Texas Managed Care Quality Strategy

Texas Health and Human Services Commission

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Managed Care Quality Strategy

Since 1991, the Texas Health and Human Services Commission (HHSC) has overseen and coordinated the planning and delivery of health and human service programs in Texas. HHSC was established in accordance with Texas Government Code Chapter 531 and is responsible for ensuring the delivery of services in a manner that: uses an integrated system to determine client eligibility; maximizes the use of federal, state, and local funds; and emphasizes coordination, flexibility, and decision-making at the local level. HHSC uses its Managed Care Quality Strategy in accordance with Title 42, Code of Federal Regulations, Section 438.340 to assess and improve the quality of health care and services provided through the managed care system, prioritizing the goals outlined in Table 1.

Table 1: Managed Care Quality Strategy Goals

Managed Care Quality Goals
Promoting optimal health for Texans at every stage of life through prevention and by engaging individuals, families, communities, and the healthcare system to address root causes of poor health
Strengthening person and family engagement as partners in their care to enhance respect for individual's values, preferences, and expressed needs
Keeping patients free from harm by contributing to a safer delivery system that limits human error
Providing the right care in the right place at the right time to ensure people can easily navigate the health system to receive timely services in the least intensive or restrictive setting appropriate

Managed Care Quality Goals
Promoting effective practices for people with chronic, complex, and serious conditions to improve people's quality of life and independence, reduce mortality rates, and better manage the leading drivers of health care costs
Attracting and retaining high-performing Medicaid providers, including medical, behavioral health, dental, and long-term services and supports providers to participate in team based, collaborative, and high-value care

HHSC policy making and program activities related to healthcare value will align with these goals. See Attachment C for how HHSC's quality initiatives, reports, and the external quality review organization (EQRO) activities align with and work toward achieving the goals set forth in Table 1. Transforming Medicaid and the Children's Health Insurance Program (CHIP) into a value-based system will be a long-term endeavor involving many decisions and coordinated actions by HHSC programs and stakeholders. Ongoing efforts will support system-wide change to achieve better care and health for individuals and populations while managing healthcare costs.

Managed Care Programs

There are multiple Texas Medicaid and CHIP managed care programs serving different populations. For a map of MCOs by program and service area, see the HHSC website. For purposes of this quality strategy, when MCOs are mentioned, the term also includes dental maintenance organizations (DMOs), unless otherwise specified.

All members in Medicaid managed care are assigned a primary care provider (PCP) and receive the following services:

- Regular checkups at the doctor and dentist[1]
- Prescription drugs and vaccines
- Hospital care and services
- X-rays and lab tests
- Vision and hearing care
- Access to medical specialists and mental health care
- Treatment of special health needs and pre-existing conditions
- A 24/7 nurse hotline for caregivers and caseworkers

STAR

State of Texas Access Reform (STAR) is the largest Medicaid managed care program and serves low-income families, children, and pregnant women, as well as some former foster care youth. The STAR service array includes primary, acute care, behavioral health care, and pharmacy services.

On September 1, 2017, the Texas Department of Family and Protective Services' (DFPS) Adoption Assistance (AA) and Permanency Care Assistance (PCA) programs transitioned to managed care. Members in AA and PCA not receiving Supplemental Security Income (SSI) or SSI-related Medicaid continue to receive the same Medicaid benefits as they did previously, through the STAR program.

STAR+PLUS

STAR+PLUS provides coverage for primary, acute, behavioral health care, pharmacy services, and long-term services and supports (LTSS) for adults who have a disability or who are age 65 and older. Examples of LTSS may include attendant care, day activity and health services, or nursing facility care. In addition, STAR+PLUS is distinguished by a comprehensive

[1] Only Medicaid managed care members under 21 are eligible to receive state plan dental services.

service coordination benefit, especially for members with complex medical or behavioral health needs. Service coordinators conduct needs assessments, coordinate care, and ensure that members' health and safety needs are met. On September 1, 2017, most women in the Medicaid Breast and Cervical Cancer (MBCC) program began receiving services through STAR+PLUS. These members previously received services through the fee-for-service delivery model.

STAR+PLUS also includes the STAR+PLUS Home and Community Based Services (HCBS) program, a waiver program designed to allow eligible individuals who qualify for a nursing facility (NF) level of care to receive LTSS in the community rather than an institution.

Dual Demonstration

The Dual Eligible Integrated Care Demonstration Project, or Dual Demonstration, is a fully integrated managed care model for individuals age 21 and older who are dually eligible for Medicare and Medicaid and required to be enrolled in the STAR+PLUS program. This capitated model involves a three-party contract between an MCO with an existing STAR+PLUS contract, HHSC, and the Centers for Medicare & Medicaid Services (CMS) for the provision of the full array of Medicaid and Medicare services. The Dual Demonstration is testing an innovative payment and service delivery model to alleviate fragmentation and improve coordination of services, enhance quality of care, and reduce costs for both the state and the federal governments. Under this initiative, the MCO is responsible for the full array of Medicare and Medicaid covered services, including acute care and LTSS. Eligible clients are passively enrolled into the program if they do not actively opt in and can opt-out monthly. The demonstration does not include certain clients who reside in an intermediate care facility for individuals with intellectual disabilities (ICF/IID) or individuals enrolled in a 1915(c)waiver program for individuals with intellectual or developmental disabilities. The demonstration operates in Bexar, Dallas, El Paso, Harris, Hidalgo, and Tarrant counties.

STAR Health

STAR Health is a Medicaid managed care program for children in state conservatorship. These children are a high-risk population with greater medical and behavioral health care needs than most children in Medicaid, and their changing circumstances make continuity of care an ongoing challenge. STAR Health serves children as soon as they enter state conservatorship and continues to serve them in two transition categories:

- Young adults up to 22 years of age with voluntary foster care placement agreements
- Young adults below 21 years of age who were previously in foster care and continue to receive Medicaid services

The Medically Dependent Children Program (MDCP) is a 1915(c) waiver that provides supports to families and primary caregivers of children and youth under age 21 who meet a nursing facility level of care who wish to live in the community. MDCP services are delivered through the STAR Health model to eligible members.

STAR Health is the only program administered under a contract with a single statewide MCO.

STAR Kids

STAR Kids provides acute care and LTSS to children and young adults who are age 20 and younger and have disabilities. LTSS includes private duty nursing and personal care services. STAR Kids was implemented statewide on November 1, 2016. As in STAR Health, MDCP is also delivered in the STAR Kids model and provides supports to families and primary caregivers of members in STAR Kids under age 21 who meet a nursing facility or hospital level of care and live in the community. In addition to existing Medicaid benefits, all STAR Kids members receive comprehensive, holistic, person-centered assessment of member and family needs and preferences using the STAR Kids Screening and Assessment Instrument (SK-SAI), an individual service plan, and comprehensive transition planning from age 15 to 21.

Dental

Most Texas Medicaid members under age 21 receive dental benefits through a managed care model as part of the Children's Medicaid Dental Services (CMDS) program. Members who receive dental services through a Medicaid managed care dental plan are required to select a primary dentist who serves as the client's dental home and is responsible for providing routine care, maintaining the continuity of patient care, and initiating referrals for specialty care.

CHIP

CHIP provides primary and preventive health care to: low-income, uninsured children through age 18 who do not qualify for Medicaid and have household incomes up to 201 percent of the Federal Poverty Level (FPL); and to unborn children with household incomes up to 202 percent of the FPL. CHIP covers children in families who have too high of an income to qualify for Medicaid but cannot afford to buy private insurance.

Basis for Managed Care Quality Strategy

In accordance with Title 42, CFR, Section 438.340, the state must implement a quality strategy for assessing and improving the quality of healthcare and services provided through managed care. The state must review and update the quality strategy no less than every three years. The draft updated Quality Strategy is made available for public comment, including obtaining input from the Medical Care Advisory Committee and consulting with tribes in accordance with the state's tribal consultation policy.

The effectiveness of the quality strategy will be evaluated annually as a part of the EQRO's Summary of Activities Report and made available on HHSC's website. Updates to the quality strategy will, as appropriate, take into

consideration recommendations made by the EQRO. The updated quality strategy will be submitted to CMS whenever significant changes are made to it. Significant changes include:

- Adding new populations to the managed care programs
- Expanding managed care programs to new parts of the state
- Carving new services into the managed care programs

The Managed Care Quality Strategy encompasses the preceding programs and describes the EQRO, the main HHSC departments and advisory committees identified below, and their role in the quality strategy.

External Quality Review Organization

The federal Balanced Budget Act of 1997 requires state Medicaid agencies to provide an annual external independent review of quality outcomes, timeliness of services, and access to services provided by Medicaid and CHIP MCOs and prepaid ambulatory health plans. To comply with this requirement and to provide HHSC with data analysis and information to effectively manage its Medicaid managed care programs, HHSC contracts with an EQRO for Medicaid managed care. Using information and analysis provided by the EQRO, HHSC evaluates, assesses, monitors, guides, and directs the Texas Medicaid managed care programs and organizations. Since 2002, Texas has contracted with the University of Florida's Institute for Child Health Policy (ICHP) to conduct EQRO activities.

