
**Annual Report
Medicaid and CHIP Quality-Based
Initiatives
and
Recommendations by the
Medicaid and CHIP
Quality-Based Payment Advisory
Committee**

**As Required by S.B. 7, 82nd Legislature,
First Called Session, 2011**

**Health and Human Services Commission
October 20, 2014**

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I. Executive Summary

Senate Bill 7, 82nd Legislature, First Called Session, 2011, requires the Health and Human Services Commission (HHSC) to submit an annual report to the Legislature regarding quality-based outcome and process measures which include the progress on the implementation of quality-based payment systems and other payment initiatives.

Additionally, HHSC shall report outcome and process measures that have been developed by:

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

Senate Bill 7, 82nd Legislature, First Called Session, 2011, established the Medicaid and Children's Health Insurance Program (CHIP) Quality-Based Payment Advisory Committee (QBPAC) to advise HHSC on establishing reimbursement policies and systems that reward high quality and cost-effective care, and to advise HHSC on outcome and process measures, and standards and benchmarks used to measure performance.

Accordingly, this annual report provides the following:

- Quality-based outcome and process measures, and available data regarding those measures.
- An update, as of July 15, 2014, on the progress and implementation of quality-based payment systems initiatives and other key Medicaid and CHIP initiatives focused on quality and efficiency improvement.
- The 2013 final and interim 2014 recommendations from the QBPAC.

The QBPAC recommendations include:

- Increasing the minimum managed care plan size requirement.
- Using measures for performance-based incentives which span a large enough population and are closely correlated with positive outcomes and potential cost efficiencies.
- Making all fields on the Nursing Home Minimum Data Set (MDS) Facility report required data entry fields.
- Implementing changes in the enrollment process to move new enrollees immediately into managed care, eliminating the fee-for-service segment which causes delays in care.

- Extending eligibility for pregnant women to six months post-delivery.
- Developing a cost neutral shared savings model with the managed care organizations.
- Making changes to telemedicine policy which impedes access to care.
- Extending the QBPAC Committee past the statutory end date of September 2015.

II. Legislation

Senate Bill 7, 82nd Legislature, First Called Session, 2011, requires HHSC to submit an annual report to the Legislature regarding quality-based outcome and process measures, to include the progress on the implementation of quality-based payment systems and other payment initiatives. Additionally, HHSC shall report outcome and process measures that have been developed by:

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

The Texas Medicaid program is evolving from a fee-for-service model where the state directly pays medical care providers to a managed care model in which the state contracts with multiple managed care organizations (MCOs). New services and populations are also being "carved in" to Medicaid managed care over time by adding these services to the managed care contracted services rather than keeping them separately payable under fee for service. The ongoing evolution of Texas' Medicaid program can make attempts for "apples to apples" comparisons difficult, especially over multiple years.

Senate Bill 7, 82nd Legislature, First Called Session, 2011, established the Medicaid and CHIP QBPAC to advise HHSC on establishing reimbursement policies and systems that reward high quality and cost-effective care by managed care organizations, physicians, and other health care providers. In addition, the Committee advises HHSC on outcome and process measures, and standards and benchmarks used to measure performance.

III. Quality-Based Outcome and Process Measures

HHSC uses a wide array of measures to assess quality. These measures can be used to support quality-based payment systems or incentive/disincentive programs in Texas Medicaid. The measures include:

- **Process measures** the activities carried out by health care professionals to deliver services. The data that are used for these measures consists of fee-for-service claims and MCO encounters (administrative data), and in some cases are augmented by information from provider medical records. For example, a process measure for diabetes care could include whether testing a patient's average blood sugar levels for the past two or three months has occurred.
- **Outcome measures** the result of health care activities. The data that are used for these measures usually consists of data gleaned from sources other than claims, such

as lab results or weight from electronic health records (EHRs) or medical records (hybrid data), or sometimes from claims and encounters (administrative data). Using diabetes as an example, an outcome measure could indicate whether the same patient's average blood sugar levels for the past two or three months as found in the medical record or EHR is within certain ranges (i.e., controlled), or if there have been any emergency room or inpatient admissions related to diabetes found in claims.

- **Patient perception of care** measures consumers' experiences with health care. Data used for this are the results of patient surveys such as the Consumer Assessment of Healthcare Providers and Systems (CAHPS).
- **Composite measures** combine factors of quality and cost to measure efficiency of health care. An example would be combining measures of diabetes care (quality) with the costs per member month paid for diabetes admissions (cost). The data used for these measures may be from either or both administrative and medical records data.

Process and outcome measures are listed in detail in Appendix A. Most of the measures used are endorsed by the National Quality Forum (NQF), meaning that they have gone through a rigorous review by a national body of experts. This ensures that each measure actually measures what is intended.

Sometimes, a measure's specifications preclude its use because there are an insufficient number of observations to enable statistically sound measurement. In the Texas Medicaid and CHIP programs, this can occur because there are a relatively large number of MCOs under contract. This sometimes results in MCOs with relatively low enrollment. Because there is an insufficient volume of members who meet the measure's specifications, the measure is not statistically significant, and therefore, cannot be used reliably. Most of the standard measures used in health insurance to track quality require a minimum denominator of 30 for the calculation of the measure to be considered reliable.

IV. Progress of Quality-Based Initiatives

There is a considerable amount of literature related to how health care systems use measures, specifically what the most effective measures are to evaluate quality and efficiency. This is something that HHSC also weighs heavily when determining which measures to include in its various initiatives. HHSC is continuing to explore new tools to incentivize and measure quality and efficiency, as well as refine existing tools. The Medicaid fee-for-service program still has a considerable amount of activity, and there are some quality-based payment initiatives within this model. However, the majority of quality-related activities are increasingly within managed care (STAR, STAR+PLUS, NorthSTAR, STARHealth, and CHIP). The Delivery System Reform Incentive Payment (DSRIP) program, which targets Medicaid beneficiaries in both managed care and fee-for-service, individuals with low-income, and the uninsured, also has a number of quality initiatives (Appendix B).

Below is a status update, as of July 15, 2014, on major pre-operational, operational or exploratory initiatives.

Table 1: Major Initiatives

Initiative	Description	Status	Expected Outcomes
HHSC Quality Website	Creation of a dedicated website to communicate status of projects and share data about MCO and provider performance.	Operational	Improve communications with stakeholders of HHSC quality initiatives underway and in development. Accelerate quality improvement.
	A feature of the website is to increase the accessibility of performance information and enhance public reporting.	Operational	Accelerate quality improvement.
S.B. 1542 Web Portal	A web portal to solicit/research and analyze external ideas for clinical quality initiatives.	Operational	Fulfills requirements of S.B. 1542, 83 rd Legislature, Regular Session, 2013.
HHSC Quality Operations Workgroup	Internal HHSC workgroup dedicated to quality operations issues.	Operational	Ensure that there is a focus on the efficacy and effectiveness of current initiatives.
HHSC Quality Visioning Workgroup	Internal HHSC workgroup dedicated to brainstorming forward-thinking ideas on quality improvement.	Operational	Ensure that there is a focus on strategic direction as it relates to quality, and to vet new quality proposals.

Initiative	Description	Status	Expected Outcomes
MCO Pay-for-Quality Program	This initiative creates incentives and penalties for MCOs based on their performance on certain measures. Health plans that excel on meeting quality measures are eligible for a bonus of up to 4 percent of their capitation payments. Health plans with inadequate performance can lose up to 4 percent of their capitation payments.	Operational	Highlight state priorities and incentivize MCO performance.
Dental Pay-for-Quality Program	This initiative creates incentives and disincentives for dental managed care organizations (DMOs) based on their performance on certain measures. Dental managed care plans can be penalized up to 2 percent of their capitation payments if they fail to meet certain quality measures.	Operational	Highlight state priorities and incentivize DMO performance.
MCO Report Cards	The report cards for each MCO in STAR , STAR+PLUS and CHIP are developed for each program and managed care service area to allow enrollees to easily compare the health plans on specific quality of care and patient satisfaction measures. The report cards are included in the enrollment packets to help enrollees make more informed decisions about selecting a health plan.	Operational	Provide enrollees with meaningful information about MCO performance across select clinical quality and patient experience of care in order to help them make informed decisions about their care. An ancillary benefit to this process is that it serves as a succinct and easily understandable public reporting mechanism.
MCO, Behavioral Health	HHSC requires each Texas Medicaid and CHIP MCO, BHO, and DMO to complete	Operational	Locally identified targeted and/or collaborative quality

Initiative	Description	Status	Expected Outcomes
Organization (BHO), and DMO Performance Improvement Projects (PIPs)	PIPs designed to improve the quality of care for their members. Performance improvement projects help them improve the quality of their services by identifying root causes of undesirable health care outcomes and implementing interventions to improve those outcomes. Each MCO, BHO, and DMO is scored based on the design and outcomes of their PIPs. HHSC requires each health plan to conduct two PIPs per program.		Improvement projects within regions to achieve sustained improvement in targeted healthcare outcomes as a result of PIP interventions.
Potentially Preventable Events (PPEs)	HHSC holds MCOs and hospitals financially accountable for low performance on PPEs , including Potentially Preventable Complications (PPCs) and Potentially Preventable Readmissions (PPRs). Adjustments are made to fee-for-service hospital inpatient claims based on performance of these measures. Similar adjustments are made in each MCOs' experience data, which impact capitation rates.	Operational	Reduce rates of potentially preventable visits to the emergency department, potentially preventable inpatient admissions, PPRs, and PPCs. Improve provider care coordination, hospital discharge processes, and MCO coordination of care.
Alternative value-based purchasing/ payment reform strategies to promote quality and efficiency	An initiative to explore additional strategies used by other states regarding MCO capitation/payment reform that would help promote quality and efficiency and provider payment reform.	Exploratory	Understand, and if applicable, adopt the most effective strategies and quality/efficiency improvements.
MCO quality- and efficiency-	HHSC is exploring an incentive program that potentially could assign more Medicaid members	Exploratory	Potentially drive improvements through the use of incentives

Initiative	Description	Status	Expected Outcomes
based enrollment incentive program	to health plans with better performance. This process may be based on health plan quality of care, scores on performance improvement projects, or other outcome measures, such as PPEs.		(more enrollees) to high quality/high efficiency MCOs.
Experience rebate to promote quality and efficiency	HHSC has a formula that requires medical and dental health plans to return profits to the State of Texas that are above certain thresholds. HHSC is developing ways to potentially use these funds to provide incentives to health plans to promote quality of care, encourage payment reform, reward local service delivery reform, increase efficiency, and reduce PPEs.	Exploratory	Determine if there are cost effective investments that HHSC may make with MCO excess profits to promote quality and efficiency.
MCO value-based purchasing/contracting with providers	Health plans are required to submit plans to HHSC outlining proposed payment methods that encourage quality outcomes and reduce inappropriate utilization of services. The plans must include incentive payments to doctors, hospitals, and other providers for quality care. On an ongoing basis, HHSC will evaluate and provide feedback to each health plan to ensure appropriateness of the clinical goals, metrics used, and types of providers included. Also assessed is the scale of the provider incentive project relative to overall health plan payments and membership (dollar amount and enrollees impacted). This will allow HHSC to better assess	Operational	Payment reform. Fee-for-service payment models are generally seen by health care experts to incentivize volume and not necessarily promote quality. The goal is to put more focus on quality and not volume.

