Annual Report on Quality Measures and Value-Based Payments

As Required by
Texas Government Code
Section 536.008

Texas Health and Human Services
December 2021

TEXAS
Health and Human Services

Table of Contents

Executive Summary

Texas Government Code, Section 536.008, directs the Health and Human Services Commission (HHSC) to report annually on its efforts to develop its quality measurement and quality-based (or value-based) payment initiatives.[1,2] Furthermore, Senate Bill (S.B.) 750 (86th Legislature, Regular Session, 2019), required HHSC to develop or enhance statewide initiatives contracted managed care organizations (MCOs) must implement to improve the quality of maternal health care in Texas and submit a report to the legislature summarizing progress.

This annual report presents information on HHSC's healthcare quality improvement activities for the Texas Medicaid programs and the Children's Health Insurance Program (CHIP). Specifically, it provides historical and current information on:

- Managed Care Value-Based Payment Programs,
- 1115 Healthcare Transformation Waiver,
- Directed Payment Programs, and
- Trends in key Quality Measures.

This year, the report includes an addition, titled "*Statewide Initiatives to Improve Quality of Maternal Health Care*," in response to the S.B. 750 requirement.

HHSC is charting a fundamental change in course away from paying for volume to paying for the value of healthcare services. This transformation aims to achieve better care for individuals, better health for populations and lower cost for the state. To this end, HHSC has implemented contract requirements for managed care organizations (MCOs) to achieve minimum levels of alternative payment model (APM) agreements with their providers and redesigned its medical and dental Pay-for-Quality (P4Q) programs. Calendar year 2018 was the first measurement year for these meaningful value-based payment (VBP) initiatives, and HHSC's MCOs and dental maintenance organizations (DMOs) have met expectations on both initiatives since they were introduced. The impact of the novel coronavirus (COVID-19) public health emergency on the entire healthcare system, including Medicaid and CHIP,

[1] https://statutes.capitol.texas.gov/Docs/GV/htm/GV.536.htm
[2] Also, House Bill (H.B.) 1629, 85th Legislature, Regular Session, 2017, required HHSC to include in the report data collected using a quality-based outcome measure for Medicaid and CHIP enrollees with human immunodeficiency virus (HIV) infection: https://capitol.texas.gov/BillLookup/Text.aspx?LegSess=85R&Bill=HB1629

led HHSC to temporarily suspend the P4Q programs for 2020 and 2021 and to freeze APM level requirements for 2022.

HHSC is also actively working to sustain a Texas Medicaid program that continues to advance value-based care and other effective delivery system reforms as funding for the Delivery System Reform Incentive Payment (DSRIP) program winds down. During 2021, HHSC submitted a set of reports to the Centers for Medicare and Medicaid Services (CMS) addressing each of the milestones in its DSRIP Transition Plan approved by CMS in 2020. The milestone reports lay the groundwork to develop strategies, programs and policies to sustain successful DSRIP activities and incorporate emerging areas of innovation into the Medicaid program.

Directed Payment Programs (DPPs) provide another important catalyst for improving quality in the Medicaid program. During 2021, HHSC continued efforts in this area by enhancing the Nursing Facility Quality Incentive Payment Program (QIPP) and the Uniform Hospital Rate Increase Program (UHRIP). HHSC proposed new quality measures for QIPP and the replacement of UHRIP with a Comprehensive Hospital Increase Reimbursement Program (CHIRP). HHSC also proposed the implementation of additional DPPs to advance the goals of the Texas Managed Care Quality Strategy. As of November 15, 2021, CMS has approved the update to QIPP as well as a new DPP for Behavioral Health Services (DPP-BHS), both effective September 1, 2021.

During its regular session, the 87th Legislature directed HHSC to continue advancing value and transparency in the Medicaid program through a set of bills and riders. The legislation is described in a new section of this report on '*Advancing Value-Based Care'*.

Introduction

HHSC administers various programs and measures to improve healthcare quality and outcomes while containing costs in Medicaid and CHIP. These initiatives complement each other to achieve the Medicaid and CHIP value-based care strategy. All are built on a foundation of key quality measures.

Major Initiatives

Medicaid Managed Care Value-Based Payment Programs

Over 95 percent of Texas Medicaid and 100 percent of CHIP recipients are enrolled in an MCO. HHSC contracts with 17 MCOs and three DMOs that manage networks of healthcare providers in their respective service areas.

Over time, Texas has transitioned most of its Medicaid population from fee-for-service (FFS) to managed care and is evolving its Medicaid and CHIP programs from paying for volume to paying for value. The following managed care VBP programs incentivize MCOs and providers towards this goal:

- Medical and dental Pay-for Quality (P4Q) programs[3],
- Alternative Payment Models (APM) Targets[4] to promote MCOs and DMOs to increase APM contracts with providers, and
- Hospital Quality-Based Payment (HQBP) program[5] targeting reductions in some potentially preventable events.

1115 Healthcare Transformation Waiver Program: Delivery System Reform Incentive Payment Program

Under the Medicaid 1115 Transformation Waiver, the DSRIP program funds locally developed, innovative and value-based solutions for uninsured and Medicaid

[3] P4Q information available at: https://hhs.texas.gov/about-hhs/process-improvement/medicaid-chip-quality-efficiency-improvement/pay-quality-p4q-program
[4] MCO value-based contracting information available at: https://hhs.texas.gov/about-hhs/process-improvement/medicaid-chip-quality-efficiency-improvement/value-based-contracting
[5] Hospital quality based payment program available at: https://hhs.texas.gov/about-hhs/process-improvement/medicaid-chip-quality-efficiency-improvement/potentially-preventable-events

populations. DSRIP is funded with inter-governmental transfers (IGTs) from local governmental entities and federal Medicaid matching funds. DSRIP funds flow directly to providers participating in DSRIP (not through the MCOs).

During the first six years of the waiver (2011–2017), DSRIP providers reported on process and outcome measures for specific projects that were selected based on regional assessments of community needs performed by each Regional Healthcare Partnership (RHP). Beginning in Demonstration Year 7 (federal fiscal year 2018), DSRIP providers began reporting on achievement of health outcomes at their system level to measure the continued transformation of the Texas healthcare system.

Directed Payment Programs

DPPs are permitted under federal Medicaid managed care regulations (42 CFR § 438.6(c)). DPPs allow the state Medicaid agency to direct MCOs to make increased payments through adjustments to provider reimbursement rates. The state develops the programs, specific to a class of providers, and directs MCOs to implement the associated provider payments. DPPs must advance the state's Medicaid Quality Strategy and require approval from CMS to authorize federal matching funds. Annual CMS approval is needed to continue the programs.

Existing DPPs that make additional payments to nursing facilities and hospitals, some linked to measures of quality, include:

- Quality Incentive Payment Program for Nursing Facilities (QIPP)[6], and
- Uniform Hospital Rate Increase Program (UHRIP).[7]

The state also proposed four new DPPs: Comprehensive Hospital Increase Reimbursement Program (CHIRP), which would replace UHRIP; Texas Incentives for Physicians and Professional Services (TIPPS); Rural Access to Primary and Preventive Services (RAPPS) and the Directed Payment Program for Behavioral Health Services (DPP-BHS). As of November 15, 2021, QIPP and DPP-BHS have been approved by CMS with an effective date of September 1, 2021.

[6] QIPP information available at: https://hhs.texas.gov/services/health/medicaid-chip/provider-information/quality-incentive-payment-program-nursing-homes
[7] Uniform Hospital Rate Increase Program (UHRIP) - information available at: https://rad.hhs.texas.gov/hospitals-clinic/hospital-services/uniform-hospital-rate-increase-program

Key Quality Measures

HHSC routinely monitors and reports on key indicators of healthcare quality and efficiency. For most indicators, HHSC reports the results by managed care program (e.g., STAR, STAR+PLUS), hospital, MCO/DMO, service area and statewide. Quality measures tracked by HHSC reflect industry standards from reliable sources such as the National Committee for Quality Assurance's (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS) and the Agency for Healthcare Research and Quality (AHRQ). Progress on the frequency and relative costs of potentially preventable inpatient complications, potentially preventable hospital admissions, potentially preventable emergency department visits and potentially preventable hospital readmissions is also documented in this report. These trends in key quality measures are presented across all the Medicaid managed care programs.

To view performance of all its quality and efficiency measures, HHSC developed the Texas Healthcare Learning Collaborative Portal (THLCPortal.com), originally as a tool to support and inform HHSC, MCOs, and DMOs on quality improvement activities. The portal evolved into a public reporting platform that enables users to compare performance of Medicaid and CHIP programs, MCOs and DMOs across process and outcome measures and over multiple time periods and service areas. Through expanded analytics and enhanced data visualizations, the portal allows users to better understand and compare performance and download data for customized analytics. The portal also helps providers understand opportunity areas for value-based contracting with MCOs and DMOs.

Appendix 1 of this report includes additional performance data on statewide initiatives to improve the quality of maternal health care. This information meets requirements for Senate Bill 750, 86th Legislature, 2019.

Value-Based Care Strategy

HHSC's value-based care strategy for Texas Medicaid and CHIP encompasses the VBP programs (e.g., P4Q, APMs and HQBP), the DSRIP program, the DPPs and regular evaluation and reporting of MCO and DMO performance on key quality measures.

As HHSC pursues VBP, it strives to adhere to the guiding principles outlined in its 2021 VBP Roadmap:[8]

1. Continuous Engagement of Stakeholders,
2. Harmonize Efforts,
3. Administrative Simplification,
4. Data Driven Decision-Making,
5. Movement through the VBP Continuum, and
6. Reward Success.

The move to a managed care delivery and payment system in Texas created conditions for the adoption of an effective VBP approach. Rather than only paying providers based on the volume of services delivered, MCOs and DMOs have flexibility and incentives to use VBPs to encourage providers to engage in evidence-based practices, collaborate with peers and connect their members to appropriate clinical and nonclinical services.

The continued, evolutionary shift to value-based care requires collaboration between HHSC, MCOs/DMOs, providers and many other stakeholders. HHSC's Value-Based Payment and Quality Improvement (VBPQI) Advisory Committee plays an important role in supporting collaboration between all Medicaid stakeholders to advancing value-based care. During its August 2021 meeting, the Committee recommended that HHSC adopt a more comprehensive contractual framework to assess MCO and DMO achievement on APMs. In offering this guidance, the Committee pointed out that a focus only on whether MCOs/DMOs meet targets for the volume of APMs could become counter-productive and that HHSC policy should also encourage ongoing evaluation of innovative models, the sharing of key data and best practices, administrative simplification and deeper engagement between MCOs and providers. The committee suggested that rather

[8] Value-Based Payment Roadmap provided at: https://www.hhs.texas.gov/sites/default/files/documents/laws-regulations/policies-rules/Waivers/medicaid-1115-waiver/value-based-payment-roadmap.pdf

than just APM targets, MCOs should be credited for success on a menu of activities designed to advance value-based care in Texas Medicaid.

These recommendations were added to those made previously by the Advisory Committee in September 2020:

- Aligning APMs and performance metrics for maternal and newborn care in Medicaid managed care,
- Adopting VBP methodologies that address social drivers of health to lower healthcare costs and improve outcomes,
- Leveraging multi-payer data to advance collaboration on VBP and quality improvement initiatives across major payers of healthcare,
- Developing strategies to increase adoption of effective APMs by Medicaid MCOs and providers, including by reducing administrative simplification, and
- Identifying lessons learned during the COVID-19 public health emergency to strengthen care delivery and value-based care in Medicaid, such as through the increased deployment of tele-services.

As recognized by the VBPQI Advisory Committee, data sharing, whether by an MCO, DMO or provider, is essential in a VBP environment. For example, managed care providers with APM contracts need regular information from MCOs on their performance on agreed upon quality metrics. For HHSC, public reporting of MCO performance can be an effective strategy to accelerate improvement and establish a transparent and accountable system. With this approach in mind, HHSC provides information about VBP initiatives on its website, including payment arrangements between MCOs and their providers. HHSC is exploring additional ways to leverage its THLC portal[9] to support MCOs, DMOs and providers to pursue APMs that improve outcomes and efficiency.

Additionally, timely access to clinical data is critical to coordination of care. In November 2019, HHSC finalized and submitted to CMS a Health Information Technology (Health IT) Strategic Plan that identified strategies to promote greater sharing of electronic health records and other clinical data among providers, MCOs, DMOs and HHSC.

[9] THLC portal accessed at: https://thlcportal.com/home

Advancing Value-Based Care

The Texas legislature sets the requirements and direction for HHSC's value-based care strategy. During its regular session, the 87th Legislature enacted several bills and riders that impact the trajectory of value-based care:

- Rider 20 (S.B. 1, 87th Legislature, Regular Session, 2021, Article II, HHSC) requires HHSC to develop quality of care and cost efficiency benchmarks for MCOs participating in Medicaid and CHIP by September 1, 2022.
- Special Provision 10.06 (S.B. 1, 87th Legislature, Regular Session, 2021, Article IX) extends the requirement for cross-agency[10] coordination of healthcare strategies and measures supported by the University of Texas Health Science Center (UTHSC)-Houston, Center for Health Care Data (CHCD).
- S.B. 1136 (87th Legislature, Regular Session, 2021) requires HHSC to coordinate with hospitals and other providers that receive uncompensated care (UC) pool payments, to identify and implement initiatives to reduce Medicaid recipient's utilization of hospital emergency department (ED) services. This bill also requires HHSC to encourage Medicaid providers to continue implementing DSRIP-informed effective interventions and best practices.
- House Bill (H.B.) 2090 (87th Legislature, Regular Session, 2021) authorizes the Texas Department of Insurance (TDI) to establish an all payor claims database to increase public transparency of health care information and improve the quality of health care in Texas. This bill also requires the CHCD at the University of Texas Health Science Center in Houston to administer the database and manage the information submitted for inclusion in the database. Medicaid will be represented on a stakeholder advisory group that will be created to provide input on this database.
- House Bill (H.B.) 2658 (87th Legislature, Regular Session, 2021) establishes nursing facilities' minimum performance standards, adopts rules for establishing standards and monitoring provider performance, and sharing data regarding the requirements of the bill with the MCOs, and adds requirements to QIPP for improving nursing facility (NF) staff to patient ratios by January 1, 2025.

[10] There are five agencies involved in the collaboration: Department of State Health Services (DSHS), Employee Retirement System (ERS), Teacher Retirement System (TRS), Texas Department of Criminal Justice (TDCJ) and HHSC.

Managed Care Value-Based Payments Programs

The agency's primary drivers for advancing value-based care in Medicaid managed care include:

1. Pay-for-Quality (P4Q) program,
2. Alternative Payment Models (APM) Requirements for MCOs and DMOs,
3. Hospital Quality Based Payment (HQBP) program, and
4. Medicaid MCO Value-Based Enrollment.

Pay-for-Quality Program

The P4Q program is required for all MCOs and DMOs. The program uses financial risks and rewards, coupled with performance measures, to catalyze performance improvement.

Medical P4Q Program

For the medical P4Q program, up to three percent of each MCO's capitation is at-risk of recoupment. MCOs not meeting target performance thresholds for the P4Q measures could lose capitation dollars that are at risk. Performance is measured against benchmarks (performance within the year relative to state and national benchmarks) and against self (year-to-year improvement over an MCO's own performance).

Recouped capitation dollars from low performing MCOs for at-risk measures are redistributed to high performing MCOs. If there are any remaining funds after the collection and redistribution process, they form a bonus pool to reward high-performing MCOs on specific measures. Because there are significant capitation dollars for an MCO to lose or gain, this program incentivizes MCOs to collaborate with providers to develop VBP models that can help ensure their success. The at-risk measures and effective years for the medical P4Q program (for 2018–2023)[11] are shown in Table 1. Table 2 lists the bonus pool measures and effective years for the same period. HHSC suspended the medical and dental P4Q programs for

[11] Details of measures and methodology available at: https://hhs.texas.gov/sites/default/files/documents/laws-regulations/handbooks/umcm/6-2-14.pdf

measurement years 2020 and 2021 because of the COVID-19 pandemic. Tables 1 and 2 reflect this change.

Table 1. At-Risk Measures for the Medical P4Q Program

Measures	STAR+ PLUS	STAR	STAR Kids	CHIP
Potentially Preventable Emergency Department Visits (PPVs)	2018 2019 2022 2023	2018 2019 2022 2023	2022 2023	2018 2019 2022 2023
Potentially Preventable Admissions (PPAs)		2022 2023		
Potentially Preventable Readmissions (PPRs)	2022 2023			
Appropriate Treatment for Children with Upper Respiratory Infection (URI)		2018 2019		2018 2019 2022 2023
Prenatal and Postpartum Care (PPC)		2018 2022 2023		
Well Child Visits in the First 30 months of Life (W30), First 15 Months of Life[12]		2018 2019		
Diabetes Control - HbA1c < 8% (CDC)	2018 2019 2022 2023			
Diabetes Screening for Members with Schizophrenia or Bipolar Disorder Who are Using Antipsychotics (SSD)	2018 2019			
Cervical Cancer Screening (CCS)	2018 2019 2022 2023			
Child and Adolescent Well-Care Visits (WCV), 12-21 years of age[13]				2018 2019

[12] For Measurement Years 2018 and 2019, this measure was Well Child Visits in the first 15 Months of Life (W15).
[13] For Measurement Years 2018 and 2019, this measure was Adolescent Well Care (AWC).

Measures	STAR+ PLUS	STAR	STAR Kids	CHIP
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (WCC)[14]				2018 2019 2022 2023
Follow-up After Hospitalization for Mental Illness (FUH)	2022 2023		2022 2023	
Childhood Immunization Status (CIS) Combination 10		2022 2023		2022 2023
Follow-up Care for Children Prescribed ADHD Medication (ADD)[15]		2022 2023		
Getting Specialized Services Composite			2022 2023	
Assistance with Care Coordination			2022 2023	

** Note: Prenatal and Postpartum Care was removed from P4Q (STAR) for 2019 due to a change in specifications by the National Committee for Quality Assurance (NCQA). For 2021, only the postpartum care sub measure is used.*
*** For 2021, only the counseling for nutrition sub measure is used.*

[14] For 2018 and 2019, the counseling for nutrition and counseling for physical activity sub-measures are used. For 2022 and 2023, only the BMI percentile documentation sub-measure is used.
[15] For 2022 and 2023, only the initiation sub-measure is used.

