TEXAS
Health and Human Services

MCO Quality Meeting

April 16, 2021

Agenda

1. Welcome/Introductions
2. Discussion: Potentially Preventable Readmissions
3. Audit of Provider Preventable Conditions: The Other PPCs
4. Discussion: APM contract requirements
5. Wrap-up

TEXAS
Health and Human Services

STAR and STAR+PLUS PPR Trends: Calendar Years 2015-2019

Jimmy Blanton, *Director*, Value Based Initiatives

TEXAS
Health and Human Services

PPR Trends: Discussion Questions

The Annual Report on Quality Measures and Value-Based Payments, published December 1, 2020, noted that **Potentially Preventable Readmissions** have been increasing over the past six years.

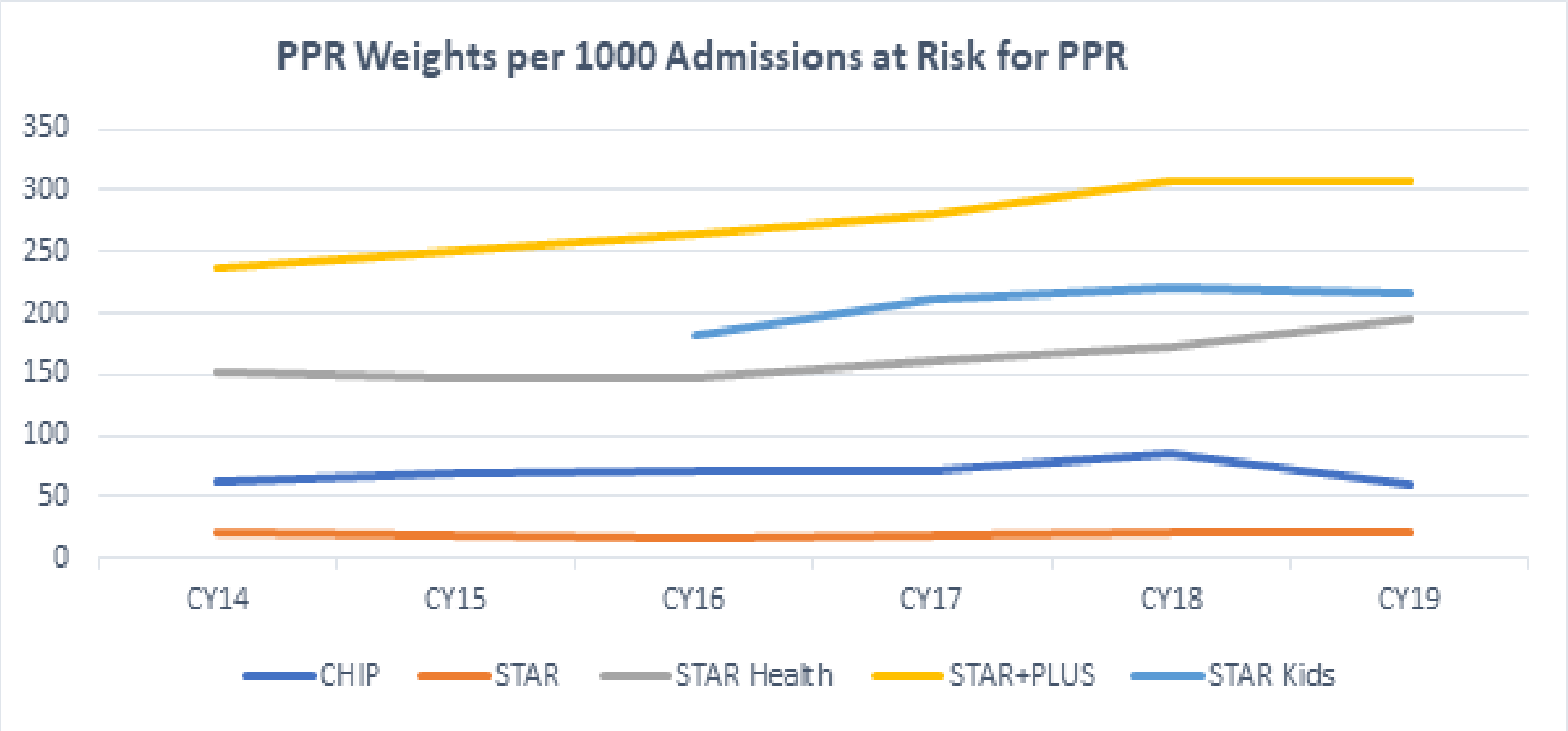
What factors do you believe may help explain these PPR trends?

- At a regional level:
  - Difference between Service Areas;
  - Difference between urban and rural areas (MRSAs);
- Within and across program types:
  - STAR;
  - STAR+PLUS.
- Medical conditions for hospital readmissions.
- Changes in the healthcare system
- Other factors, i.e., related to care coordination, discharge planning, incentives, measurement . . .

What quality improvement steps may be available to address the trend?