Initiative	Description	Status	Expected Outcomes
	MCO/DMO progress in this area.		
HHSC-MCO Payment Reform Workgroup	HHSC has established a workgroup consisting of key MCO representatives and HHSC staff to focus on creating a unified strategy to further advance MCO payment models that more directly link provider payments to quality and efficiency of care, rather than quantity of care. This workgroup will focus on barrier identification, tools to catalyze/accelerate reform, etc. and may include providers in the future.	Operational	<ul style="list-style-type: none"> • MCO and provider payments are more directly linked to outcomes: Incentivize good clinical outcomes and efficiency. • Payer-Provider Collaboration: Foster an environment that leads to increased MCO-provider collaboration toward more coordinated and efficient patient care. • Efficiency: Over time, efficiencies achieved through MCO payment models to providers will be reflected in MCO capitation.
HHSC-led approach to super-utilizers	HHSC's contract with Medicaid/CHIP health plans requires each plan to have specialized programs for targeting, outreach, education, and intervention for members who have excessive utilization patterns that indicate typical disease management approaches are not effective. On an ongoing basis, HHSC will evaluate and provide feedback to each health plan to ensure appropriateness of the clinical goals, metrics used,	Operational	Understand how MCOs manage high cost populations, and evaluate those efforts. This should lead to a more collaborative relationship with MCOs to achieve the desired outcome of superior clinical care for this population. This may lead to a more standardized approach to care

Initiative	Description	Status	Expected Outcomes
	and types of providers included.		management based on best practices.
Increased Data Sharing	<p>HHSC is working on the following data sharing initiatives:</p> <ul style="list-style-type: none"> • The Department of State Health Services (DSHS) and HHSC are developing a process in which birth record data will be shared with Medicaid health plans. • HHSC has a data use agreement with the Centers for Medicare & Medicaid Services (CMS) to obtain Medicare data. One focus will be to examine the dually eligible population. • The Department of Aging and Disability Services (DADS) is sharing institutional long-term services and supports data with HHSC. • Provision of historical claims and encounter data to MCOs and DMOs. • Improve data sharing and care coordination in the Dallas service area where the 	<p>Operational</p> <p>Operational</p> <p>Operational</p> <p>Operational</p> <p>Operational</p>	<p>Provide MCOs with vital data to improve coordination of care to prevent premature births. This should improve outcomes and lower costs.</p> <p>Understand utilization patterns of dually eligible enrollees. This will enable HHSC to better understand current care and build service baselines and projections as well as quality-based payment models.</p> <p>Create workable institutional long-term services and supports quality measures and payment approaches.</p> <p>Enable Medicaid and CHIP MCOs to be better prepared for incoming members and provide more appropriate case management.</p> <p>Facilitate better care coordination of members in the Dallas</p>

Initiative	Description	Status	Expected Outcomes
	NorthSTAR pilot continues wherein behavioral health services are carved out of managed care and provided through a contract with a BHO. (NorthSTAR, STAR, and STAR+PLUS).		area who access behavioral health services through NorthSTAR.
Collaborative Mental Health Treatment Quality Improvement Projects	HHSC is testing certain measures related to safe and effective clinical practices in pharmacological and psychosocial mental health treatment. HHSC is sharing this information with health plans and is continuing to refine these measures.	Operational	<ul style="list-style-type: none"> • Enable more effective monitoring of quality in this area. • Identify and target opportunities for MCO quality improvements in the area of antipsychotic prescribing and corresponding mental health care. • Improve clinical quality care and patient safety as well as save money. <p>Although operational, this project is still identifying where there may be opportunities to support the managed care carve-in of mental health services (S.B. 58, 83rd Legislature, Regular Session, 2013).</p>

Initiative	Description	Status	Expected Outcomes
Better Birth Outcomes Interagency Projects	<p>HHSC and DSHS are working on several projects associated with improving birth outcomes. This coordinated effort builds on previous HHSC projects in this area (numerous quality/cost containment initiatives per legislative riders or laws, including:</p> <ul style="list-style-type: none"> • H.B. 1983, 82nd Legislature, Regular Session, 2011 • H.B. 2636, 82nd Legislature, Regular Session • S.B. 7, 83rd Legislature, Regular Session, 2013 • H.B. 15, 83rd Legislature, Regular Session, 2013 • DSHS efforts (e.g., Healthy Texas Babies, Maternal Mortality and Morbidity Task Force, etc.) which include a continued review of effectiveness of the pre-39 week elective induction policy. 	Operational	Help ensure continuity and coordination among the various projects and to achieve quality improvements and cost savings.
DSRIP Program	<p>Incentive payments to hospitals and other providers that develop programs or strategies to enhance access to health care and increase the quality of care, the cost-effectiveness of care provided, and the health of the patients and families served.</p> <p>Under the Texas Health Care Transformation and Quality Improvement Program (1115 Waiver), eligibility for Uncompensated Care or DSRIP payments requires participation in a Regional</p>	Operational	Transform delivery systems to improve care for individuals (including access, quality, and health outcomes); improve health of the population; and contain costs through efficiencies and improvements.

Initiative	Description	Status	Expected Outcomes
	Healthcare Partnership (RHP). Within an RHP, participants include government entities providing public matching funds known as intergovernmental transfers (IGT), Medicaid providers, and other stakeholders. Participants develop a regional plan identifying partners, community needs, and proposed projects. Each partnership must have one anchoring entity which acts as a primary point of contact for HHSC in the region and is responsible for seeking regional stakeholder engagement and coordinating development of the regional plan. As of August 2014, there are 1,491 approved and active DSRIP projects being implemented through 20 RHPs (see Appendix B).		
DSRIP - MCO Coordination	HHSC activities to identify opportunities for increased coordination between quality-related activities within DSRIP and MCO models.	Exploratory	Reduce administrative complexity and to create synergy and efficiency between these initiatives.
Texas Dual Eligible Integrated Care Project	Project goals are to have one health plan be responsible for both Medicare and Medicaid services; improve quality and individual experience in accessing care; and promote independence in the community.	Pre-Operational	Provide data and analysis that allows for evaluation of the quality component of this project. The implementation date is March 1, 2015.
Texas Healthcare Learning	This is a web-based tool to provide information to MCOs on their performance across a wide	Operational	Provide a mechanism where MCOs and HHSC staff can

Initiative	Description	Status	Expected Outcomes
Collaborative	array of quality metrics.		generate graphical reports of health plan- and program-specific performance.

V. HHSC Advisory Committees and Councils that Focus on Quality

The Texas Legislature established a number of notable advisory groups in the 2011 and 2013 legislative sessions.

82nd Legislature, 2011

Texas Institute of Health Care Quality and Efficiency

The Texas Institute of Health Care Quality and Efficiency (Institute) was established by S.B. 7, 82nd Legislature, First Called Session, 2011, to improve health care quality, accountability, education, and cost containment by encouraging health care provider collaboration, effective health care delivery models, and coordination of health care services. The Institute is not strictly an HHSC advisory committee as it is organizationally outside of HHSC although staffed by HHSC employees.

The Institute leverages its unique public/private, multi-stakeholder, multi-agency structure to engage the commercial, non-profit, and public sectors to develop and facilitate high value recommendations and collaborative projects that catalyze sustained improvement in health care quality, accountability, education, and cost containment for Texas. Institute activities support a vision for optimizing health system performance by applying the Institute for Healthcare Improvement's Triple Aim framework to enhance Texans' experience of care, improve the health of the population, and reduce trends for per capita health care cost growth. That framework combines the following: improving the patient experience, improving the health of the population, and reducing the per capita cost of health care.

The Institute Board includes ex officio representation from nine state agencies and six public university systems with significant administrative, service delivery, and research interests in the health care system. This board structure provides a forum for multiple agencies to exchange information and work together to pursue health care quality improvement initiatives. For example, the Institute is partnering with HHSC, DSHS, DADS, the University of Texas School of Public Health, and the Meadows Mental Health Policy Institute to build a comprehensive, cross agency database of the adult Medicaid serious and persistent mental illness population. This partnership will result in an analytical report describing service utilization patterns for this population, the identification of promising and best practices to inform the integration of behavioral health services into Medicaid, and the development of relevant policy recommendations.

Quality-Based Payment Advisory Committee

The Quality-Based Payment Advisory Committee, created under S.B. 7, 82nd Legislature, First Called Session, 2011, advises HHSC on:

- Establishing Medicaid and CHIP reimbursement systems to reward the provision of high-quality, cost-effective health care; quality performance; and quality-of-care outcomes with respect to health care services.
- Developing standards and benchmarks for quality performance, quality-of-care outcomes, efficiency, and accountability by MCOs and health care providers and facilities.
- Developing programs and reimbursement policies that encourage high-quality, cost-effective health care delivery models that increase appropriate provider collaboration, promote wellness and prevention, and improve health outcomes.
- Developing outcome and process measures which can be used to support these endeavors.

The 2013 final annual report and the 2014 interim report are found in Appendix C. A summary of their recommendations is as follows:

2013 Recommendation #1

Increase the minimum managed care plan size requirement. With the current breakout of multiple plans in each program and service delivery area and knowing the new STAR Kids plan will be added for a smaller population, finding measures of any kind where there is sufficient denominator size across all plans is extremely difficult. Other states combine all programs into one product and MCOs wishing to participate must provide care across the full continuum.

2013-2014 Recommendation #2

Use the following measures, which span a large enough population and are closely correlated with positive outcomes and potential cost efficiencies, in at risk and other performance incentive calculations.

- Pediatrics: Immunization combo 4; relative resource use to people with asthma (ASM); and Consumer Assessment of Health Care Providers and Systems survey for family satisfaction.
- Pregnancy: Risk-adjusted primary cesarean section.
- Long Term Services and Supports (LTSS) measures from the National Quality Forum (NQF):
 - NQF 0679: Percent of Residents with Pressure Ulcers (Long Stay).

- NQF 0681: Percent of Residents Assessed and Appropriately Given the Seasonal Influenza Vaccine (Long Stay).
- NQF 0683: Percent of Residents Assessed and Appropriately Given the Pneumococcal Vaccine (Long Stay).
- NQF 0674: Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay).

2014 Recommendation #3

HHSC should make all the fields currently on the monthly Nursing Home MDS Facility report as required data entry fields; require the Texas Medicaid and CHIP claims administrator to configure the portal if possible; ensure that the data submitted is maintained in a data file that can easily be used to compare facility performance, and; make some or all of this data publically available. DADS or another entity should randomly sample the entries for accuracy. Note: Nursing facilities are required to enter data monthly into the claims administrator portal for the Nursing Home MDS Facility report.