Table 2. Bonus Pool Measures for the Medical P4Q Program

Bonus Pool Measures	STAR+ PLUS	STAR	STAR Kids	CHIP
Potentially Preventable Readmissions (PPR)	2018 2019			
Potentially Preventable Admissions (PPA)		2018 2019		
Prevention Quality Indicator (PQI) Composite	2018 2019 2022 2023			
Potentially Preventable Complications (PPC)	2018 2019 2022 2023			
Follow-up Care for Children Prescribed ADHD Medication (ADD) - Initiation Sub-measure			2022 2023	
Low Birth Weight		2018 2019 2022 2023		
Childhood Immunization Status (CIS) Combination 10				2018 2019
Immunizations for Adolescents (IMA) Combination 2				2022 2023
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM) - Glucose and Cholesterol Combined, All Ages		2022 2023		
Chlamydia Screening in Women (CHL)		2022 2023		
Cesarean Sections, uncomplicated deliveries		2022 2023		
Risk of Continued Opioid Use, Total members have >=15 days coverage	2022 2023			
Adherence to Antipsychotic Medications for Individuals with Schizophrenia, 80% Coverage	2022 2023			
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics			2022 2023	

Bonus Pool Measures	STAR+ PLUS	STAR	STAR Kids	CHIP
Breast Cancer Screening, Non-Medicare Total	2022 2023			
Appropriate Treatment for Children with Upper Respiratory Infection (URI) – All Ages			2022 2023	
Pregnancy-Associated Outcomes		2022 2023		
Good Access to Urgent Care	2018 2019	2018 2019		2018 2019
Rating Health Plan a 9 or 10	2018 2019	2018 2019		2018 2019
Rating Their Child's Personal Doctor, a 9 or 10				2022 2023
Getting Care Quickly Composite				2022 2023
Transition to Care as an Adult			2022 2023	
Access to Routine Care, adult survey		2022 2023		
How well doctors communicate composite				2022 2023

The impact of the COVID-19 pandemic on P4Q measures was significant because of members delaying or avoiding preventive and primary care and temporary closures of medical offices in Texas. Because of these impacts, HHSC cannot compare 2020 or 2021 to prior year performance or the national benchmarks established based on prior year performance. Therefore, the P4Q program was suspended for 2020 and 2021. MCOs will not be subject to any recoupments or distributions based on calendar year 2020 or 2021 performance.

Table 3 includes the amounts recouped or distributed per MCO in STAR, STAR+PLUS and CHIP for measurement year 2019. For additional details on the Medical P4Q program results, please refer to the THLC Portal.

Table 3. Medical Pay-for-Quality Program Recoupments and Distributions for 2019 by MCO and Program

MCO	STAR	STAR+ PLUS	CHIP	Total	Percentage of Capitation
Aetna Better Health	$26,510	N/A	$1,830	$28,340	0.0130%
Amerigroup	($2,802,439)	($8,196,121)	$9,534	($10,989,026)	-0.3719%
Blue Cross Blue Shield of Texas	($659,134)	N/A	$4,365	($654,769)	-0.6839%
Cigna-HealthSpring	N/A	$1,802,588	N/A	$1,802,588	0.4028%
Community First Health Plans	$156,208	N/A	$16,660	$172,868	0.0525%
Community Health Choice	$434,478	N/A	$41,172	$475,650	0.0535%
Cook Children's Health Plan	$182,619	N/A	$16,975	$199,594	0.0628%
Dell/Seton Health Plan	$6,290	N/A	$2,250	$8,540	0.0142%
Driscoll Health Plan	$189,317	N/A	($26,957)	$162,360	0.0321%
El Paso Health	$92,822	N/A	$6,056	$98,878	0.0514%
FirstCare	$30,131	N/A	($140,558)	($110,427)	-0.0458%
Molina Healthcare of Texas, Inc.	$195,674	($5,366,214)	$20,018	($5,150,522)	-0.4379%
Parkland Community Health Plan	$126,555	N/A	($71,037)	$55,518	0.0105%
RightCare from Scott & White Health Plan	$50,500	N/A	N/A	$50,500	0.0386%
Superior HealthPlan	$636,716	$3,207,540	$20,502	$3,864,758	0.0919%
Texas Children's Health Plan	$996,169	N/A	$88,288	$1,084,457	0.1110%
UnitedHealthcare Community Plan	$337,585	$8,552,207	$10,901	$8,900,693	0.4551%

Dental P4Q Program

In the dental P4Q program, 1.5 percent of each DMO's total calendar year capitation is at-risk of recoupment. Each DMO's performance on selected measures is compared to performance from two years prior. DMOs that decline in performance overall could lose some of their at-risk capitation. Recouped capitation dollars from a DMO that declines overall may be redistributed to a DMO that improved. The dental P4Q program uses Dental Quality Alliance (DQA) measures to assess preventive care, including oral evaluations, sealants and topical fluoride. The at-risk measures for the dental P4Q program are shown in Table 4.

Table 4. 2018 Measures for Dental Pay-for-Quality Program

Measure	Description	Medicaid	CHIP
DQA Oral Evaluation, Dental Services	Percentage of enrolled children: • who received a comprehensive or periodic oral evaluation within the reporting year	2018 2019 2021 2022	2018 2019 2021 2022
DQA Topical Fluoride for Children at Elevated Caries Risk, Dental Health Services	Percentage of enrolled children: • at "elevated" risk for cavities (i.e. "moderate" or "high") and • who received at least 2 topical fluoride applications within the reporting year	2018 2019 2021 2022	2018 2019 2021 2022
DQA Sealants for 6-9-year-old Children at Elevated Risk, Dental Services	Percentage of enrolled children: • at "elevated" risk for cavities (i.e. "moderate" or "high") and • who received a sealant on a permanent tooth within the reporting year	2018	2018
DQA Sealants for 10-14-year-old Children at Elevated Risk, Dental Services	Percentage of enrolled children: • at "elevated" risk for cavities (i.e. "moderate" or "high") and • received a sealant on a permanent second molar tooth within the reporting year	2018	2018
DQA Measure: Sealant Receipt on Permanent 1st Molars, One Sealant and All Four Sealants	Percentage of enrolled children, who have ever received sealants on permanent first molar teeth: • at least one sealant • all four molars sealed by the 10th birthdate	2021 2022	2021 2022

Measure	Description	Medicaid	CHIP
DQA Measure: Sealant Receipt on Permanent 2nd Molars, One Sealant and All Four Sealants	Percentage of enrolled children, who have ever received sealants on permanent second molar teeth: • at least one sealant • all four molars sealed by the 15th birthdate	2021 2022	2021 2022

HHSC suspended the dental P4Q program for 2020 because of the COVID-19 pandemic. The dollar amounts recouped and distributed for 2018 dental P4Q are listed in Table 5.

Table 5. Dental Pay-for-Quality Program Recoupments and Distributions for 2018 and 2019 by DMO and Program

Year	DMO	CHIP	Medicaid	Total	Percentage of Capitation
2018	DentaQuest	$0	$0	$0	0.00%
	MCNA	($10,530)	($478,108)	($488,638)	-0.09%
2019	DentaQuest	$0	($1,354,657)	($1,354,657)	-0.19%
	MCNA	$0	$0	$0	0.00%

Alternative Payment Model Requirements for MCOs

The medical and dental P4Q programs serve as a catalyst for MCOs and DMOs to pursue VBP arrangements with providers to achieve required P4Q outcomes. In addition, HHSC's MCO and DMO contracts require them to reach escalating APM targets each year, from calendar year 2018 through 2021. Revised contract language is being considered following the recommendations made by the VBPQI Advisory Committee (page 7). The APM targets from 2021 will remain the same for calendar year 2022 because of COVID-19 and will be modified for subsequent years. The recommendations of the VBPQI Advisory Committee, MCOs/DMOs and other stakeholders will inform HHSC decisions.

HHSC uses the Healthcare Payment Learning and Action Network (HCP LAN) Alternative Payment Model (APM) Framework[16] (Figure 1) to help guide this effort. This framework provides a menu of payment models from which MCOs could choose to develop APM contracts with their providers. Moving from one category to the next adds a level of risk to the payment model. MCOs can choose any of these models in their transition to a payment structure based on value.

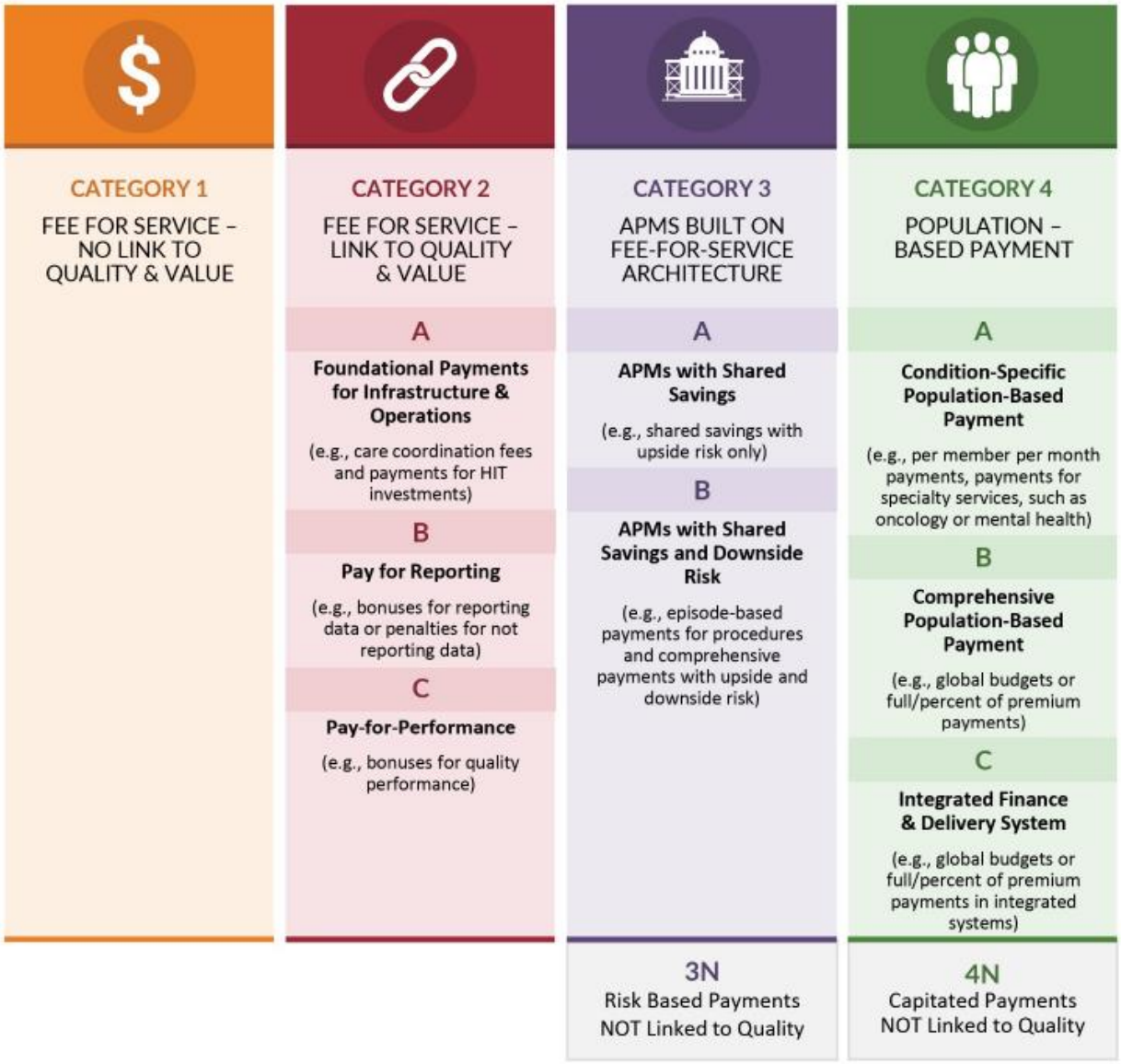
In spring 2019, the HCP LAN developed a Roadmap for Driving High Performance in Alternative Payment Models[17] (the "Roadmap"), an interactive, web-based implementation guide that public and private payers can use to work with providers, purchasers, patients, consumers and others. The Roadmap offers users a robust set of promising practices organized around three domains: APM Design, Payer-Provider Collaboration, and Patient-Centered Care, which provide real-world guidance for organizations seeking to design, operate and scale APMs. The interactive design enables Roadmap users to access specific resources relevant to their own context and challenges.

In Fall 2019, the HCP LAN revised their goals for establishing APMs across the United States for various payers, focusing on two-sided APMs (APMs with downside risk for providers). For Medicaid programs, the HCP LAN recommends APM targets of 15 percent in 2020, 25 percent in 2022, and 50 percent in 2025.

[16] LAN Framework provided at: http://hcp-lan.org/workproducts/apm-framework-onepager.pdf
[17] LAN Roadmap for Driving High Performance in Alternative Payment Models provided at: https://hcp-lan.org/apm-roadmap/

This framework represents payments from public and private payers to provider organizations (including payments between the payment and delivery arms of highly integrated health systems).

Figure 1. HCP LAN Alternative Payment Model (APM) Framework



It is designed to accommodate payments in multiple categories that are made by a single payer, as well as single provider organizations that receive payments in different categories—potentially from the same payer. Although payments will be classified in discrete categories, the Framework captures a continuum of clinical and financial risk for provider organizations as it moves from Category 1 to 4.

Specifically, the risk models are considered by LAN starting with Category 3B up to 4C. The APMs are incentive-based models that pay bonuses to providers that hit predetermined quality benchmarks, develop VBP infrastructure, or report their quality data.

Table 6. HCP LAN Alternative Payment Model (APM) Framework[18]

Category 1: Fee-for-Service – No Link to Quality & Value	Category 2: Fee-for-Service – Link to Quality & Value	Category 3: APMs Built on Fee-for-Service Architecture	Category 4: Population-Based Payment
	CATEGORY 2A: Foundational Payments for Infrastructure & Operations (e.g. care coordination fees and payments for HIT investments)	**CATEGORY 3A: APMs with Shared Savings** (e.g. shared savings with upside risk only)	**CATEGORY 4A: Condition-Specific Population-Based Payment** (e.g. per member per month payments for specialty services, such as oncology or mental health)
	Category 2B: Pay for Reporting (e.g. bonuses for reporting data or penalties for not reporting data)	**Category 3B: APMs with Shared Savings and Downside Risk** (e.g. episode-based payments for procedures and comprehensive payments with upside and downside risk)	**Category 4B: Comprehensive Population-Based Payment** (e.g. global budgets or full/percent of premium payments)
	Category 2C: Pay for Performance (e.g. bonuses for quality performance)		**Category 4C: Integrated Finance & Delivery Systems** (e.g. global budgets or full/percent of premium payments in integrated systems)
		3N: Risk Based Payments NOT Linked to Quality	**4N: Capitated Payments NOT Linked to Quality**

[18] Table 6 is an accessible version of Figure 1, HCP LAN APM Framework.

Effective in calendar year 2018, HHSC introduced contractual requirements for MCOs and DMOs to promote VBP, as follows:[19]

- *Establishment of MCO and DMO APM targets:* Overall and risk-based APM contractual targets were established for MCO expenditures on VBP contracts with providers relative to all medical and pharmacy expenses. For MCOs, the targets start at 25 percent of provider payments in any type of APM and 10 percent of provider payments in risk-based APMs for calendar year 2018. These targets increase over four years up to 50 percent overall and 25 percent risk-based by calendar year 2021. For DMOs, these targets were set at 25 percent overall and two percent risk-based in 2018. The targets for DMOs increase to 50 percent, with 10 percent risk-based by 2021.
- MCOs and DMOs must submit inventories of their APM initiatives developed with providers every year: These reports are used to calculate the accomplishment level of the targets and the negative or positive gap between accomplishment and targets.
- Requirements for MCOs and DMOs to establish and maintain data sharing processes with providers: MCOs and DMOs must share data and reports with providers and collaborate on common formats, if possible.
- Requirements for MCOs and DMOs to adequately resource this activity: MCOs and DMOs must dedicate sufficient resources for provider outreach and negotiation, assist with data and/or report interpretation and initiate collaborative activities to support VBP and provider improvement.
- Requirements for MCOs and DMOs to have a process in place to evaluate APM models: MCOs and DMOs are required to evaluate the impact of APM models on utilization, quality, cost and return on investment.

HHSC collects MCO and DMO reports on their APM initiatives on an annual basis. In general, most of the reported APM initiatives involve primary care providers, are incentive-based and build on an FFS payment approach with financial distributions for achieving established quality measures or lowering total cost of enrollee care. Additionally, MCOs have reported APMs with specialists (including obstetricians/ gynecologists), behavioral health providers, hospitals, nursing facilities and long-term services and support providers.

[19] Texas Uniform Managed Care Contract provided at: https://www.hhs.texas.gov/sites/default/files/documents/services/health/medicaid-chip/programs/contracts/uniform-managed-care-contract.pdf (page 8-95)

The APM targets are established at the program level.[20] Examining the first two target years (2018 and 2019) shows the APM targets were exceeded each year in both overall and risk-based APMs, with a notable increase in the adoption of APMs in the second year (see Figure 2 and Figure 3).

Figure 2. Overall APM Achievement by Program, CYs 2018–2019

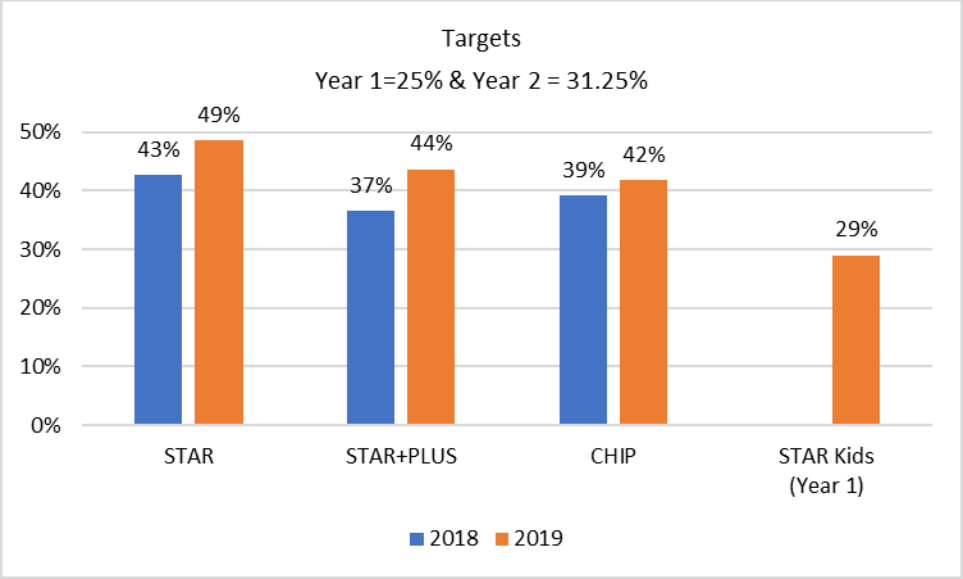
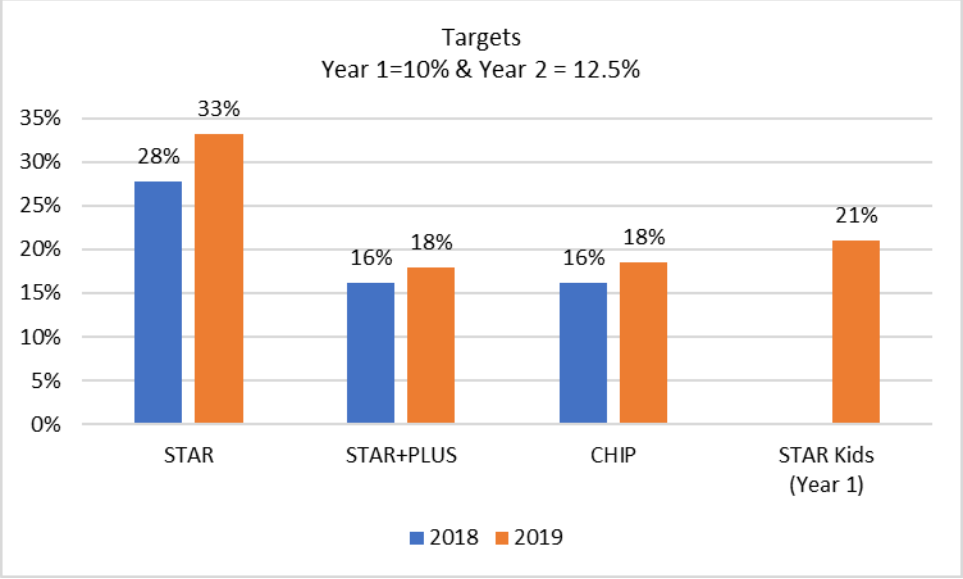


Figure 3. Risk-based APM Achievement by Program, CYs 2018–2019



[20] Starting with 2018, the APM targets were applied to STAR, STAR+PLUS, CHIP, and STAR Health programs. STAR Kids requirements were effective beginning in 2019.