ICHP performs the following three CMS-required functions:

- Validation of performance improvement projects
- Validation of performance measures
- A review to determine MCO compliance with certain federal Medicaid managed care regulations

ICHP also conducts focused quality of care studies, performs encounter data validation and certification, assesses member satisfaction, assists with rate setting activities, and completes other reports and data analysis as requested by HHSC. The EQRO develops studies, surveys, or other analytical

approaches to assess quality and outcomes of enrollee's care and to identify opportunities for MCO improvement. To facilitate these activities, HHSC ensures that ICHP has access to enrollment, health care claims and encounter, pharmacy, and immunization registry data. The MCOs collaborate with ICHP to ensure medical records are available for focused clinical reviews. In addition to these activities, ICHP collects and analyzes data on potentially preventable events (PPEs) for the Delivery System Reform Incentive Payment (DSRIP) program.

Health and Human Services Commission

Medicaid and CHIP Services Department

The Medicaid and CHIP Services (MCS) Department serves as the primary HHSC department performing quality-related activities for the Medicaid and CHIP programs. MCS is led by the State Medicaid Director. MCS develops and oversees the Texas Medicaid and CHIP policies that determine client services while complying with federal program mandates. MCS develops benefit policies that apply to both fee-for-service and managed care and manages Medicaid and CHIP state plan and waiver programs.

Other HHSC Departments

MCS works with other HHSC departments such as Access and Eligibility Services, Actuarial Analysis, Provider Finance, and the Center for Analytics and Decision Support. Each of these departments informs and assists MCS in quality-related Medicaid and CHIP services.

Advisory Committees

Advisory committees such as the Intellectual and Developmental Disabilities System Redesign Committee, Medical Care Advisory Committee, Policy Council for Children and Families, STAR Kids Managed Care Advisory Committee, State Medicaid Managed Care Advisory Committee, and Value-Based Payment and Quality Improvement Advisory Committee provide HHSC and the Texas Legislature with recommendations on quality-related activities.

Evidence-Based Care and Quality Measurement

Measurement

Texas relies on a combination of established sets of measures and state-developed measures that are validated by the EQRO in its quality programs. This approach allows the state to collect data comparable to nationally recognized benchmarks and ensure validity and reliability in collection and analysis of data that is of interest to Texas. Measure sets used by Texas include:

- National Committee for Quality Assurance Healthcare Effectiveness Data and Information Set (HEDIS®)
- Agency for Healthcare Research and Quality Pediatric Quality Indicators /Prevention Quality Indicators
- 3M Software for Potentially Preventable Events
- Consumer Assessment of Healthcare Providers & Systems (CAHPS®) Surveys
- National Core Indicators-Aging and Disabilities (NCI-AD)
- CMS Core Sets of Adult and Child Health Care Quality Measures

Demographics

The state obtains race, ethnicity, and information about primary language spoken by a member from the enrollment form completed by that member. Applications are processed through the Texas Integrated Eligibility Redesign System (TIERS) and routed to a third-party enrollment broker. The enrollment broker transmits a file containing the race/ethnicity and primary language of each enrollee to the MCO monthly.

Health Disparities

The EQRO evaluates health disparities in several deliverables incorporating quality measures that include demographic data:

- Annual quality of care administrative and hybrid HEDIS and AHRQ measures data tables disparities
- Annual MCO level reports for potentially preventable hospital admissions (PPAs), potentially preventable hospital readmissions (PPRs), potentially preventable emergency room visits (PPVs), potentially preventable complications (PPCs) and potentially preventable services (PPSs)
- Annual MCO report cards surveys

Many of the key quality measures are analyzed by additional demographic categories, including sex, race/ethnicity, and health status. This information has been applied to implement initiatives to reduce health disparities such as the development of performance improvement projects. Results are used to tailor and target initiatives to specific populations such as populations that disproportionately experience negative health outcomes (e.g., Black pregnant women). Stratifying results by demographic groups has also allowed us to conduct research to better understand how social determinants of health (SDOH) drive health disparities in populations that experience persistent inequities in health outcomes. For example, a recent study examined SDOH in relation to childhood asthma, type 2 diabetes, and ADHD rates. A clear link was identified between race, poverty and rates of asthma. Interestingly, diabetes prevalence was associated with neighborhoods for all demographic groups except non-Hispanic white children. The Nueces service area had the highest rates of asthma, type 2 diabetes, and ADHD across every demographic group. This level of data helps inform more effective interventions and quality initiatives. Additionally, as part of the DSRIP transition plan, HHSC is researching SDOH factors that impact Medicaid clients and will be developing recommendations to address identified issues.

Managed Long Term Services and Supports (MLTSS)

Disability also is one of the factors related to health disparities. The state collects several disability-related indicators including:

- Medicaid eligibility determined by the Social Security Administration (SSI or SSI-related)
- Medicaid eligibility determined by Medicaid for the Elderly and People with Disabilities (MEPD) for individuals who qualify for a waiver program as medical assistance only or participation in a waiver program
- STAR+PLUS or STAR Kids enrollment
- LTSS needs or as indicated by participation in an HCBS program, claims history, or MCO assessment

Texas utilizes quality measures to monitor the MCOs that provide MLTSS. MLTSS in Texas Medicaid is newer than other programs, as STAR+PLUS expansion, nursing facility carve in, the Dual Demonstration, and STAR Kids implementation have all occurred in the past few years. Because of this, Texas Medicaid continues to work on incorporating more MLTSS quality measures into the programs.

Texas has relied on the NCI surveys and the following state-developed measures which are tracked and reported on the Texas Healthcare Learning Collaborative (THLC) Portal:

- Utilization of Consumer Directed Services (CDS) option for STAR+PLUS and STAR Kids

- Nursing Facility (NF) measures for STAR+PLUS and Dual Demonstration Programs
  - Rate of admissions to nursing facility from the community pre – and post- carve in
  - Rate of admissions to nursing facility from hospital pre- vs. post - carve in
  - Number of individuals who went from community to hospital to nursing facility and remained in nursing facility
  - Number of individuals who transitioned from nursing facility to the community who were readmitted to the nursing facility (within three months)

In 2018, CMS issued specifications for four new HEDIS MLTSS s measures:

- LTSS Comprehensive Assessment and Update (LTSS-CAU)
- LTSS Comprehensive Care Plan and Update (LTSS-CPU)
- LTSS Reassessment/Care Plan Update After Inpatient Discharge (LTSS-RAC)
- LTSS Shared Care Plan with Primary Care Practitioner (LTSS-SCP)

HHSC is collaborating with the EQRO to implement these measures for STAR+PLUS.

Texas is also leveraging the SK-SAI data for performance measurement to evaluate key elements of MLTSS quality among STAR Kids MCOs.

Quality Data Reporting

The analysis and dissemination of quality data is primarily conducted using MCO-generated data and reports, and EQRO data analysis and summary reports. Quality data is disseminated to the public, including policymakers, through the Texas Healthcare Learning Collaborative (THLC) Portal (www.thlcportal.com). Information about MCO performance on quality

measures is disseminated to members through MCO report cards, which are included in enrollment packets and on the HHSC website. For additional information on the THLC portal, see the section below in data sharing and transparency.

Encounter Data Requirements

MCOs are required to submit complete and accurate encounter data for all covered services, including value-added services, at least monthly to a data warehouse. The data file must include all encounter data and encounter data adjustments processed by the MCO no later than the 30th calendar day after the last day of the month in which the claim was adjudicated. The Texas Medicaid claims administrator contractor developed and maintains the data warehouse and is responsible for collecting, editing, and storing MCO encounter data.

HHSC contracts with the EQRO to validate and certify the accuracy and completeness of MCO encounter data. To validate encounter data, the EQRO requests medical records for a sample of encounters for each MCO and compares the information contained in the medical record to the encounter data. The data certification reports support rate-setting activities and provide information relating to the quality, completeness, and accuracy of the MCO encounter data. Certification reports include a quality assessment analysis to assure data quality within agreed standards for accuracy, a summary of amounts paid by service type and month of service, and a comparison of paid amounts reported in the encounter data to financial statistical reports provided by the MCO.

Encounter data must follow the format and data elements as described in the Health Insurance Portability and Accountability Act-compliant 837 Companion Guides and Encounter Submission Guidelines. HHSC specifies the method of transmission, the submission schedule, and any other requirements in the Uniform Managed Care Manual (UMCM). Original records must be made available for inspection by HHSC for validation purposes. Encounter data that does not meet quality standards must be corrected and returned within a time period specified by HHSC.

MCO Monitoring

MCOs report specific data to MCS each fiscal quarter by program and service area. MCS analyzes the deliverables and creates summary quarterly reports. These reports capture performance data on the following elements[2]:

- Enrollment
- Provider network
- Member hotline, behavioral health hotline, and provider hotline performance
- Member appeals and member and provider complaints
- Claims processing
- Out-of-network utilization
- Encounter data reconciliation

While the MCO is the initial point of contact to address member and provider concerns, MCS assists with issues that have been escalated to HHSC. Inquiries and complaints are referred to MCS from a variety of sources including elected officials, the Office of the Ombudsman, and other state agencies and departments. Provider inquiries and complaints are received directly from providers. MCS also monitors member appeal outcomes to identify potential issues in which it appears MCOs may have denied services inappropriately.