2014 Recommendation #4 Regarding Enrollment

- HHSC to implement the following enrollment processes for pregnant women and individuals whose eligibility is income based such as Temporary Assistance for Needy Families (TANF), newborns, and children:
 - Implement enrollment in Medicaid at the time of application.
 - Implement enrollment directly into managed care upon approval for Medicaid, avoiding a fee-for-service segment.
- HHSC to implement the following eligibility for pregnant women, newborns, and children:
 - Change the eligibility segment for birth to age 18 to no less than 12 months (Restorative enrollment, July 2014 implementation).
 - Change the eligibility segment for pregnant women to six months post-delivery or miscarriage.

2014 Recommendation #5 Regarding Alternative Payment Models

Develop the means for MCOs to keep accrued savings above the current percentage when HHSC approves a shared savings project proposed by the MCO. It is understood that this may require administrative or legislative changes. The following are the components of the shared savings approach.

- No additional dollars will be used. Rather, existing dollars may be left on the table for future projects.
- MCOs will propose projects and HHSC will either approve or deny.

The projects must have:

- A stated time period.
 - A defined target population/service.
 - A baseline for utilization and/or costs per member, or overall costs, depending on the project.
 - A clearly defined means to measure savings at intervals and at the project end.
 - An amount of money needed to initiate the project.
 - Any contractual changes needed.
 - A plan for sharing the savings with, or in some other way incenting the providers who will be impacted.
- Project approval will consider:
 - The potential impact in healthcare dollars and quality.
 - The potential impact on other MCOs in the same service area(s).
 - Savings to the state will be measured:
 - With consideration for inflation, changes in the cost of goods and services at the unit level.
 - With consideration of cost avoidance.
 - Trended over the lifespan of the project with annual projections.
 - Also consider improved outcomes (no associated dollar savings).
 - Initial funding for projects will come from one or more of the following:
 - Experience rebate funds being placed in a special account.
 - Changing how money is returned to the state.
 - Other sources such as Title V of the Social Security Act or Health Resources and Services Administration grants.
 - Shared savings will allow an MCO to keep 60 percent of the savings accrued over the project life. However, if the MCO cannot maintain savings over the subsequent two years, a portion (to be determined) must be refunded to the state.
 - Shared savings are to be used to jump start future projects as well as provide profit to the MCO and a long term savings to the state.

2014 Recommendation #6 Regarding Telemedicine

- Work with the major stakeholders to reduce barriers to hospital credentialing for telemedicine providers.
- Remove all limitations on the location of the patient site, allowing any enrolled provider's location to be used so long as it meets all other requirements for equipment, data transmission, and patient site presenter.
- Allow a patient site fee to be paid in both telemedicine and telehealth, and to the extent possible, for all patient site locations.

- Remove the requirement that the patient site presenter must maintain the records created at the distant site unless the distant site provider maintains the records in an EHR format.
- Remove the telehealth requirement that clients must receive an in-person evaluation for the same diagnosis or condition, with the exception of a mental health diagnosis or condition, before receiving service.
- Continue the current requirement that telehealth clients must receive an in-person evaluation by a person who is qualified to determine a continued need for services at least once in 12 months. Extend that to telemedicine.
- Incentivize use of telemedicine through an additional fee amount such as \$5 for professional claims billed with the GT modifier.
- Investigate options for ensuring that reimbursement for dual eligible members is equal to Medicaid.

2014 Recommendation #6 Regarding Quality-Based Payment Advisory Committee Function and Continuation

The HHSC Executive Commissioner to extend the committee without legislative mandate to continue work on quality measures, alternative payment system, and quality projects.

83rd Legislature, 2013

Perinatal Advisory Council

This council was formed by H.B.15, 83rd Legislature, Regular Session, 2013, and is continuing the work of the former Neonatal Intensive Care Unit Council, per H.B. 2636, 82nd Legislature, Regular Session, 2011. This Council is charged with developing recommendations for a statewide hospital designation process and standards for levels of neonatal intensive care as well as maternity levels of care, and tying these standards to Medicaid reimbursement. This effort will also include the back transport handling of mother and babies, as well as hospital quality reporting requirements. Back transport is the transfer of an infant from a higher level of care facility back to a lower level of care in the infant's home community. HHSC will collaborate closely with DSHS on this project to ensure DSHS regulatory and designation activities are coordinated with the Medicaid program.

STAR+PLUS Quality Council

The STAR+PLUS Quality Council, created by S.B. 7, 83rd Legislature, Regular Session, 2013, advises HHSC on the development of policy recommendations to ensure eligible Medicaid consumers receive quality, person-centered, consumer-directed acute care and

LTSS in an integrated setting under the STAR+PLUS Medicaid managed care program. The council is legislatively mandated to annually report to the HHSC Executive Commissioner an analysis and assessment of the quality of acute care services and LTSS provided by STAR+PLUS and recommendations on how to improve STAR+PLUS services and ensure STAR+PLUS consumers receive person-centered, consumer-directed care in the most integrated setting achievable. The STAR+PLUS Quality Council, in conjunction with HHSC, is also legislatively mandated to report to the Legislature every even numbered year the assessments and recommendations contained in the annual reports to the HHSC Executive Commissioner.

The Intellectual and Developmental Disability System Redesign Advisory Committee

The Intellectual and Developmental Disability (IDD) System Redesign Advisory Committee, created by S.B. 7, 83rd Legislature, Regular Session, 2013, advises HHSC and DADS on the implementation of the acute care services and LTSS system redesign for individuals with IDD. S.B. 7 requires HHSC and DADS to design and implement an acute care services and LTSS system for individuals with IDD that supports the following goals:

- Provide Medicaid services to more individuals in a cost-efficient manner by providing the type and amount of services most appropriate to the individuals' needs.
- Improve individuals' access to services and supports by ensuring that the individuals receive information about all available programs and services, including employment and least restrictive housing assistance, and how to apply for the programs and services.
- Improve the assessment of individuals' needs and available supports, including the assessment of individuals' functional needs.
- Promote person-centered planning, self-direction, self-determination, community inclusion, and customized, integrated, and competitive employment.
- Promote individualized budgeting based on an assessment of an individual's needs and person-centered planning.
- Promote integrated service coordination of acute care services and LTSS.
- Improve acute care services and LTSS, including reducing unnecessary institutionalizations and PPEs.
- Promote high-quality care.
- Provide fair hearing and appeals processes in accordance with applicable federal law.
- Ensure the availability of a local safety net provider and local safety net services.
- Promote independent service coordination and independent ombudsmen services.
- Ensure that individuals with the most significant needs are appropriately served in the community and that processes are in place to prevent inappropriate institutionalization of individuals.

STAR Kids Managed Care Advisory Committee

The STAR Kids Managed Care Advisory Committee, created by S.B. 7, 83rd Legislature,

Regular Session, 2013, advises HHSC on the establishment and implementation of the STAR Kids Medicaid managed care program. The STAR Kids Medicaid managed care program is legislatively mandated to provide services for children with disabilities who have Medicaid coverage in order to improve coordination and customization of care, access to care, health outcomes, cost containment, and quality of care. The STAR Kids model must require a health home, care management, and provide comprehensive coordination of acute care and long-term service benefits.

State Medicaid Managed Care Advisory Committee

The State Medicaid Managed Care Advisory Committee, created by S.B. 7, 83rd Legislature, Regular Session, 2013, provides recommendations and ongoing input to HHSC on the statewide implementation and operation of Medicaid managed care. The committee looks at a range of issues, including program design and benefits; systemic concerns from consumers and providers; efficiency and quality of services delivered by Medicaid managed care organizations; contract requirements for Medicaid managed care; provider network adequacy; and trends in claims processing.

The committee also will help HHSC with policies related to Medicaid managed care and share information on best practices with the Medicaid Regional Advisory Committees. The State Medicaid Managed Care Advisory Committee serves as the central source for stakeholder input on the implementation and operation of Medicaid managed care.

STAR+PLUS Nursing Facility Advisory Committee

The STAR+PLUS Nursing Facility Advisory Committee, created by S.B. 7, 83rd Legislature, Regular Session, 2013, advises HHSC on implementation and associated activities related to Medicaid services provided to individuals who reside in nursing facilities and are members of the STAR+PLUS managed care program.

Behavioral Health Integration Advisory Committee

The Behavioral Health Integration Advisory Committee, created by S.B. 58, 83rd Legislature, Regular Session, 2013, is charged with addressing, planning, and developing the integration of Medicaid behavioral health services, including targeted case management, mental health rehabilitative services, and physical health services, into Medicaid managed care by September 1, 2014. With the exception of the Dallas service area which continues to have separate behavioral and physical health managed care components under the NorthSTAR program, those services now are under managed care as of September 1, 2014. The Committee was to seek input from the behavioral health community on these issues and produce formal recommendations to HHSC on how to accomplish integrating behavioral and physical health within Medicaid managed care.

VI. Future Path for HHSC Regarding Quality

Both S.B. 7 and S.B. 58, 83rd Legislature, Regular Session, 2013, require the transition of mental health and certain institutional LTSS into the managed care system, thus moving the Medicaid and CHIP service delivery system to an almost exclusively managed care model. Also, S.B. 7 includes numerous provisions that are designed to promote quality and efficiency with respect to the MCO model. Through the DSRIP program which is outside of the MCO model, there are many locally driven, diverse projects being implemented by RHPs that are designed to build capacity and improve quality and efficiency. The current effort to align Medicaid managed care and DSRIP quality outcomes is important. Critical input from providers, MCOs, advocacy organizations, etc., is vital to the success of this collaboration. Continued progress in this area will likely accelerate efforts toward quality and efficiency improvement; enable more consistent and empirical evaluation of projects; and lead to administrative simplification both at HHSC and within the MCO and provider systems.

The continued effort to align the work of the various business units within HHSC is essential to ensure:

- Optimal coordination of care between Medicaid and CHIP populations that may be served within various waivers and programs coordinated by different agencies.
- The more efficient use of the analysis groups within HHSC and its agencies via being able to leverage each other's work and specialized data insights.
- Quality of care and case management improvement opportunities that for the dual eligible population as HHSC integrates Medicare data into its analysis processes.
- A smoother transition of remaining fee-for-service and carved-out services populations into managed care.
- A greater ability to integrate multiple social services programs not usually associated with health care together to match individual client needs for housing, food, family, and social connections appropriately while avoiding duplication of effort.
- An enhanced ability to work with other health care stakeholders, such as hospitals, doctors, academics, and others, on collaborative quality improvement projects.
- More complete, robust, and timely data on outcomes, costs, and efficiency for legislators and the general public.

