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# MCO Quality Meeting

**Quality & Program Improvement**

**Medicaid & CHIP Services**

**November 2 ,2022**

# Agenda

1. Welcome
2. Introductions
3. Plan Perspective
4. Alternative Payment Models Update
5. VBPQIAC Recommendations
7. Directed Payment Program Updates
8. Update on Report Cards
9. CMS Core Measure Rules
10. Open Discussion & Close

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# Welcome

**Emily Sentilles, *Deputy Associate Commissioner***

**MCS Quality & Program Improvement**

# Introduction: Valerie Mayes

## Deputy Executive Commissioner
## Policy and Quality

# Plan Perspective: APMs and Provider Engagement

Tam Flaherty
Driscoll Health Plan

# Value-Based Care/Alternative Payment Models (APM) Update

Jimmy Blanton, Director

Office of Value-Based Initiatives

Medicaid & CHIP Services

# MCO APM Requirements

- **Managed Care Contract changes**

- APM Chapter in Uniform Managed Care Contract (UMCC) amended effective 9/1/2022
- Introduces an APM Performance Framework
- Purpose - offer a wider range of options for MCOs to advance APM initiatives with their Providers
- HHSC staff working on amending the Uniform Managed Care Manual (UMCM) to reflect the APM Performance Framework

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# APM Challenges (1 of 2)

**MCO perceptions of challenges to meeting APM targets include:**

- LTSS providers are experiencing critical staffing shortages impacting ability to participate in APMs with downside risk
- CHIP enrollment has dropped as members shifted to STAR during the PHE
- Changes in utilization patterns during the PHE have impacted APM performance
- Rural providers face unique challenges participating in APMs

# APM Challenges (2 of 2)

**Strategies to address APM targets:**

- Rural provider outreach
- Telehealth
- APM agreements with FQHCs
- Provider incentives for z-code reporting for non-medical drivers of health

# Value-Based Payment and Quality Improvement Advisory Committee (VBPQIAC) Legislative Report

## Recommendations to the 88th Texas Legislature

# About the VBPQIAC

- Provides a forum to promote public-private, multistakeholder collaboration in support of quality improvement and value-based payment initiatives for Medicaid, other publicly funded health services, and the wider health care system.
- Studies and makes recommendations regarding:
  - 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 value-based purchasing and quality improvement.

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# APM Workgroup Recommendations (1 of 2)

**Recommendation #1**: HHSC should adopt a more comprehensive contractual APM framework to assess MCO achievement.

- Move away from a specific focus on meeting APM targets.
- Provide a menu of approaches to give MCOs credit for a broader range of work promoting value-based care (e.g., sharing more data with providers, reporting on evaluation results for APMs, addressing non-medical drivers of health, collaborating with another MCO on standard measures/models).
- Revise the current APM reporting tool to collect only needed data in as streamlined a format as possible.

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# APM Workgroup Recommendations (2 of 2)

**Recommendation #2:** HHSC should work to align next steps for its APM program with the CMS Innovation Center's strategy refresh released in October 2021, including working to increase the number of Medicaid beneficiaries in a care relationship with accountability for quality and total cost of care.

- Endorse a standard primary care health home model aligning with the CMS Primary Care First Model, a pregnancy medical home model, and/or key THSteps measures.
- Support a formal structure for dissemination of best practices for APMs.

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# *NDOH Workgroup Recommendations (1 of 2)

**Recommendation #1:** The Legislature should direct HHSC to approve at least one service that addresses non-medical drivers of health as an in lieu of service (ILOS) under 42 C.F.R. § 438.3(e)(2).

- HHSC should consider at a minimum the following services as potential ILOS:
  - Asthma remediation,
  - Food is Medicine interventions,
  - Services designed to support existing housing programs.

*NDOH: Non-Medical Drivers of Health

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# NDOH Workgroup Recommendations (2 of 2)

**Recommendation #2:** The Legislature should direct HHSC to create an incentive arrangement that rewards MCOs that partner with community-based organizations, other MCOs, and network providers to offer ILOS that address non-medical drivers of health and build related capacity.

- The Legislature should authorize HHSC to use a portion of amounts received by the state under Tex. Gov't Code § 533.014 (i.e., "experience rebates") for this purpose.

# Data Workgroup Recommendations (1 of 4)

**Recommendation #1:** HHSC should educate key Texas Medicaid staff and stakeholders about the admit, discharge, and transfer (ADT) and clinical (C-CDA) data it receives from the Texas Health Services Authority and establish an annual process to prioritize implementation of new use cases to leverage the data to improve the Medicaid program in light of evolving operational needs and implementation of new projects.