Although active since late 2016, the STAR Kids program had its first APM target year in 2019 and like the other three programs outperformed its targets in both overall and risk-based APMs.

Because of the impact of COVID-19, the APM targets for 2021 will remain the same for 2022. Following that, new APM targets and other requirements will be introduced for years 2023 through 2025, informed by stakeholder input through the VBPQI Advisory Committee and national work occurring through the LAN.

Following the challenges presented by COVID-19, in the Fall of 2020, the HCP LAN launched its Healthcare Resiliency Collaborative and associated framework. This framework promotes collaboration between payers, providers and multi-stakeholders to shift payments away from FFS approaches that did not work in the pandemic into more flexible APMs. In this sense, HCP-LAN "population-based payment" models promote resiliency through coordination of care within a person-centered approach.

Furthermore, as of summer of 2021, HCP-LAN is aligning its strategy with CMS's Center for Medicare and Medicaid Innovation commitment to value-based care. The leading principles of this alignment are seeking consensus around outcomes for value-based care, healthcare transformation with the patient at the center of the system, a focus on heath equity and partnership between public and private sectors.

Initial APMs established in Medicaid have tended to focus on primary care models, followed by hospitals and specialists/behavioral health providers (Table 7). For 2018, nearly three-fourths of all models are for those provider types, with over 40 percent in primary care alone. That proportion was maintained in calendar year 2019, with an increase in primary care APMs, a decrease in hospital representation, and a slight decrease in specialists, including behavioral health APMs.

As noted previously, APMs are not common for long-term services and supports (e.g. nursing facilities/home care), an area with significant Medicaid expenditures. The VBPQI Advisory Committee has established a workgroup that will issue recommendations in 2022 to promote APMs within the LTSS system, particularly home health services.

Table 7. Distribution of APMs by Provider Type, CYs 2018–2019

Provider Type	Number of APMs	Number of APMs	Percentage of APMs	Percentage of APMs
Year	2018	2019	2018	2019
Primary Care	143	181	41%	45%
Hospitals	62	60	18%	15%
Specialist and Behavioral Health	50	51	14%	13%
Accountable Care Organization	36	43	10%	11%
Obstetrics/Gynecology	27	29	8%	7%
Pharmacy and Laboratory	17	16	5%	4%
Nursing Facilities and Home Care	9	13	3%	3%
Emergency and Urgent Care Services	7	5	2%	1%
Case Management		1		0%
Total	**351**	**399**	**100%**	**100%**

The state's goals on the future development and expansion of its VBP strategy through APMs has been captured in several documents published in state fiscal year 2021 as part of HHSC's DSRIP Transition Plan. The following are summaries of the information detailed in these Transition Plan deliverables published as Transition Milestone Updates:

- The *"Value Based Payment (VBP) Roadmap"* (March 2021), while centered on HHSC healthcare quality goals, describes how the state plans to move forward with VBP, the status of its current programs, along with its guiding principles for success;
- The "*Alternative Payment Models in Texas Medicaid*" (March 2021), which accompanied the VBP Roadmap, includes a report of managed care organizations' APM achievement to that point in time. This document highlights the role of APMs in managed care, along with other aspects of the

state's VBP strategy that are helping to transform Texas Medicaid from a volume to a value-based system;

- An "*Assessment of Financial Incentives for Alternative Payment Models*" (June 2021) and "*Quality Improvement Cost Guidance*" supplemented the VBP Roadmap and the APM report (above). The assessment demonstrated the effectiveness of financial incentives to improve quality as evidenced by better MCO performance on quality measures associated with a financial incentive than on measures without an incentive.

HHSC plans to continue support for the APM initiative and work with stakeholders to facilitate new and more advanced arrangements as recommended by the HCP-LAN.

Hospital Quality-Based Payment Program

HHSC administers the HQBP Program for all hospitals in Medicaid and CHIP in both the managed care and FFS delivery systems.[21] Hospitals are measured on their performance for risk-adjusted rates of potentially preventable hospital readmissions within 15 days of discharge (PPR) and potentially preventable inpatient hospital complications (PPC) across all Medicaid Programs and CHIP, as these measures have been determined to be reasonably within hospitals' ability to improve. Hospitals can experience reductions to their payments for inpatient stays: up to two percent for high rates of PPRs and 2.5 percent for PPCs. Measurement, reporting and application of payment adjustments occur on an annual cycle.[22]

Hospital Performance: Potentially Preventable Readmissions

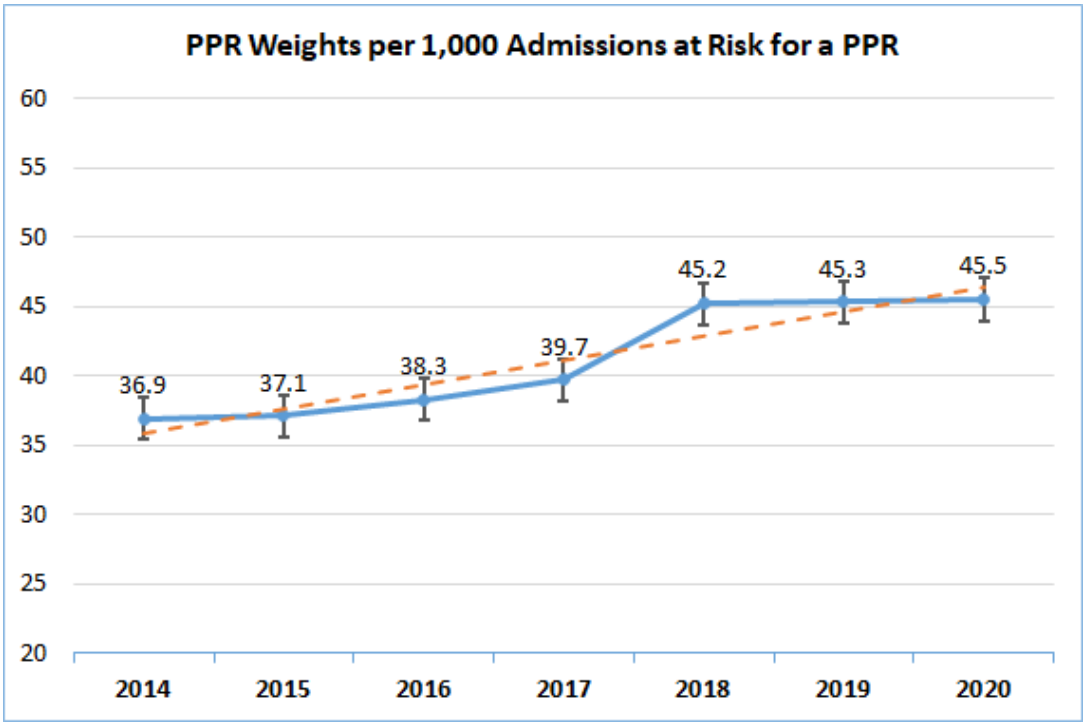
Changes in hospital performance on PPRs for 2014 to 2020 are shown in Figure 4. Decreases indicate better performance, while an increase means worse performance.

For each year, the "weight" per 1,000 admissions at risk for a PPR is shown for all hospitals measured. The "weight" captures changes in resources consumed by hospitals for readmissions (including financial), rather than just changes in the actual rate of those events. Not all readmissions are equal, and the use of weighted rates provides a standardized representation of relative costs. For example, if two

[21] HQBP program information available at: https://hhs.texas.gov/about-hhs/process-improvement/medicaid-chip-quality-efficiency- improvement/potentially-preventable-events
[22] Texas Administrative Code, Title 1, Part 15, Chapter 354, Subchapter A, Division 35, Reimbursement Adjustments for Potentially Preventable Events.

hospitals have the same PPR event rate, but one hospital's PPRs were costlier, it would have a higher "weighted" rate. From 2014 to 2020, there was a 23 percent increase in hospital PPR "weighted" rates per 1,000 admissions at risk for a PPR, which indicates increasing total costs associated with PPRs. The worsening trend can be attributed to increased readmissions with higher costs, independent of hospital overall cost increases over time. The hospital-level PPR rates were weighted based on expected resource use to examine the trend in hospital PPR performance across the state as seen in Figure 4.

Figure 4. Changes in hospital PPR performance for 2014–2020



In 2020 HHSC studied the "weighted" and "unweighted" risk-adjustment methods for evaluating individual hospital's performance on PPRs, as directed by S.B. 1207 (86th Legislature, Regular Session, 2019). As a result, HHSC began using the "unweighted" method for its state fiscal year 2022 HQBP reimbursement reductions.[23] However, the use of "weighted" PPR performance is appropriate to assess aggregate performance of all hospitals, as presented below. The "weighted"

[23] Though it is appropriate to compare "weighted" PPR performances for all hospitals across this time period, it should be noted that event based PPR rates were used to assess hospital level reimbursement reductions for the state fiscal year 2020 report cycle. In other words, the state fiscal year 2020 hospital report cycle used the actual PPR rate within a hospital compared to the expected rate based on statewide results in order to determine potential reimbursement adjustments.

PPR rate is also used in the representation of this performance measure on the HHSC THLC Portal.

As required by the 85th Legislature, HHSC conducted an evaluation of Medicaid managed care in Texas in 2018.[24] The evaluation report identified the increasing PPR trends 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 increase efforts to reduce their rates of PPRs by at least 10 percent. Implementation of this efficiency adjustment lowered fiscal year 2020 capitation rates by $21.4 million.

Hospital Performance: Potentially Preventable Complications

Beginning with the 2017 measurement period the state's PPC methodology changed,[25] slightly reducing the number of complications considered potentially preventable. Results for the most frequently occurring PPCs from 2017 to 2020 mostly decreased in statewide cumulative weights after the methodology changes. Figures 5 and 6 show the trends for these five most frequent complications from 2014 to 2016 (previous methodology) and from 2017 to 2020 (new methodology), respectively.

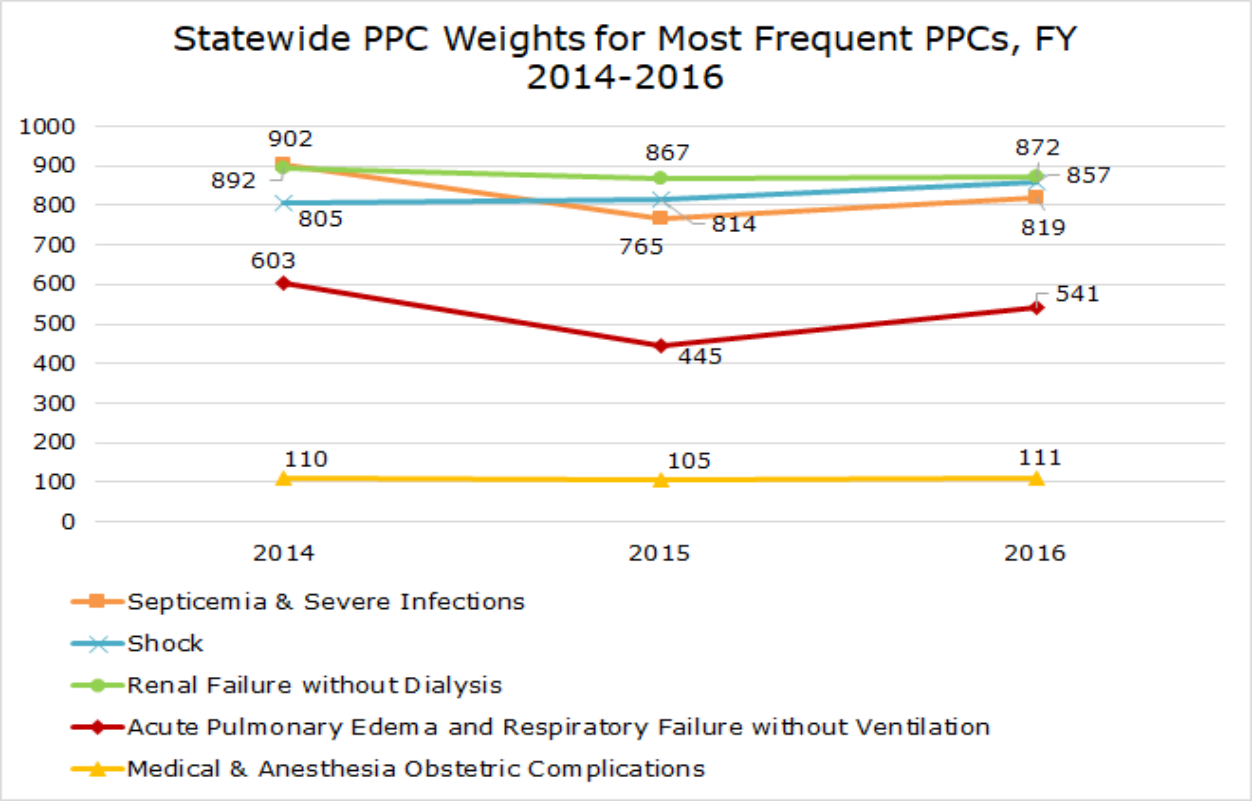
As shown (Figure 5), in the first three years of observation the predominant PPCs were Renal Failure without Dialysis, Septicemia and Severe Infections, and Shock, followed at distance by Acute Pulmonary Edema and Respiratory Failure (without Ventilation), and Medical and Anesthesia Obstetric Complications. The profile did not change much during the last four years (Figure 6). However, while the same three main causes remained the top conditions, the order changed: Septicemia and Severe Infections were the most frequent followed by Shock and Renal Failure without Dialysis.

It is valid to compare the weights within each figure, but trends from the 2014 to 2016 period should not be compared to the 2017 to 2020 period due to the methodology changes. All five PPCs weights were relatively stable in each time

[24] The 2018-19 General Appropriations Act, Senate Bill 1, 85th Texas Legislature, Regular Session, 2017 (Article II, HHSC, Rider 61): Texas Health and Human Services Commission (HHSC). Deliverable 7 – Rider Report 61. Final Comprehensive Report. Rider 61: Evaluation of Medicaid and CHIP Managed Care. August 17, 2018.
[25] Texas Potentially Preventable Complications Methodology provided at: https://hhs.texas.gov/sites/default/files/documents/about-hhs/process-improvement/PPC-methodology-overview.pdf

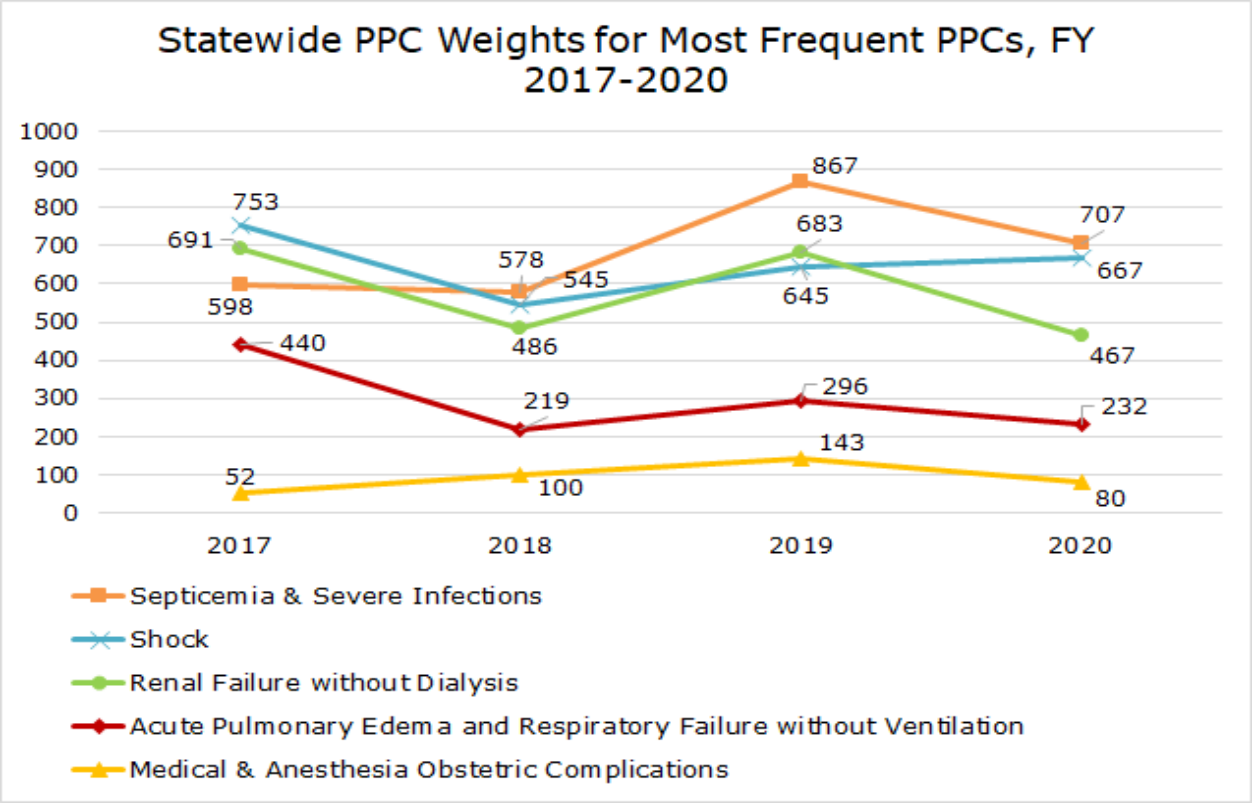
period. Septicemia and Severe Infections and Medical and Anesthesia Obstetric Complications each saw increases in cumulative weights from 2017 to 2019.

Figure 5. Changes in hospital PPC performance for 2014–2016



Concomitantly, there were relative improvements during this time period, with general decreases in three of the five: Shock and Acute Pulmonary Edema, with Renal Failure fluctuating. Finally, apart from Shock, all the other four PPCs improved during 2020, perhaps because of COVID-19 as an interfering factor.

Figure 6. Changes in hospital PPC performance for 2017–2020



Some increases were observed in the weighted rates for the most frequent PPRs, but data presented later in this report, for the full range of PPCs, indicate a relatively consistent improvement in performance over the years, particularly for the STAR+PLUS program (See Figures 14 and 15).

Medicaid Value-Based Enrollment

Texas Government Code, Section 533.00511[26] "directed HHSC to create an incentive program to automatically enroll a greater percentage of recipients who did not actively choose their managed care plan, in a managed care plan based on:

1. The quality of care provided through the MCO offering that managed care plan,
2. The organization's ability to efficiently and effectively provide services, taking into consideration the acuity of populations primarily served by the organization, and

[26] As added by Acts 2013, 83rd Legislature, Regular Session, Chapter 1310 (Senate Bill 7), Section 4.03, effective September 1, 2013.