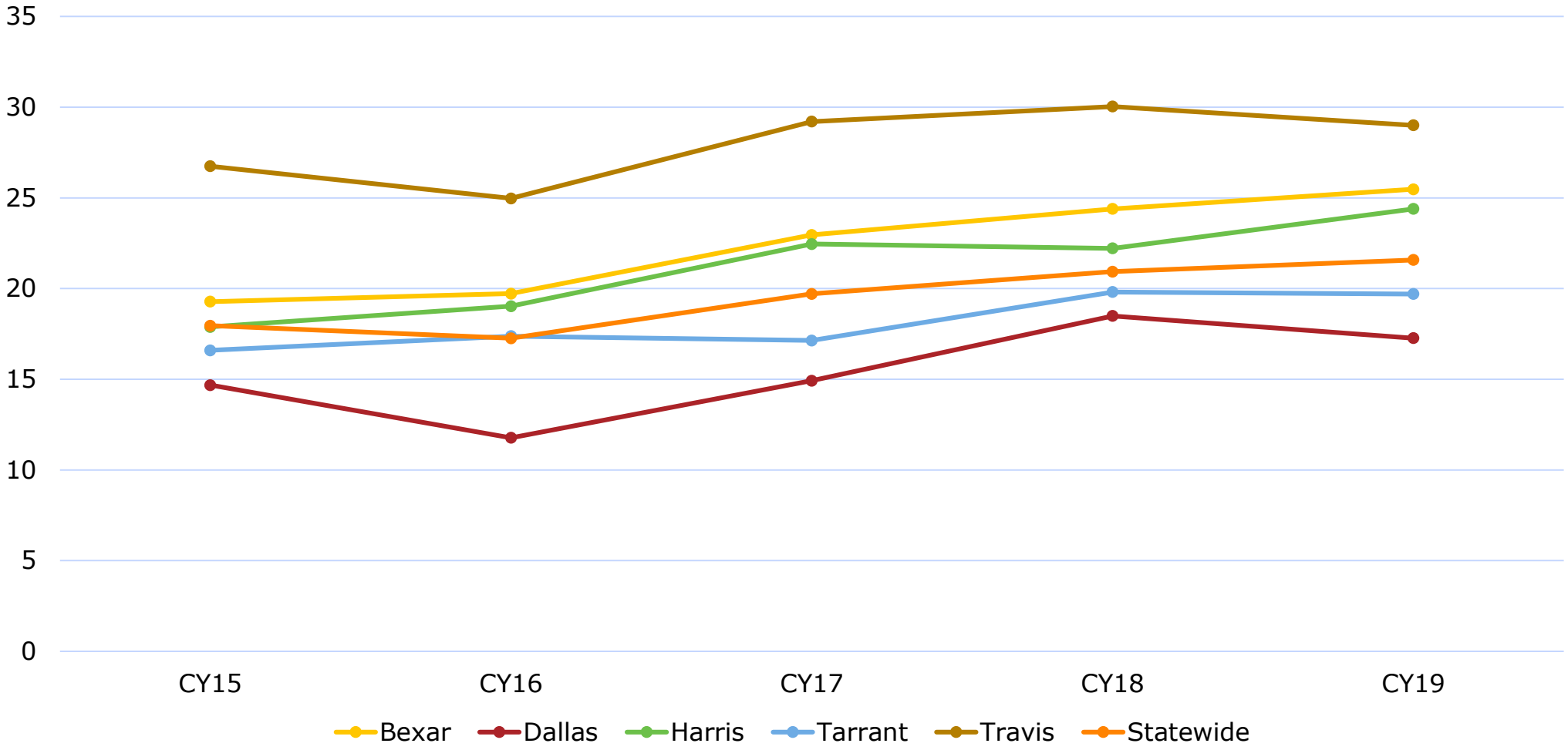
HHSC plans to conduct an in-depth analysis on causes for the increase in PPR rates. Your input will be valuable in guiding the design of that project.