Based on findings from monthly and quarterly self-reported performance data or current potential non-compliant information or complaint discrepancies, MCS determines if further analysis or corrective action is necessary. MCS may conduct enhanced monitoring, desk reviews, and/or

[2] This list is not meant to be all-inclusive, but rather a highlight of data collected.

targeted operational on-sites. MCS monitors immaterial and material non-compliance and may recommend one or more of the following remedies for each item of material non-compliance in accordance with the Uniform Managed Care Contract (UMCC):

- Assessment of liquidated damages
- Accelerated and/or escalated monitoring which includes corrective action plans (CAPs) and more frequent or extensive monitoring by HHSC
- Requiring additional financial or programmatic reports
- Requiring additional or more detailed financial or programmatic audits or other reviews
- Terminating or declining to renew or extend an MCO contract
- Appointing temporary MCO management under the circumstances described in Title 42, CFR, Section 438.706
- Initiating or suspending member enrollment
- Withholding or recouping payment to the MCO
- Requiring forfeiture of all or part of the MCO's performance bond

MCS determines the scope and severity of the material non-compliance, and the appropriate remedy, on a case-by-case basis. Article 12, Remedies & Disputes, of the Uniform Terms and Conditions of all MCO contracts contains a list of sanctions HHSC may assess against MCOs for noncompliance with the contract. Sanctions may be assessed for failure to provide medically necessary services or for premiums or charges that exceed those permitted under the Medicaid or CHIP program. See Attachment C for how MCO monitoring aligns with the goals prioritized in Table 1.

MCOs must report annually to HHSC their Value-Based Payment (VBP) arrangements with providers, including a detailed description of the alternative payment models (APM) and the expense amounts associated with the APMs. Using the data from these reports, HHSC calculates the annual

level of target achievement for each MCO by program type[3]. If the APM reports do not meet HHSC requirements or are not submitted by the required deadline, the MCO is required to submit a CAP and may be subject to additional contractual remedies, including liquidated damages. However, improvements have been noted every reporting year in both the quality of the reports and the volume of APMs developed by the MCOs with their providers. See Attachment C for how VBP aligns with goals prioritized in Table 1.

MCO-Generated Data and Reports

Quality Assessment and Performance Improvement (QAPI)

Each MCO must develop, maintain, and operate a QAPI that meets state and federal requirements. The MCO must approach all clinical and nonclinical aspects of quality assessment and performance improvement based on principles of Continuous Quality Improvement/Total Quality Management and must:

- Evaluate performance using objective quality indicators
- Foster data-driven decision-making
- Recognize that opportunities for improvement are unlimited
- Solicit member and provider input on performance and Quality Assessment and Performance Improvement activities
- Support continuous ongoing measurement of clinical and non-clinical effectiveness and member satisfaction
- Support programmatic improvements of clinical and non-clinical processes based on findings from ongoing measurements
- Support re-measurement of effectiveness and member satisfaction, and continued development and implementation of improvement interventions as appropriate

[3] More description on HHSC approach to VBP and APM target schedule, is given in Section "*Minimum MCO Alternative Payment Model Thresholds"* of this document.

The MCO must adopt at least two evidence-based clinical practice guidelines per program (e.g., STAR, STAR+PLUS) as outlined in the UMCM, Chapter 5.7.1. Practice guidelines must be based on valid and reliable clinical evidence, consider the needs of the MCO's members, be adopted in consultation with network providers, and be reviewed and updated periodically, as appropriate. The MCO must adopt practice guidelines based on members' health needs and opportunities for improvement identified as part of the QAPI. Through the QAPI process, HHSC reviews the MCOs policies and procedures to ensure compliance. Commonly adopted evidence-based clinical practice guidelines for plans that serve children are the Centers for Disease Control and Prevention D Preventive Service Guideline for Immunizations, and the National Heart, Lung, and Blood Institute (NHLBI) guideline for asthma. See Attachment C for how QAPI aligns with goals prioritized in Table 1.

Performance Improvement Projects (PIPs)

The EQRO recommends topics for PIPs based on MCO performance results on key quality measures and goals set forth in Table 1. HHSC, with input from the MCOs, selects goals, which become projects that enable each MCO to target specific areas for improvement. These projects are measurable and reflect areas that present significant opportunities for performance improvement for each MCO. When conducting PIPs, MCOs are required to follow the ten-step CMS protocol published in the CMS External Quality Review (EQR) Protocols. For example, in 2020, HHSC and an MCO began to examine follow-up after hospitalization for mental illness as a PIP topic, hoping to improve a key HEDIS quality indicator. In the two-year PIP, the health plan will report to HHSC annually on whether incentives had a significant improvement in follow-up visits versus a control population. PIP topics and scores are posted on the HHSC website under Performance Improvement Projects. See Attachment C for how PIPs align with the goals prioritized in Table 1.

HHSC concluded Medicare-Medicaid Plans' Medicare quality improvement projects (QIPs) for the Dual Demonstration on December 31, 2019, with final reports submitted October 1, 2020.

Accreditation

HHSC reviews annually each MCO's national accreditation status, sends a report to CMS, and posts the report on the HHSC website under data and reports. MCOs must be accredited by the National Committee for Quality Assurance (NCQA) or URAC by September 1, 2022. This will allow MCOs to choose an accreditation option most appropriate to their organization and the populations they serve. DMOs will need to be URAC accredited as it is the only entity offering dental plan accreditation. See Attachment C for how accreditation aligns with the goals set forth in Table 1.

EQRO processes and reports

MCO Administrative Interviews

To ensure Medicaid MCOs are meeting state and federal requirements related to providing care to Medicaid members, the EQRO conducts MCO administrative interviews and on-site visits to assess the following domains:

- Organizational structure
- Children's programs
- Care coordination and disease management programs
- Utilization and referral management
- Provider network and contractual relationships
- Provider reimbursement and incentives
- Member enrollment and enrollee rights and grievance procedures
- Data acquisition and health information management

The MCOs complete the administrative interview tool online and are required to provide supporting documentation. For example, when describing disease management programs, the MCO must also provide copies of all evidenced-based guidelines used in providing care to members. The EQRO analyzes all responses and documents and generates follow-up questions for each MCO as necessary. The follow-up questions are addressed during in-person site visits. HHSC will begin assessing CAPs in 2021 for plans that fail to address

follow-up questions and provide appropriate policies and documentation. See Attachment C for how administrative interviews align with the goals prioritized in Table 1.

Monthly MCO Reports

Texas's EQRO provides monthly data reports to the MCOs on their PPE rates. These reports contain member-level details without a claims lag to enable timely intervention for PIPs and Pay-for-Quality (P4Q). In addition to PPE being a medical P4Q measure in all programs, at least one health plan is conducting a PIP in 2021 to reduce their PPE rate. The monthly reports allow the health plan to determine if their intervention is successful and adjust accordingly before getting an annual report. The reports generally help MCOs to ensure better service coordination for members who have had a recent hospital visit.

Encounter Data Validation Certification Reports

The information contained in these data certification reports is used for actuarial analysis and rate setting and meets the requirements of Title 4, Texas Government Code, Section 533.0131, Use of Encounter Data in Determining Premium Payment Rates. Analyses include volume analysis based on service category, data validity and completeness, consistency analysis between encounter data and MCO financial summary reports, and validity and completeness of provider information (not performed for pharmacy data). Data certification is completed annually. See Attachment C for how encounter data validation reports align with the goals prioritized in Table 1.

Encounter Data Validation Record Review Report

Encounter data validation by record review ensures the data used for rate setting and calculating quality of care measures is valid. Encounter data validation is the strongest approach to ensure that high quality data is available for analysis and reporting. The report summarizes the results of

the EQRO's assessment of the accuracy of the information found in the MCOs' claims and encounter data compared to corresponding medical records. The EQRO validates all encounter data every two years, alternating between Medicaid records and CHIP and dental records.

Summary of Activities Report

The Summary of Activities Report is the CMS-required annual detailed technical report that summarizes findings on access and quality of care. MCS provides the Summary of Activities report to CMS annually as evidence of EQRO activities. The report includes an annual summary of all quality of care activities, PIP information, MCO and DMO structure and processes, and a description of all findings and quality improvement activities. Additionally, the report includes recommendations for the state, which are incorporated to the extent possible in the relevant programs. The annual report serves as a report on the implementation and effectiveness of the quality strategy in accordance with 42 CFR 438.202(e). The report is posted on HHSC's website under External Quality Review after submission to CMS. See Attachment C for how the Summary of Activities report aligns with the goals prioritized in Table 1.

Quality of Care Reports

CMS requires the EQRO to validate performance measures. This is done through analysis of data used to develop quality of care reports. Additionally, the EQRO calculates the quality of care measures that rely on administrative data (i.e., enrollment, health care claims and encounter data). This provides the state with a comprehensive set of measures calculated using NCQA-certified software and audited by an NCQA-certified auditor. Data tables are provided by program with a breakdown of MCO and service area level performance. Results are also posted publicly on the THLC portal. See Attachment C for how the quality of care reports align with the goals prioritized in Table 1.