3. The organization's performance with respect to exceeding, or failing to achieve, appropriate outcome and process measures developed by the commission, including measures based on potentially preventable events."[27]

At the time the statute was enacted, HHSC determined that there would be cost impacts to implement these requirements. To comply with the statute and to empower prospective enrollees to make informed choices about MCOs in their service area, HHSC created annual report cards of MCO performance. Report cards for CHIP, STAR, STAR+PLUS and most recently STAR Kids are posted on HHSC's website and mailed to prospective enrollees with their enrollment packets. HHSC's goals for creating the report cards included the intention to lower the percentage of candidates '*defaulted*' into an MCO, by providing prospective members information about each MCOs' overall quality measured by active member's experience with care, staying healthy, and common chronic conditions.

In the past, when an individual was enrolled in Medicaid and CHIP, s/he (and/or their caregivers), were encouraged to select an MCO using the report cards. If a Medicaid client did not select an MCO, HHSC assigned the respective client to an MCO and a primary care physician (PCP) using a '*default*' methodology. Under that process, the number of clients auto assigned to an MCO reflected the percentage of members in a service area choosing that MCO.

The 86th Legislature[28] further directed HHSC pursuant to Government Code 533.00511 to "create an incentive program that automatically enrolls a greater percentage of Medicaid recipients who have not selected a managed care plan into a managed care plan based on quality of care, efficiency and effectiveness of service provision and performance." Accordingly, HHSC developed a value-based enrollment methodology that incorporates information from key cost, quality of care and member satisfaction metrics. MCOs with better performance than others measured using the value-based factors listed below, receive a higher share of Medicaid enrollments than under the current '*default*' methodology.

The Value-Based Enrollment (VBE) methodology employs three main domains:

- Risk-Adjusted Actual to Expected **Spending Ratio** (measure Cost or Efficiency),

[27] "Potentially preventable event" means a potentially preventable admission, a potentially preventable ancillary service, a potentially preventable complication, a potentially preventable emergency department visit, a potentially preventable readmission, or a combination of those events. (Texas Government Code Sec. 536.001).
[28] 2020-21 General Appropriations Act, H.B. 1, 86th Legislature, Regular Session, 2019, (Article II, HHSC, Rider 43, pg. II-62).

- Risk-Adjusted **Potentially Preventable Events (PPE) Ratios** (measure Cost and Quality), and
- Composite **MCO Composite Report Card Scores** (measure Quality and Member Satisfaction):
  - Member experience with doctors and the MCO – derived from results of member surveys;
  - Staying healthy – MCO performance on preventive care measures; and
  - 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 calculates a value score combining quality, cost, and member satisfaction data from the three domains. The value score is then used to determine monthly MCO auto enrollment for members who do not choose an MCO.

HHSC used a phased approach to implement the program starting on September 1, 2020 in three Medicaid programs: STAR, STAR+PLUS, and STAR Kids. In Phase I, HHSC introduced the new methodology with a "soft launch" during which it sent to MCOs simulations of their monthly auto enrollment of clients from September 1, through November 30, 2020.These simulations also showed each MCO the difference in their member enrollment by comparing the numbers using the old and the new enrollment methodology.

In Phase II, HHSC began its actual implementation with a "hard launch" using the new value-based methodology for auto enrollments starting on December 1, 2020.

HHSC released a report to the Governor on January 15, 2021 which describes the new enrollment program, its progress status and the metrics applied in the new value-based methodology.[29]

The data used to calculate the VBE is released in April for the report cards, in June for the Spending Ratios, and in September for PPEs. The Value Scores for each domain will be updated as data are released twice every year, first in May using the report card data update and second in September using updated cost and PPE data. Once the VBE is updated, the enrollment reports are sent monthly to the MCOs by HHSC.

[29] https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2020/hb1-value-based-enrollment-incentive-program-jan-2021.pdf

After implementation, HHSC assessed the effect of the VBE process based on six months of enrollment data for STAR, STAR+PLUS, and STAR Kids. Table 8 shows the impact of VBE on MCOs, both cumulative and for each program. Statewide, for 17 participating MCOs across the STAR, STAR+PLUS, and STAR Kids programs combined, five plans gained greater than 2.5 percent in auto-enrollments compared to the previous process, five plans lost at least 2.5 percent, and seven plans saw changes of no greater than 2.5 percent. Overall enrollment based on the new methodology varied between over 12 percent gains to almost 12 percent losses in cumulative proportions across the three Medicaid programs.

Table 8. Statewide Auto-Enrollment Pool Percent Changes
December 2020 –May 2021

Health Plan	Cumulative	STAR	STAR+PLUS	STAR Kids
Aetna Better Health	-3.2%	-3.5%		0.5%
Amerigroup	0.5%	0.4%	0.9%	3.2%
Blue Cross Blue Shield of Texas	-10.9%	-11.9%		-4.6%
Cigna HealthSpring	-4.7%		-4.7%	
Community First Health Plans	0.2%	0.5%		-4.9%
Community Health Choice	7.1%	7.1%		
Cook Children's Health Plan	8.8%	9.2%		-1.7%
Dell Children's Health Plan	12.2%	12.2%		
Driscoll Health Plan	5.1%	5.0%		8.8%
El Paso First Health Plans	4.9%	4.9%		
FirstCare Health Plans	-2.2%	-2.2%		
Molina Healthcare of Texas	-7.9%	-10.7%	-2.7%	
Parkland Community Health Plan	1.2%	1.2%		
Baylor Scott & White Health Plan	1.3%	1.3%		
Superior HealthPlan	-0.2%	-0.6%	2.2%	0.7%
Texas Children's Health Plan	-2.1%	-2.1%		-2.2%
UnitedHealthcare Community Plan	-4.3%	-7.1%	0.5%	1.2%

1115 Healthcare Transformation Waiver

Delivery System Reform Incentive Payment (DSRIP) Program

CMS originally approved the Texas Healthcare Transformation and Quality Improvement Program 1115 Waiver as a five-year demonstration program from December 2011 to September 2016 (Demonstration Years [DY] 1-5).[30] An initial one-year extension continued the waiver through DY 6 (October 2016 to September 2017). On December 21, 2017, CMS approved an additional five-year extension of the Waiver from October 2017 to September 2022 (DY 7-11) and a four-year extension of DSRIP through September 30, 2021. On August 13, 2021, CMS offered to extend DSRIP for an additional year, through September 30, 2022.

The Texas 1115 Healthcare Transformation Waiver extension continues Medicaid managed care statewide and maintains funding pools for Uncompensated Care and the DSRIP program. The DSRIP funding pool was extended only for four years through September 30, 2021.

The DSRIP program provides incentive payments to Texas hospitals, physician practices, community mental health centers, and local health departments for investments in delivery system reforms. During DY 2-6 (October 2012 to September 2017), approximately 300 DSRIP providers implemented over 1,450 locally driven projects to increase access to healthcare, improve the quality of care, and enhance the health of patients and families served.

Beginning with DY 7 (October 2017 to September 2018), the DSRIP program structure evolved from project-level reporting to provider-level outcome reporting. HHSC worked with clinical experts and stakeholders throughout the state to develop a menu of measures that align with Medicaid program goals and state priorities. State priority measure bundles were developed to include measures related to chronic disease management for diabetes and heart disease, preventive care and chronic disease screening, pediatric primary care, and chronic disease management, improved maternal care and maternal safety and behavioral health care.

[30] https://hhs.texas.gov/laws-regulations/policies-rules/waivers/medicaid-1115-waiver

When CMS renewed the waiver in December 2017, it authorized DSRIP through September 30, 2021 and required Texas to submit a transition plan outlining how the state would sustain healthcare transformation without DSRIP funding. In September 2019, Texas submitted a draft DSRIP Transition Plan to CMS.[31] On September 2, 2020, CMS approved the state's revised DSRIP Transition Plan. The milestones included in this transition plan lay the groundwork to develop strategies, programs, and policies to sustain successful DSRIP activities and for emerging areas of innovation in health care. The DSRIP Transition Plan contains the following goals for continued delivery system reform:

- Advance APMs that target specific quality improvements,
- Support further delivery system reform that builds on the successes of the Waiver and includes current priorities in health care,
- Explore innovative financing models,
- Develop cross-focus areas such as social drivers of health that use the latest national data and analysis to continue to innovate in Texas, and
- Strengthen supporting infrastructure for increased access to health care and improved health for Texans.

HHSC has submitted the following completed DSRIP Transition deliverables to CMS. All deliverables are available on the HHSC DSRIP Transition web page:[32]

- Submitted in December 2020
  - Report on analysis of Demonstration Year (DY) 7-8 DSRIP quality data and related core activities, and
  - Proposals for new programs, including state directed payment programs, to sustain key DSRIP initiative areas in DY 11.
- Submitted in March 2021
  - Updated Texas Medicaid Managed Care Quality Strategy,
  - Value Based Payment (VBP) Roadmap and report of managed care organizations' alternative payment model achievement,
  - Assessment of Social Factors impacting Health Care Quality in Texas Medicaid, and

[31] https://hhs.texas.gov/laws-regulations/policies-rules/waivers/medicaid-1115-waiver/dsrip-transition
[32] https://www.hhs.texas.gov/laws-regulations/policies-rules/waivers/medicaid-1115-waiver/dsrip-transition

    - Texas Medicaid Managed Care SDOH Focus Study and Addendum.
- Submitted in June 2021
    - Assessment of Incentives for Alternative Payment Models report and Guidance for MCOs on Quality Improvement Cost Reporting,
    - Assessment of Telemedicine and Telehealth report, and
    - Options for the RHP Structure Post DSRIP report.
- Submitted in September 2021
    - Summary of analysis of options for new programs and initiatives to implement after DSRIP funding ends.

DSRIP Success in Achieving Performance Goals

In DYs 7-10 (October 2017-September 2021), the DSRIP program was renewed and re-structured to prioritize provider-level outcome reporting. For DSRIP Category C reporting, targeted Measure Bundles were developed for hospitals and physician practices and lists of measures are available for community mental health centers and local health departments. Measure Bundles consist of measures that share a unified theme, apply to a similar population and are impacted by similar activities. DSRIP providers selected Measure Bundles or measures to adopt based on their system infrastructure and community needs. A minimum number of measures or Measure Bundles must be selected to participate, which is determined by a calculation that considers the provider's total monetary valuation in the DSRIP program and the provider type. Providers are required to report most measures as pay-for-performance (P4P). Providers receive an incentive payment for reporting data to HHSC and an incentive payment for achieving performance improvement over the provider's baseline for those measures.

For P4P measures, providers that demonstrated improved performance on selected Category C outcome measures qualified for a partial incentive payment if they achieved at least 25 percent of the improvement goal. The improvement goal was set with a standard formula for each outcome measure that calculates improvement over a reported baseline relative to national benchmarks. The full incentive payment was earned if a provider met or exceeded 100 percent of the improvement goal. The number of Category C P4P outcome measures for which performance was reported and the number of outcomes that earned a partial or full incentive payment based on the results are shown in Tables 9, 9.i, 9.ii and 9.iii. As noted in

the tables, most reported outcomes achieved at least 25 percent of their goal, and a high percentage achieved 100 percent of their goal, which is evidence of quality improvements across the state.

The COVID-19 pandemic resulted in significant changes in care delivery. In August 2020, in recognition of these challenges, CMS approved multiple allowances that support providers in improving performance and earning incentive payments for calendar year 2020 (DY 9). These flexibilities have been renewed for DY 10. Approved COVID-19 reporting accommodations included:

- Providers could earn payment for DY 9 achievement milestones based on the higher of their approved DY 8 achievement, the statewide average approved DY 8 achievement per measure or measure bundle, or DY 9 achievement in calendar year 2020,
- For measures that have been selected by 10 or fewer providers, the average approved DY 8 achievement per bundle for measure was approved as the minimum payment for a provider's DY 9 achievement milestone, and
- Providers were required to report calendar year 2020 data to be eligible for payment on the Category C DY 9 achievement milestones.

The following information summarizes the achievement of DSRIP providers on Category C P4P outcomes in DYs 7-9 and for some of the most frequently reported measures in DY 9. All DY 9 achievement percentages include CMS approved COVID-19 allowances.

Table 9. DSRIP Category C Achievement for All P4P Outcomes, DYs 7-9

Demonstration Year (DY)	Number of P4P Outcomes in DY[33]	Percentage of Measures with 100% Goal Achievement
DY 7	2,590	86%
DY 8	2,590	96%
DY 9[34]	2,625	76%

[33] This is the total number of pay-for-performance outcomes eligible to be reported per DY. There are approximately 300 DSRIP providers.
[34] Achievement data for DY 9 only reflects results for outcomes that have reported calendar year 2020 data. Providers have reported calendar year 2020 data for 93 percent of outcome measures. Providers have until October 2021 to report calendar year 2020 data and have until April 2022 to achieve DY 9 goals.

Table 9.i. DSRIP Category C Achievement for Selected P4P Outcomes Reported by Hospitals and Physician Practices in DY 9

Outcome Measure	Number of Providers Reporting Outcome	Greater than 25% Goal Achieved	100% Goal Achieved
Chronic Disease Management – Diabetes: HbA1c poor control (>9.0)	74	100%	83%
Chronic Disease Management - Heart Disease: Controlling High Blood Pressure	37	100%	78%
Rural Emergency Care: Documentation of Current Medications in Patient Medical Record	30	100%	95%
Improved Maternal Care: Post-Partum Follow-Up and Care Coordination	19	100%	100%

Table 9.ii. DSRIP Category C Achievement for Selected P4P Outcomes Reported by Community Mental Health Centers in DY 9

Outcome Measure	Number of Providers Reporting Outcome	Greater than 25% Goal Achieved	100% Goal Achieved
Screening for Clinical Depression and Follow-Up Plan	20	100%	95%
Follow-Up After Hospitalization for Mental Illness	23	100%	96%

Table 9.iii. DSRIP Category C Achievement for Selected P4P Outcomes Reported by Local Health Departments in DY 9

Outcome Measure	Number of Providers Reporting Outcome	Greater than 25% Goal Achieved	100% Goal Achieved
Latent Tuberculosis Infection Treatment Rate	8	100%	88%
Diabetes care: HbA1c poor control (>9.0%)	6	100%	100%

Directed Payment Programs

CMS, under 42 C.F.R. § 438.6(c), allows states to direct MCO expenditures "… to assist states in achieving their overall objectives for delivery system and payment reform and performance improvement."[35] The state develops the programs, specific to a class of provider, and directs MCOs to implement the associated provider payments. DPPs must help the state advance its quality strategy and require approval from CMS to authorize federal matching funds. Annual CMS approval is needed to continue the programs.

HHSC requested approval for year five of its Nursing Facility Quality Incentive Payment Program (QIPP) and proposed four new DPPs for state fiscal year 2022: CHIRP, TIPPS, RAPPS and DPP-BHS. As of November 15, 2021, QIPP and DPP-BHS received CMS approval effective September 1, 2021. CHIRP, TIPPS and RAPPS are pending CMS approval. Each one of these programs is described below.

Nursing Facility Quality Incentive Payment Program (QIPP)

QIPP is designed to incentivize nursing facilities to improve quality and innovation in the provision of nursing facility services.[36] The program began in state fiscal year 2018 and has been approved for a fifth year which is the state fiscal year 2022.

QIPP Years One and Two (State Fiscal Year 2018–2019) Performance

For year one, 514 nursing facilities participated in QIPP, including 430 non-state governmental owned (NSGO) nursing facilities and 84 private nursing facilities. The budget for year one was approximately $400 million. In program year two, 556 nursing facilities participated in QIPP, including 461 NSGO nursing facilities and 95 private nursing facilities. The budget for year two was $446 million. The program's structure included three components, each with performance requirements the providers must meet to qualify for incentive payments. Component One was exclusively available to NSGO nursing facilities. Components two and three were

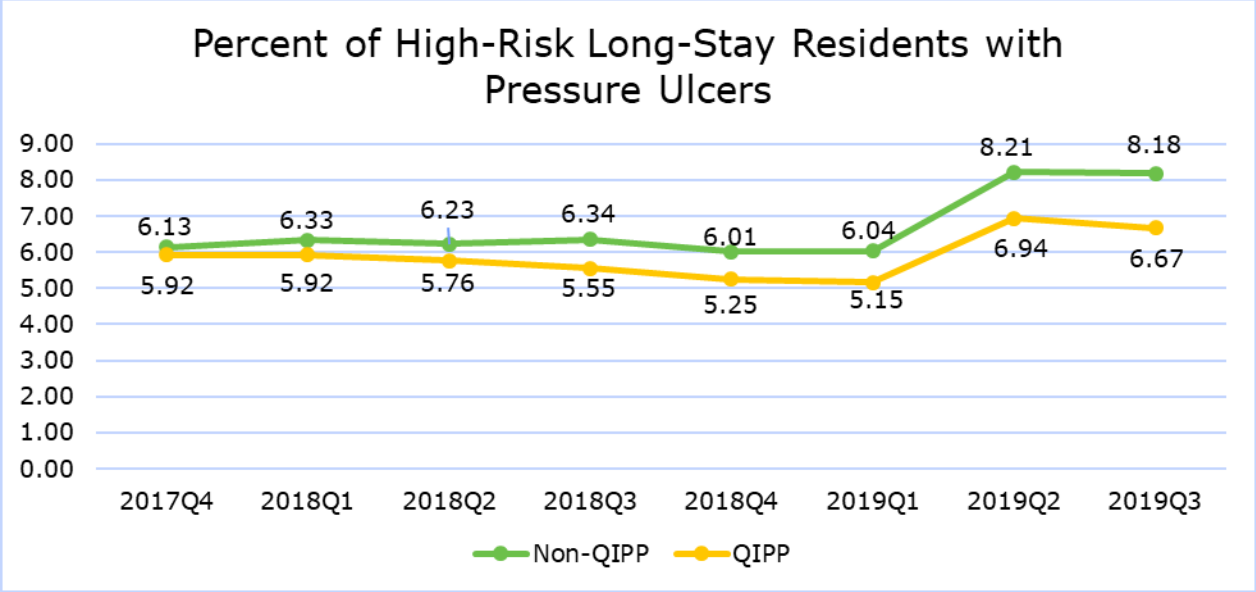
[35] CMS State Medicaid Director Letter (SMD# 21-001), January 8, 2021, https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/smd21001.pdf
[36] https://hhs.texas.gov/services/health/medicaid-chip/provider-information/quality-incentive-payment-program-nursing-homes

available to all participating QIPP facilities and were triggered by meeting the national benchmark or by demonstrating improvement on the following CMS long-stay nursing facility quality metrics:

- High-risk long-stay residents with pressure ulcers,
- Percent of residents who received an antipsychotic medication,
- Residents experiencing one or more falls with major injury, and
- Residents who were physically restrained.

After the two full years of data became available on Nursing Home Compare,[37] HHSC compared the performance of facilities enrolled in QIPP and facilities not enrolled in QIPP. Active facilities with non-suppressed data available on the CMS website during the reporting periods most closely aligning with QIPP quarters (2017 quarter 4–2019 quarter 3) were tracked retrospectively as QIPP or non-QIPP facilities based on QIPP year one enrollment. In Figures 7 through 10, below, each trend line displays the average score per quarter for the four QIPP quality measures in Years 1–2. Lower scores are better.