Potentially Preventable Readmissions Have Been Increasing

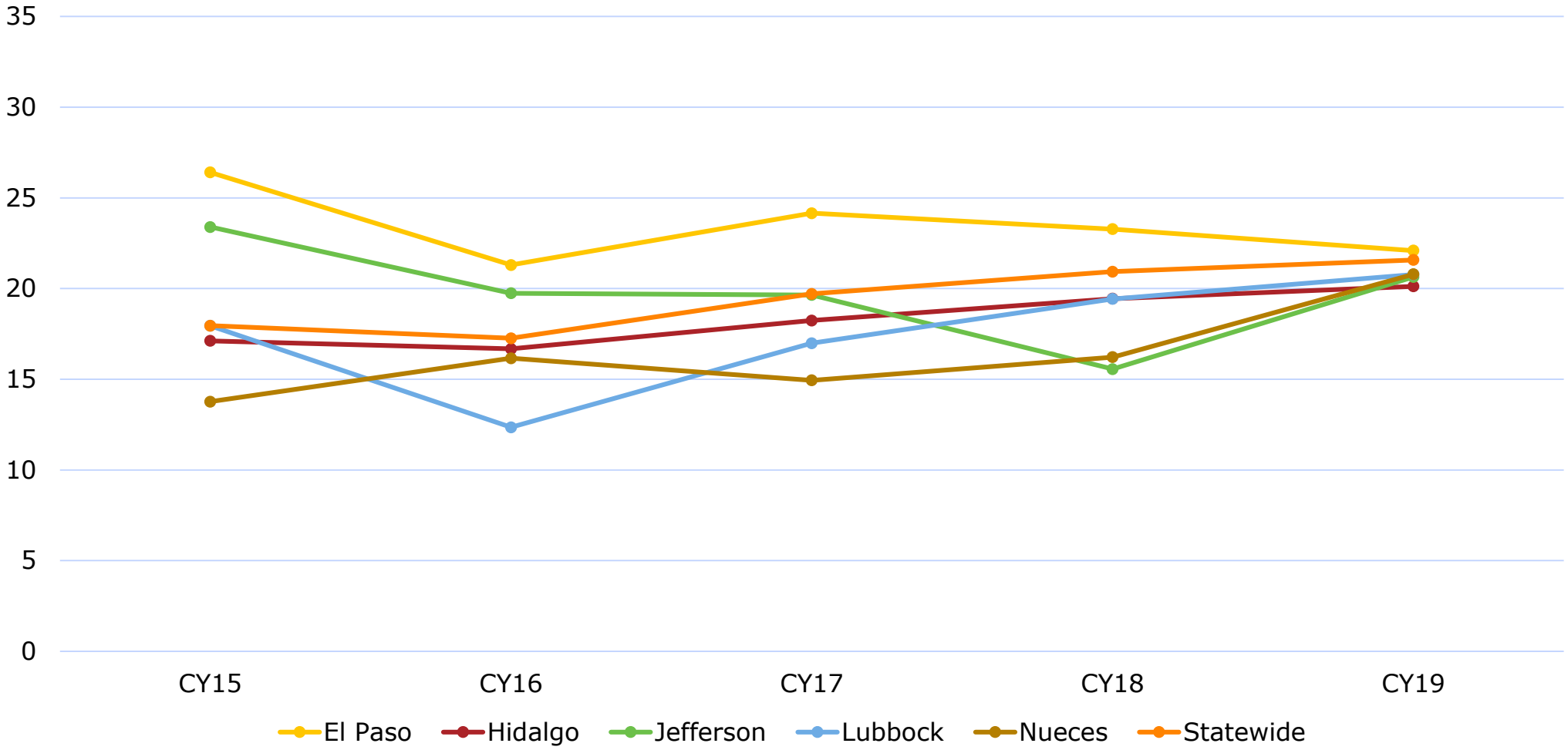


Source: Annual Report on Quality Measures and Value-Based Payments, HHSC, December 2020.

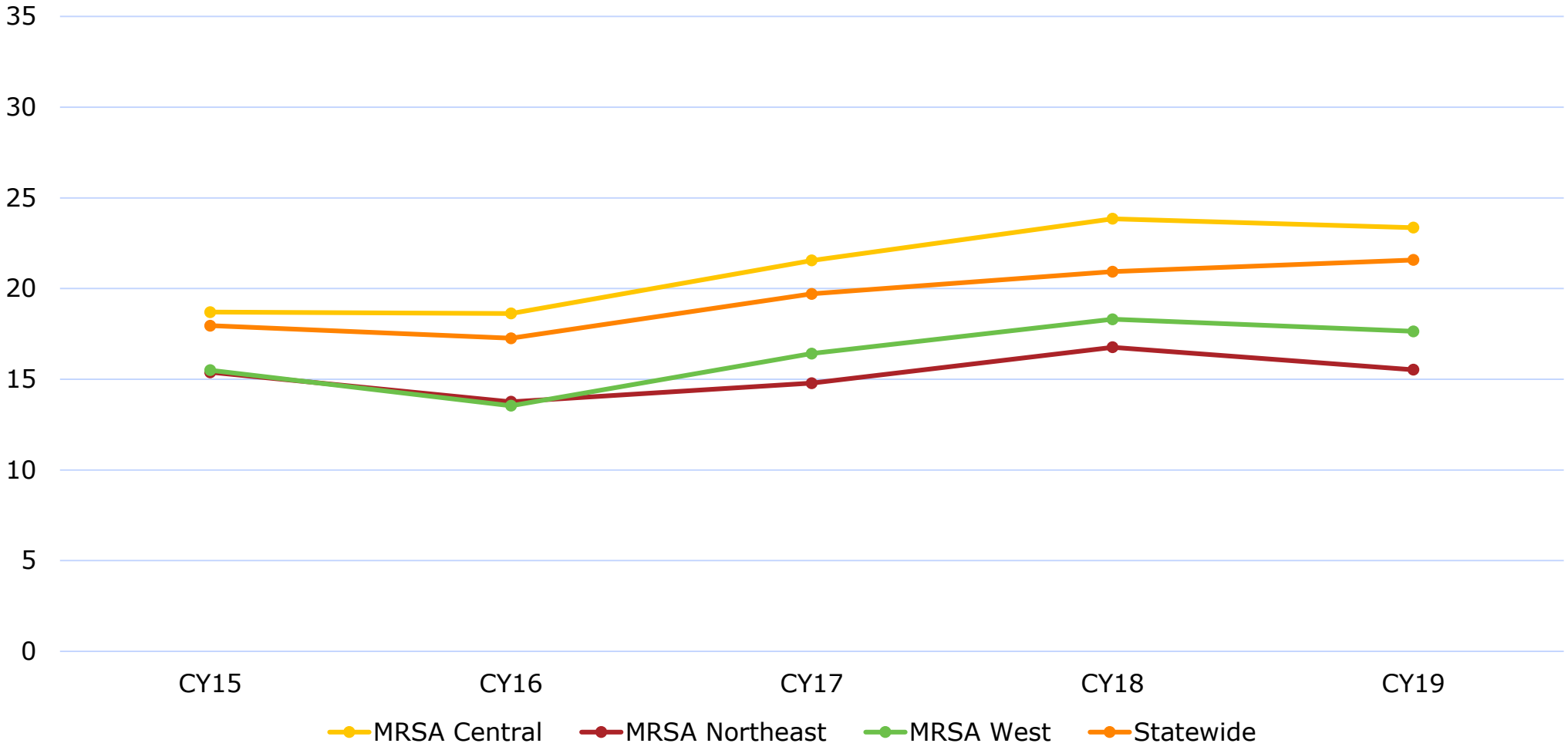
STAR: Actual PPR Weights Per 1,000 Admissions at Risk, by Service Area and Calendar Year (1 of 3)