# Data Workgroup Recommendations (2 of 4)

**Recommendation #2:** HHSC should assess options for how to securely share additional data with Medicaid providers about their patients to help inform their participation in more advanced alternative payment models and identify strategies to support providers' use of that data.

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# Data Workgroup Recommendations (3 of 4)

**Recommendation #3:**

- HHSC should conduct a six-month review of the CMBHS system to determine how the system can share data with all Medicaid Mental Health Targeted Case Management and Rehabilitative Service providers, MCOs, and how aggregate data can be easily shared with the public.
- The review workgroup should include members from the VBPQI Advisory Committee, the Texas Council for Community Centers, MCOs, providers, and other stakeholders.

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# Data Workgroup Recommendations (4 of 4)

**Recommendation #4:**

- HHSC should help support the development of a modernized data system at the county level that would permit rapid access to data related to suicide for researchers and the public while protecting individual privacy.

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# Home Health Workgroup Recommendations (1 of 2)

**Recommendation:** HHSC should work with MCOs, home health agencies, and stakeholders to:

- Define, measure, and publicly report quality, experience, and cost-efficiency for Medicaid providers of in-home care/attendant services.
- Identify new or expanded training and reporting requirements for home care attendants to improve the care experience and health outcomes for the Medicaid population.

# Home Health Workgroup Recommendations (2 of 2)

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- Analyze enrollee movement between home health agencies to identify patterns, trends, and opportunities for improvement.
- Identify and develop value-based payment models specific to community-based long-term services and supports (LTSS) delivered through the STAR+PLUS and STAR Kids programs.
  - These models should reward high performing attendants and offer creative solutions to help address workforce shortages to provide needed home-based care for enrollees in these programs.

# Pharmacy Workgroup Recommendations

**Recommendation 1:**

- HHSC should establish standards and a working definition for an Accountable Pharmacy Organization (APO) and work with stakeholders to increase engagement with APOs.

**Recommendation 2:**

- HHSC should develop guidance for MCOs to reimburse pharmacists for services within a pharmacist's scope of practice.

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# Thank You

Jimmy Blanton, Director
Office of Value-Based Initiatives
Medicaid & CHIP Services

# Directed Payment Programs Quality Update

## CHIRP, TIPPS, DPP BHS, RAPPS

**Noelle Gaughen, Director of Quality/Evaluation**

**Delivery System Quality & Innovation**

**Medicaid/CHIP Services**

# DPPs and the Medicaid Quality Strategy

Texas must demonstrate that each directed payment arrangement advances at least one of the goals and objectives in the Texas Managed Care Quality Strategy. Texas expects the five DPPs to advance the objectives of the following quality strategy goals.

| Quality Strategy Goal | CHIRP | QIPP | TIPPS | BHS | RAPPS |
|---|---|---|---|---|---|
| Promoting optimal health for Texans | X | | X | X | X |
| Keeping patients free from harm | X | X | | | |
| Promoting effective practices for people with chronic, complex, and serious conditions | X | X | X | X | X |
| Attracting and retaining high-performing Medicaid providers, including medical, behavioral health, dental, and long-term services and supports providers to participate in team based, collaborative, and coordinated care | X | X | | | |

# Quality Reporting & Evaluation Measurement Periods

| | |
|---|---|
| | Complete |
| | In Process |
| | Planning Phase |

| Program Year | Eval Plan Due to CMS | Process & Outcome Measure Prelim Data | Structure Measures Implemented by | Process & Outcome Measure Final Data | EQRO Evaluation Data | Prelim Eval Due to CMS | Final Eval Due to CMS |
|---|---|---|---|---|---|---|---|
| Year 1 SFY 22 | Feb 21 | Jan – Jun 21 | Aug 31, 21 | Jan – Dec 21 | Jan – Dec 21 | Feb 22 | Feb 23 |
| Year 2 SFY 23 | Feb 22 | Jan – Jun 22 | Aug 31, 22 | Jan – Dec 22 | Jan – Dec 22 | Feb 23 | Feb '24 |
| Year 3 SFY 24 | Feb 23 | Jan – Jun 23 | Aug 31, 23 | Jan – Dec 23 | Jan – Dec 23 | Feb 24 | Feb 25 |
| Year 4 SFY 25 | Feb 24 | Jan – Jun 24 | Aug 31, 24 | Jan – Dec 24 | Jan – Dec 24 | Feb 25 | Feb 26 |
| Included in Prelim Eval | | | | | | | |
| Included in Final Eval | | | | | | | |

# Year 1 Update

- Reporting is complete
- Evaluation in progress
- Final data posted to the reporting portal bulletin board

# Year 2 Update

- Round 1 reporting deadline is Sunday, November 6
  - Structure measure implementation as of August 31, 2022
  - Process and outcome measures from Jan – June 2022
- “Office hours” for program participants
- Requirements for Medicaid Managed Care stratification

# Planning Workgroups

HHSC presents findings and proposals to program workgroups.