Figure 7. Percent of High-Risk Long-Stay Residents with Pressure Ulcers



Note: The spike between 2019Q1 and 2019Q2 corresponds with an updated CMS methodology reflected in the change from measure NHC ID 403 to 453.

[37] Nursing Home Compare provides information on nursing homes certified by Medicare and Medicaid, including inspection results, and their performance certain CMS quality of care measures. https://www.medicare.gov/nursinghomecompare/search.html

Figure 8. Percent of Long-Stay Residents Who Were Physically Restrained

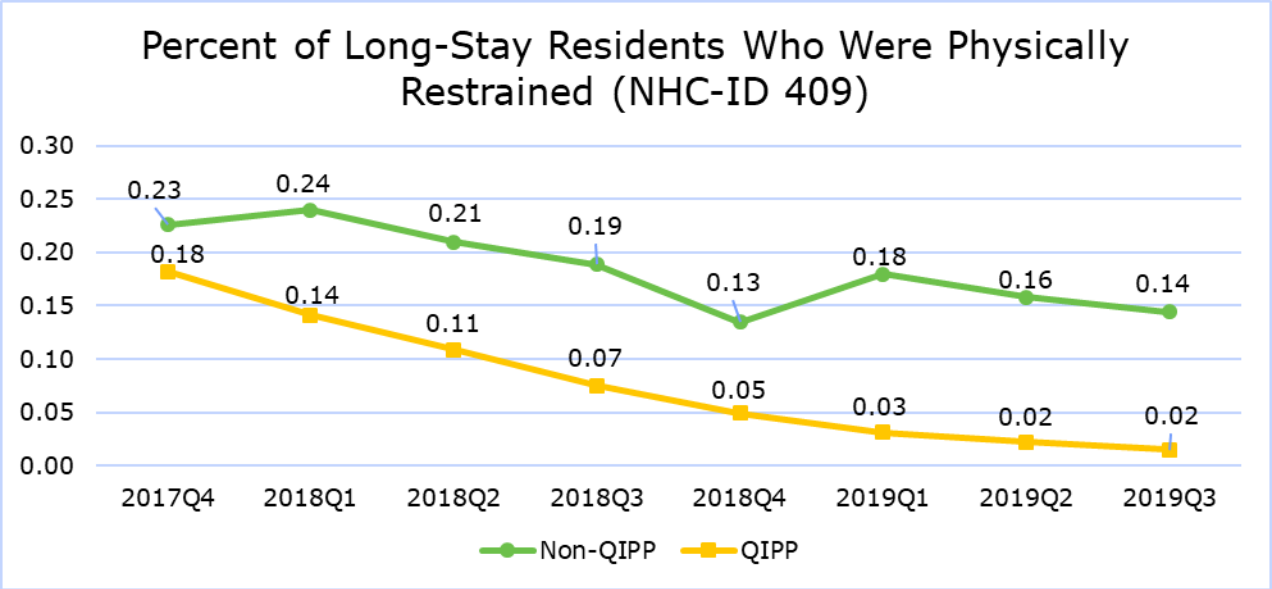


Figure 9. Percent of Long-Stay Residents Experiencing One or More Falls with Major Injury

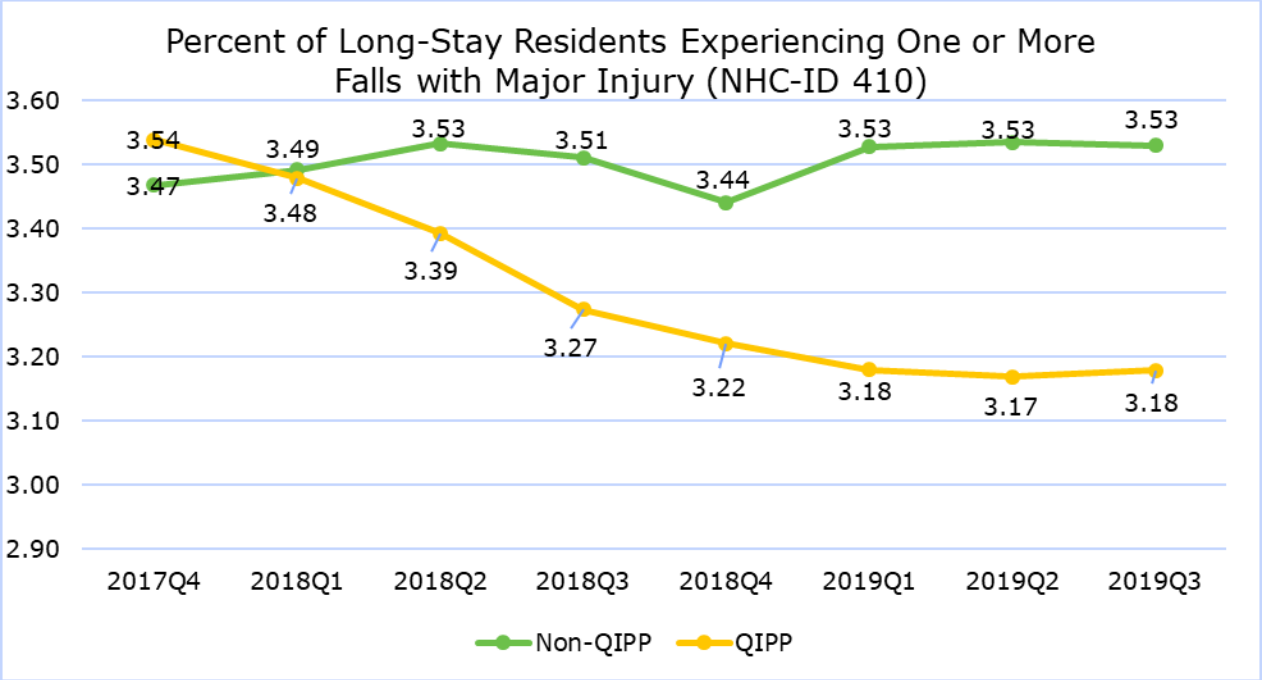
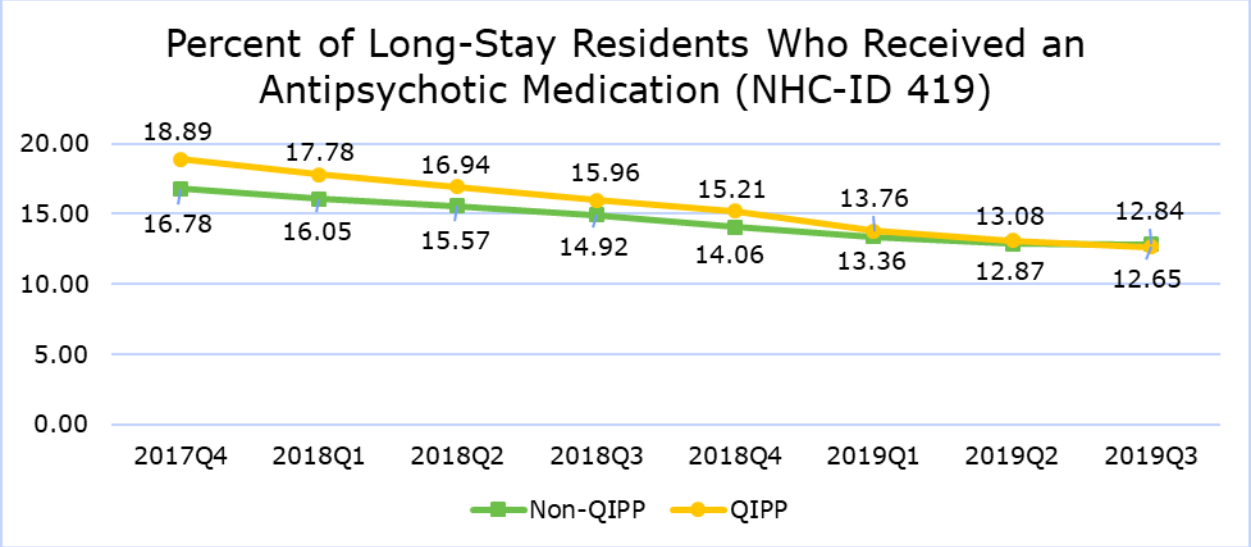


Figure 10. Percent of Long-Stay Residents Who Received an Antipsychotic Medication



In summary, these results indicate that QIPP was successful in achieving significant performance gains by participating facilities on key measures of residents' health and safety. Associated payments to QIPP facilities for Years One and Two are presented in Table 10. Paid funds are the actual funds paid to the facility through the component payment and non-dispersed funds. Earned funds are funds the facility is eligible to receive when they have met the payment component requirements. Furthermore, the term "earned" is used to describe the payments received only through meeting component metrics. "Paid" funds should equal earned plus non-dispersed.

Table 10. Total QIPP Payments per Component, Years 1 and 2

QIPP Year and Component	Number of NFs Paid	Total Funds Earned	Total Non-Disbursed Paid
Year 1 (SFY 2018)	**514**	**$355,256,364**	**$15,595,424**
Component 1: QAPI	430	$188,141,522	$1,850,477
Component 2: Moderate MDS Improvement	512	$ 51,957,058	$2,157,118
Component 3: Strong MDS Improvement	512	$115,157,784	$ 11,108,626
Year 2 (SFY 2019)	**554**	**$ 346,829,079**	**$ 36,580,105**
Component 1: QAPI	452	$ 188,896,937	$ 2,503,899
Component 2: Moderate MDS Improvement	554	$ 56,075,435	$ 943,811
Component 3: Strong MDS Improvement	554	$ 101,856,707	$ 31,188,201

QIPP Years Three and Four (State Fiscal Year 2020–2021) Design

To continue incentivizing nursing facilities to improve quality and innovation in the provision of nursing facility services, HHSC adopted new quality measures, eligibility requirements and financing components for QIPP to begin in program Year Three (state fiscal year 2020) and continue through Year Four (state fiscal year 2021). The new measures were developed by a workgroup comprised of stakeholders and HHSC staff and were approved by CMS. For fiscal years 2020 and 2021, MCOs received QIPP funds through STAR+PLUS nursing facility MCO capitation rates. MCOs distributed the funds to enrolled nursing facilities based on each facility's performance on the quality measures in four program components, as follows.[38]

Component One: Quality Assurance and Performance Improvement (QAPI) Meetings

Funds in this Component are distributed monthly on a "Met" or "Not Met" basis, contingent upon proper submission of the QAPI Validation Report. Payments for Component 1 are based on the nursing facility's submission of an attestation of a monthly QAPI review and are only available to the NSGO providers. Federal law requires nursing facilities to develop QAPI programs and review them quarterly.

Component Two: Workforce Development

All participating facilities are eligible to earn Component Two payments. Payment is based on nursing facility improved performance on three metrics: (1) Nursing facility maintains four additional hours of registered nurse (RN) staffing coverage per day, beyond the CMS mandate; (2) Nursing facility maintains eight additional hours of RN staffing coverage per day, beyond the CMS mandate; and (3) Nursing facility has a staffing recruitment and retention program that includes a self-directed plan and monitoring outcomes. Nursing facilities may also use telehealth services for scheduling hours beyond the federally mandated eight in-person hours per day.

[38] Details for QIPP Year Four Quality Metrics are available on the HHS site at: https://www.hhs.texas.gov/sites/default/files/documents/services/health/medicaid-chip/programs/qipp/qipp-final-quality-metric-packet-fy-2021.pdf

Component Three: Minimum Data Set CMS Five-Star Quality Measures

All participating facilities are eligible to earn Component Three payments. QIPP features three quality metrics, which nursing facilities are required to report to CMS: (1) Percent of high-risk residents with pressure ulcers; (2) Percent of residents who received an antipsychotic medication; and (3) Percent of residents whose ability to move independently has worsened. The measures are also used by CMS in their Five-Star Quality Rating System.

Component Four: Infection Control Program

HHSC designates three equally weighted quality measures for Component Four which is open only to NSGO providers: (1) Percent of residents with a urinary tract infection; (2) Percent of residents whose pneumococcal vaccine is up to date; and (3) Facility has an infection control program that includes antibiotic stewardship.

QIPP Years Three and Four (State Fiscal Year 2020–2021) Mid-Year COVID-19 Response

In response to the COVID-19 public health emergency, CMS waived certain reporting requirements for nursing facilities effective March 1, 2020, including timeframe requirements for MDS assessments and transmission. To account for the lack of sufficient MDS data, HHSC waived the following performance requirements connected to QIPP MDS-based quality measures, effective March 1, 2020:[39]

- All quality measures related to Component Three. Funds dedicated to this component were disbursed in monthly payments to all enrolled nursing facilities to support responses to COVID-19, such as workforce recruitment and retention and infection control, and
- Percent of Residents with Urinary Tract Infection (CMS ID: N024.02). Component Four continued on a quarterly schedule with funds reliant on the two remaining quality measures.

Furthermore, to help relieve the administrative burden on facilities during this time of critical functioning, HHSC waived the Component 1 QAPI reporting requirements for the program, effective beginning March 1 and for the rest of state fiscal year 2020.

[39] https://hhs.texas.gov/about-hhs/communications-events/news/2020/06/qipp-performance-reporting-requirement-adjustments-due-covid-19

QIPP Year Three (state fiscal year 2020) funds dedicated to Component Three were disbursed in monthly payments to all enrolled NFs to support responses to COVID-19, such as workforce recruitment and retention, and infection control. The changes to the Component Three payment schedule were implemented from the May 2020 scorecard and included retroactive Component Three payments for March and April 2020. As CMS maintained the MDS reporting flexibilities into the beginning of state fiscal year 2021, HHSC continued the COVID-19 waiver implemented for QIPP Year Three into Year Four.[40] The changes to the QIPP Year Four payment schedule for Component Three were reflected in the December 2020 scorecard and included all retroactive Component payments for September through November 2020.

The COVID-19 accommodations continued through the first three quarters of Year Four. When CMS reinstated MDS reporting requirements effective May 10, 2021, HHSC followed suit by reinstating QIPP reporting requirements effective June 1, 2021. Performance requirements for MDS-based quality measures were reinstated for the fourth quarter and reporting requirements for Component One QAPI measure were reinstated as of June 1, 2021.[41]

QIPP Year Three (State Fiscal Year 2020) Performance Summary

For Year Three, 807 nursing facilities participated in QIPP, representing 507 NSGO nursing facilities and 300 private nursing facilities. The approved budget for year three was $600 million. HHSC evaluates facility performance on the quality metrics on a monthly and quarterly basis. Table 11 includes performance results and payments for quarters one through four. The adjustment period is the time following the program period in which the MCO may adjust the member months. The total adjustment period is 23 months and a total of three payments are made during that period. Adjustments may be positive or negative depending on the adjustments made by the MCO's for the time period each facility may have been eligible for payment.

[40] https://www.hhs.texas.gov/about-hhs/communications-events/news/2020/12/qipp-sfy-2021-performance-reporting-requirement-adjustments-due-covid-19
[41] https://www.hhs.texas.gov/about-hhs/communications-events/news/2021/05/qipp-reporting-performance-requirements-reinstated

Table 11. QIPP Year 3 NF Performance by Component and Metric Payments through Adjustment 2

Component/Metric	Percentage of Nursing Facilities Achieved Metric	Total Payments
Component 1		**$254,992,570**
QAPI Program	99%	
Component 2		**$57,026,304**
+4 RN Hours	82%	
+8 RN Hours	78%	
Workforce Plan	92%	
Component 3	**Component 3 Percentages for Q1 & Q2 Only**	**$134,705,152**
*Pressure Ulcers**	72%	
*Antipsychotic Medication**	80%	
*Move Independently**	70%	
Component 4	**UTI Percentages for Q1 & Q2 Only**	**$88,366,832**
*Urinary Tract Infection**	87%	
Pneumococcal Vaccine	88%	
Infection Control Program	96%	
Total Earned Year 3 to date		**$535,090,857**
Total Non-Dispersed Year 3		**$40,870,010**

**Metric achievement for MDS measures is only for Quarters 1 and 2 (COVID-19 impact).*

QIPP Year Four (State Fiscal Year 2021) Performance to Date

Year Four began on September 1, 2020. Initial participation increased to 865 nursing facilities, representing 547 NSGO nursing facilities and 318 privately-owned nursing facilities. The budget for year four was almost $1.1 billion. The Year Four program structure and quality measures are the same as those for Year Three. HHSC evaluates facility performance on the quality metrics on a monthly and quarterly basis. Table 12 includes performance results and payments for quarters one through three.

Table 12. QIPP Year 4 NF Performance by Component and Metric

Quarters 1–3 Component/Metric	Percentage of Nursing Facilities Achieved Metric	Total Payments
Component 1		$297,508,805
QAPI Program	Reporting Requirements Waived Quarters 1-3	
Component 2		**$76,261,202**
+4 RN Hours	86%	
+8 RN Hours	83%	
Workforce Plan	90%	
Component 3	**Reporting Requirements Waived Quarters 1-3**	**$200,240,845**
*Pressure Ulcers**	N/A	
*Antipsychotic Medication**	N/A	
*Move Independently**	N/A	
Component 4		**$111,623,256**
*Urinary Tract Infection**	Metric not used Quarters 1-3	
Pneumococcal Vaccine	92%	
Infection Control Program	96%	
Total Earned Year 3 to date		**$685,634,108**
Total Non-Dispersed Year 3		**$16,890,851**

**Metric achievement for MDS measures were waived for Quarters 1-3 (COVID-19 impact).*

QIPP Year Five (State Fiscal Year 2022) Design Changes

HHSC continued to develop program quality measures for QIPP Year Five, which led to an expansion of existing metrics in Components One and Two, an increase in the number of MDS-based quality measures in Component Three and a restructuring of the Infection Control Program that constitutes Component Four. CMS approved program Year Five on November 15, 2021 with an effective date of September 1, 2021.

Component One

As a condition for participation in Component 1, providers are required to submit their QAPI Validation Report form as well as data related to a NF-specific performance improvement project (PIP) every month. The metric states the facility holds a QAPI meeting each month that accords with quarterly deferral requirements and pursues specific outcomes developed by the NF as part of a focused PIP. This metric entails monthly reporting of ongoing data collection and analysis that inform the development and implementation of the NF's PIP, which must focus on a CMS long-stay MDS data with data published on the CMS Nursing Home Compare website. As part of their QAPI process, the NF will be required to discuss the workforce development metric (see "Component Two" below) to review progress that is being made to improve the workforce in areas such as recruitment and retention, turnover and vacancy rates.

Component Two

Beginning in QIPP Year Five, Component Two will be worth 40 percent of program funds remaining after accounting for Components One and Four. While Component Two metrics regarding registered nurse (RN) coverage are unchanged, HHSC expanded Component Two Metric Three to require a PIP. This metric establishes a NF has a workforce development program in the form of a PIP that includes a self-directed plan and monitoring outcomes. For this expanded metric, each NF will submit a self-directed PIP on the topic of resident-centered culture change, workforce development, and staff retention during the first reporting period and subsequently report outcomes related to that plan throughout the eligibility period. HHSC will not determine specific outcomes required for meeting the metric; rather, each NF must monitor and regularly report ongoing development of its self-directed goals and outcomes. Consideration of workforce development activities specific to Certified Nursing Assistants is encouraged as part of the PIP process.