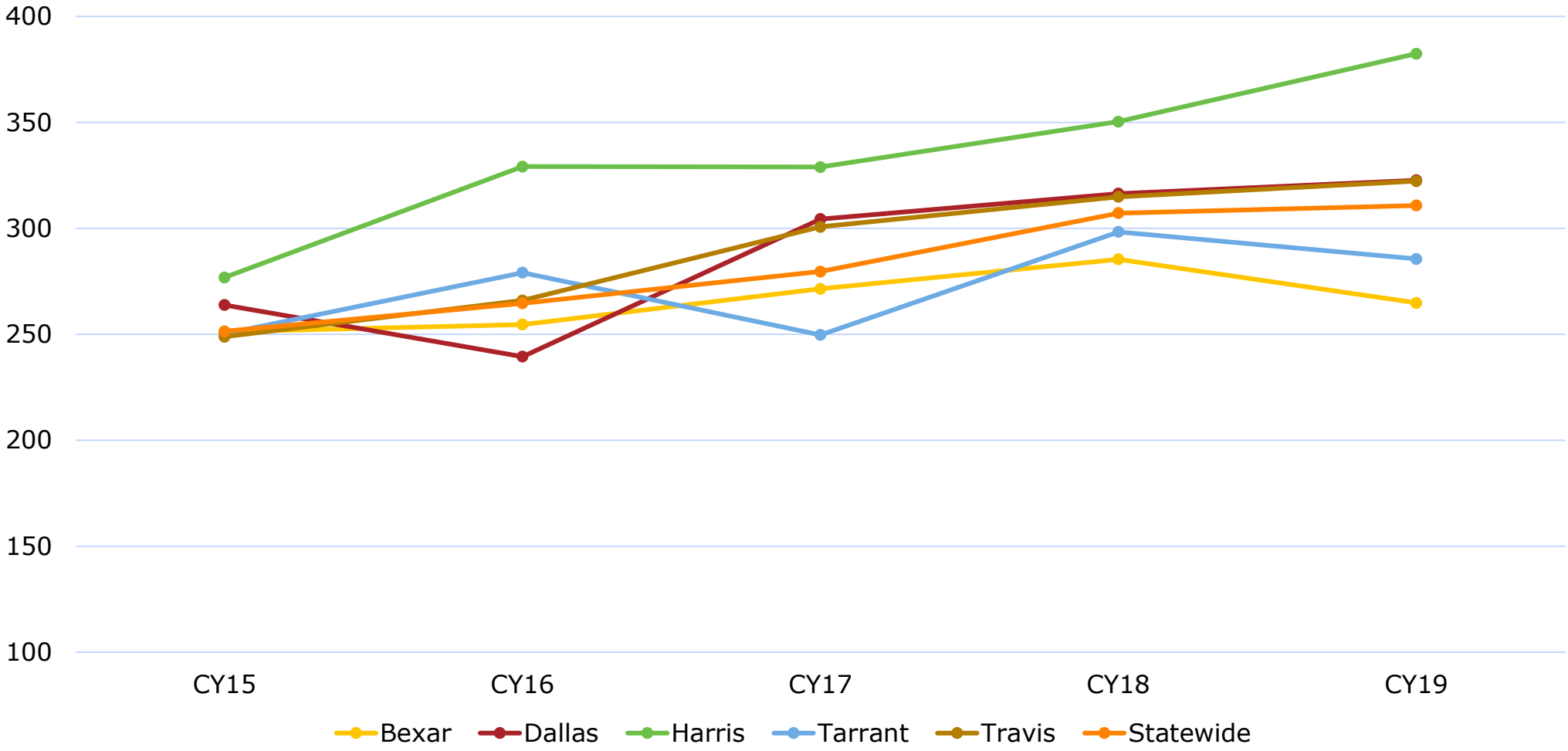
STAR: Actual PPR Weights Per 1,000 Admissions at Risk, by Service Area and Calendar Year (2 of 3)



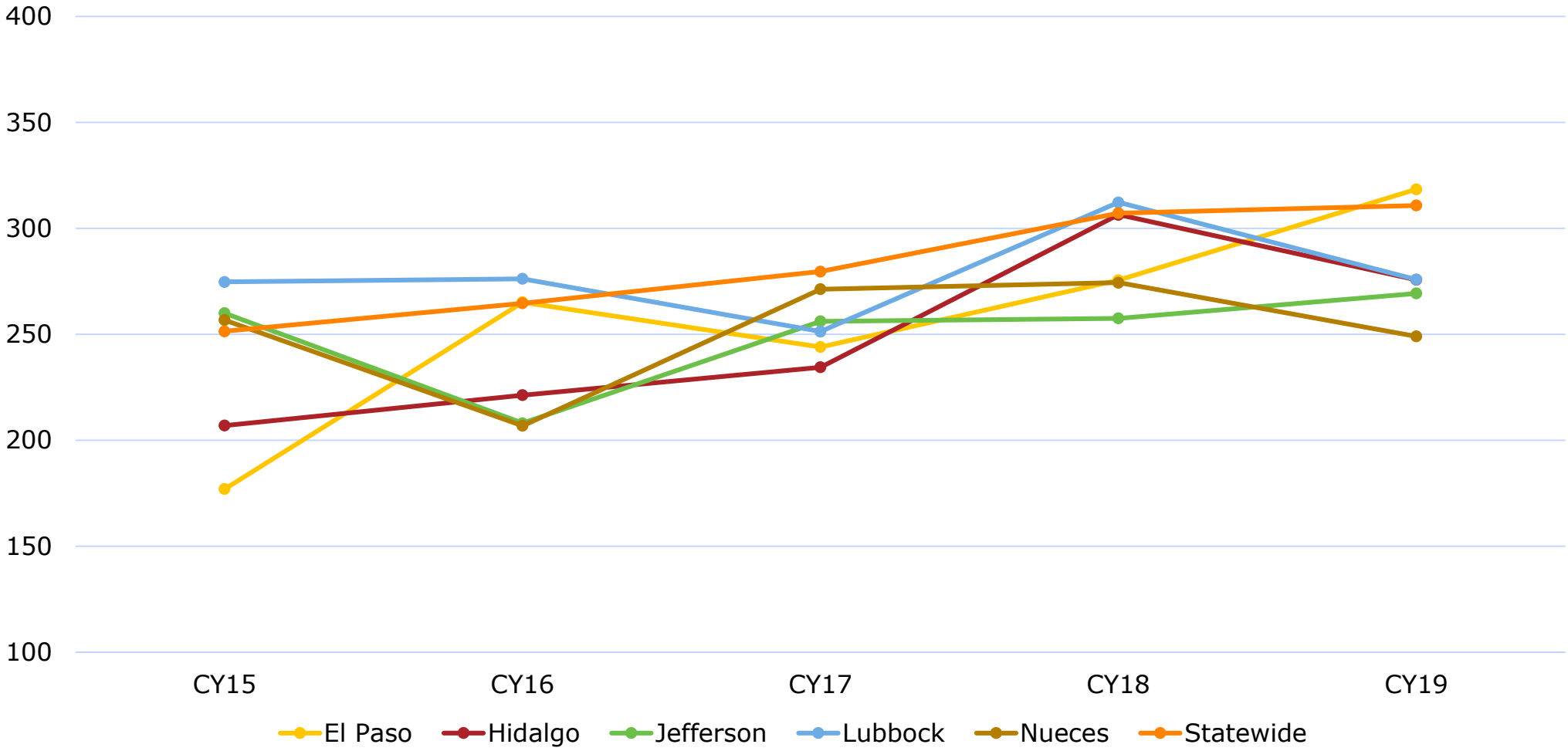
STAR: Actual PPR Weights Per 1,000 Admissions at Risk, by Service Area and Calendar Year (3 of 3)