Frew Report

As a result of the 1993 class action lawsuit *Frew v. Hawkins,* ICHP calculates rates by plan code for Texas Health Steps checkups given to new and existing members based on the Medicaid Managed Care Texas Health Steps Medical Checkups Utilization Report instructions. The results are compiled and compared with MCO-submitted reports to determine if the MCO-submitted reports are within an eight percent threshold of EQRO calculated rates. See Attachment C for the connection between the *Frew* Report and the quality goals prioritized in Table 1.

Surveys

ICHP conducts biannual member and caregiver surveys for all managed care programs. ICHP uses questions from the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) surveys, including the Health Plan Survey (Medicaid module), supplemental questions, questions from the Clinician and Group Survey on the patient-centered medical home, and questions from the Cultural Competence item set. ICHP also uses questions they have developed pertaining to member demographic and household characteristics. The Experience of Care and Health Outcomes (ECHO®) Questionnaire for Children - behavioral health organization (BHO) and MCO versions are utilized for measuring and reporting consumer experiences with their health plan (MCO or BHO) and behavioral health care providers. See Attachment C for how surveys align with the goals set forth in Table 1.

Texas Quality Initiatives

HHSC and ICHP have implemented multiple quality initiatives, as well as tools to help HHSC and the MCOs identify areas for improvement and implement interventions to improve quality of care. These tools and initiatives stem from state legislation, quality report findings, state agency initiatives, and EQRO recommendations

Appointment Availability Studies

Senate Bill (SB) 760, 84th Legislature, Regular Session, 2015 directed HHSC to establish and implement a process for direct monitoring of an MCO's provider network, including the length of time a recipient must wait between scheduling an appointment with a provider and receiving treatment from the provider. To fulfill this direction, Section 8.1.3 of the UMCC specifies that Medicaid and CHIP MCOs must assure that all members have access to all covered services on a timely basis, consistent with medically appropriate guidelines and accepted practice parameters.

The state's EQRO conducts the Appointment Availability Study, which evaluates MCO compliance with UMCC appointment availability standards. Using a "mystery shopper" methodology to examine member experience in scheduling appointments, the Appointment Availability Study is comprised of four reports: behavioral health, prenatal, primary care, and vision. The Study has been conducted annually since 2015. See Attachment C for how Appointment Availability Studies align with the goals set forth in Table 1.

Continuity of Care/Transition of Care

The state requires MCOs to ensure newly enrolled members' care is not disrupted or interrupted. Section 8.2.1 of the UMCC outlines requirements for continuity of care/transition of care and requirements for out-of-network providers.

When a member is enrolled in an MCO from fee-for-service, the MCO receives a three-year history of the member's claims data, including medical and pharmacy claims. In effect, this provides the MCO the medical and medication history for their new member. Similarly, when a member moves from one MCO to a new MCO, HHSC transfers three years of encounters to the new MCO. See Attachment C for how continuity of care aligns with the goals prioritized in Table 1.

Beneficiaries with Complex Care Needs and High Costs (BCNs)

HHSC encourages MCOs to focus on beneficiaries with complex care needs and high costs. MCOs are required to submit to HHSC their plans for targeting BCNs, including intervention strategies, and resources dedicated to care management of this group, allowing HHSC to better assess MCO progress in this area. MCOs are currently conducting a PIP on this topic, but due to the COVID-19 pandemic the PIP has been extended for an additional year. Additionally, the THLC portal has a super-utilizer dashboard that is available for plans to isolate areas of high use to inform effective interventions. The super-utilizer dashboard allows the user to define a "super-utilizer" by selecting the number of emergency department visits and/or the number of inpatient admissions. The user can then see data on emergency department and inpatient utilization and expenditures, PPVs, and PPAs for members meeting the selected criteria. Data also shows the percentage of selected members with a chronic behavioral and/or physical health condition. The user can filter by year, program, health plan, and demographics. See Attachment C for how BCNs align with the goals set forth in Table 1.

Collaboration to Improve Texas Birth Outcomes

Prenatal care, delivery, newborn care, and postpartum care are focus areas of ongoing quality improvement. HHSC recognizes that this quality improvement requires close coordination with the Department of State Health Services (DSHS), Texas' public health agency. HHSC and DSHS collaborate on targeted projects of mutual concern in this area. The EQRO conducts data analysis to support these efforts. Better Birth Outcome (BBO) Research Projects study Texas Medicaid and vital statistics data and analyses of risk adjustment calculations, regional variations, and the incorporation of outcome and other quality measures. These analyses include maps and other information posted on the THLC portal. The following BBO Research

Projects are currently under development: Reducing Low-Need C-Section Deliveries; Improving Neonatal Abstinence Syndrome Care; and Reviewing Perinatal Hospital Transfers. See Attachment C for how collaboration to improve Texas birth outcomes aligns with the goals set forth in Table 1.

Utilization Review

Texas Medicaid employs robust utilization review to ensure appropriate, consistent delivery of acute care and LTSS services. The Medicaid LTSS utilization review team is responsible for conducting annual reviews of the STAR+PLUS HCBS and STAR Kids/STAR Health MDCP programs. Annual reviews include member service plan reviews and home visits (in person or by telephone) with members or legally authorized representatives to determine if the MCO is compliant with contract requirements. The MCS Utilization Review Team also provides clinical consultancy on Medicaid managed care members cases, including individuals with high-needs or transitioning from services for children to adult programs.

The Acute Care Utilization Review (ACUR) team monitors Medicaid MCOs to ensure the efficacy of their prior authorization and utilization review processes. The focus is on ensuring the reduction of authorization of unnecessary and inappropriate services. In addition, the review team safeguards against access to care disparities by ensuring that MCOs are providing necessary and appropriate acute care services. The team also ensures Texas Medicaid managed care members have access to medically necessary and quality acute care services provided efficiently See Attachment C for how both LTSS and Acute Care Utilization Review align with the goals set forth in Table 1.

Financial Incentive Programs

Medical Pay-for-Quality (P4Q) Program

Texas Medicaid implemented the medical P4Q program in 2014. Medical P4Q provides financial incentives and disincentives to MCOs based on performance on a set of quality measures. The quality of care measures used in this initiative are a combination of process and outcome measures

which include select PPEs as well as other measures specific to the program's enrolled populations. The medical P4Q program measures were selected to focus on prevention, chronic disease management including behavioral health, and maternal and infant health. HHSC staff considered legislative requirements, HHSC goals set forth in Table 1, the number of members affected, the severity of the problem, the need for improvement, and feasibility of the measures as criteria for measure selection. The medical P4Q program was redesigned and implemented in 2018, with STAR Kids to be added in 2021. P4Q uses nationally recognized and established measures to the degree possible. HHSC included MCOs, provider organizations, and advisory committees in the development of the redesigned P4Q program and the selection of measures.

The P4Q program includes an at-risk pool that is a percentage of the MCO capitation rate. All funds recouped from MCO for poor performance are redistributed to MCOs that performed well. No funds are returned to the state. Participation in this program is required for all Texas MCOs in STAR, STAR+PLUS, and CHIP.

In 2018, MCOs performed well overall. Two MCOs in CHIP, one MCO in STAR, and no MCOs in STAR+PLUS were subject to recoupment. Across all programs, only one MCO had a net recoupment. The lack of recoupments indicates that most plans improved. Across all programs, a total of $3,769,083 was recouped and redistributed. In comparing 2017 and 2018 program measure rates, all at-risk measures in all programs showed improvement except for PPVs in STAR and CHIP. Detailed results are posted on the THLC portal. Measures, methodology, and performance targets are published in the UMCM, Chapter 6.2.14. See Attachment C for how the medical P4Q program aligns with goals set forth in Table 1.

Dental P4Q Program

In the dental P4Q program, 1.5 percent of each DMO's total calendar year capitation payment is at-risk of recoupment. Measures and methodology are published in the UMCM, Chapter 6.2.15. DMOs may be subject to recoupment or distribution based on their performance on selected dental measures. HHSC reviews the dental P4Q program measures at least every

other year. Measures are considered for inclusion based on HHSC quality goals set forth in Table 1, number of members affected, past performance, and stakeholder input. Priorities include oral evaluations and primary prevention against dental caries. As a result, the following Dental Quality Alliance (DQA) measures are currently in use for the dental P4Q program:

- Oral Evaluation,
- Topical Fluoride for Children at Elevated Caries Risk,
- Sealants for 6-9-year-old Children at Elevated Risk, and
- Sealants for 10-14-year-old Children at Elevated Risk.

While DMOs performed well overall in measurement year 2018, HHSC recouped more than it distributed. Beginning with measurement year 2021, HHSC implemented a bonus pool to allow plans to earn additional distributions when funds remain after the at-risk measure recoupments and distributions are complete.

The following DQA measures are currently in use for the dental P4Q bonus pool:

- Ambulatory Care Sensitive Emergency Department Visits for Dental Caries in Children
- Care Continuity, Dental Services

See Attachment C for how dental P4Q aligns with goals set forth in Table 1.