Workgroup members provide feedback on proposed changes. Processes for collecting feedback will depend on program needs and time available.

HHSC updates proposals, incorporates changes into draft program requirements and measure specifications documents, and posts for public comment.

Stakeholders provide public comment on posted documents.

HHSC analyzes feedback, makes needed changes, and sends preprint to CMS.

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# Discussion Questions

1. How can providers identify which of their plan contracts are a given managed care program? Several DPP participants are struggling with being able to identify if a client is enrolled in STAR, STAR+PLUS, or STAR Kids. Stratifying by managed care program is required for their DPP quality reporting.
2. Are you connected to HIETexas EDEN or other HIEs already? How do you receive notifications of admissions, discharges, and transfers of your members from hospitals? CHIRP asks hospitals to report on HIE participation status.
3. How do the DPPs align with your APM and quality initiatives? Do they complement, duplicate, work against, or have no impact on your goals for APMs and quality improvement?
4. How can the DPPs best be used to further the state’s Medicaid Managed Care Quality Strategy in future program years?

# Resources

- Medicaid DPP Quality
- Texas Medicaid Managed Care Quality Strategy – July 21
- CMS DPP Application Template (Preprint)
- Reporting Portal Bulletin Board
  - Data Master for Year 1
  - Program participants only, Requires login credentials

# Texas Medicaid DPPs SFY23

| CHIRP | QIPP | TIPPS | DPP BHS | RAPPS |
|---|---|---|---|---|
| Comprehensive Hospital Increased Reimbursement Program | Quality Incentive Payment Program | Texas Incentive for Physicians & Professional Services | Directed Payment Program for Behavioral Health Services | Rural Access to Primary and Preventive Services |
| $5.2 Billion<br>406 Hospitals | $1.1 Billion in Year 6 | $738 Million in Year 2 | $253 Million in Year 2 | $31 Million in Year 2 |
| STAR<br>STAR+Plus | 951 Nursing Facilities | 61 Physician Groups | 40 CMHCS | 160 Rural Health Clinics |
| | STAR+Plus | STAR<br>STAR+Plus<br>STAR Kids | STAR<br>STAR+Plus<br>STAR Kids | STAR<br>STAR+Plus<br>STAR Kids |

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# Thank You!

**Contact**
**DPPQuality@hhs.texas.gov**

# Update on Report Cards

Jessica Morano, *Quality Analyst*

Quality Assurance

# Key Dates

| | |
|---|---|
| **09/30/2022** | Received feedback from MCOs about Report Cards Proposal |
| **Winter 2022** | Publication of updated 2022 results |
| **12/08/2022** | Approximate date of when plans should receive complaints data for review (15 business days) |
| **12/19/2022** | Approximate date of when plans should receive 2023 rating results for review (15 business days) |
| **Spring 2023** | Publication of 2023 report cards |

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# CMS Core Measure Rules

**Denbigh Shelton, *Manager***

**Quality Assurance**

# CMS Core Measure Set

- Each year CMS publishes an adult and child Core Measure Set
- Texas currently reports most of these Core Measures to CMS and on the THLC portal
- Core Measures data is used in CMS's Medicaid and CHIP Scorecards
- In the past Core Measure reporting has been optional
- New rules make reporting of the child Core Measures and adult Core Measures for behavioral health mandatory for states
- Rule effective for FFY 2024 (MY2023) reporting

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# New Requirements

- Key provisions include:
  - Using Medicare data to report on dual eligibles
  - Including pregnant individuals receiving coverage under special CHIP child assistance programs (CHIP-P)
  - Stratification by race, ethnicity, sex, age, rural/urban status, disability, language, or other factors specified by CMS
  - Requires a State Plan Amendment attesting that the state will report the required Core Measures to CMS with the risk of federal funds being withheld for non-compliance
- Comments were submitted 10/21/22

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# Open Discussion & Close

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