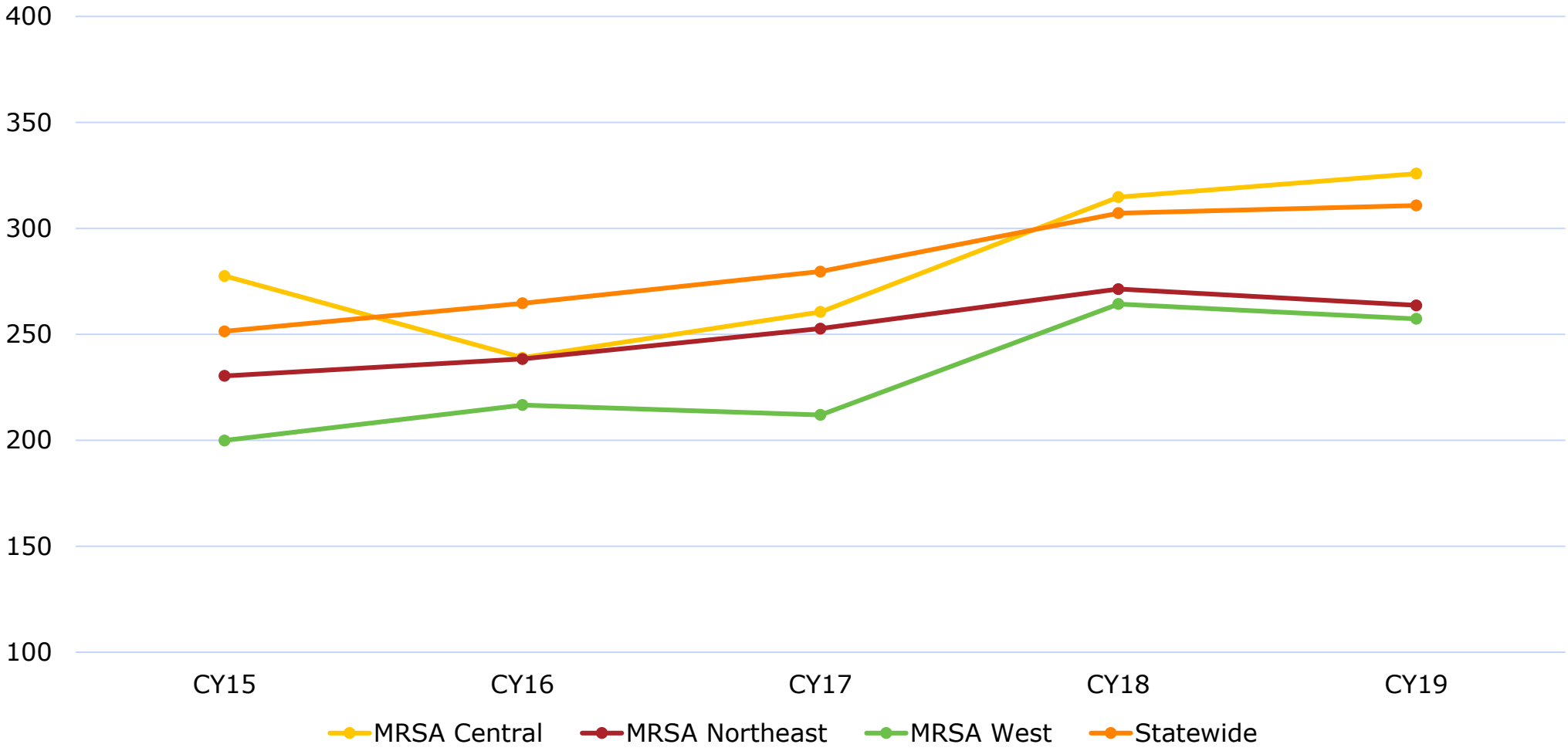
STAR+PLUS: Actual PPR Weights per 1,000 Admissions at Risk, by Service Area and Calendar Year (1 of 3)



STAR+PLUS: Actual PPR Weights per 1,000 Admissions at Risk, by Service Area and Calendar Year (2 of 3)