Hospital Quality-Based Payment Program

HHSC continues to administer the Hospital Quality Based Payment Program for all hospitals participating in Texas Medicaid and CHIP. This hospital specific program is operationalized in the MCO and fee-for-service (FFS) systems. All hospitals are measured on their performance for risk adjusted rates of PPRs and PPCs across all Medicaid and CHIP programs.

Measurement and application of disincentives/incentives is on an annual cycle. For example, Medicaid and CHIP hospitals with higher than average rates of PPR, PPC, or both in fiscal year 2019 will experience payment reductions ranging from 1 percent to 4.5 percent in fiscal year 2021. One hundred forty-four of 621 Texas hospitals will be paid a lower rate.

HHSC monitors hospital performance on PPCs and PPRs on an ongoing basis to track whether the hospital quality program and other initiatives may be helping to lower rates for these potentially preventable events. Results are available online on the THLC Portal and as part of HHSC's *Annual Report on Quality Measures and Value-Based Payments*.[4] Between 2014 and 2019, trends for PPCs and PPRs diverged. During this period, rates for PPCs improved (showing a consistent downward trajectory) while PPR rates worsened (rates increased by about 23 percent).

Reducing PPRs requires concerted action by both hospitals and MCOs. HHSC evaluates PPR rates achieved by hospitals (readmission within 15 days) and by MCOs (readmission within 30 days). In 2018, HHSC conducted an evaluation of Medicaid managed care in Texas and identified the increasing PPR trend as an opportunity to integrate actuarial efficiency factors into the MCO rate setting process. In fiscal year 2020, HHSC reduced Medicaid and CHIP capitation rates with the expectation that MCOs will successfully reduce PPR rates by at least 10 percent.

Uniform Hospital Rate Increase Program (UHRIP)

UHRIP[5] is a directed payment program in which local public funds are used to match federal Medicaid funds to increase payments to hospitals. Funds are built into MCO capitation payments and paid to eligible hospitals as a rate enhancement. It originated in SFY 2018 to mitigate the Medicaid

[4] *Annual Report on Quality Measures and Value-Based Payments* is available at: https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2020/hb-1629-quality-measures-value-based-payments-dec-2020.pdf

[5] Information on the UHRIP program is available at: https://hhs.texas.gov/doing-business-hhs/provider-portals/medicaid-supplemental-payment-directed-payment-programs/directed-payment-programs

shortfall for hospital providers and improve members' access to and satisfaction with their hospital-based care. See Attachment C for how UHRIP aligns with the goals set forth in Table 1.

HHSC is working with stakeholders to redesign the program, introducing additional quality measures, reporting requirements, and evaluation criteria to further advance certain goals of this quality strategy (from Table 1). HHSC will seek approval from CMS for the renamed Comprehensive Hospital Increased Reimbursement Program (CHIRP), to begin September 2021. CHIRP must be approved by CMS annually pursuant to 42 CFR §438.6(c).

Quality Incentive Payment Program (QIPP) for Nursing Facilities

QIPP[6] is designed to incentivize nursing facilities (NFs) participating in Medicaid to improve quality and innovation in nursing facility services[7]. The program began in SFY 2018 and was approved for a fourth year that began on September 1, 2020.

HHSC evaluates participating NFs' performance on quality measures on a quarterly basis. After the two full years of data became available, HHSC compared the performance of facilities enrolled in QIPP and facilities not enrolled in QIPP. Results indicate that QIPP was successful in achieving significant performance gains by participating facilities on program measures of residents' health and safety. Overall quality gradually improved over time for QIPP participating facilities for all four metrics. Three of four metrics showed significant improvements when compared to non-QIPP facilities, suggesting QIPP participation may influence NF quality improvements. This includes all metrics except Antipsychotic Medication. However, other state-

[6] QIPP information can be found at: https://hhs.texas.gov/services/health/provider-information/quality-incentive-payment-program-nursing-homes.

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

wide initiatives to improve NF performance on this metric may have lessened the measurable impact of QIPP specifically. Three of four metrics showed positive correlation between the implementation of QIPP and improved performance.

To continue incentivizing NFs to improve quality and innovation in the provision of NF services, HHSC adopted new quality measures, eligibility requirements and financing components for QIPP that began in program Year Three (SFY 2020) and continue through Year Four (SFY 2021). The new measures were developed by a workgroup comprised of stakeholders and HHSC staff and were approved by CMS.

MCOs receive QIPP funds through STAR+PLUS nursing facility (NF) MCO capitation rates, and distribute the funds to enrolled NFs based on each NF's performance on the quality measures in four program components:[8]

1. Quality Assurance and Performance Improvement (QAPI) Meetings
2. Workforce Development
3. CMS Five-Star Quality Measures
4. Infection Control Program

HHSC is working on changes for QIPP Year Five (SFY 2022). QIPP must be approved by CMS annually pursuant to 42 CFR §438.6(c). See Attachment C for how QIPP aligns with goals set forth in Table 1.

Performance Comparisons

Performance Indicator Dashboards

The Performance Indicator Dashboards include a series of measures that identify key aspects of performance to support transparency and MCO accountability. The Performance Indicator Dashboards are not an all-inclusive set of performance measures; HHSC measures other aspects of

[8] Details for QIPP Year Three Quality Metrics are available on the HHS site at: https://hhs.texas.gov/sites/default/files/documents/services/health/medicaid-chip/programs/qipp/qipp-final-quality-metric-packet-fy-2020.pdf

MCO's performance as well. Rather, the Performance Indicator Dashboards assemble performance indicators that assess many of the most important dimensions of MCO performance and includes measures that incentivize excellence. The Dashboard is shared on the THLC portal and includes performance targets to gauge performance. Additionally, HHSC includes program level performance data on these measures and shares this information on the HHSC website. MCOs not meeting measure thresholds are held to contract remedies. See Attachment C for how Performance Indicator Dashboards align with the goals set forth in Table 1.

MCO Report Cards

Title 4, Texas Government Code, Section 536.051 requires HHSC to provide information to Medicaid and CHIP members regarding MCO performance on outcome and process measures during the enrollment process. To comply with this requirement and other legislatively mandated transparency initiatives, HHSC develops annual MCO report cards for each program service area to allow members to easily compare the MCO on specific quality measures before enrolling in a plan. For example, MCO report cards include quality measures such as "Babies get regular checkups", "Doctors listen carefully, explain clearly and spend enough time with people", and "People get care for diabetes." MCO report cards are posted on the HHSC website and included in the Medicaid enrollment packets sent to potential members. See Attachment C for how MCO report cards align with the goals set forth in Table 1.

Data sharing and Transparency

Texas Healthcare Learning Collaborative (THLC) Portal

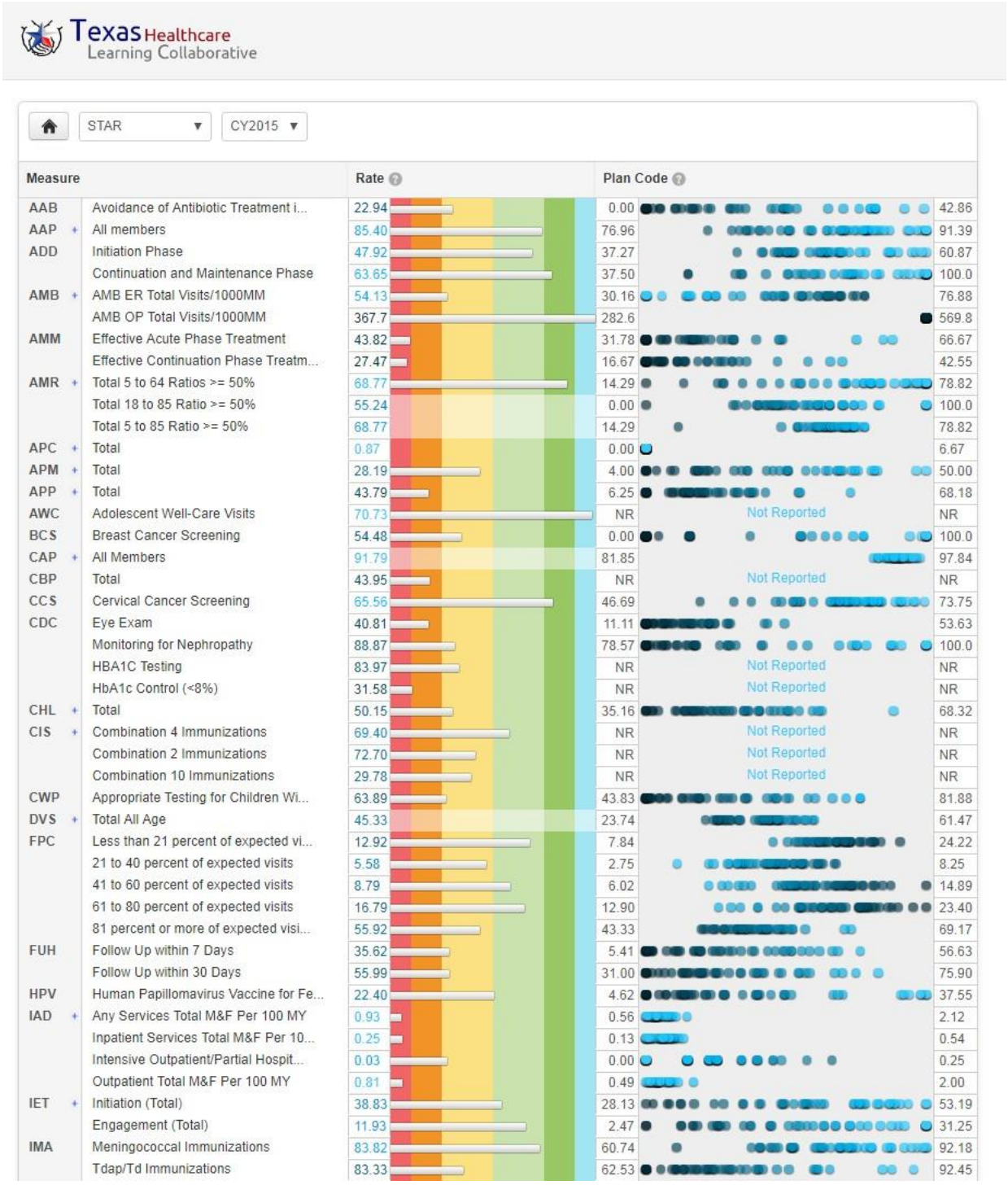
The THLC portal is a secure web portal designed and run by ICHP. The THLC portal is an online learning collaborative that includes a graphical user interface that allows the public, MCOs, HHSC, and ICHP to visualize healthcare metrics (Figure 1). The THLC portal can be used to generate graphical reports of plan and program specific performance.