List of Acronyms

ADHD	Attention Deficit-Hyperactivity Disorder
AHRQ	Agency for Healthcare Research and Quality
ASM	Acronym for an Asthma measure
BCBS	Blue Cross/Blue Shield
BHO	Behavioral Health Organization
BMI	Body Mass Index
CAHPS	Consumer Assessment for Healthcare Provider Systems
CDC	Centers for Disease Control
CHC	Community Health Choices
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare & Medicaid Services
COPD	Chronic Obstructive Pulmonary Disease
DADS	Department of Aging and Disability
DMO	Dental Managed Care Organization
DSHS	Department of State Health Services
DSRIP	Delivery System Reform Incentive Payment
EHR	Electronic Health Record
ER	Emergency Room
EQRO	External Quality Review Organization
FU	Follow Up
FUH	Follow Up Post Hospitalization
H.B.	House Bill

List of Acronyms

HEDIS	Healthcare Effectiveness Data and Information Set
HHSC	Health and Human Services Commission
ICHP	University of Florida's Institute of Child Health Policy
IDD	Intellectual and Developmental Disability
IGT	Intergovernmental Transfer
Institute	Texas Institute of Health Care Quality and Efficiency
LTSS	Long Term Services and Supports
MCO	Managed Care Organization
MDS	Minimum Data Set
MRSA	Medicaid Rural Service Area
NCQA	National Committee for Quality Assurance
NICU	Neonatal Intensive Care Unit
NorthSTAR	Texas' managed care carve-out pilot program for behavioral health services implemented in Dallas and contiguous counties in 1999
NQF	National Quality Forum
PCP	Primary Care Provider
PIP	Performance Improvement Projects
PPA	Potentially Preventable Admissions
PPC	Potentially Preventable Complications
PPE	Potentially Preventable Events
PPR	Potentially Preventable Re-admissions
PPS	Potentially Preventable Ancillary Service

List of Acronyms

PPV	Potentially Preventable Emergency Room Visits
QBPAC	Quality-Based Payment Advisory Committee
RHP	Regional Healthcare Partnership
RRU	Relative Resource Use
S.B.	Senate Bill
STAR	State of Texas Access Reform - Texas' Medicaid managed care program providing preventative, primary and acute-care services for non-disabled children, low-income families, and pregnant women
STAR Health	A statewide managed care program that provides coordinated health services to children and youth in foster and kinship care
STAR Kids	Texas' Medicaid managed care program serving youth and children who get disability-related Medicaid
STAR+PLUS	Texas' Medicaid managed care program providing integrated acute and long-term services and supports to people with disabilities and people age 65 and older
STEEEP	Safe, Timely, Effective, Equitable, and Patient-Centered
TANF	Temporary Assistance for Needy Families
UHC	United HealthCare

Appendix A: HHSC Quality Measures

Measure Definitions

Potentially Preventable Events

Potentially Preventable Event (PPE) is a term that encompasses potentially preventable emergency room visits, admissions, re-admissions, complications, and ancillary services. Each PPE is defined below:

Potentially Preventable Emergency Room Visits (PPV) means treatment of a person in a hospital emergency room or freestanding emergency medical care facility for a condition that may not require emergency medical attention because the condition could be, or could have been, treated or prevented by a physician or other health care provider in a nonemergency setting.

Potentially Preventable Admissions (PPA) means an admission of a person to a hospital or long-term care facility that may have reasonably been prevented with adequate access to ambulatory care or health care coordination.

Potentially Preventable Re-admissions (PPR) means a return hospitalization of a person within a period specified by the commission* that may have resulted from deficiencies in the care or treatment provided to the person during a previous hospital stay or from deficiencies in post-hospital discharge follow-up. The term does not include a hospital readmission necessitated by the occurrence of unrelated events after the discharge. The term includes the readmission of a person to a hospital for the following:

- Same condition or procedure for which the person was previously admitted.
- Infection or other complication resulting from care previously provided.
- A condition or procedure that indicates that a surgical intervention performed during a previous admission was unsuccessful in achieving the anticipated outcome.

*Currently that time period is 15 days for calculating fee for service readmissions for each hospital and adjusting future reimbursement; 30 days for calculating managed care readmissions and adjusting future capitation accordingly; and 30 days for DSRIP projects.

Potentially Preventable Complications (PPC) means a harmful event or negative outcome with respect to a person, including an infection or surgical complication, that:

- Occurs after the person's admission to a hospital or long-term care facility.
- May have resulted from the care, lack of care, or treatment provided during the hospital or long-term care facility stay, rather than from a natural progression of an underlying disease.

Potentially Preventable Ancillary Services (PPS) means a health care service provided or ordered by a physician or other health care provider to supplement or support the evaluation or treatment of a patient, including a diagnostic test, laboratory test, therapy

service, or radiology service, that may not be reasonably necessary for the provision of quality health care or treatment.

Healthcare Effectiveness Data and Information Set Relative Resource Use Measures

Relative Resource Use (RRU) measures are standardized ways to examine health care service cost and use for chronic conditions that also have associated Healthcare Effectiveness Data and Information Set (HEDIS) effectiveness measures. The goal for the state, health plans, and providers is to provide high quality and cost effective care. HEDIS RRU measures include diabetes, cardiovascular conditions, hypertension, chronic obstructive pulmonary disease, and asthma.

Select Quality Website Links

National Committee for Quality Assurance (HEDIS) [website](#)

Agency for Healthcare Research and Quality [website](#)

National Quality Forum [website](#)

List of 2013 Measures used for reporting managed care quality or reporting measures to the Centers for Medicare & Medicaid Services for the child and adult populations.

2013 Measures	Managed Care	Fee-for-Service
Adult Inpatient Admission Rate (per 100,000)		
• Diabetes with short term complications	X	
• Diabetes with long term complications	X	
• Chronic Obstructive Pulmonary Disease	X	
• Hypertension	X	
• Congestive Heart Failure	X	
• Low Birth Weight (per 100)	X	
• Dehydration	X	
• Angina without Procedure	X	
• Perforated Appendix	X	
• Bacterial Pneumonia	X	
• Urinary Tract Infection	X	
• Uncontrolled Diabetes	X	
• Adult Asthma	X	
• Lower Extremity Amputation in Diabetes Patients	X	

2013 Measures	Managed Care	Fee-for-Service
Pediatric Inpatient Admission Rate (per 100,000)		
• Asthma	X	
• Diabetes Short Term Complications	X	
• Gastroenteritis	X	
• Urinary Tract Infection	X	
• Perforated Appendix (per 100)	X	
Inpatient Utilization (average length of stay, days per 1,000 member months, discharges per 1,000 member month)		
By age groups and reason	X	
Adult ER utilization (per 1,000 member months)		
By age groups	X	
Pediatric ER utilization (per 1,000 member months)		
By age groups	X	
Potentially Preventable Event Rate		
• All Cause Potentially Preventable Emergency Room Visit	X	
• All Cause Potentially Preventable Hospital Admission	X	
• All Cause Potentially Preventable Re-Admissions	X	X
• Condition Specific Potentially Preventable Emergency Room Visit	X	
• Condition Specific Potentially Preventable Hospital Admission	X	
• Condition Specific Potentially Preventable Re-Admission	X	
• Potentially Preventable Complications	X	X
• Potentially Preventable Ancillary Services	Future	
Outpatient Utilization (per 1,000 member months)		
By age groups	X	
Other Measures		
• Avoidance of Antibiotic Treatment for acute bronchitis (18-64)	X	
• Use of Appropriate Medications for persons with asthma (by age groups)	X	
• Comprehensive Diabetes Care-HbA1c testing	X	
• Comprehensive Diabetes Care-Eye Exams	X	
• Comprehensive Diabetes Care-LDL-C screening	X	
• Comprehensive Diabetes Care-diabetic nephropathy	X	

2013 Measures	Managed Care	Fee-for-Service
• Appropriate Testing for Pharyngitis	X	
• Appropriate Treatment for Upper Respiratory Infection	X	
• Low Complication Cesarean Section Rate (per 100 births)	Possible	Future
• Neonatal Intensive Care Unit (NICU) Utilization for non-Low Birth Weight Infants	Possible	Future
• Well Child Visits ≥ 6 within 15 months	X	
• Well Child Visits 3rd, 4th, 5th and 6th years of life ≥ 1 visit	X	
• Adolescent Well Child Visits ≥ 1 visit	X	
• Prenatal Care	X	
• Frequency of Prenatal Care (% of enrollees who had $>80\%$ of expected visits)	X	
• Postpartum Care	X	
• Access to Preventative/Ambulatory Services by age groups	X	
• Access to Primary Care Provider by age groups	X	
• Cervical Cancer Screening	X	
• Chlamydia Screening- by age group	X	
• Breast Cancer Screening	X	
• Childhood Immunization Status	X	
• Adult Body Mass Index (BMI) Assessment	X	
• High blood pressure controlled	X	
• Follow up Care for Children Prescribed Attention Deficit- Hyperactivity Disorder (ADHD) medication- Initiation phase	X	
• Follow up Care for Children Prescribed ADHD medication -Continuation/Maintenance phase	X	
• Antidepressant medication management-Effective Acute Phase	X	
• Antidepressant medication management -Effective Continuation Phase	X	
• 7 day follow up after hospitalization for mental illness	X	
• 30 day follow up after hospitalization for mental illness	X	
• Mental Health Services Utilization by age group and service level	X	
• Substance Use Disorder Services Utilization by age group and service level	X	
• Enrollee Complaints per 1,000 member months	X	
• Enrollee Appeals of Adverse Determinations per 1,000 member months	X	
• Managed Care Organization customer service and hotline hold time and abandonment rates	X	

2013 Measures	Managed Care	Fee-for-Service
• Consumer Assessment of Healthcare Providers and Systems (CAHPS)	X	
• Provider Network Access	X	
• Relative Resource Use for People with Diabetes	Future	
• Relative Resource Use for People with Cardiovascular Conditions	Future	
• Relative Resource Use for People with Hypertension	Future	
• Relative Resource Use for People with Chronic Obstructive Pulmonary Disease (COPD)	Future	
• Relative Resource Use for People with Asthma	Future	
Dental Quality Measures		
• Check Ups	X	
• Annual Visits	X	
• Preventative Services	X	
• Home Services	X	
• Diagnostic Services	X	
• Sealants	X	
Long Term Services and Supports Measures		
• Under development		Future

Appendix B: Category 3 Outcome Measures for Delivery System Reform Incentive Payment (DSRIP) Projects

All of the measures included in the outcomes menu known as Category 3 have been approved by the Centers for Medicare & Medicaid Services (CMS). Often the source of these measures is an authoritative agency around outcome measurement (e.g., Agency for Healthcare Research and Quality (AHRQ), National Committee for Quality Assurance (NCQA), Centers for Disease Control (CDC), National Quality Forum (NQF)). Most of these measures have been validated and tested to ensure that the outcomes are measuring what they purport to measure. In some cases, where validated measures did not previously exist, measures were created based on evidence based guidelines and practices. These measures were included in the Category 3 menu to reflect outcomes pertinent to approved and active Category 1 and 2 Delivery System Reform Incentive Payment (DSRIP) projects (1,491 as of August 2014). These outcomes are salient to aspects of patient care that reflect better health and satisfaction with services, improved efficiencies in health care delivery, and cost savings.