STAR+PLUS: Actual PPR Weights per 1,000 Admissions at Risk, by Service Area and Calendar Year (3 of 3)



Overall PPR Reason Categories: CY 2015 – 2019, STAR

Row Labels	CY 15	CY 16	CY 17	CY 18	CY 19	Total (CY15-19)
Medical readmission for acute medical condition or complication that may be related to or may have resulted from care during initial admission or in post-discharge period after initial admission	42%	41%	41%	40%	41%	41%
Mental health or substance abuse readmission following an initial admission for a substance abuse or mental health diagnosis	31%	31%	33%	36%	34%	33%
Medical readmission for a continuation or recurrence of the reason for the initial admission, or for a closely related condition	15%	14%	15%	14%	13%	14%
All other readmissions for a chronic problem that may be related to care either during or after the initial admission	5%	5%	5%	5%	5%	5%
Readmission for mental health reasons following an initial admission for a non-mental health, non-substance abuse reason	3%	3%	3%	2%	2%	3%
Ambulatory care sensitive conditions as designated by AHRQ	2%	2%	2%	2%	2%	2%
Readmission for surgical procedure to address a complication that may be related to or may have resulted from care during the initial admission	2%	2%	1%	1%	2%	2%
Readmission for surgical procedure to address a continuation or a recurrence of the problem causing the initial admission	1%	1%	1%	1%	1%	1%
Readmission for a substance abuse diagnosis reason following an initial admission for a non-mental health, non-substance abuse reason	0%	0%	0%	0%	0%	0%
Grand Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

Overall PPR Reason Categories: CY 2015 – 2019, STAR+PLUS

Row Labels	CY 15	CY 16	CY 17	CY 18	CY 19	Total (CY15-19)
Mental health or substance abuse readmission following an initial admission for a substance abuse or mental health diagnosis	33%	37%	41%	40%	39%	38%
Medical readmission for acute medical condition or complication that may be related to or may have resulted from care during initial admission or in post-discharge period after initial admission	25%	22%	21%	22%	22%	22%
Medical readmission for a continuation or recurrence of the reason for the initial admission, or for a closely related condition	21%	19%	18%	18%	18%	19%
All other readmissions for a chronic problem that may be related to care either during or after the initial admission	8%	8%	7%	6%	6%	7%
Ambulatory care sensitive conditions as designated by AHRQ	5%	5%	4%	5%	5%	5%
Readmission for mental health reasons following an initial admission for a non-mental health, non-substance abuse reason	4%	5%	5%	4%	4%	5%
Readmission for surgical procedure to address a complication that may be related to or may have resulted from care during the initial admission	2%	3%	2%	2%	2%	2%
Readmission for a substance abuse diagnosis reason following an initial admission for a non-mental health, non-substance abuse reason	1%	1%	1%	1%	1%	1%
Readmission for surgical procedure to address a continuation or a recurrence of the problem causing the initial admission	1%	1%	1%	1%	1%	1%
Grand Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

Federal OIG Audit of Provider Preventable Conditions: The Other PPCs

Dan Culica, *Senior Program Specialist*, Value Based Initiatives

TEXAS
Health and Human Services

Purpose

Clarification of the differences between:

Provider Preventable Conditions

Requirements developed by the Center for Medicare and Medicaid Services (CMS)

And

Potentially Preventable Complications

Program used by HHSC in Value-Based Purchasing initiatives with MCOs and hospitals.

Comparison

	Provider Preventable Conditions	Potentially Preventable Complications
Authority	Texas Medicaid State Plan, Attachment 4.19-A, page 14 and Attachment 4.19-B, page 42, 42a.	Texas Medicaid State Plan, Appendix 3 to Attachment 4.19-A.
UMCC	8.1.4.8.1 Provider Preventable Conditions	Referenced in: 8.1.4.8.2 Safety-net Hospital Incentives
Definition	Requirements developed by the Center for Medicare and Medicaid Services (CMS)	Program that has been used by HHSC in its Value-Based Purchasing initiative
Description	Set of hospital acquired conditions and serious reportable events for which Section 2702 of the Patient Protection and Affordable Care Act of 2010 prohibits federal payments.	Set of 65 medical conditions identified using 3M Potentially Preventable Complications Grouping Software.
Approach	Uses event-based reductions. MCOs must identify Present on Admission (POA) indicators as required in UMCM Chapter 2.0, "Claims Manual," and MCOs must reduce, deny, or recoup payments for Provider Preventable Conditions that were not POA.	Is rate-based and payment reductions are applied to hospitals with high risk adjusted rates of PPC in aggregate.

Comparison (cont.)

	Provider Preventable Conditions	Potentially Preventable Complications
Process	As a condition of payment to hospital Providers, MCOs must require Providers to report Provider-Preventable Conditions on Institutional Claims using appropriate POA indicators. MCOs must include all identified POA indicators on Encounter Data submitted to the State. Upon request by the State, MCOs must report the amount of Provider payments denied, reduced, or recouped from an individual Provider for the requested service dates for provider-preventable conditions that were not POA.	HHSC also provides reports to the hospitals regarding their performance on PPC. HHSC provide a list, annually, to the MCO that identifies hospitals with poor performance on the PPCs based on HHSC's methodology for these disincentive determinations. This list will contain the hospital's NPI, name, and amount of payment reduction. The MCO may pass down payment reductions to the hospitals identified by HHSC to encourage improved performance. HHSC shall build in reductions to the MCO capitation payments by the amounts of these hospital disincentives.

Comparison (cont.)

