predict losses, and rewards high performance and improvement. All of these strengths set the foundation for the P4Q program to succeed in promoting transformation and innovation across all health plans, leading to better health outcomes for Medicaid and CHIP members.

List of Acronyms

Acronym	Full Name
ADV	Annual Dental Visit
ASC	Ambulatory Surgical Centers
AWC	Adolescent Well Care
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CBP	High Blood Pressure Controlled
CCS	Cervical Cancer Screening
CDC	Comprehensive Diabetes Care
CHIP	Children’s Health Insurance Program
CIS	Childhood Immunization Status
DQA	Dental Quality Alliance
GAA	General Appropriations Act
HEDIS	Healthcare Effectiveness Data and Information Set
HHSC	Health and Human Services Commission
ICHP	Institute for Child Health Policy
MCO	Managed Care Organization
P4Q	Pay-for-Quality
PPA	Potentially Preventable Admissions
PPC	Prenatal and Postpartum Care
PPC	Potentially Preventable Complications
PPR	Potentially Preventable Readmissions
PPS	Potentially Preventable Ancillary Services
PPV	Potentially Preventable Emergency Room Visits
SB	Senate Bill
SSD	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotics
TH Steps	Texas Health Steps

Acronym	Full Name
UMCM	Uniform Managed Care Manual
URI	Upper Respiratory Infection
W15	Well Child Visits in the First 15 Months of Life
WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents

Appendix A. P4Q Process and Procedures

P4Q Model Development Process

1. Develop a conceptual framework and logic model for P4Q
 - a. Obtain vision from the Executive Commissioner
 - b. Poll the plans and provider associations about what program elements are important to them
 - c. Conduct literature review
 - d. Conduct environmental scan
 - e. Conceptual framework will include at a minimum:
 - i. List of legislative mandates and constraints;
 - ii. Types of measures to be used;
 - iii. General explanation of how achievement will be assessed (e.g. incremental improvement, ranking, comparison with national benchmarks, etc.);
 - iv. General explanation of how goals and minimum thresholds will be set, including how health plans will be measured (e.g. pass/fail, partial credit awarded for movement towards the goal);
 - v. General explanation of how dollars will be recouped and distributed.
2. Obtain leadership approval of the conceptual framework and measure selection
 - a. Approval will be obtained from deputy director of Quality and Program Improvement, associate commissioner for Medicaid and CHIP, deputy executive commissioner for Medical and Social Services, and the executive commissioner via memo.
3. Staff develop a model or model options that adhere to the conceptual framework
 - a. Model development will include:
 - i. Running simulations to determine feasibility;
 - ii. Assessing impact of measure variability on P4Q results;
 - iii. Setting all goals, minimum thresholds, dollar amounts/percentages for recoupment/distribution, and any hold harmless zone or other special provisions; and
 - iv. If feasible staff will also develop a blank Excel workbook for P4Q result calculations to be distributed to plans.
 - b. Staff obtain input/feedback from internal stakeholders, including the Medical Director, Director of Data Analytics, other internal quality staff, and Institute for Child Health Policy (ICHP).
 - c. Make any adjustments needed based on feedback.
4. Staff obtain leadership approval of the model and measures

- a. Approval will be obtained from deputy director of Quality and Program Improvement, associate commissioner for Medicaid and CHIP, deputy executive commissioner for Medical and Social Services, and the executive commissioner via memo.
5. Staff meet with health plans in person and via webinar to share the model for feedback, including simulated results and calculations
 - a. Formal review and approval of minutes by the plans; and
 - b. Staff make any adjustments needed based on feedback.
6. If adjustments are substantial, get leadership approval. If adjustments are not substantial, move forward with developing technical specifications and excel spreadsheet with calculations.
 - a. Thoroughly review the technical specifications and validate the calculations (using internal staff and ICHP).
7. Share with plans and get sign off from each, acknowledging they have received the information and had an opportunity to express any concerns
 - a. Make any adjustments needed based on feedback.
8. Post technical specifications and measures to the UMCM
 - a. Allow 30 days for health plan comment;
 - b. Respond to health plan comments and make any additional adjustments needed; and
 - c. Post final to the Uniform Managed Care Manual (UMCM).