Delivery System Reform Incentive Payment (DSRIP) Category 3 Projects

1	Third next available appointment
2	Annual monitoring for patients on persistent medications - Angiotensin Converting Enzyme (ACE) inhibitors or Angiotensin Receptor Blockers (ARBs)
3	Annual monitoring for patients on persistent medications - Digoxin
4	Annual monitoring for patients on persistent medications- Diuretic
5	Annual monitoring for patients on persistent medications - Anticonvulsant
6	Cholesterol management for patients with cardiovascular conditions
7	Controlling high blood pressure
8	Depression management: Screening and Treatment Plan for Clinical Depression
9	Depression management: Depression Remission at Twelve Months
10	Diabetes care: HbA1c poor control (>9.0%)
11	Diabetes care: BP control (<140/90mm Hg)
12	Diabetes care: Retinal eye exam
13	Diabetes care: Foot exam
14	Diabetes care: Nephropathy
15	Peritoneal Dialysis Adequacy Clinical Performance Measure III
16	Hemodialysis Adequacy Clinical Performance Measure III
17	Hemodialysis Adequacy for Pediatric Hemodialysis Patients
18	Follow-Up After Hospitalization for Mental Illness
19	Antidepressant Medication Management
20	Comprehensive Diabetes Care LDL Screening
21	Adult Body Mass Index (BMI) Assessment
22	Asthma Percent of Opportunity Achieved
23	Tobacco Use: Screening & Cessation
24	Adolescent tobacco use
25	Adult tobacco use
26	Seizure type(s) and current seizure frequency(ies)

Delivery System Reform Incentive Payment (DSRIP) Category 3 Projects

27	Pain Assessment and Follow-up
28	Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented
29	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents
30	Hemoglobin A1c (HbA1c) Testing for Pediatric Patients
31	Medication Management for People with Asthma (MMA)
32	Asthma Medication Ratio (AMR)
33	Medical Assistance With Smoking and Tobacco Use Cessation
34	Appropriate Testing for Children With Pharyngitis
35	Congestive Heart Failure (CHF) Admission rate
36	Risk Adjusted Congestive Heart Failure (CHF) Admission rate
37	End-Stage Renal Disease (ESRD) Admission Rate
38	Risk Adjusted End-Stage Renal Disease (ESRD) Admission Rate
39	Hypertension (HTN) Admission Rate
40	Risk Adjusted Hypertension (HTN) Admission Rate
41	Behavioral Health/Substance Abuse (BH/SA) Admission Rate
42	Risk Adjusted Behavioral Health/Substance Abuse (BH/SA)
43	Chronic Obstructive Pulmonary Disease (COPD) Admission Rate
44	Risk Adjusted Chronic Obstructive Pulmonary Disease (COPD) Admission Rate
45	Adult Asthma Admission Rate
46	Risk Adjusted Adult Asthma Admission Rate
47	Diabetes Short Term Complication Admission Rate
48	Risk Adjusted Diabetes Short Term Complication Admission Rate
49	Diabetes Long Term Complications Admission Rate
50	Risk Adjusted Diabetes Long Term Complications Admission Rate
51	Uncontrolled Diabetes Admissions Rate
52	Risk Adjusted Uncontrolled Diabetes Admissions Rate
53	Flu and pneumonia Admission Rate
54	Risk Adjusted Flu and pneumonia Admission Rate
55	Ambulatory Care Sensitive Conditions Admissions Rate
56	Prevention Quality Indicators (PQI) Composite Measure Potentially Preventable Hospitalizations for Ambulatory Care Sensitive Conditions
57	Pediatric Asthma Admission Rate
58	Risk Adjusted Pediatric Asthma Admission Rate
59	Pain Admission Rate
60	Risk Adjusted Pain Admission Rate
61	Cancer Admission Rate
62	Risk Adjusted Cancer Admission Rate
63	Cellulitis Admission Rate
64	Risk Adjusted Cellulitis Admission Rate
65	Hospital-Wide All-Cause Unplanned Readmission Rate
66	Congestive Heart Failure (CHF) 30-day Readmission Rate
67	Risk Adjusted Congestive Heart Failure (CHF) 30-day Readmission Rate

Delivery System Reform Incentive Payment (DSRIP) Category 3 Projects

- 68 Diabetes 30-day Readmission Rate
- 69 Risk Adjusted Diabetes 30-day Readmission Rate
- 70 Renal Disease 30-day Readmission Rate
- 71 Risk Adjusted Renal Disease 30-day Readmission Rate
- 72 Acute Myocardial Infarction (AMI) 30-day Readmission Rate
- 73 Risk Adjusted Acute Myocardial Infarction (AMI) 30-day Readmission Rate
- 74 Coronary Artery Disease (CAD) 30-day Readmission Rate
- 75 Risk Adjusted Coronary Artery Disease (CAD) 30-day Readmission Rate
- 76 Stroke (CVA) 30-day Readmission Rate
- 77 Risk Adjusted Stroke (CVA) 30-day Readmission Rate
- 78 Behavioral Health /Substance Abuse 30-day Readmission Rate
- 79 Risk Adjusted Behavioral Health /Substance Abuse 30-day Readmission Rate
- 80 Chronic Obstructive Pulmonary Disease (COPD) 30-day Readmission Rate
- 81 Risk Adjusted Chronic Obstructive Pulmonary Disease (COPD) 30-day
Readmission Rate
- 82 Adult Asthma 30-day Readmission Rate
- 83 Risk Adjusted Adult Asthma 30-day Readmission Rate
- 84 Pediatric Asthma 30-day Readmission Rate
- 85 Risk Adjusted Pediatric Asthma 30-day Readmission Rate
- 86 Risk Adjusted All-Cause Readmission
- 87 Ventricular Assist Device 30-day Readmission Rate
- 88 Risk Adjusted Ventricular Assist Device 30-day Readmission Rate
- 89 Post-Surgical 30-day Readmission Rate
- 90 Risk Adjusted Post-Surgical 30-day Readmission Rate
- 91 Cancer Related 30-day Readmission Rate
- 92 Medication Complication 30-day Readmission Rate
- 93 Risk Adjusted Medication Complication 30-day Readmission Rate
- 94 Improvement in risk adjusted Potentially Preventable Complications rate(s)
- 95 Central line-associated bloodstream infections (CLABSI) rates
- 96 Catheter-associated Urinary Tract Infections (CAUTI) rates
- 97 Surgical site infections (SSI) rates
- 98 Patient Fall Rate
- 99 Incidence of Hospital-acquired Venous Thromboembolism (VTE)
- 100 Pressure Ulcer Rate
- 101 Sepsis mortality
- 102 Average length of stay: Sepsis
- 103 Sepsis bundle (NQF 0500)
- 104 Risk-Adjusted Average Length of Inpatient Hospital Stay
- 105 Average Length of Stay for patients of Medication Errors
- 106 Patients receiving language services supported by qualified language services
providers
- 107 Intensive Care: In-hospital mortality rate
- 108 Venous Thromboembolism Prophylaxis Bundle
- 109 Reduce Unplanned Re-operations

Delivery System Reform Incentive Payment (DSRIP) Category 3 Projects

- 110 Adverse drug events
- 111 Stroke - Thrombolytic Therapy
- 112 Warfarin management: percentage of patients on warfarin with an international normalized ratio (INR) result of 4 or above whose dosage has been adjusted or reviewed prior to the next warfarin dose, during the 6 month time period
- 113 Falls: Screening, Risk-Assessment, and Plan of Care to Prevent Future Falls
- 114 Improved Cost Savings: Demonstrate cost savings in care delivery - Cost of Illness Analysis
- 115 Improved Cost Savings: Demonstrate cost savings in care delivery - Cost Minimization Analysis
- 116 Improved Cost Savings: Demonstrate cost savings in care delivery - Cost Effectiveness Analysis
- 117 Improved Cost Savings: Demonstrate cost savings in care delivery - Cost Utility Analysis
- 118 Improved Cost Savings: Demonstrate cost savings in care delivery - Cost Benefit Analysis
- 119 Per Episode Cost of Care
- 120 Total Cost of Care
- 121 HCAHPS Communication with Doctors
- 122 HCAHPS Communication with Nurses
- 123 HCAHPS Responsiveness of Hospital Staff
- 124 HCAHPS Pain Control
- 125 HCAHPS Communication about Medicine
- 126 HCAHPS Cleanliness of Hospital Environment
- 127 HCAHPS Quietness of Hospital Environment
- 128 HCAHPS Discharging Information
- 129 HCAHPS Overall Hospital Rating
- 130 HCAHPS Likelihood to Recommend
- 131 CG-CAHPS 12-month: Timeliness of Appointments, Care, & Information
- 132 CG-CAHPS 12-month: Provider Communication
- 133 CG-CAHPS 12-month: Office Staff
- 134 CG-CAHPS 12-month: Overall Provider Rating
- 135 CG-CAHPS 12-month: Provider's Attention to Child's Growth and Development(Pediatric)
- 136 CG-CAHPS 12-month: Provider's Advice on Keeping Child Safe and Healthy(Pediatric)
- 137 CG-CAHPS 12-month: Cultural Competence Survey Supplement
- 138 CG-CAHPS 12-month: Health Information Technology Supplement
- 139 CG-CAHPS 12-month: Health Literacy Supplement
- 140 CG-CAHPS 12-month: PCMH Supplement (includes Shared Decision Making)
- 141 CG-CAHPS Visit Survey 2.0: Timeliness of Appointments, Care, & Information
- 142 CG-CAHPS Visit Survey 2.0: Provider Communication
- 143 CG-CAHPS Visit Survey 2.0: Office Staff
- 144 CG-CAHPS Visit Survey 2.0: Overall Provider Rating