	Provider Preventable Conditions	Potentially Preventable Complications
Methodology	The Texas Medicaid Management Information system requires POA indicators to be submitted with each diagnosis code on inpatient hospital claims. Those POA indicators will guide the payment of the claim. 1. The claim is initially sent to the APR-DRG grouper with all diagnosis codes and a "Non-POA" APR-DRG is assigned to the claim. 2. If the claim is found to have a diagnosis that was not present at the time of admission based on the POA indicator, that diagnosis is disallowed and the claim is re-grouped. The process will downgrade the assigned APR-DRG to a lesser APR-DRG, which will result in a smaller payment. 3. Where DRGs are not applicable, claims with any Other Provider Preventable Conditions identified will not be paid.	Using inpatient claims during the reporting time period and HHSC-designated software and methodology, HHSC calculates an actual PPC rate and an expected PPC rate for each hospital included in the analysis. HHSC calculates then the actual-to-expected ratio using relative weights of PPCs based on a combination of national and Texas specific weights. The Actual-to-Expected Ratio is rounded to two decimal places and used to determine reimbursement adjustments.

Mapping Provider Preventable Conditions and Potentially Preventable Complications

Hospital Acquired Conditions (HAC)	Potentially Preventable Complications (PPC)
HAC 01 Foreign Object Retained After Surgery	PPC 45 Post-procedure Foreign Bodies
HAC 02 Air Embolism	PPC 48 Other Complications of Medical Care
HAC 03 Blood Incompatibility	PPC 32 Transfusion Incompatibility Reaction
HAC 04 Stage III and IV Pressure Ulcers	PPC 31 Pressure Ulcer
HAC 05 Falls and Trauma:	PPC 28 In-Hospital Trauma and Fractures
HAC 06 Catheter-Associated Urinary Tract Infection (UTI)	PPC 66 Catheter-Related Urinary Tract Infection PPC 65 Urinary Tract Infection
HAC 07 Vascular Catheter-Associated Infection	PPC 54 Infections due to Central Venous Catheters
HAC 09 Manifestations of Poor Glycemic Control	PPC 26 Diabetic Ketoacidosis & Coma
Surgical Site Infection Following:	
HAC 08 Surgical Site Infection- Mediastinitis after Coronary Bypass Graft (CABG)	PPC 05 Pneumonia & Other Lung Infections
HAC 11 Surgical Site Infection - Bariatric Surgery	PPC 38 Post-Operative Wound Infection & Deep Wound Disruption with Procedure
HAC 12 Surgical Site Infection - Certain Orthopedic Procedure of Spine, Shoulder and Elbow	PPC 38 Post-Operative Wound Infection & Deep Wound Disruption with Procedure
HAC 10 Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) Following Total Knee Replacement or Hip Replacement with pediatric and obstetric exceptions	PPC 16 Venous Thrombosis

Next Steps for PPCs and PPCs

- Communicating with MCOs to ensure that differences in requirements between the two programs are understood.
- Clarifying the description of the two program types in UMCC.
- Providing instructions to establish the process in UMCM.

TEXAS
Health and Human Services

Medicaid Alternative Payment Models Initiative: Beyond 2021

TEXAS
Health and Human Services

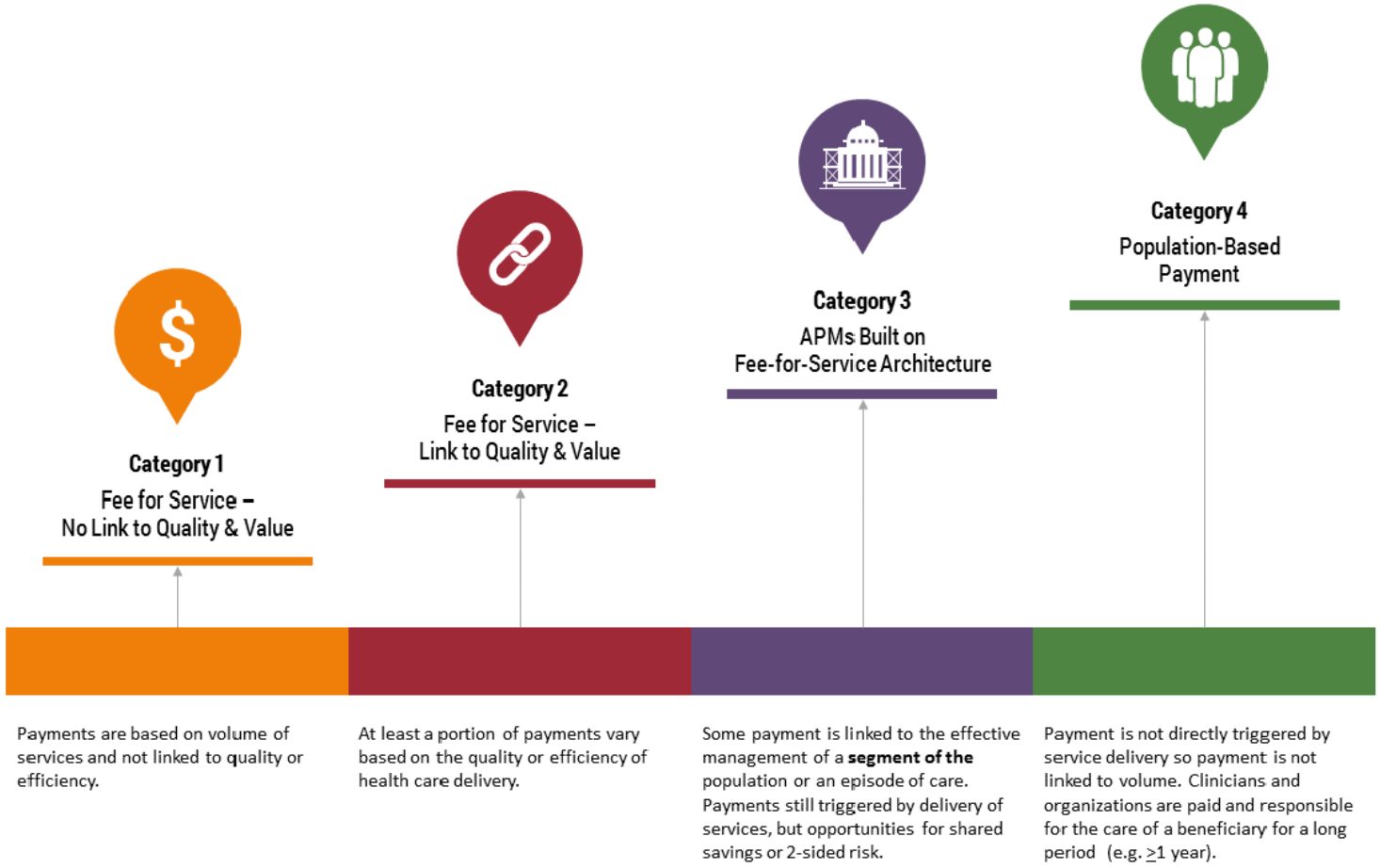
Jimmy Blanton, Director, Value Based Initiatives