Policies for P4Q Measure Selection/Retirement/Changes

Staff will receive approval of selected measures from the executive commissioner via memo. Health plans will have received at least two years of results from HHSC before the measure is implemented in P4Q. HHSC will run simulated P4Q results using the most recently available data to determine the feasibility of use, and HHSC will share simulated results with the health plans.

Measures for each year of P4Q will be added to Chapter 6.2.11 of the UMCM prior to the start of the measurement year. Should measures change, Chapter 6.2.11 will be modified accordingly with opportunity for comment via the usual UMCM process.

When measures are selected, Quality Assurance will document decisions/reasons regarding the design of medical and dental payment structures (cost-neutrality, penalties, recoupment, or cost-pool approaches).

Criteria for Measure Selection

- Legislative requirements
- HHSC priorities
 - Determined via input from leadership, stakeholders, and HHSC workgroups, and additional factors, such as the legislative environment, federal direction, and alignment with the state quality strategy. HHSC will also use nationally recognized and established measures to the degree possible.
- Prevalence/the number of members affected
 - Each health plan will have to have a sufficient denominator in order for a measure to be utilized.
- Severity of the problem
- Areas where improvement is needed
 - Quality Assurance will use past performance and national benchmarks where available to assess the need for improvement.
- Feasibility
 - Quality Assurance and ICHP have or can obtain access to data and other resources needed.
 - The ability of plans to assess health plan progress.

Criteria for Measure Retirement

Measures will be reviewed annually for:

- Change in legislative requirements;
- Change in HHSC priorities;
- Low denominators;
- Plans consistently demonstrate high performance, with little variation among health plans (HHSC would continue to track the measure and monitor performance, as appropriate);
- Changes in standards of care, science or health care delivery; and
- Retirement/change of measure specifications by NCOA or other national organizations.

Criteria and Process for Changes to Measure Specifications

HHSC will follow specifications for standardized measure (e.g. HEDIS, DQA). When measures specifications change, HHSC will follow the new specifications. HHSC may deviate from the specifications if mandated by the legislature or HHSC executive leadership.

For PPEs, the EQRO will follow 3M specifications and work with 3M as needed to ensure calculations align with 3M guidance. HHSC may continue to use prior versions of the software, if deemed necessary to most accurately measure health

plan performance. HHSC may deviate from the specifications under legislative direction.

For measures that are state-developed (e.g. current dental measures), HHSC will publish new measure specifications when there are changes. Changes will be considered based on changes in clinical best practices and if the accuracy of the measure is enhanced.

Process for Making Changes to the Methodology

Quality Assurance will evaluate potential changes to the methodology using the following criteria:

- Is the change in line with the P4Q conceptual framework?
- Does the change promote quality improvement?
- Is the change necessary for the model to work?
- Does the change enhance fairness?
- Does the change increase transparency?

If staff agree that the change is worth considering, they will brief leadership on the proposed change including pros and cons. If the change is significant, staff will run simulations.

Staff will document leadership decisions in writing using OneNote. Staff will not change the P4Q methodology after the measurement year has started unless necessary and approved by leadership.

Communicating Program Updates to Stakeholders

As P4Q program changes are developed, Quality Assurance will provide opportunities for input from stakeholders. Quality Assurance will communicate to health plans changes to the framework, measures, methodology, and processes, using the Quality distribution list, as early as feasible. These communications will also be posted and retained in the Texas Healthcare Learning Collaborative Portal in the P4Q folder.

If there are significant changes to the methodology or measures, the UMCM will be updated accordingly and health plans will have the opportunity for input via the usual UMCM process. HHSC will use regular quality call with the plans to communicate P4Q updates, receive feedback, and answer questions

Calculation and Validation of Results

Going forward, Quality Assurance will calculate the P4Q results and recoupments and distributions to the degree possible using measure results provided by the EQRO. If the EQRO is utilized to run any part of the P4Q results, Quality assurance will review the EQRO's SAS code related to P4Q calculations.

Quality Assurance will conduct a risk assessment to identify which elements of the P4Q measure calculations will be validated with the following considerations:

- Quality Assurance will review the EQRO's process for calculating PPEs.
- Quality Assurance will not validate the calculation of HEDIS measures for P4Q due to the resources this would require and due to the fact the results are already validated by an NCOA-certified auditor.

Quality Assurance will utilize HHSC staff and the EQRO to validate P4Q results.