The THLC portal provides reports on MCO and DMO performance across a variety of measures including HEDIS, CAHPS, and PPEs. The reports are interactive and the MCOs/DMOs can query the data to create more customized summaries of the quality results. A redesigned THLC portal with enhanced user capabilities was launched in summer 2017. The following features were made available to the public:

- Medical quality of care data
- Medical data downloader
- Dental quality of care data
- CMS Core measure set data
- PPE trends
- PPA data
- PPR data (at both the hospital and MCO level)
- PPV data
- PPC data (at both the hospital and MCO level)
- HHSC performance indicator dashboard (made public in 2020)
- P4Q dashboard (added in 2020)
- Resources including CAHPS and National Core Indicator survey data

See Attachment C for how the THLC portal aligns with goals prioritized in Table 1.

Figure 1: Screenshot of the THLC Portal



Medicaid Quality Assurance and Improvement Webpage

The Medicaid Quality Assurance and Improvement webpage serves as a tool for communication and information-sharing about initiatives and other efforts to improve quality and efficiency of the Texas Medicaid program with external stakeholders such as health care providers, MCOs/DMOs, and the public, as well as internal HHSC divisions. The webpage also promotes transparency and public reporting related to quality of care and efficiency of services provided to Medicaid beneficiaries, and provides a centralized location for stakeholders to access information such as MCO data, presentations, specialized reports, and advisory committee information.

Innovation

Texas continues to develop new strategies to measure and encourage quality service delivery in Medicaid managed care. Several examples of these activities are outlined here.

DSRIP

DSRIP provides financial incentives that encourage hospitals and other providers to develop programs or strategies to enhance access to health care, quality of care, cost-effectiveness, and the health of patients and families served. As funding winds down, the DSRIP transition plan outlines the steps HHSC will take to develop new programs, policies, and strategies to sustain successful DSRIP activities and to advance alternative payment models and healthcare system transformation. The plan includes achievable milestones, and HHSC risks federal financial participation if it does not meet transition plan milestone deliverables.

The following transition plan focus areas align with the state quality strategy goals (see Attachment C):

- Sustain access to critical health care services
- Behavioral health
- Primary care

- Patient navigation, care coordination, and care transitions, especially for patients with complex conditions that have high costs and high utilization
- Chronic care management
- Health promotion and disease prevention
- Maternal health and birth outcomes, including in rural areas of the state
- Pediatric care
- Rural health care
- Integration of public health with Medicaid
- Telemedicine and telehealth; and
- Social drivers of health.

Minimum MCO Alternative Payment Model Thresholds

In 2012, HHSC began assessing the payment methodologies that contracted MCOs used to pay their providers. That assessment confirmed that while MCOs were paid based on a capitated payment model, they were largely paying providers based on a FFS payment model, unlinked to quality metrics. In 2014, HHSC added a contract provision to the managed care contracts that required MCOs and DMOs to implement VBP models with providers and submit to HHSC annual reports on the volume of APMs established with their providers.

To accelerate service delivery and payment transformation from volume-based to value-based models, HHSC has implemented managed care contract requirements to establish minimum levels of Medicaid and CHIP payments to providers associated with alternative payment models (APMs). HHSC established four-year targets, beginning in January 2018, requiring 25 percent (increasing to 50 percent) of payments to be associated with APMs, and 10 percent (increasing to 25 percent) must be associated with APMs in which providers accept some level of risk. If the MCO does not achieve the minimum APM targets and exception conditions provided in the contract do not apply, the MCO is required to submit a corrective action plan and may be

subject to additional contractual remedies, including liquidated damages. If an MCO performs exceptionally well on two key quality measures but does not meet the APM targets, the MCO is excepted from corrective actions. HHSC has adopted the Health Care Payment Learning and Action Network's APM Framework in implementing the alternative payment model approach. See Attachment C for how minimum MCO alternative payment model thresholds align with the goals set forth in Table 1.

Reducing Inappropriate Use of Antipsychotic Medications for Nursing Facility Residents

Since 2014, Texas has worked to reduce the inappropriate use of antipsychotic medications to treat behaviors of individuals with Alzheimer's disease or other dementia-related conditions in individuals residing in nursing facilities. HHSC's Quality Monitoring Program has provided education and technical assistance to nursing facilities and launched the Texas Reducing Antipsychotics in Nursing homes (T.R.A.I.N) initiative. Other best practices and initiatives have also been developed and promoted state-wide, both online and in person, including the Music and Memory program and the One a Month Campaign. HHSC established a multi-disciplinary approach to provide educational resources to nursing facility leadership, nurses, pharmacists, and prescribers. The rate of antipsychotic drug use has dropped significantly. Since CMS launched its National Partnership to Improve Dementia in Nursing Homes, in 2012, Texas has drastically reduced the inappropriate use of antipsychotic medication in nursing facilities. As of October 2020, Texas had improved its rank to 11th lowest in the nation in the prevalence of antipsychotic drug use for long-stay residents.[9] See Attachment C for how reducing inappropriate use of antipsychotic medications for nursing facility residents aligns with the goals prioritized in Table 1.

[9] https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/National-Partnership-to-Improve-Dementia-Care-in-Nursing-Homes, accessed January 27, 2021.

Medicaid Value-Based Enrollment

The Texas Legislature directed HHSC to create an incentive program that automatically enrolls a greater percentage of Medicaid recipients who have not selected a health plan into a plan based on quality of care, efficiency, and effectiveness of service provision and performance. Accordingly, HHSC developed a value-based enrollment methodology that incorporates results from key cost, quality, and member satisfaction metrics into the existing method. MCOs with better performance than other MCOs on the factors listed below receive a higher share of enrollments than under the current methodology.

- Risk-Adjusted Ratio of Actual to Expected Spending (Cost or Efficiency)
- Risk-Adjusted Potentially Preventable Events (PPE) Ratios (Cost and Quality)
- Composite Report Card Scores (Quality and Member Satisfaction)
  - Member experience with doctors and the health plan – derived from results of member surveys
  - Staying healthy – MCO performance on preventive care measures
  - Controlling chronic diseases – MCO performance on important quality measures regarding care for asthma, Attention Deficit Hyperactivity Disorder, Chronic Obstructive Pulmonary Disease, depression, or diabetes, depending on the program

HHSC phased in implementation of the program beginning on September 1, 2020. In Phase I, HHSC reported to MCOs their monthly default enrollment under a value-based methodology. In Phase II, in December 2020, HHSC began using the value-based methodology for default enrollments.

Attachment A - CFR and External Quality Review Organization Activities Crosswalk

This chart illustrates how the EQRO meets CFR Requirements and which activities are included in the annual Summary of Activities Report.