Andy Vasquez, Deputy Associate Commissioner, Quality and Program Improvement

Transformation of Medicaid from a volume-based to a value-based program is supported by contract provisions, first effective for 2018, requiring Medicaid managed care organizations (MCOs) to achieve targets for alternative payment models (APMs) with their providers (Table 1). Year 2021 is the final year of the initial targets for all programs, except STAR Kids.

Table 1 - The annual MCO targets established by HHSC by Calendar Year		
HHSC will require that MCOs increase their total APM and risk based APM ratios according to the following schedule*		
Period	**Minimum Overall APM Ratio**	**Minimum Risk-Based APM Ratio**
Calendar Year 1	>= 25%	>= 10%
Calendar Year 2	Year 1 Overall APM Ratio +25%	Year 1 Risk-Based APM Ratio +25%
Calendar Year 3	Year 2 Overall APM % + 25%	Year 2 Risk-Based APM % + 25%
Calendar Year 4	>= 50%	>= 25%
* An MCO entering a new program or a new service area, will begin on Calendar Year 1 of the targets as of the first day of its first calendar year in the program.		

Alternative Payment Model (APM) Framework



The CMS Framework assigns payments from payers to health care providers to four Categories, such that movement from Category 1 to Category 4 involves increasing provider accountability for both quality and total cost of care, with a greater focus on population health management (as opposed to payment for specific services).

** Source: hcp-lan.org*

Texas Medicaid intends to continue to encourage APMs, as recommended by the Health Care Payment Learning and Action Network (HCPLAN), and is working to update contract language to advance the program into the future. We are seeking your input.

WHAT ARE THE BEST APPROACHES FOR CONTINUING CONTRACT TARGETS THROUGH 2025?

- Incrementally increase current targets to higher levels for both overall and risk-based APMs.
- Increase risk-based targets according to HCPLAN established goal (50% percent of APMs reflect two-sided risk by 2025).
- Include the 3A HCPLAN category as part of the risk-based targets.
- Establish minimum requirements or contract targets on the percentage of dollars available as incentives to providers or held at risk through APMs.

SHOULD HHSC FOCUS ON MORE GRANULAR TARGETS AND DATA COLLECTION?

- Collect data to identify models in rural regions.
- Require reporting on APMs related to social determinants of health (SDOH).
- Establish sector-specific targets for services, such as home-health and/or behavioral health.

HOW CAN SUPPORTING CONTRACT REQUIREMENTS BE MADE MORE ACTIONABLE/MEASURABLE?

- Current contract language includes the following requirements (please consider how HHSC and MCOs can work to ensure these requirements are being implemented):
- MCOs must implement processes to share data and performance reports with providers on a regular basis.
- MCOs shall dedicate sufficient resources for provider outreach and negotiation, assistance with data and/or report interpretation, and other activities to support provider improvement.
- To the extent possible, MCOs within service areas should collaborate on the development of standardized formats for performance reports and data requested from providers.
- MCOs must dedicate resources to evaluate the impact of APMs on utilization, quality and cost, as well as return on investment.
- For STAR, STAR+PLUS, CHIP, see Uniform Managed Care Contract, sec. 8.1.7.8.2 *MCO Alternative Payment Models with Providers*. Substantively similar provisions exist as sec. 8.1.7.9.2 in the STAR Health Managed Care Contract and the STAR Kids Managed Care Contract

OTHER CHANGES IN CONTRACT LANGUAGE

- Currently, MCOs can gain an exception to contract remedies related to the APM provisions if they demonstrate high performance on PPVs and PPAs. Please consider other options for establishing these exceptions, for example:
- Revise exceptions to the APM targets to include additional outcomes/quality metrics.
- Provide additional exceptions through which MCOs can demonstrate progress toward initiative objectives, such as implementing certain types of quality improvement projects or SDOH initiatives.

TEXAS Health and Human Services

Questions?

For more information contact:

Jimmy Blanton, Director

Office of Value-Based Initiatives

Jimmy.Blanton@HHS.Texas.gov

Visit the HHSC Medicaid/CHIP Quality & Efficiency Improvement Webpage:

https://hhs.texas.gov/about-hhs/process-improvement/improving-services-texans/medicaid-chip-quality-efficiency-improvement

TEXAS
Health and Human Services

Thank you

Texas Health and Human Services Commission
Medicaid and CHIP Services Department
Quality and Program Improvement
Office of Value-Based Initiatives
HPCS_UMCC_Provisions@hhsc.state.tx.us

TEXAS
Health and Human Services

Wrap-up

Next meetings:

- June 15, 2021
- October 19, 2021