Delivery System Reform Incentive Payment (DSRIP) Category 3 Projects

- 145 CG-CAHPS Visit Survey 2.0: Provider's Attention to Child's Growth and Development (Pediatric)
- 146 CG-CAHPS Visit Survey 2.0: Providers Advice on Keeping Child Safe and healthy (Pediatric)
- 147 Client Satisfaction Questionnaire 8 (CSQ-8)
- 148 Visit-Specific Satisfaction Instrument (VSQ-9)
- 149 Health Center Patient Satisfaction Survey
- 150 PSQ-III General Satisfaction
- 151 PSQ-III Technical Quality
- 152 PSQ-III Interpersonal Aspects
- 153 PSQ-III Communication
- 154 PSQ-III Financial Aspects
- 155 PSQ-III Time Spent w/ Doctors
- 156 PSQ-III Access, Availability, & Convenience
- 157 PSQ-18 General Satisfaction
- 158 PSQ-18 Technical Quality
- 159 PSQ-18 Interpersonal Aspects
- 160 PSQ-18 Communication
- 161 PSQ-18 Financial Aspects
- 162 PSQ-18 Time Spent w/ Doctors
- 163 PSQ-18 Access, Availability, & Convenience
- 164 Experience of Care and Health Outcomes (ECHO) 3.0
- 165 Dental Sealant: Children
- 166 Cavities: Children
- 167 Early Childhood Caries – Fluoride Applications
- 168 Topical Fluoride application
- 169 Proportion of older adults aged 65 to 74 years who have lost all their natural teeth
- 170 Urgent Dental Care Needs in Children: Percentage of children with urgent dental care needs
- 171 Urgent Dental Care Need in Older Adults
- 172 Chronic Disease Patients Accessing Dental Services
- 173 Dental Treatment Needs Among Chronic Disease Patients
- 174 Cavities: Adults
- 175 Utilization of Services: Children
- 176 Oral Evaluation: Children
- 177 Prevention: Sealants for 6 – 9 year-old Children at Elevated Risk
- 178 Prevention: Sealants for 10 – 14 year-old Children at Elevated Risk
- 179 Prevention: Topical Fluoride Intensity for Children at Elevated Caries Risk
- 180 Preventive Services for Children at Elevated Caries Risk
- 181 Treatment Services: Children
- 182 Usual Source of Services
- 183 Care Continuity: Children
- 184 Per Member Per Month Cost of Clinical Services (PMPM Cost): Children
- 185 Annual Dental Visit

Delivery System Reform Incentive Payment (DSRIP) Category 3 Projects

- 186 Diabetes mellitus: percent of patients who obtained a dental exam in the last 12 months (NQMC:1600)
- 187 Timeliness of Prenatal/Postnatal Care
- 188 Percentage of Low Birth- weight births
- 189 Early Elective Delivery
- 190 Antenatal Steroids
- 191 Frequency of ongoing prenatal care
- 192 Cesarean Rate for Nulliparous Singleton Vertex
- 193 Birth Trauma Rates
- 194 Neonatal Mortality
- 195 Youth Pregnancy Rate
- 196 Pregnancy Rate
- 197 Healthy term newborn
- 198 Pre-term birth rate
- 199 NICU days/delivery
- 200 Exclusive Breastfeeding at 3 Months
- 201 Exclusive Breastfeeding at 6 Months
- 202 Any Breastfeeding at 6 Months
- 203 Any Breastfeeding at 12 Months
- 204 Rate of Exclusive Breastfeeding
- 205 Post-Partum Follow-Up and Care Coordination
- 206 Developmental Screening in the First Three Years of Life
- 207 Well-Child Visits in the First 15 Months of Life (6 or more visits)
- 208 Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life
- 209 Children and Adolescents' Access to Primary Care Practitioners (CAP)
- 210 Adolescent Well-Care Visits (AWC)
- 211 Sudden Infant Death Syndrome Counseling
- 212 Routine prenatal care: percentage of pregnant patients who receive counseling about aneuploidy screening in the first trimester (NQMC:8031)
- 213 Behavioral health risk assessment (for pregnant women)
- 214 Decrease in mental health admissions and readmissions to criminal justice settings such as jails or prisons
- 215 Reduce Emergency Department (ED) visits for Ambulatory Care Sensitive Conditions (ACSC) per 100,000
- 216 Reduce Pediatric Emergency Department (ED) visits for Ambulatory Care Sensitive Conditions (ACSC) per 100,000
- 217 Emergency Department (ED) visits per 100,000
- 218 Pediatric Emergency Department (ED) visits per 100,000
- 219 Reduce Emergency Department visits for Congestive Heart Failure
- 220 Reduce Emergency Department visits for Diabetes
- 221 Reduce Emergency Department visits for End Stage Renal Disease
- 222 Reduce Emergency Department visits for Angina and Hypertension
- 223 Reduce Emergency Department visits for Behavioral Health/Substance Abuse
- 224 Reduce Emergency Department visits for Chronic Obstructive Pulmonary Disease

Delivery System Reform Incentive Payment (DSRIP) Category 3 Projects

- 225 Reduce Emergency Department visits for Asthma
- 226 Reduce Emergency Department visits for Dental Conditions
- 227 Pediatric/Young Adult Asthma Emergency Department Visits
- 228 Reduce low acuity ED visits
- 229 Emergency department (ED) visits where patients left without being seen
- 230 Emergency department (ED) visits where patients with a mental health complaint without being seen
- 231 Care Transition: Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care [Home/Self Care] or Home Health Care)
- 232 Transition Record with Specified Elements Received by Discharged Patients (Inpatient Discharges to Home/Self Care or Any Other Site of Care)
- 233 ED throughput Measure bundle
- 234 Median Time from ED Arrival to ED Departure for Discharged ED Patients
- 235 Median time from admit decision time to time of departure from the ED for ED patients admitted to inpatient status
- 236 Median time from ED arrival to time of departure from the emergency room for patients admitted to the facility from the ED
- 237 Assessment of Quality of Life (AQoL-4D)
- 238 Assessment of Quality of Life (AQoL-6D)
- 239 Assessment of Quality of Life (AQoL-7D)
- 240 Assessment of Quality of Life (AQoL-8D)
- 241 Pediatric Quality of Life Inventory (PedsQL)
- 242 RAND Medical Outcomes Study: Measures of Quality of Life Survey Core Survey (MOS)
- 243 RAND Short Form 12 (SF-12v2) Health Survey
- 244 RAND Short Form 36[1] (SF-36) Health Survey
- 245 Quality of Life Enjoyment and Satisfaction Questionnaire (Q-LES-Q)
- 246 McGill Quality of Life (MQOL) Index
- 247 Palliative Care Outcome Scale (POsv1)
- 248 Palliative Care Outcome Scale (POsv2)
- 249 Functional Assessment of Cancer Therapy (FACT-G)
- 250 Missoula-VITAS Quality of Life Index (MVQOLI)
- 251 CDC Health-Related Quality of Life (HRQoL) Measures
- 252 Child Health Questionnaire Parent CHQ-PF50
- 253 Child Health Questionnaire Parent CHQ-PF28
- 254 Child Health Questionnaire Child Form (CHQ-CF87)
- 255 Family Experiences Interview Schedule (FEIS)
- 256 Supports Intensity Scale (SIS)
- 257 Lawton Instrumental Activities of Daily Living (IADLs) Scale
- 258 Activity Measure for Post-Acute Care (AMPAC)
- 259 The Duke Health Profile (Duke)
- 260 Battelle Development Inventory-2 (BDI-2)
- 261 Problem Areas in Diabetes (PAID) Scale

Delivery System Reform Incentive Payment (DSRIP) Category 3 Projects

- 262 Developmental Profile 3 (DP-3)
- 263 Vineland Adaptive Behavior Scales, 2nd Edition (VABS II)
- 264 Bayley Scales of Infant and Toddler Development-Third Edition (Bayley-III)
- 265 Adult Mental Health Facility Admission Rate
- 266 Youth Mental Health Facility Admission Rate
- 267 IDD/ICF Admissions to a Care Facility
- 268 IDD/SPMI Admissions and Readmissions to State Institutions
- 269 Adherence to Antipsychotic Medications for Individuals with Schizophrenia
- 270 Follow-up Care for Children Prescribed ADHD Medication (ADD)
- 271 Initiation of Depression Treatment
- 272 Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
- 273 Care Planning for Dual Diagnosis
- 274 Diabetes Screening for People with Schizophrenia or Bipolar Disorder Prescribed Antipsychotic Medications (SSD)
- 275 Diabetes Monitoring for People With Diabetes and Schizophrenia
- 276 Cardiovascular monitoring for people with cardiovascular disease and schizophrenia (SMC)
- 277 Assignment of Primary Care Physician to Individuals with Schizophrenia
- 278 Annual Physical Exam for Persons with Mental Illness
- 279 Depression Screening by 18 years of age
- 280 Assessment for Substance Abuse Problems of Psychiatric Patients
- 281 Assessment of Risk to Self/Others
- 282 Bipolar Disorder (BD) and Major Depression (MD): Appraisal for alcohol or substance use
- 283 Assessment for Psychosocial Issues of Psychiatric Patients
- 284 Bipolar Disorder and Major Depression: Assessment for Manic or hypomanic behaviors
- 285 Assessment of Major Depressive Symptoms
- 286 Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment
- 287 Vocational Rehabilitation for Schizophrenia
- 288 Housing Assessment for Individuals with Schizophrenia
- 289 Independent Living Skills Assessment for Individuals with Schizophrenia
- 290 Texas Adult Mental Health (AMH) Consumer Survey
- 291 Quick Inventory of Depressive Symptomatology (QIDS)
- 292 Generalized Anxiety Disorder (GAD-7)
- 293 Daily Living Activities (DLA-20)
- 294 Positive Symptom Rating Scale (PSRS)
- 295 Aberrant Behavior Checklist (ABC)
- 296 Adult Needs and Strength Assessment (ANSA)
- 297 Children and Adolescent Needs and Strengths Assessment (CANS-MH)
- 298 Patient Health Questionnaire 9 (PHQ-9)
- 299 Patient Health Questionnaire 15 (PHQ-15)
- 300 Patient Health Questionnaire: Somatic, Anxiety, and Depressive Symptoms (PHQ-

Delivery System Reform Incentive Payment (DSRIP) Category 3 Projects

- SADS)
- 301 Patient Health Questionnaire 4 (PHQ-4)
 - 302 Edinburg Postpartum Depression Scale
 - 303 Breast Cancer Screening
 - 304 Cervical Cancer Screening
 - 305 Colorectal Cancer Screening
 - 306 Pneumonia vaccination status for older adults
 - 307 Pneumococcal Immunization- Inpatient
 - 308 Influenza Immunization -- Ambulatory
 - 309 Influenza Immunization- Inpatient
 - 310 Immunization for Adolescents- Tdap/TD and MCV
 - 311 Childhood immunization status
 - 312 Adults (18+ years) Immunization status
 - 313 HPV vaccine for adolescents
 - 314 Immunization and Recommended Immunization Schedule Education
 - 315 Mammography follow-up rate
 - 316 Prostate Cancer: Avoidance of Overuse Measure – Bone Scan for Staging Low-Risk Patients
 - 317 Abnormal Pap test follow-up rate
 - 318 High-risk Colorectal Cancer Follow-up rate within one year
 - 319 Intensive behavioral dietary counseling for adult patients with hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic disease
 - 320 ABI Screening for Peripheral Arterial Disease
 - 321 Osteoporosis: Screening or Therapy for Women Aged 65 Years and Older
 - 322 Hospice and Palliative Care – Pain assessment
 - 323 Hospice and Palliative Care – Treatment Preferences
 - 324 Hospice and Palliative Care – Proportion with more than one emergency room visit in the last days of life
 - 325 Hospice and Palliative Care – Proportion admitted to the ICU in the last 30 days of life
 - 326 Hospice and Palliative Care – Percentage of patients receiving hospice or palliative care services with documentation in the clinical record of a discussion of spiritual/religions concerns or documentation that the patient/caregiver did not want to discuss
 - 327 Palliative Care: Percent of patients who have documentation in the medical record that an interdisciplinary family meeting was conducted on or before day five of ICU admission
 - 328 Oncology: Pain Intensity Quantified – Medical Oncology and Radiation Oncology
 - 329 Oncology: Plan of Care for Pain – Medical Oncology and Radiation Oncology
 - 330 Number of practicing primary care practitioners per 1000 individual in HPSAs or MUAs
 - 331 Number of practicing nurse practitioners and physician assistants per 1000 individuals in HPSAs or MUAs
 - 332 Number of practicing psychiatrists per 1000 individuals in HPSAs or MUAs