CFR Requirement	HHSC Report		Included in Summary of Activities Report?
§438.364(a)(1)	A detailed technical report that describes the way the data from all activities conducted in accordance with §438.358 were aggregated and analyzed, and conclusions were drawn as to the quality, timeliness, and access to the care furnished by the MCO or PIHP.	Summary of Activities Report	N/A

CFR Requirement	HHSC Report		Included in Summary of Activities Report?
§438.364(a)(3)	Assessment of each MCOs' and PIHPs' strengths and weaknesses with respect to quality, timeliness, and access to health care services furnished to Medicaid beneficiaries.	Administrative Interviews Member Surveys Quality of Care data tables QAPI Evaluations PIP Evaluations	Yes

CFR Requirement	HHSC Report		Included in Summary of Activities Report?
§438.364(a)(4)	Recommendations for improving quality of health care services furnished by each MCO or PIHP.	Administrative Interviews Member Surveys Quality of Care data tables QAPI Evaluations PIP Evaluations Summary of Activities Report	Yes

CFR Requirement	HHSC Report		Included in Summary of Activities Report?
§438.364(a)(5)	Methodologically appropriate, comparative information for all MCOs/PIHPs. This information should align with what the state outlines in its quality strategy as methodologically appropriate.	Member Surveys Quality of Care data tables Administrative Interviews QAPI Evaluations PIP Evaluations	Yes
§438.364(a)(6)	Assessment of the degree to which each MCO or PIHP has addressed effectively the recommendations for quality improvement made by the External Quality Review Organization (EQRO) during the previous year's EQR.	QAPI Evaluations	Yes

CFR Requirement	HHSC Report		Included in Summary of Activities Report?
Validation of Performance Improvement Projects (PIPs)			
§438.358(b)(1)(i)	Information on the validation of PIPs required by the state to comply with requirements set forth in §438.330(b)(1) and that were underway during the preceding 12 months.	PIP Evaluations Health Plan PIP Reports Summary of Activities Report	Yes
§438.364(a)(1)	Description of the way the data from the validation of PIPs were aggregated and analyzed, and conclusions were drawn as to the quality, timeliness, and access to the care furnished by the MCO or PIHP.	PIP Evaluations Health Plan PIP Reports Summary of Activities Report	Yes

CFR Requirement	HHSC Report		Included in Summary of Activities Report?
§438.364(a)(2)(i-iv)	The following information related to the validation of PIPs: • Objectives; • Methods of data collection and analysis (Note: this should include a description of the validation process/methodology, e.g., was the CMS PIP validation protocol used, or a method consistent with the CMS protocol); • Description of data obtained; and • Conclusions drawn from the data.	PIP Evaluations Health Plan PIP Reports Summary of Activities Report	Yes

CFR Requirement	HHSC Report		Included in Summary of Activities Report?
§438.364(a)(2)(i-iv)	Assessment of the overall validity and reliability of study results and includes any threats to accuracy/confidence in reporting.	PIP Evaluations Health Plan PIP Reports Summary of Activities Report	Yes
§438.358(b)(1)(i)	Validation results for all state-required PIP topics for the current EQR review cycle.	PIP Evaluations Health Plan PIP Reports Summary of Activities Report	Yes

CFR Requirement	HHSC Report		Included in Summary of Activities Report?
§438.358(b)(1)(i)	Description of PIP interventions and outcomes information associated with each state-required PIP topic for the current EQR review cycle.	PIP Evaluations Health Plan PIP Reports	No[10]
Validation of Performance Measures (PMs)			
§438.358(b)(1)(ii)	Information on the validation of MCO or PIHP PMs reported (as required by the state) or MCO or PIHP PMs calculated by the state during the preceding 12 months to comply with requirements set forth in §438.330(b)(2).	Quality of Care data tables Summary of Activities Report	Yes

[10] The Summary of Activities Report typically focuses on selected PIP interventions.

CFR Requirement	HHSC Report		Included in Summary of Activities Report?
§438.364(a)(1)	Description of the way the data from the validation of PMs were aggregated and analyzed, and conclusions were drawn as to the quality, timeliness, and access to the care furnished by the MCO or PIHP.	Quality of Care data tables	Yes
§438.364(a)(2)(i-iv)	The following information related to the validation of PMs: • Objectives; • Methods of data collection and analysis (Note: this should include a description of the validation process/methodology, e.g., was the CMS PM validation protocol used, or a method consistent with the CMS protocol); • Description of data obtained; and • Conclusions drawn from the data.	Quality of Care data tables	Yes

CFR Requirement	HHSC Report		Included in Summary of Activities Report?
§438.364(a)(2)(i-iv)	Documentation of which PMs the state required the EQRO to validate for the current EQR review cycle (Note: this may be a subset of reported PMs or all reported PMs).	Quality of Care data tables	Yes
§438.364(a)(2)(i-iv)	EQR assessment of the MCO/PIHP information system as part of the validation process.	Administrative Interviews	Yes
§438.364(a)(2)(i-iv)	Outcomes information associated with each PM for the current EQR review cycle.	Quality of Care data tables Summary of Activities Report-MCO profiles	Yes

CFR Requirement	HHSC Report		Included in Summary of Activities Report?
§438.358(b)(1)(iii)	Information on a review, conducted within the previous 3-year period, to determine the MCO's or PIHP's compliance with standards established by the state to comply with the requirements of §438.330.	Administrative Interviews Quality of Care data tables Member Surveys QAPI Evaluations	Yes[11]
§438.364(a)(1)	Description of the way the data from the compliance review were aggregated and analyzed, and conclusions were drawn as to the quality, timeliness, and access to the care furnished by the MCO or PIHP.	Administrative Interviews Quality of Care data tables Member Surveys QAPI Evaluations	Yes

[11] The Summary of Activity report typically includes a summary of selected results from the Administrative Interview reports.

CFR Requirement	HHSC Report		Included in Summary of Activities Report?
§438.364(a)(2)(i-iv)	The following information related to the compliance review: • Objectives; • Methods of data collection and analysis (Note: this should include a description of the validation process/methodology, e.g., was the CMS PM validation protocol used, or a method consistent with the CMS protocol); • Description of data obtained; and • Conclusions drawn from the data.	Administrative Interviews Quality of Care data tables Member Surveys QAPI Evaluations	Yes

CFR Requirement	HHSC Report		Included in Summary of Activities Report?
§438.358(b)(1)(iii)	Compliance assessment results for each MCO/PIHP from within the past three years.	Administrative Interviews Quality of Care data tables Member Surveys QAPI Evaluations	Yes[12]

[12] Three-year trends have been shown in prior Summary of Activity reports, but typically only at the program level, and not the MCO level.

CFR Requirement	HHSC Report		Included in Summary of Activities Report?
§438.364(a)(2)(i-iv)	If appropriate, the following information related to encounter data validation: • Objectives; • Methods of data collection and analysis; • Description of data obtained; and • Conclusions drawn from the data.	Summary of Activities Report - Addendum Encounter Data Validation	Yes

CFR Requirement	HHSC Report		Included in Summary of Activities Report?
§438.364(a)(2)(i-iv)	If appropriate, the following information related to the administration or validation of consumer or provider surveys of quality of care: • Objectives; • Methods of data collection and analysis; • Description of data obtained; and • Conclusions drawn from the data.	STAR Adult and Caregiver Member Survey data tables STAR+PLUS Adult Member Survey data tables CHIP Caregiver Survey data tables STAR Health Caregiver Survey data tables	Yes

CFR Requirement	HHSC Report		Included in Summary of Activities Report?
§438.364(a)(2)(i-iv)	If state contracts with the EQRO to calculate PMs in addition to those reported by an MCO or PIHP and validated by an EQRO (as described in §438.358(c)(3)), the technical report must include the following related to that EQR activity: • Objectives; • Methods of data collection and analysis; • Description of data obtained; and • Conclusions drawn from the data.	Quality of Care data tables	Yes

CFR Requirement	HHSC Report		Included in Summary of Activities Report?
§438.364(a)(2)(i-iv)	The following information related to the conducting of PIPs: • Objectives; • Methods of data collection and analysis; • Description of data obtained; and • Conclusions drawn from the data.	PIP Evaluations	Yes
§438.364(a)(2)(i-iv)	If appropriate, the following information related to studies on quality that focus on a particular aspect of clinical or nonclinical services at a point in time: • Objectives; • Methods of data collection and analysis; • Description of data obtained; and • Conclusions drawn from the data.	Ad Hoc Focus Studies Ad Hoc Quarterly Topic Reports	Yes

Attachment B – CFR and Relevant MCO Contract Requirements

This chart illustrates how HHSC fulfills CFR requirements in its managed care contracts. While HHSC has multiple managed care contracts covering different programs, this table portrays the Uniform Managed Care Contract (UMCM) and the STAR Kids Contract terms and conditions as examples to demonstrate how CFR requirements are fulfilled.

42 CFR	Element	UMCC Terms and Conditions	STAR Kids Contract Terms and Conditions
Access Standards			
§ 438.206	Availability of services	8.1.2 Covered Services; 8.1.3 Access to Care; 8.1.4 Provider Network; 8.1.5.8 Cultural Competency Plan; 8.1.12 Services for People with Special Health Care Needs;	8.1.2 Covered Services; 8.1.3 Access to Care; 8.1.4 Provider Network; 8.1.4.10.2 Health Home; 8.1.5.8 Cultural Competency Plan;

		8.1.13 Service Management for Certain Populations; 8.1.15 Behavioral Health (BH) Network and Services; 8.1.21 Pharmacy Services; 8.1.24 Immunizations; 8.1.25 Dental Coverage; 8.1.26 Health Home Services; 8.2.1 Continuity of Care and Out-of-Network Services; 8.2.2 Provisions Related to Covered Services for Medicaid Members	8.1.13 Services for Members with Special Health Care Needs; 8.1.16 Behavioral Health (BH) Services and Network; 8.1.17 Pharmacy Services; 8.1.24.13 Immunizations; 8.1.23 Continuity of Care and Out-of-Network Providers; 8.1.24 Provisions Related to Covered Services for Members; 8.1.36 Covered Community-Based Services; 8.1.41 Substance Abuse Benefit; 8.1.45 Facility-Based Care;

			8.1.46 Telemedicine, Telehealth, and Telemonitoring Access; 8.3.2 MDCP STAR Kids Covered Services
§ 438.207	Assurances of adequate capacity and services	8.1.3 Access to Care	8.1.3 Access to Care
§ 438.208	Coordination and continuity of care/Transition of care[13]	8.2.1 Continuity of Care and Out-of-Network Providers; 8.2.7.2.3 Care Coordination; 8.3.2 Service Coordination	8.1.23 Continuity of Care and Out-of-Network Providers; 8.1.38 Service Coordination; 8.3.3 Additional Service Coordination Requirements for MDCP STAR Kids Members

[13] CMS sent feedback from 2017 Quality Strategy submission, received by HHSC in an email on 08/26/2020. CMS indicated they expected transition of care to be included with coordination and continuity of care.