Component Three

Beginning in QIPP Year Five, Component Three will be worth 60 percent of program funds remaining after accounting for Components One and Four. HHSC moved the MDS-based quality measure regarding urinary tract infections from Component Four to Component Three, increasing the total number of metrics in this component to four. HHSC also added escalating improvements to the program-wide performance targets for MDS-based quality measures. Program-wide targets are set at the most recently published national average for each quality metric in quarter one and

increase by five percent each subsequent quarter, up to 15 percent relative improvement by quarter four. NF initial baselines and quality metric benchmarks were posted to the QIPP website in August 2021. For a quality metric to be considered "Met" in a quarter, the NF must perform equal to or better than its facility-specific target or equal to or better than the program-wide target.

Component Four

HHSC designated one quality metric for Component Four that entails alternating performance targets over the four quarters of the program year. This metric states that a facility has an active infection control program that includes pursuing improved outcomes in vaccination rates and antibiotic stewardship. The performance targets for quarter one provides the NF must submit evidence-based infection control policies and supporting documentation that include at least some antibiotic stewardship elements. For quarter two, the NF must submit supporting documentation for certain infection control training elements. The performance target for quarter three mirror requirements from quarter one. Quarter four performance targets establish that MDS measures related to vaccination rates will be measured against program-wide benchmarks derived from the most recently published national average at the beginning of the eligibility period.

Comprehensive Hospital Increase Reimbursement Program (CHIRP)

CHIRP is a proposed directed payment program that would provide increased Medicaid payments for inpatient and outpatient services to participating Texas hospitals. The program began as the Uniform Hospital Rate Increase Program (UHRIP) in state fiscal year 2018. UHRIP was then renewed annually in state fiscal year 2019, 2020 and 2021. For state fiscal year 2022, HHSC proposed a new program, CHIRP, comprised of UHRIP and a new component, the Average Commercial Incentive Award (ACIA). CHIRP is pending CMS approval at the time of this report.

UHRIP Years One – Four (State Fiscal Year 2018–2021)

UHRIP was implemented as a pilot program on December 1, 2017, in the El Paso and Bexar managed care service areas. The program expanded statewide on

September 1, 2018 (state fiscal year 2019), for program year two, and was subsequently renewed for years three and four in state fiscal years 2020 and 2021.

MCOs received UHRIP funding through their monthly capitation rate and were directed to increase the reimbursement rate paid to hospitals for inpatient and outpatient services. The percentage rate increase was uniform for hospitals within a class within an MCO service area.

CHIRP (State Fiscal Year 2022) Design

If approved, CHIRP will replace UHRIP for state fiscal year 2022 as a statewide directed payment program that provides increased Medicaid payments for inpatient and outpatient services to participating hospitals. However, to continue incentivizing hospitals to improve access, quality, and innovation in the provision of hospital services, HHSC has developed new eligibility requirements, hospital classes and financing components for the program. HHSC also proposed new quality metrics for evaluating the program and new reporting requirements as a condition of participation in the new program.

Six classes of hospitals are eligible to participate: (1) children's hospitals, (2) rural hospitals, (3) state-owned hospitals that are not institutions for mental diseases (IMDs), (4) urban hospitals, (5) non-state-owned IMDs and (6) state-owned IMDs.

Upon approval, CHIRP funds will be paid through two components of the MCO capitation rate. MCOs will be directed to increase the reimbursement rate to enrolled hospitals for inpatient and outpatient services. The percentage increase is uniform for hospitals within a class within a service area, but increases may vary between classes of hospitals based on the hospital's choice to participate in the payment component, ACIA. Hospitals apply for participation in CHIRP, and hospitals are required to report program measures as a condition of participation for each component in which they participate.

Texas Incentives for Physicians and Professional Services (TIPPS)

TIPPS is a proposed DPP for certain physician groups providing health care services to children and adults enrolled in the STAR, STAR+PLUS and STAR Kids Medicaid programs. HHSC created the TIPPS program as a part of an effort to replace funding provided under the Texas Delivery System Reform Incentive Payment (DSRIP) program and the Network Access Improvement Program (NAIP). Three

classes of physician groups are eligible to participate: (1) Health-Related Institution (HRI) physician groups, (2) Indirect Medical Education (IME) physician groups and (3) other physician groups.

Physician groups must report all required quality measures as a condition of participation. The provider-reported measures will be used for evaluating the program's efficacy at advancing the Quality Strategy goals and objectives. TIPPS is pending CMS approval at the time of this report.

Rural Access to Primary and Preventive Services (RAPPS)

RAPPS is a proposed DPP for rural health clinics (RHCs) that provide primary and preventive services to persons in rural areas of the state enrolled in Medicaid STAR, STAR+PLUS and STAR Kids programs.

HHSC developed the RAPPS program to help continue funding for key activities started under DSRIP. Two classes of RHCs are eligible for the program: (1) Hospital-based RHCs, which include non-state government-owned and private RHCs, and (2) free-standing RHCs. Only RHCs that choose to report on quality metrics could participate in RAPPS.

In RAPPS year one (state fiscal year 2022), funds are paid through two components of the MCO capitation rate. MCOs distribute RAPPS payments to participating RHCs for reporting quality metrics. The participating RHC must report all eligible quality metrics semi-annually and must have provided at least one Medicaid service to a Medicaid client in each reporting period. The provider-reported data will be used for the evaluation of the program. RAPPS is pending CMS approval at the time of this report.

Directed Payment Program for Behavioral Health Services (DPP-BHS)

The DPP-BHS is a DPP for Community Mental Health Centers (CMHCs) to promote and improve access to behavioral health services, care coordination, and successful care transitions. It also incentivizes continuation of care for STAR, STAR+PLUS and STAR Kids members using the Certified Community Behavioral Health Clinic (CCBHC) model of care. HHSC created the DPP-BHS program as a part of an effort to replace the DSRIP program funding. Two classes of CMHCs are eligible for the

program: (1) CMHCs with the CCBHC certification and (2) CMHCs without CCBHC Certification.

In DPP-BHS, funds will be paid through two components of the MCO capitation rate. MCOs distribute BHS payments to participating CMHCs that must report all required quality metrics as a condition of participation in the program. Participating CMHCs must report all required quality measures and must have provided at least one Medicaid service to a Medicaid client in each reporting period. The program will be evaluated using provider-reported data.

CMS approved DPP-BHS in November 2021, with an effective date of September 1, 2021.

HHS Quality Webpages

Public reporting of measurement results can be an effective strategy to advance quality and efficiency in healthcare. HHSC continues to increase the information about quality initiatives and data available to MCOs, DMOs, providers and other stakeholders through its Medicaid and CHIP Quality and Efficiency Improvement (HHS Quality) webpage[42] and the THLC portal.

Medicaid and CHIP Quality and Efficiency Improvement (HHS Quality Webpage)

In June 2014, HHSC launched a Medicaid and CHIP Quality and Efficiency Improvement webpage to increase transparency and public reporting. The Quality webpage serves as a one-stop information resource for Medicaid and CHIP quality improvement efforts. It aims to increase transparency and public reporting by providing easy to navigate information for the public and policymakers in one place. Regularly refreshed information on various HHSC quality improvement efforts is provided to the public, including the Texas Managed Care Quality Strategy and the latest Value-Based Payment Roadmap.

In addition, the page provides links to the latest information regarding key quality improvement projects and resources, including:

- Quality Assurance programs, such as the Pay-for-Quality programs and performance improvement projects (PIPs);
- Access to the Value-Based Care web page with information about:
    - APM initiative and MCO Value-Based Contracting,
    - Value-Based Enrollment,
    - VBPQI Advisory Committee,
    - DSRIP and DSRIP Transition,
    - Texas Medicaid HIE Connectivity Project, a key part of the Health Information Technology (Health IT) Strategic Plan, and
    - THLC;

[42] Quality webpage available at: https://hhs.texas.gov/about-hhs/process-improvement/medicaid-chip-quality-efficiency-improvement

- Potentially Preventable Events, including the Hospital Quality Based Payment program.

Texas Healthcare Learning Collaborative (THLC) Portal

HHSC's external quality review organization (EQRO)[43] developed the THLC Portal (THLCPortal.com) originally as a tool to support and inform MCOs and DMOs on quality improvement activities. In collaboration with HHSC, the EQRO modified the THLC portal to serve as a public reporting platform that enables users to compare performance of programs, MCOs, DMOs and service areas across process and outcome measures, and multiple time periods. Through expanded analytics and enhanced data visualizations, the portal allows users to better understand and compare performance and download data for customized analytics. The portal also helps providers understand opportunity areas for value-based contracting with MCOs and DMOs.

The public features of the portal include:

- Medical quality of care data;
- Medical data downloader;
- Medical P4Q results;
- Dental quality of care data;
- CMS Core measure set data;
- Potentially preventable events trends;
- Potentially preventable admission data;
- Potentially preventable readmission data (at hospital and MCO level);
- Potentially preventable emergency department visit data;
- Potentially preventable complications data (at hospital and MCO level);
- HHSC performance indicator dashboards;
- Survey measure dashboard;
- Resources.

HHSC works with its EQRO on an ongoing basis to develop portal enhancements.

[43] Information about EQRO is available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html

Trends in Key Quality Measures

This section presents MCO performance on critical quality measures across the Medicaid and CHIP programs. What follows is information about Potentially Preventable Events, the HHSC Performance Indicator Dashboard, HIV Viral Load Suppression[44] and Relocation to a Community-Based Setting.

Trends in Potentially Preventable Events, 2014-2020

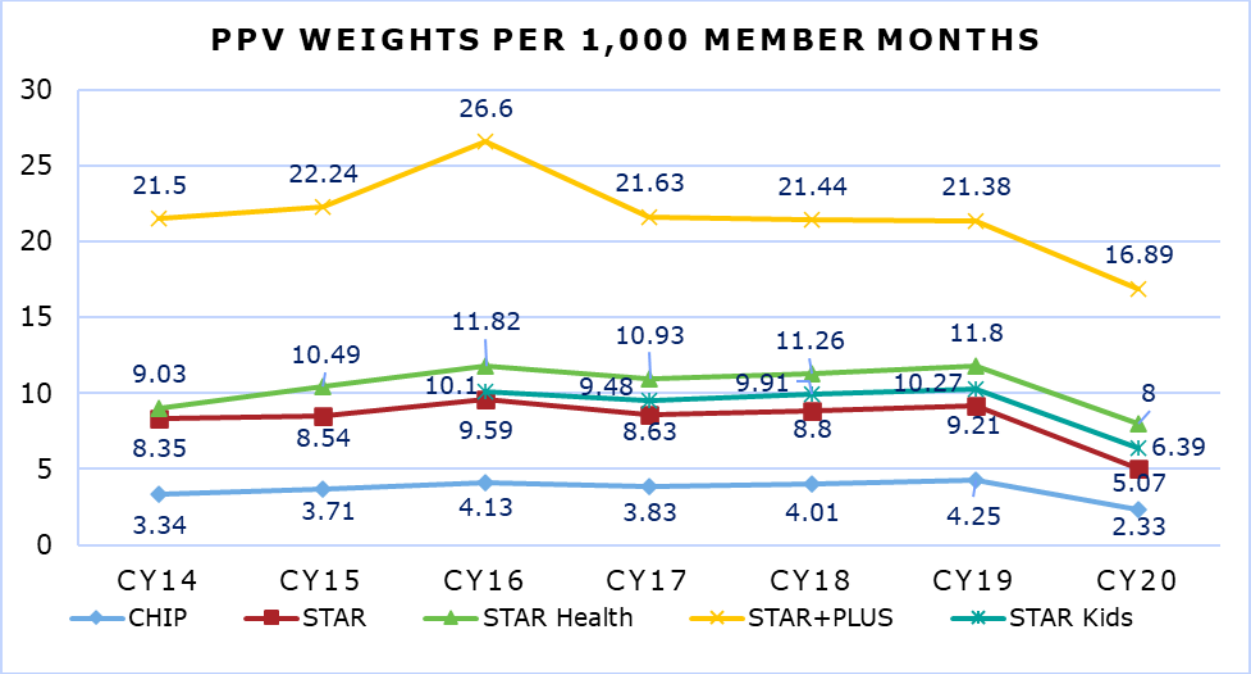
For all tables included in this section, a negative percentage change signifies improving performance and a positive percentage change signifies worsening performance, except as indicated. Each table is stratified by managed care program. These data are also available on the THLC Portal.

Potentially Preventable Emergency Department Visits (PPVs)

The graph below (Figure 11) shows the seven-year trend for weighted rates of PPVs relative to how many people are enrolled in the program (member months). PPV is a medical P4Q measure applied across all programs. Results are presented below at the program level.

[44] Per Section 536.003(g) (H.B. 1629, 85th Legislature, Regular Session, 2017) HIV Viral Suppression Rate (HIV) has recently been added to the suite of measures

Figure 11. Seven-Year Trends of PPV Weights per 1,000 Member Months - All Programs



Each PPV is assigned a relative weight reflecting the estimated resources needed to provide effective treatment (Y axis in graphs). National relative weights for calendar year 2020 were used to determine resource utilization.

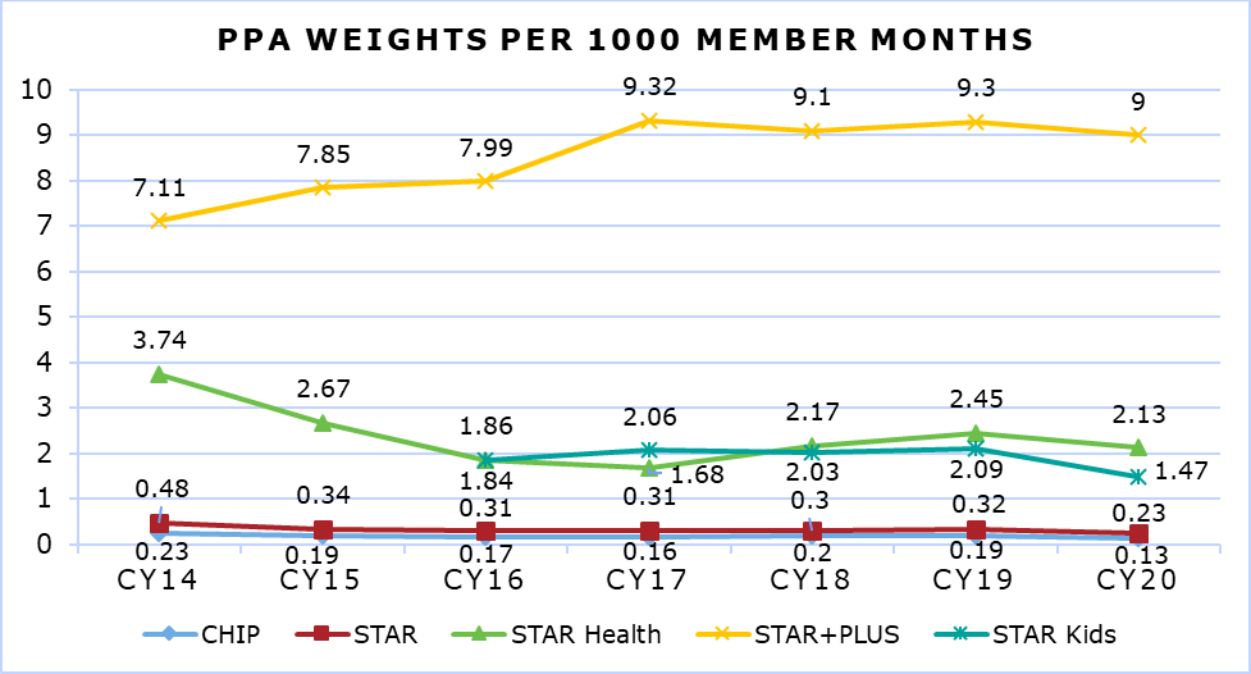
Between 2014 and 2019, PPV rates increased slightly across all programs except STAR+PLUS. In 2020, PPV rates dropped for all programs. COVID-19 likely impacted trends in PPV as people were more reluctant or not able to seek hospital care. In addition, increased use of teleservices may have contributed to a decrease in PPVs. To help address PPV rates, many MCOs instituted VBP models that focus on reducing emergency department usage. Also, HHSC has included PPVs as a metric in its new value-based enrollment method to further increase accountability for MCOs.

Potentially Preventable Hospital Admissions (PPAs)

The graph below shows the seven-year trend in weighted rates of PPAs relative to the number of enrollees (member months) per program. Each PPA is assigned a relative weight of the estimated resources needed to provide effective treatment. Figure 12 shows the PPA weights for all Medicaid programs and CHIP over the seven-year observation period to facilitate relative comparisons between programs.

In 2020, there was a decrease of PPAs in all programs. Like PPVs, COVID-19 may have impacted PPA rates. In addition, HHSC added PPAs to the value-based enrollment methodology to incentivize plans to take additional actions to improve performance.

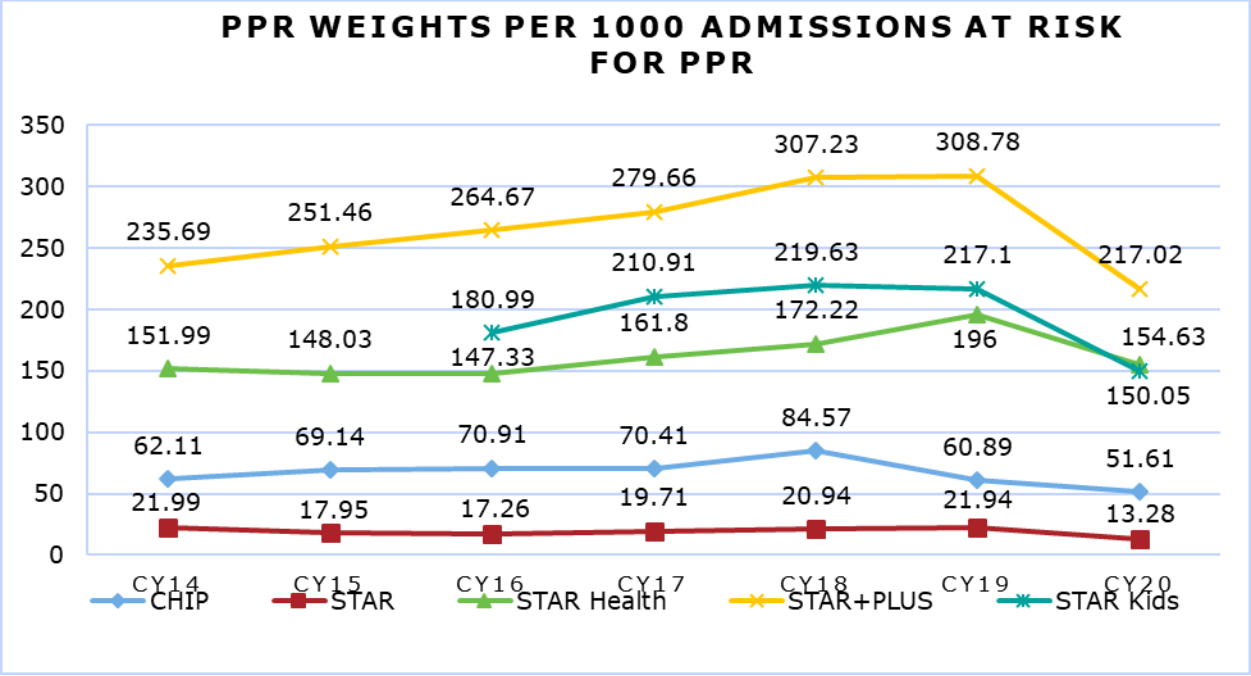
Figure 12. Seven-Year Trends of PPA Weights per 1,000 Member Months - All Programs



Potentially Preventable Hospital Readmissions (PPRs)

The graph below (Figure 13) shows the seven-year trend for weighted PPRs within 30 days of initial admission that were at-risk for readmission. From 2014 to 2019, PPRs increased in Medicaid and CHIP, particularly in the STAR+PLUS and STAR Health program. As noted previously, in state fiscal year 2020, HHSC reduced Medicaid and CHIP capitation rates by approximately $21.4 million with the expectation that MCOs will increase efforts to reduce their rates of PPRs by at least 10 percent. Also, for STAR+PLUS, PPRs are included as a metric for value-based enrollment. These changes and COVID-19 may have accounted for the decreased rates of PPR in all programs in 2020.