Delivery System Reform Incentive Payment (DSRIP) Category 3 Projects

- 333 Percent of graduates who practice in a HPSA or MUA
- 334 Percent of graduates who work in a practice that has a high Medicaid share that reflects the distribution of Medicaid in the population
- 335 Percent of trainees who have spent at least 5 years living in a health- professional shortage area (HPSA) or medically underserved area
- 336 Percent of trainees who report that they plan to practice in HPSAs or MUAs based on a systematic survey
- 337 Percent of trainees who report that they plan to serve Medicaid populations based on a systematic survey
- 338 Number of practicing specialty care practitioners per 1000 individuals in HPSA or MUA
- 339 HIV medical visit frequency
- 340 Prescription of Antiretroviral Medications
- 341 HIV Screening: Patients at High Risk of HIV
- 342 HIV/AIDS: Tuberculosis (TB) Screening
- 343 HIV/AIDS: Sexually Transmitted Diseases - Screening for Chlamydia, Gonorrhea, and Syphilis
- 344 Chlamydia screening in women
- 345 Chlamydia Screening and Follow up in adolescents
- 346 Follow-up testing for C. trachomatis among recently infected men and women
- 347 Syphilis screening
- 348 Syphilis positive screening rates
- 349 Follow-up after Treatment for Primary or Secondary Syphilis
- 350 Gonorrhea screening rates
- 351 Gonorrhea Positive Screening Rates
- 352 Follow-up testing for N. gonorrhea among recently infected men and women
- 353 High Intensity Behavioral Counseling to prevent STIs for all sexually active adolescents and for adults at increased risk for STIs
- 354 Curative Tuberculosis (TB) treatment rate
- 355 Latent Tuberculosis Infection (LTBI) treatment rate
- 356 Hepatitis C Cure Rate

Appendix C: Quality-Based Payment Advisory Committee Report

Executive Summary of the Quality-Based Payment Advisory Committee Report

Senate Bill 7, 82nd Legislature, First Called Session, 2011, created the Quality-Based Payment Advisory Committee (QBPAC). One of the charges to the Committee was to develop performance measures that could be used across programs and delivery models and which would improve the quality of health care and reduce costs. This has been the focus throughout 2013.

Summary of 2013 Recommendations

There are hundreds of measures that could be used. There are limitations inherent in most of the measures because they were not designed for use in evaluating managed care plans, and most measure processes rather than actual clinical outcomes. There are 100 different combinations of managed care organizations (MCOs), programs, and service areas which negatively impact the Texas Health and Human Services Commission's (HHSC's) ability to compare them. Too often, a measure can only be calculated for a small percent of the MCO/program/areas; and therefore, cannot be used to compare MCO performance across a program or within a service area.

The QBPAC chose to focus on a handful of measures that had the greatest potential for changing the quality of health care and reducing overall costs. It identified four clinical categories and chose measures for each as follows:

- **Pediatrics:** Immunization combo 4; relative resource use to people with asthma (ASM); and consumer assessment of health care providers and systems survey for family satisfaction.
- **Pregnancy:** Risk-adjusted primary cesarean section.
- **Behavioral Health:** The committee was not able to reach consensus on any measures at this time.
- **Long-Term Services and Supports (LTSS):** The committee felt strongly that this should be deferred until the three new LTSS members were able to contribute. Those decisions are reflected in the 2014 recommendations.

Summary of 2014 Recommendations and 2014-2015 Pending Work

Based upon discussions in 2013, the QBPAC formed new workgroups to look at alternative payment models, telemedicine opportunities, and Medicaid and CHIP enrollment processes. It continued to work on performance measures. All areas were considered underpinnings to the goals of improving the quality of health care delivery and reducing avoidable costs.

- **Enrollment:** This group looked at how current enrollment policies and processes affect health outcomes and costs and made recommendations on changes to the

enrollment process for individuals whose eligibility is income based such as Temporary Assistance for Needy Families (TANF), newborns, and children.

- **Telemedicine:** This group drafted recommendations for future changes in legislation and policy to improve access to telemedicine services.
- **Reimbursement:** They developed a recommendation for a shared savings reimbursement approach between HHSC and the MCOs.
- **Measures:** They added to the measures selected in 2013. The new workgroups for the remainder of 2014 and 2015 include hospice/end of life care, alternative payments, and potentially preventable events. The committee appreciates the opportunity to work with HHSC. It is to be disbanded September 28, 2015 unless the Executive Commissioner wishes it to continue.

Legislation

Senate Bill 7, 82nd Legislature, First Called Session, 2011, established the QBPAC. The intent was for the Committee to make recommendations to HHSC, and for HHSC to consult with the Committee on the following:

- Reimbursement systems used to compensate physicians or other health care providers under those programs that reward the provision of high-quality, cost-effective health care and quality performance and quality of care outcomes with respect to health care services.
- Standards and benchmarks for quality performance, quality of care outcomes, efficiency, and accountability by MCOs, physicians, and other health care providers.
- Programs and reimbursement policies that encourage high-quality, cost-effective health care delivery models that increase appropriate provider collaboration, promote wellness and prevention, and improve health outcomes.
- Outcome and process measures.

The outcome and process measures should promote the provision of efficient, quality health care that can be used in Medicaid and the Children's Health Insurance Program (CHIP) to implement quality-based payments for acute and LTSS across all delivery models and payment systems, including fee-for-service and managed care payment systems. To the extent feasible, they should apply across all program delivery models and payment systems, taking into account appropriate patient risk factors, including the burden of chronic illness on a patient and the severity of a patient's illness; have the greatest effect on improving quality of care and the efficient use of services; and are similar to outcome and process measures used in the private sector, as appropriate.

Background

Texas Medicaid has moved into a full managed care model. Small plan size limits the options for comparing performance because the small plans have insufficient population meeting inclusion criteria for most measures. Additionally, the further breakout by program may result in a similar effect. Many measures require enrollment over a year or more, yet Medicaid policy does not extend enrollment periods to optimize care and

allows members to move between plans even when treatment will be affected. The end result is an ever diminishing population that meets criteria for a measure.

HHSC is required to include as MCOs any that are:

- Wholly-owned and operated by a hospital district.
- Anon-profit corporation with a contract with a hospital district with a requirement to cover indigent patients.
- Anon-profit corporation acting as the agent for a hospital district.

These MCOs are awarded and renewed based on a matching funds agreement and may not be subject to the size or performance requirements otherwise specified in Texas Government Code, Chapter 533.

Table 2 provides a visual of the 2012 Quality of Care measures for the STAR program calculated by the University of Florida's Institute of Child Health Policy (ICHP) in their role as our External Quality Review Organization (EQRO). These are measures that have been used to compare plan performance between Com. Also note that the Dallas Service Area is being measured on behavioral health services in spite of those services being carved out of the Dallas area MCO contracts.

The empty cells represent plans with insufficient number of members meeting criteria for the measure. In part, that is due to some plans and areas not having a full 12 months of Medicaid enrollment for the measure because they were implemented March 1, 2012.

Not one of the measures in Table 2 had all plans/programs included making it difficult to use the measures for plan or region comparisons or for pay-for-performance models.

Table 2: 2012 STAR Quality of Care Measures by MCO/Service Area Inclusion

Plan Code	Plan	Service Area	FU ADHD- Initiation	FU ADHD- Continuation	AMM- Acute	AMM- Continuation	Asthma Med- Total Pop	Appropriate Asthma Rxs- Combined Rate	Adolescent Well Care	Breast Cancer Screening	Child Adolescent Access PCP	Cervical Cancer Screening	Comprehensive Diabetes Care	FUH 7 and 30 day	Med Management Asthma- total
43	Aetna	Bexar	x				x	x	x		x	x	x	x	x
44	Amerigroup	Bexar												x	
42	Community First	Bexar	x	x	x	x	x	x	x		x	x	x	x	x
40	Superior	Bexar	x	x	x	x	x	x	x		x	x	x	x	x
90	Amerigroup	Dallas					x	x			x	x	x		x
95	Molina	Dallas							x						
93	Parkland	Dallas					x	x	x		x	x	x		x
37	El Paso First	El Paso	x	x	x	x	x	x	x	x	x	x	x	x	x
31	Molina	El Paso													
36	Superior	El Paso	x	x	x	x	x	x	x	x	x	x	x	x	x
71	Amerigroup	Harris	x	x			x	x	x		x	x	x	x	x
79	Community Health Choices (CHC)	Harris	x	x	x	x	x	x	x		x	x	x	x	x
7G	Molina	Harris					x	x	x		x	x		x	x
72	Texas Children's	Harris	x	x			x	x	x		x	x	x	x	x
7H	United HealthCare (UHC)	Harris	x				x	x	x		x	x	x	x	x
H4	Driscoll	Hidalgo												x	

Plan Code	Plan	Service Area	FU ADHD- Initiation	FU ADHD- Continuation	AMM- Acute	AMM- Continuation	Asthma Med- Total Pop	Appropriate Asthma Rx- Combined Rate	Adolescent Well Care	Breast Cancer Screening	Child Adolescent Access PCP	Cervical Cancer Screening	Comprehensive Diabetes Care	FUH 7 and 30 day	Med Management Asthma- total
H3	Molina	Hidalgo												x	
H2	Superior	Hidalgo												x	
H1	UHC	Hidalgo													
8G	Amerigroup	Jefferson							x		x	x			
8H	CHC	Jefferson							x		x	x		x	
8J	Molina	Jefferson							x		x	x			
8K	Texas Children's	Jefferson							x		x	x		x	
8L	UHC	Jefferson							x		x	x			
53	Amerigroup	Lubbock													
50	FirstCare	Lubbock	x				x	x	x		x	x	x	x	x
52	Superior	Lubbock	x				x	x	x		x	x	x	x	x
C1	Amerigroup	Medicaid Rural Service Area (MRSA) Cent												x	
C3	RightCare	MRSA Cent												x	
C2	Superior	MRSA Cent												x	
N1	Amerigroup	MRSA NE												x	
N2	Superior	MRSA NE												x	
W2	Amerigroup	MRSA West												x	

Plan Code	Plan	Service Area	FU ADHD- Initiation	FU ADHD- Continuation	AMM- Acute	AMM- Continuation	Asthma Med- Total Pop	Appropriate Asthma Rxs- Combined Rate	Adolescent Well Care	Breast Cancer Screening	Child Adolescent Access PCP	Cervical Cancer Screening	Comprehensive Diabetes Care	FUH 7 and 30 day	Med Management Asthma- total
W4	FirstCare	MRSA West												x	
W3	Superior	MRSA West												x	
81	Amerigroup	Nueces	x												
88	CHRISTUS	Nueces													
82	Driscoll	Nueces	x	x			x	x	x		x	x	x	x	x
83	Superior	Nueces	x				x	x	x		x	x	x	x	x
67	Aetna	Tarrant	x				x	x	x		x	x	x	x	x
63	Amerigroup	Tarrant	x	x	x	x	x	x	x		x	x	x	x	x
66	Cook Children's	Tarrant	x	x			x	x	x		x	x		x	x
16	Amerigroup	Travis	x												
1P	Blue Cross/Blue Shield (BCBS)	Travis													
1N	Sendero	Travis													
1A	Seton	Travis													
10	Superior	Travis	x	x	x	x	x	x	x	x	x	x	x	x	x

Note: Plan code represents plan-service area.