§ 438.210	Coverage and authorization of services	8.1.2 Covered Services	8.1.18 Financial Requirements for Covered Services; 8.1.2 Covered Services;
Structure & Operation Standards			
§ 438.214	Provider selection	8.1.4 Provider Network; 8.1.22 Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs); 8.2.3 Medicaid Significant Traditional Providers	8.1.4 Provider Network; 8.1.23 Continuity of Care and Out-of-Network Providers; 8.1.25 Medicaid Significant Traditional Providers; 8.1.26 Payments to Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs); 8.1.40 Community-Based Service Providers

§ 438.224	Confidentiality	8.1.18.4 Health Insurance Portability and Accountability Act (HIPAA) Compliance	11.0 Disclosure and Confidentiality of Information; 8.1.38.12 Centralized Medical Record and Confidentiality
§ 438.228	Grievance and appeal systems	8.1.5.9 Member Complaint and Appeal Process; 8.2.4 Provider Complaints and Appeals; 8.2.6 Medicaid Member Complaint and Appeal System	8.1.27 Provider Complaints and Appeals; 8.1.29 Member Complaint and Appeal System; 8.1.5.9 Member Complaint and Appeal Process
§ 438.230	Subcontractual relationships and delegation	4.08 Subcontractors; 4.09 HHSC's Ability to Contract with Subcontractors; 8.1.20 General Reporting Requirements	4.05 Responsibility for MCO personnel and Subcontractors; 4.08 Subcontractors and Agreements with Third Parties;

			4.09 HHSC's Ability to Contract with Subcontractors
Measurement & Improvement Standards			
§ 438.236	Practice guidelines	8.1.7.6 Clinical Practice Guidelines; 8.1.8 Utilization Management; 8.1.9 Early Childhood Intervention (ECI): 8.1.10 Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) – Specific Requirements; 8.1.12 Services for People with Special Health Care Needs; 8.1.14 Disease Management	8.1.7.6 Clinical Practice Guidelines; 8.1.9 Utilization Management; 8.1.10 Early Childhood Intervention (ECI): 8.1.11 Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) – Specific Requirements; 8.1.13 Services for Members with Special Health Care Needs; 8.1.14 Disease Management

§ 438.330	Quality assessment and performance improvement program	8.1.1.1 Performance Evaluation; 8.1.7 Quality Assessment and Performance Improvement	8.1.1.1 Performance Evaluation; 8.1.7 Quality Assessment and Performance Improvement
§ 438.242	Health information systems	8.1.18 Management Information System Requirements	8.1.20 Management Information System Requirements

Attachment C – Quality Deliverables to Goals Matrix

This chart explains how each HHSC Quality Initiative, Report, and EQRO activity aligns with and works toward achieving HHSC's goals set forth in Table 1.

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[14] Bolded X's indicate primary priority of quality activity.

Quality Initiatives, Projects, Reports, and EQRO activities	Promoting optimal health for Texas	Strengthening person and family engagement as partners in their care	Providing the right care at the right time	Keeping patients free from harm	Promoting effective practices for people with chronic, complex, and serious conditions	Attracting and retaining high-performing Medicaid providers, including medical, behavioral health, dental, and long-term services and supports providers
Delivery System Reform Incentive Payment (DSRIP)	X		**X** Healthcare providers earn incentive payments for improvement on quality measures like reducing potentially preventable admissions, readmissions, and ED visits.	X	**X** Healthcare providers earn incentive payments for improvement on quality measures for diabetes, heart disease, asthma, and end of life care.	X

LTSS Utilization Review		**X** Annual review and member interview that ensures MCOs are following contractual requirements for LTSS services.	X	X	X	X
MCO Monitoring		X	X	**X** HHSC uses regular data sources to investigate member complaints to ensure appropriate care is provided.	X	X

Quality Assessment and Performance Improvement (QAPIs)	X	X	**X** Annual review of plans quality initiatives to ensure projects are targeting areas that need improvement. That data is being collected and used to inform effective interventions.	X	X	X

Performance Improvement Projects (PIPS)	**X** PIPs are designed to achieve, through ongoing measurements and interventions, significant improvement over time with a favorable effect on health outcomes and member satisfaction.	X	**X** PIP topics are based on health plan performance, and state and federal priorities.	X	**X** PIPs are evaluated for sustained statistical improvement and describes the characteristic of high-risk target populations.	X

Accreditation				X		**X** Requiring plans to have national accreditation ensures plans have been thoroughly vetted through a third party.
Administrative Interviews			**X** A complete review of all policies and procedures every three years to ensure plans are coordinating care and in compliance with federal regulations.	X	X	X

Encounter Data Validation Reports			X			**X** Certifies data for rate setting, which can affect provider recruitment and retention.
Quarterly Topic Reports	**X** The EQRO produces four quarterly topic reports and an annual focused study each year to provide in-depth analysis of issues to inform effective quality interventions.	X	**X**	X	**X**	X

Summary of Activities Report	**X** Texas provides the Summary of Activities report to CMS annually as substantiation of EQRO activities.	X	X	X	X	X
Quality of Care Reports	**X** There are several HEDIS measures included in the QOC report that evaluate whether members are getting appropriate preventive care to ensure optimal health, like immunizations, well child visits, prenatal and postpartum care.	X	X	X	X	X

Frew Report	X		**X** Ensures children and youth under 21 receive timely checkups.	X		
Surveys	X	**X** Asking members about their experience ensures appropriate care is provided.	X	X	X	X
Continuity of Care			**X** Ensuring plans have appropriate continuity of care for members to receive continuous care during transitions.	X	X	X

Focused analysis and quality improvement efforts with MCOs on Beneficiaries with Complex Care Needs and High Costs (BCNs)		X	X	X	**X** 2019 MCO PIP topics address beneficiaries with complex needs. After receiving final reports, HHSC plans to host a best practice panel of MCO representatives whose PIPs demonstrated sustained statistical improvement.	X
Intra- and Interagency Collaboration to improve Texas birth outcomes	**X** Coordinating implementation of maternal health initiatives with DSHS.			X		

Medical Pay-for-Quality Program (P4Q)	**X** Holding a percentage of capitation at-risk for performance on specific metrics.	X	X	X	**X** Choosing specific performance measures that target chronic conditions.	X
Dental P4Q	**X** Holding a percentage of capitation at- risk for performance on specific metrics.	X	X	X	X	X
Uniform Hospital Rate Increase Program (UHRIP)		X	X	X Increases payments to hospitals to advance goals and objectives in the managed care quality strategy, including reducing the rate of adverse healthcare events.		**X**

Quality Incentive Payment Program (QIPP)			X	**X** QIPP incentivizes quality improvement for participating NFs by attaching funds to performance targets across domains of care that include MDS Five-Star quality metrics, workforce development, and infection control.	X	X
Performance Indicator Dashboards	**X** Performance Indicator Dashboards include a series of measures that identify key aspects of performance to support MCO accountability.	X	X	**X** MCOs falling below minimum performance standards on one-third or more of the dashboard measures are subject to corrective action plans.	X	X

MCO Report Cards	X	**X** MCO Report Cards provide newly enrolled Medicaid and CHIP members and their caregivers information to support selection of a managed care health plan in their service area.	X	X	X	X
THLC Portal	**X** A secure web portal where HHSC, MCOs, and the public can track plans performance on numerous quality measures.	X	X	X	X	X

Value Based Purchasing	X Shift in paying for volume to paying for value of healthcare services.	X	X Aims to achieve better care for individuals, better health for populations, and lower cost for the state.	X	X	X
Minimum MCO Alternative Payment Model Thresholds	**X** Improves health outcomes for members, empowers members and improves experience of care, while incentivizing providers.	X	X	**X** Transition provider payment methodologies from volume-based to quality-based, increasing yearly percentages of provider payments linked to measures of quality and/or efficiency.	X	X

Reducing Inappropriate Use of Antipsychotic Medications for Nursing Home Residents				**X** Antipsychotic Medication usage in nursing facilities is monitored using the CMS Antipsychotic Medication Usage Quality Measure (QM) for long stays.	X	