Figure 13. Seven-Year Trends of PPR Weights per 1,000 Admissions at Risk for PPR - All Programs



Potentially Preventable Complications (PPCs)

The graphs below show the seven-year trends in weighted hospital inpatient PPCs for admissions that were at-risk for a complication.

As noted previously, the state's PPC methodology changed beginning with the 2017 measurement period. It is valid to conclude that overall PPC weights have declined over the seven-year period, though PPC weights for calendar year 2013 through 2015 (Figure 14) should not be directly compared to PPC weights for 2016–2020 (Figure 15). However, the weights for 2013–2015 and 2016–2020 are comparable within each individual graph.

Overall, the PPC rates have declined in the last five years (2016–2020), most remarkably in the STAR+PLUS program that saw a notable drop in 2018. However, for 2020, PPCs increased in CHIP. HHSC is investigating the reasons for this increase. Like other PPEs presented in this report, COVID-19 could have impacted the PPC trend for 2020.

Figure 14. Three-Year Trends of PPCs Per 1,000 Admissions at Risk for PPC All Programs, 2013 - 2015

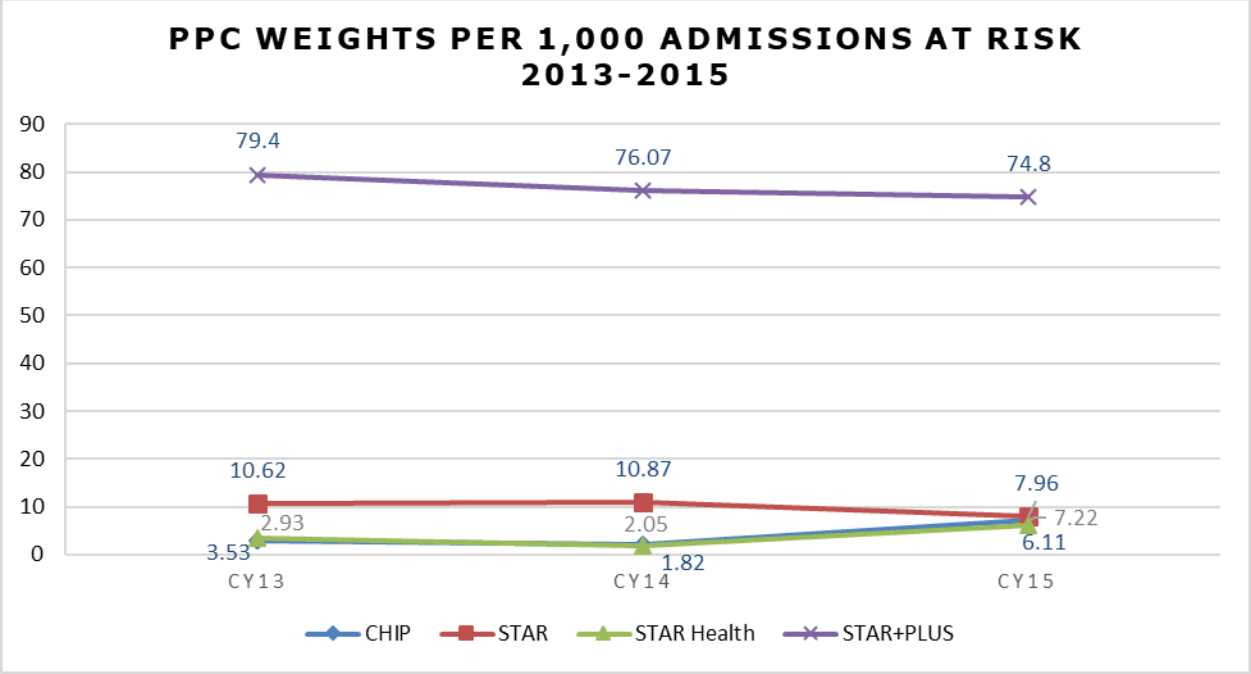
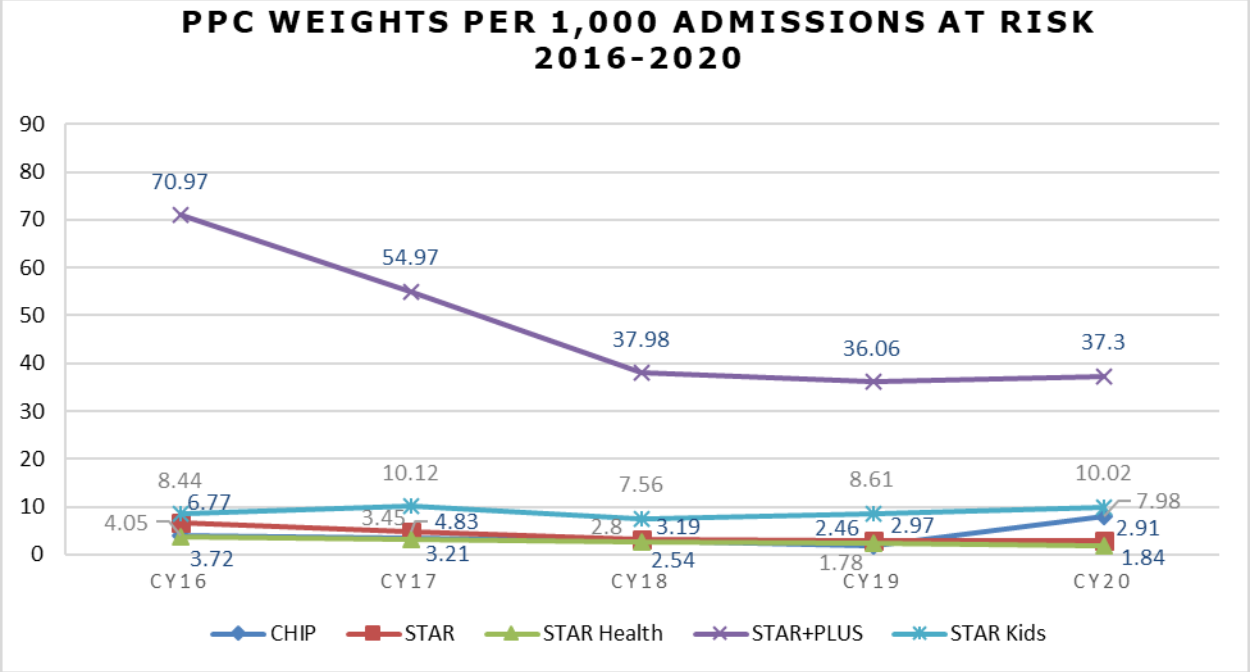


Figure 15. Four-Year Trends of PPCs Per 1,000 Admissions at Risk for PPC All Programs, 2016–2020



Note: the PPC methodology changed in calendar year 2017. Results shown for calendar years 2016, 2017, 2018, 2019 and 2020, should not be compared directly to results for calendar years 2013 through 2015.

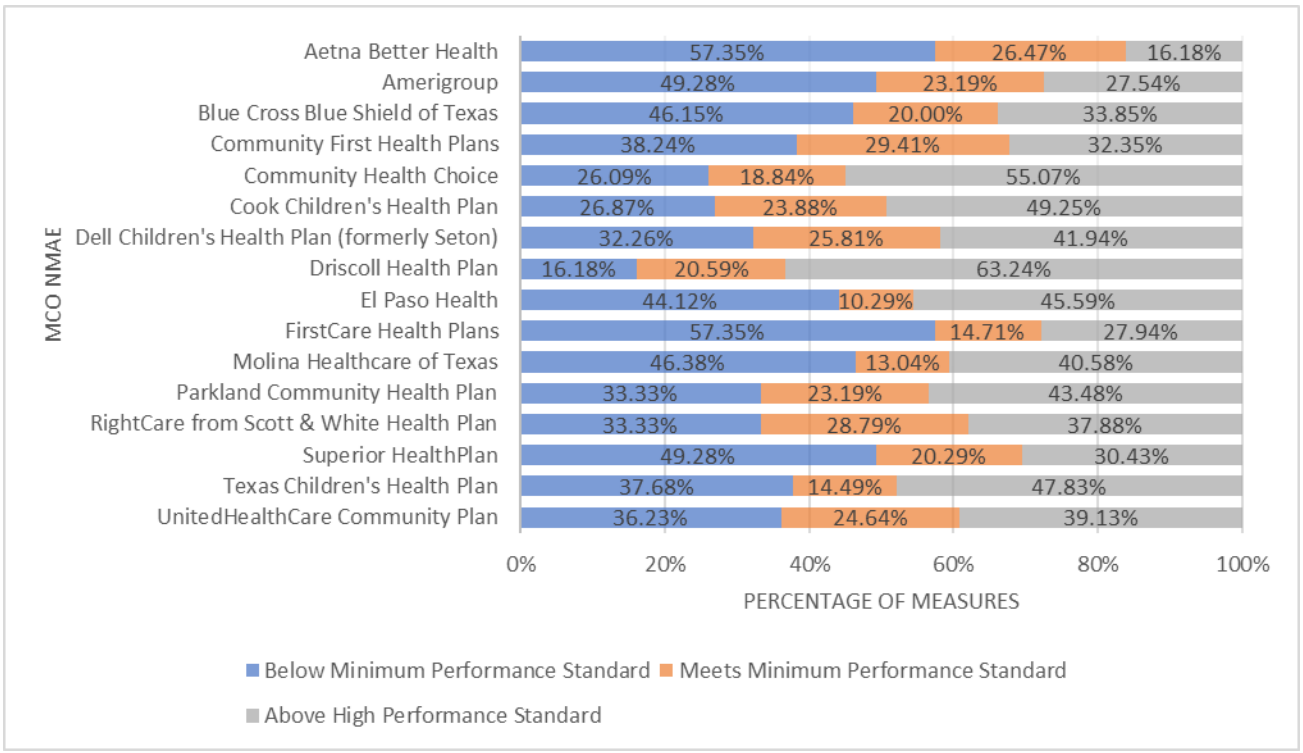
Additional Measurement Activities

HHSC Performance Indicator Dashboard

HHSC expects Medicaid and CHIP MCOs to meet or surpass the HHSC-defined minimum standard on more than two-thirds of the measures on the Performance Indicator Dashboard. The minimum standard is the program rate or the national average, whichever is lower, from two years prior to the measurement year.

Beginning with the measurement year 2018, an MCO whose per-program performance is below the minimum standard on more than 33.33 percent of the measures on the dashboard is subject to remedies under the contract, such as placement on a corrective action plan (CAP). For more information, please see Chapter 10.1.14 of the Uniform Managed Care Manual.[45] Calendar year 2019 Performance Indicator Dashboard results for STAR are presented in Figures 16 and Table 13 below and added detail for these and other programs is available on the THLC portal.

Figure 16. STAR Performance Indicator Dashboard Results by MCO Calendar Year 2019



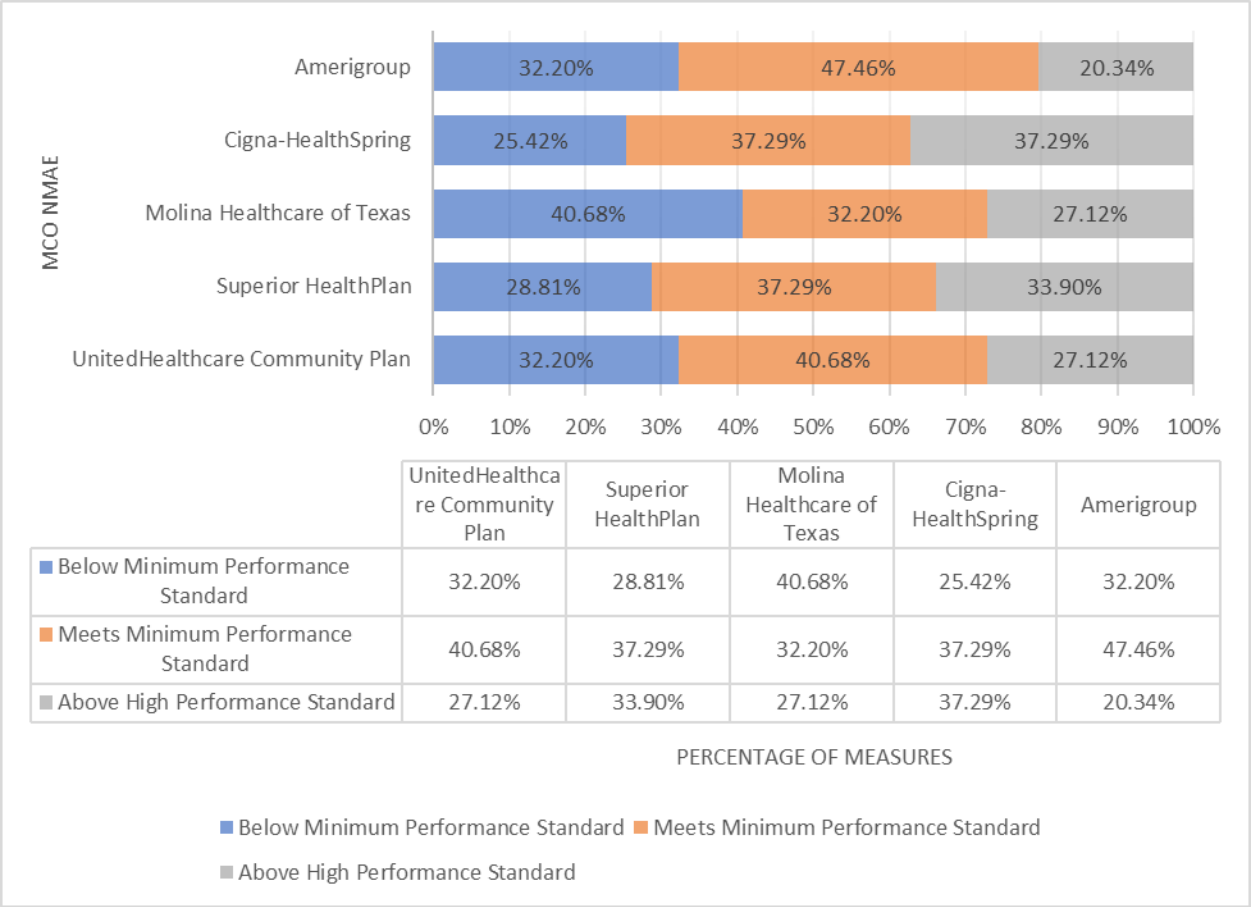
[45] https://hhs.texas.gov/sites/default/files/documents/laws-regulations/handbooks/umcm/10-1-14.pdf

Table 13 – Level of Performance Standard met by MCOs in Calendar Year 2019

MCO	Below Minimum	Met Minimum	Was Above
Aetna Better Health	57.35%	26.47%	16.18%
Amerigroup	49.28%	23.19%	27.54%
Blue Cross Blue Shield of Texas	46.15%	20.00%	33.85%
Community First Health Plans	38.24%	29.41%	32.35%
Community Health Choice	26.09%	18.84%	55.07%
Cook Children's Health Plan	26.87%	23.88%	49.25%
Dell Children's Health Plan (formerly Seton)	32.26%	25.81%	41.94%
Driscoll Health Plan	16.18%	20.59%	63.24%
El Paso Health	44.12%	10.29%	45.59%
FirstCare Health Plans	57.35%	14.71%	27.94%
Molina Healthcare of Texas	46.38%	13.04%	40.58%
Parkland Community Health Plan	33.33%	23.19%	43.48%
RightCare from Scott & White Health Plan	33.33%	28.79%	37.88%
Superior HealthPlan	49.28%	20.29%	30.43%
Texas Children's Health Plan	37.68%	14.49%	47.83%
UnitedHealthcare Community Plan	36.23%	24.64%	39.13%

Calendar year 2019 Performance Indicator Dashboard results for STAR+PLUS, are presented in Figure 17 below and added detail for these and other programs is available on the THLC portal.

Figure 17. STAR+PLUS Performance Indicator Dashboard Results by MCO Calendar Year 2019



	UnitedHealthcare Community Plan	Superior HealthPlan	Molina Healthcare of Texas	Cigna-HealthSpring	Amerigroup
Below Minimum Performance Standard	32.20%	28.81%	40.68%	25.42%	32.20%
Meets Minimum Performance Standard	40.68%	37.29%	32.20%	37.29%	47.46%
Above High Performance Standard	27.12%	33.90%	27.12%	37.29%	20.34%

HIV Viral Load Suppression

H.B. 1629, 85th Legislature, Regular Session, 2017, requires HHSC to develop a quality-based outcome measure for individuals with HIV in the CHIP and Medicaid programs. To fulfill this requirement, HHSC is monitoring MCO performance using the HIV viral load suppression measure (HIV measure) from CMS as calculated by the Texas Department of State Health Services (DSHS).

The HIV measure is defined as the percentage of patients, regardless of age, with a diagnosis of HIV and a suppressed viral load (HIV viral load less than 200 copies/mL at their last HIV viral load test) during the measurement year. Beginning with calendar year 2018, HHSC added the measure to its Performance Indicator Dashboard as an incentive for MCOs to continue to improve their performance on this measure. Table 14 shows the percentage of individuals with a suppressed HIV viral load by Medicaid program for calendar year 2019.

Table 14. Percentage of Individuals with a Suppressed HIV Viral Load by Program, Calendar Year 2019

Program	Total Individuals with HIV	Percent Virally Suppressed	Program Mean
STAR	667	67%	63%
STAR+PLUS	4081	70%	68%

Detailed HIV measure results by MCO and service area in all Medicaid and CHIP managed care programs are published on the THLC portal under the Medical Quality of Care section and the HHSC Performance Indicator Dashboard.

As a measure in the Performance Indicator Dashboard, HHSC calculated a minimum performance standard and a high-performance standard per program, per year. The program mean-value of the most current results available for a complete calendar year is the minimum standard and the high-performance standard is set five percentage points above the minimum standard.

For calendar year 2019, there were four STAR MCOs that exceeded the high-performance standard, three that were below the minimum standard, and nine with a low denominator. All STAR+PLUS MCOs met the minimum performance standard.