Some measures in use have such a low occurrence as to be of little value (i.e. perforated appendix). Other measures have limited value for improving the quality of health care (i.e., chlamydia screening for women ages 21-24 years old). Still others measure performance that may not be easily affected by a managed care plan, such as prenatal visit in the first trimester or within 42 days of enrollment when the date being used is as the enrollment date is prior to the plan being notified of the member, or potentially preventable emergency room visits if providers will not add after hours care.

The inability to compare plans on measures impacts the choices HHSC has for pay-for-performance models. Any measure used must be comparable across all plans in that program.

Also, it must be noted that the data currently used for performance measurement is more than two years old. Many things may have changed in the interim that affect how that plan/program/area will look the following year, but none of the activities undertaken in the current year will be responsible for the subsequent rate. For example, for fiscal year 2013, the data used to compare performance were from calendar year 2012. A plan that wanted to do well on measurement would be unable to affect the results because all those events had taken place between September 1, 2011, and August 31, 2012, prior to the start of the performance period.

The QBPAC sought to maximize the impact of a few measures. Factors and conditions were considered that had the highest financial cost and greatest potential for changing health outcomes. Where possible, the Committee chose outcome rather than process measures. The selection process was based on the STEEEP approach developed by the Institute of Medicine. This method involves examining measures within categories across the following dimensions: Safe, Timely, Effective, Efficient, Equitable, and Patient-Centered.

After being notified that the QBPAC's end date per Texas Administrative Code, Title 1, Part 15, §351.3 is September 28, 2015, there was discussion regarding the value of the Committee and what work they felt still needed to be done. Note that the QBPAC would welcome interaction with other S.B. 7 committees with overlapping charges.

Rationale

Pediatrics

A number of measures were considered, such as well child check-ups. However, there is no strong correlation between the frequency of the visits and health outcomes for healthy children. There was general agreement that immunizations, whether given during a well-child check or other visit, actually prevent future illness.

Asthma was recognized as a cost driver across the outpatient office, pharmacy, emergency room, and inpatient hospital categories. A child may be given a diagnosis of asthma without a spirometry test, and while that was of interest to the Committee, teasing

those out of administrative data was deemed too difficult. Correct treatment, including patient and family education, has been shown to reduce the use of emergency care. Since this is a multifaceted issue, it was decided that a combination approach looking at the relative resource use across the care continuum worked best. It also allows for inclusion of all plan/program/service area groupings because it is not dependent on sample size.

Perception of care was recognized as a factor for this population, thus the Consumer Assessment of Healthcare Providers and Systems (CAHPS) was chosen as a measure. Unfortunately, it is a hybrid measure that only samples 411 members of the population and is currently done every other year. Nonetheless, the QBPAC felt this is valuable information for measuring STAR MCO performance.

Pregnancy

While children are the focus of both Medicaid and CHIP, healthy children do not pose the healthcare costs and challenges to the healthcare system as do low birth weight newborns and those who suffer a preventable birth injury. A number of measures were reviewed and rejected. Some of the decision points are included below.

Frequency of prenatal care is not correlated with birth outcomes. The measure for prenatal care in the first trimester or 42 days of enrollment is a poor choice since the enrollment date shown in the claims database is the retroactive date and may be as much as 60 days prior to the actual enrollment into a plan.

Postpartum care within 21-54 days postpartum is also problematic since the Texas Medicaid program pays for postpartum care as a service, regardless of the number or timing of the visits. Medicaid providers will bill at the time of the first visit which frequently occurs before 21 days. CHIP includes postpartum care in the delivery fee, and it is not separately billed, although the service should occur and be found in the medical record. In order to properly use this measure, it would require medical record review, and the QBPAC felt the benefit did not outweigh the cost.

The Committee also looked at creating a measure for the administration of pertussis vaccine to pregnant women but could not achieve consensus.

Mental Health

There have been robust discussions on possible measures. The University of Florida (ICHP) did look at the measure for 7- and 30-day follow up post mental health discharge and concluded that our readmissions and cost data does not support any correlation with the measure's results. Also, its literature search did not find support for the measure from others. Other possible measures do not have sufficient numerators from plan population to be used well. Therefore, work in this area will continue.

In 2014, the Medicaid/CHIP Behavioral Health Integration Advisory Committee made initial recommendations for behavioral health performance measures which QBPAC

supports.

Long Term Services and Supports

The committee felt it was better to wait on these until the new members representing this population could be engaged in the discussion. The focus was on the nursing home and community based living populations to be carved in September 1, 2014.

2013 Recommendations

There are two sets of recommendations related to performance measurement or pay for performance. The first involves changes to the current system which makes measurement difficult, and the second is the measures from the QBPAC.

Recommendation #1

Increase the minimum plan size requirement. With the current breakout of multiple plans in each program and service delivery area and knowing the new STAR Kids plan will be added for a smaller population, finding measures of any kind where there is sufficient denominator size across all plans is extremely difficult. Other states combine all programs into one product and MCOs wishing to participate must provide care across the full continuum.

Recommendation #2

The following are the first measures to achieve full approval of the committee. They span a large enough population and are closely correlated with positive outcomes and potential cost efficiencies that the QBPAC felt it should be used in at risk and other performance incentive calculations.

- Pediatrics: Immunization combo 4; relative resource use to people with asthma (ASM); and Consumer Assessment of Health care Providers and Systems survey for family satisfaction (CAHPS).
- Pregnancy: Risk-adjusted primary cesarean section.
- LTSS: Nursing facilities are required to enter data monthly into the claims administrator portal for the Nursing Home Minimum Data Set (MDS) Facility report. HHSC should make all the fields currently on the monthly Nursing Home MDS Facility report required entry fields; require Texas Medicaid & Healthcare Partnership to configure the portal if possible; ensure that the data submitted is maintained in a data file that can easily be used to compare facility performance, and; make some or all of this data publically available. DADS or another entity should randomly sample the entries for accuracy.

The following National Quality Foundation (NQF) MDS measures are recommended by the Committee:

- NQF 0679: Percent of Residents with Pressure Ulcers (Long Stay).
- NQF 0681: Percent of Residents Assessed and Appropriately Given the Seasonal Influenza Vaccine (Long Stay).
- NQF 0683: Percent of Residents Assessed and Appropriately Given the Pneumococcal Vaccine (Long Stay).
- NQF 0674: Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay).

2014 Recommendations

Enrollment

- HHSC implement the following enrollment processes for pregnant women and individuals whose eligibility is income based such as TANF, newborns, and children:
 - Implement enrollment in Medicaid at the time of application.
 - Implement enrollment directly into managed care upon approval for Medicaid, avoiding a fee-for-service segment.
- HHSC implement the following eligibility for pregnant women, newborns, and children:
 - Change the eligibility segment for birth to age 18 to no less than 12 months (Restorative enrollment, July 2014 implementation).
 - Change the eligibility segment for pregnant women to six months post-delivery or miscarriage.

Alternative Payment Models

Develop the means for MCOs to keep accrued savings above the current percentage when HHSC approves a shared savings project proposed by the MCO. It is understood that this may require administrative or legislative changes. The following are the components of the shared savings approach.

- No additional dollars will be used. Rather, existing dollars may be left on the table for future projects.
- MCOs will propose projects and HHSC will either approve or deny.

The projects must have:

- A stated time period
- A defined target population/ service
- A baseline for utilization and/or costs per member, or overall costs, depending on the project
- A clearly defined means to measure savings at intervals and at the project end
- An amount of money needed to initiate the project

- Any contractual changes needed
- A plan for sharing the savings with, or in some other way incenting the providers who will be impacted
- Project approval will consider:
 - The potential impact in healthcare dollars and quality.
 - The potential impact on other MCOs in the same service area(s).
- Savings to the state will be measured:
 - With consideration for inflation, changes in the cost of goods and services at the unit level.
 - With consideration of cost avoidance.
 - Trended over the lifespan of the project with annual projections.
 - Also consider improved outcomes (no associated dollar savings).
- Initial funding for projects will come from one or more of the following:
 - Experience rebate funds being placed in a special account.
 - Changing how money is returned to the state.
 - Other sources such as Title V of the Social Security Act or Health Resources and Services Administration grants.
- Shared savings will allow an MCO to keep 60 percent of the savings accrued over the project life. However, if the MCO cannot maintain savings over the subsequent two years, a portion (to be determined) must be refunded to the state.
- Shared savings are to be used to jump start future projects as well as provide profit to the MCO and a long term savings to the state.

Telemedicine

- Work with the major stakeholders to reduce barriers to hospital credentialing for telemedicine providers.
- Remove all limitations on the location of the patient site, allowing any enrolled provider's location to be used so long as it meets all other requirements for equipment, data transmission, and patient site presenter.
- Allow a patient site fee to be paid in both telemedicine and telehealth, and to the extent possible, for all patient site locations.
- Remove the requirement that the patient site presenter must maintain the records created at the distant site unless the distant site provider maintains the records in an EHR format.

- Remove the telehealth requirement that clients must receive an in-person evaluation for the same diagnosis or condition, with the exception of a mental health diagnosis or condition, before receiving service.
- Continue the current requirement that telehealth clients must receive an in-person evaluation by a person who is qualified to determine a continued need for services at least once in 12 months. Extend that to telemedicine.
- Incentivize use of telemedicine through an additional fee amount such as \$5 for professional claims billed with the GT modifier.
- Investigate options for ensuring that reimbursement for dual eligible members is equal to Medicaid.

Quality-Based Payment Advisory Committee Function and Continuation

The HHSC Executive Commissioner to extend the committee without legislative mandate to continue work on quality measures, alternative payment system, and quality projects.

Appendix D: Summary of Literature Review

American College of Obstetricians and Gynecologists, Committee Opinion Number 566, June 2013, [Update on Immunization and Pregnancy: Tetanus, Diphtheria, and Pertussis Vaccination.](#)

The Institute of Medicine, 2001 Consensus report, Crossing the Quality Chasm: A New Health System for the 21st Century.