Relocation to a Community-Based Setting

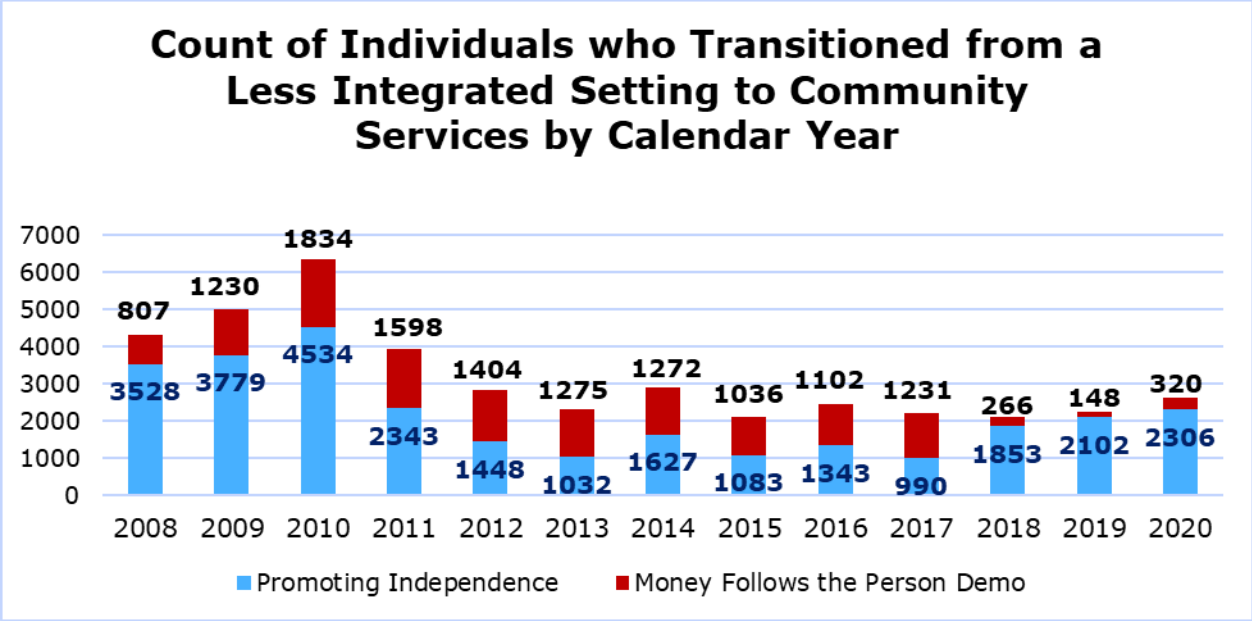
S.B. 7, 83rd Legislature, Regular Session, 2013, requires HHSC, as appropriate, to report the number of recipients who relocated to a community-based setting from a less integrated setting. The two initiatives analyzed are Promoting Independence (PI)[46] and Money Follows the Person (MFP).[47]

The data in this section provides a snapshot over time of the progress made in moving individuals from institutional care to community-based settings. The PI and MFP initiatives combined have had an important impact in Texas. The 81st, 82nd, 83rd, and 84th Legislatures appropriated a significant amount of general revenue (GR) to community-based programs to reduce Medicaid 1915(c) long-term services and supports waiver interest lists and support individuals transitioning from institutional to community-based settings. HHSC has been able to meet the transition needs of all who ask and are qualified to transition. HHSC fulfills these

[46] Information regarding Promoting Independence available at https://hhs.texas.gov/doing-business-hhs/provider-portals/resources/promoting-independence-pi
[47] Information regarding Money Follows the Person available at https://hhs.texas.gov/doing-business-hhs/provider-portals/resources/promoting-independence/money-follows-person-demonstration-project

requests by filling attrition slots. As Figure 18 indicates, since its implementation in 2003, 27,968 people transitioned to the community under the Promoting Independence Initiative. MFP has helped another 13,500 individuals transition from institutional to community-based services. The combined total of transitions since 2003 is 41,491. An MFP evaluation by Mathematica found that Texas led all 44 MFP states in the cumulative number of transitions at 11,433 at the time of the 2016 final report. In 2020, the total number of transitions was 2,626, compared with 2,250 the previous year.

Figure 18. Promoting Independence and Money Follows the Person Programs – Transitions from Less-Integrated Settings



Data Source: DADS QAI Data Mart. 10 MFP Demo Semi- Annual Newly Enrolled Participants by Target Population Report. Report Generated July 13, 2021.

Conclusion

HHSC is charting a fundamental change in course, away from paying for volume, and toward paying for the value of healthcare services in the Medicaid and CHIP programs. Transforming the state's medical assistance programs into an accountable, value-based system requires ongoing coordination and improvement efforts spanning numerous stakeholders from the Medicaid program itself to MCOs, providers, patients and families, professional organizations, RHPs, academic centers, faith and community-based organizations, and others. Working together, this diverse collaborative can achieve the HHS mission to improve the health, safety, and well-being of Texans with good stewardship of public resources.

This latest annual review of quality measures and APMs finds the state meeting important milestones in its transition to value-based care. The state's primary quality and value-based incentive programs (Medical and Dental P4Q, MCO APM contract requirements, MCO Value-Based Enrollment, Nursing Facility QIPP, and the HQBP program) continue to reward MCOs and providers that achieve high results on key outcome measures. HHSC also continues to work towards new and enhanced quality initiatives to be implemented in future years.

Along with these successes, challenges remain. Texas performs well on several key quality measures, but the state has not achieved sustained improvement at reducing potentially preventable readmissions or emergency department visits. And, unforeseeably, the COVID-19 public health emergency has greatly impacted healthcare utilization during 2020 and 2021, necessitating immediate changes and continued assessment of the state's quality and value-based programs and measures.

Over the next year, HHSC will continue to track and review these emerging trends and engage stakeholders to find timely solutions that advance quality and value in Medicaid and CHIP for better care, healthier people and lower costs.

List of Acronyms

Acronym	Full Name
ACIA	Average Commercial Incentive Award
AHRQ	Agency for Healthcare Research and Quality
APM	Alternative Payment Models
AWC	Adolescent Well Care
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CAP	Corrective Action Plan
CBP	Blood Pressure Controlled
CCS	Cervical Cancer Screening
CDC	Center for Disease Control
CHIP	Children Health Insurance Program
CHIRP	Comprehensive Hospital Increase Reimbursement Program
CIS	Childhood Immunization Status
CMS	Centers for Medicare and Medicaid Services
DADS	Department of Aging and Disability Services
DMO	Dental Maintenance Organization
DPP-BHS	Directed Payment Program for Behavioral Health Services
DQA	Dental Quality Alliance
DSHS	Department of State Health Services
DSRIP	Delivery System Reform Incentive Payment
DY	Demonstration Year
ED	Emergency Department
EQRO	External Quality Review Organization
FFS	Fee-For-Service
H.B.	House Bill
HCP LAN	Healthcare Payment Learning and Access Network
HEDIS	Healthcare Effectiveness Data and Information Set
HHS	Health and Human Services
HHSC	Health and Human Services Commission
HIV	Human Immunodeficiency Virus
HQBP	Hospital Quality-Based Payment
IGT	inter-governmental transfers
LAN	Learning and Action Network
MCO	Managed Care Organization
MFP	Money Follows the Person
NAIP	Network Access Improvement Program
NCQA	National Center for Quality Assurance
NF	Nursing Facility
NSGO	Non-State Government Owned
P4Q	Pay-for-Quality
PI	Promoting Independence
PMPM	Per Member Per Month
PPA	Potentially Preventable Hospital Admissions

Acronym	Full Name
PPC	Potentially Preventable Hospital Complications
PPR	Potentially Preventable Hospital Readmissions
PPV	Potentially Preventable Emergency Department Visits
QAI	Quality Assurance and Improvement
QIPP	Quality Incentive Payment Program
RAPPS	Rural Access to Primary and Preventive Services
RHP	Regional Healthcare Partnership
S.B.	Senate Bill
SSD	Screening for People with Schizophrenia or Bipolar Disorder
STAR	State of Texas Access Reform
STAR+PLUS	State of Texas Access Reform Plus
TDI	Texas Department of Insurance
THLC	Texas Healthcare Learning Collaborative
TIPPS	Texas Incentives for Physicians and Professional Services
UHRIP	Uniform Hospital Rate Increase Program
URI	Upper Respiratory Infection
VBP	Value-Based Payment
VBPQI	Value-Based Payment and Quality Improvement
WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents

Appendix A. Statewide Initiatives to Improve Quality of Maternal Health Care

As Required by Senate Bill 750, 86th Legislature, Regular Session 2019.

Page intentionally left blank.

Statewide Initiatives to Improve Quality of Maternal Health Care

As Required by
Senate Bill 750, 86th Legislature,
Regular Session, 2019

Texas Health and Human Services
December 2021

TEXAS
Health and Human Services

Table of Contents

Executive Summary

Senate Bill (S.B.) 750, 86th Legislature, Regular Session, 2019, Section 3 requires the Texas Health and Human Services Commission (HHSC) to develop or enhance statewide initiatives to improve the quality of maternal health care services, specify initiatives contracted managed care organizations (MCOs) must implement to improve quality of maternal health care in Texas and submit a report to the legislature summarizing progress. The bill also encourages MCOs to incorporate their own initiatives to improve maternal healthcare services.

S.B. 750 lists potential topics the initiatives may address, including prenatal and postpartum care rates, maternal health disparities for minority and high-risk women, social determinants of health (SDOH), or other agency priorities.

HHSC implemented the following statewide managed care initiatives in 2021 to improve the quality of maternal health care services:

- New Pregnancy-Associated Outcome Measures,
- Assessing changes to MCO performance thresholds for prenatal appointment availability studies, and
- Assessing the success of prenatal or postpartum performance improvement projects (PIPs) for minority or high-risk women.

Results from these initiatives are detailed in the report.

Based on outcomes from the previous initiatives, and ongoing work on maternal health issues, the following initiatives are being pursued for 2022:

- Including additional maternal measures in the pay-for-quality program,
- Developing performance measures to ensure quality of care for women transitioning from Medicaid for Pregnant Women to the Healthy Texas Women (HTW) program, and
- Implementing PIPs focused on SDOH for pregnant members or reducing health disparities for pregnant members.

1. Introduction

Maternal mortality and severe maternal morbidity (SMM) continue to be a concern, both in Texas and nationally.[1] National studies indicate inequities in maternal health outcomes are evident among under-insured and publicly-insured women;[2,3,4] particularly among racial/ethnic minorities, women living in rural areas where availability of obstetric-gynecological (OB-GYN) care is low, and women living in poverty.[5,6,7,8,9] These trends have prompted efforts by policymakers and other stakeholders to address maternal health in state Medicaid programs. In Texas, state legislative initiatives address maternal health in Medicaid, including directives in S.B. 750.

S.B. 750, Section 3 requires HHSC to develop or enhance statewide initiatives to improve the quality of maternal health care services and outcomes for women in this state. HHSC shall specify the initiatives that each contracted MCO must incorporate in the organizations' managed care plans. The initiatives may address:

- Prenatal and postpartum care rates;
- Maternal health disparities that exist for minority women and other high-risk populations of women in Texas;
- SDOH; or
- Other HHSC priorities.

MCOs may implement additional initiatives to improve the quality of maternal health care services for women enrolled in their plans.

This report details efforts to identify and implement important maternal healthcare initiatives in managed care to improve the lives of Texas Medicaid members.

2. Background

State Landscape

As of October 2021, Texas had over 5 million full benefit Medicaid clients and more than 360,000 clients enrolled in Medicaid for Pregnant Women.[10]

A 2018 Joint Report by the Maternal Mortality and Morbidity Task Force (since renamed as the Maternal Mortality and Morbidity Review Committee) found that 68.5 percent of maternal deaths in 2012 were among women with Medicaid coverage at delivery. According to the Texas Maternal Mortality and Morbidity Review Committee (MMMRC) definitions, maternal morbidity is a pregnancy-related health condition occurring during pregnancy, labor, or delivery or within one year of delivery or end of pregnancy. Similarly, SMM is a maternal morbidity that constitutes a life-threatening condition.[11] The Healthy Texas Mothers and Babies Data Book indicates that the SMM rate in Texas remains relatively stable since 2009.[12]

The leading causes of maternal death in the Texas 2013 cohort were cardiovascular and coronary conditions, mental disorders, obstetric hemorrhage, preeclampsia and eclampsia, infection, embolism, cardiomyopathy, and pulmonary conditions (excluding adult respiratory disease syndrome).[13] The Joint Report and the Texas Department of State Health Services (DSHS) found that African-American women had the greatest risk for maternal death in 2013.[14] Also in 2018, a report by the Texas External Quality Review Organization (EQRO) found higher rates of SMM and hemorrhage among Black women, consistent with findings from the MMMRC-DSHS 2020 report.[15] A 2019 report found that African-Americans are disproportionately affected by SDOH such as housing, food insecurity, and education, and low access to health insurance in Texas.[16] Moreover, the toll of ongoing stress is especially harmful to birth outcomes in African-American families.[17, 18]

Texas Quality Initiatives

HHSC uses quality measures to assess MCO performance in providing services to improve birth outcomes including prenatal and postpartum care, low birthweight, potentially preventable complications, and access to contraception. These metrics are reported by program, MCO, and service area on the Texas Healthcare Learning Collaborative portal. Table 1 describes the maternal health quality measures and

how they are used to improve outcomes. Each quality initiative uses multiple measures that pull from a diverse data set to ensure MCOs are held accountable.

Table 1: Maternal Health Measures

Measure	Definition	Use
Prenatal and Postpartum Care* (NCQA - Healthcare Effectiveness Data and Information Set)	Two sub-measures: • Timeliness of Prenatal Care - The percentage of deliveries that received a prenatal care visit as a member of the MCO in the first trimester, on the enrollment start date or within 42 days of enrollment. • Postpartum Care - The percentage of deliveries that had a postpartum visit on or between seven and 84 days after delivery.	State of Texas Access Reform (STAR) MCO report cards 2018 STAR 2018, and 2022-2023 medical Pay-for-Quality (P4Q) At-Risk Measure 2018-2019 PIPs CMS Core Measure reporting
Low Birthweight (Centers for Disease Control and Prevention)	The percentage of live births that weighed less than 2,500 grams.	2018-2019 and 2022-2023 STAR P4Q Bonus Pool measure CMS Core Measure reporting
Potentially Preventable Complications (3M - Potentially Preventable Events)	An in-hospital complication—not present on admission—that might result from insufficient care or treatment rather than from natural progression of the underlying disease. Complications for obstetric reasons can be identified.	2018-2019 and 2022-2023 STAR+PLUS P4Q Bonus Pool measure

Measure	Definition	Use
Cervical Cancer Screening (NCQA - Healthcare Effectiveness Data and Information Set)	The percentage of women 21–64 years of age who were screened for cervical cancer using either of the following criteria: • Women 21–64 years of age who had cervical cytology performed within the last three years. • Women 30–64 years of age who had cervical high-risk human papillomavirus (HPV) testing performed within the last five years. • Women 30–64 years of age who had cervical cytology/high-risk human papillomavirus (HPV) co-testing within the last five years.	2018-2019 and 2022-2023 STAR+PLUS P4Q At-Risk measure HTW 2020 measure
Contraceptive Care - All women (Centers for Disease Control and Prevention)	Among women ages 15 to 44 at risk of unintended pregnancy, the percentage that: • Were provided a most effective or moderately effective method of contraception. • Were provided a long-acting reversible method of contraception (LARC).	CMS Core Measure reporting HTW 2020 measure
Contraceptive Care – postpartum (Centers for Disease Control and Prevention)	Among women ages 15 to 44 who had a live birth, the percentage that: • Were provided a most effective or moderately effective method of contraception within three and 60 days of delivery. • Were provided a long-acting reversible method of contraception (LARC) within three and 60 days of delivery.	CMS Core Measure reporting
Chlamydia Screening in Women (NCQA - Healthcare Effectiveness Data and Information Set)	The percentage of women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.	2022-2023 STAR P4Q Bonus Pool measure CMS Core Measure reporting

Measure	Definition	Use
Cesarean Sections	The percentage of deliveries given by Cesarean Section. Three rates are reported: • C-Sections Among All Deliveries. • C-Sections Among Deliveries with Complications. • C-Sections Among Deliveries without Complications.	2022-2023 STAR P4Q Bonus Pool measure
Pregnancy Associated Outcomes	The percentage of deliveries associated with SMM. Two rates are reported for each (one excluding the cases identified only by transfusion): • SMM Among All Deliveries. • SMM Among Deliveries with Hemorrhage. • SMM Among Deliveries with Preeclampsia.	2022-2023 STAR P4Q Bonus Pool measure

[*] *The National Committee for Quality Assurance (NCQA) changed the specifications for this measure for HEDIS 2020 (calendar year 2019).*

Appointment Availability Study

Title 4, Texas Government Code, Section 533.0063 directed HHSC to establish and implement a process for direct monitoring of a STAR or Children's Health Insurance Program (CHIP) 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, HHSC and Texas' EQRO conduct appointment availability studies which use a "mystery shopper" methodology to examine member experience in scheduling appointments. As part of this study, appointment wait-times are evaluated by MCO for routine prenatal care, high-risk prenatal care, and prenatal care for a new member in the third trimester. MCOs who do not meet appointment availability thresholds are subject to corrective action plans.

Performance Improvement Projects

To ensure compliance with Title 42, Code of Federal Regulations, Section 438.330, HHSC requires that MCOs conduct two, two-year PIPs per program. One of these PIPs must be completed in collaboration with another MCO, a Delivery System Reform Incentive Payment provider, or a community-based organization. The 2018 PIP topic for all STAR plans, STAR Health, and three STAR+PLUS plans was improving the timeliness of prenatal care and/or the rate of postpartum care. HHSC

encouraged MCOs to address a subtopic or subpopulation with their PIPs. Subtopics and subpopulations for 2018 PIPs included: women with or at risk of depression, pregnant women with substance use disorders, and improving care for African American women. These PIPs were implemented January 1, 2018 and concluded December 31, 2019. The results of these PIPs were shared at the 2021 Annual Quality Forum and are described in Section 3 of this report. More information about current PIPs can be found on the HHSC website.

Medical Pay-for-Quality Program

The medical Pay-for-Quality program creates financial incentives and disincentives for MCOs based on their performance on a set of quality measures. A percentage of each MCO's capitation is at-risk based on their performance on a number of key metrics, while bonus pool measures allow health plans to earn additional funds without financial risk.

Historically, the prenatal and postpartum care measure and low birth weight measure have been included for STAR P4Q. Due to the novel coronavirus (COVID-19) public health emergency, the medical P4Q program was suspended for 2020 and 2021.

Texas Senate Bill 17

As required by Section 8, S.B. 17, 85th Legislature, First Called Session, 2017, HHSC studied the feasibility of adding the Alliance for Innovation on Maternal Health (AIM) maternal safety bundles as an indicator of quality for HHSC's data and medical assistance quality-based payment purposes. HHSC commissioned the EQRO to conduct a report to examine ways to leverage current data to assess maternal morbidity. The AIM measures are designed for a hospital setting and were deemed inappropriate to apply at the MCO level. The 2018 S.B. 17 report indicated that the AIM maternal morbidity measures may be useful as a baseline for developing an approach to evaluate maternal health outcomes at the MCO level. Based on these findings, HHSC commissioned a set of Pregnancy-Associated Outcome Measures discussed in Section 3 of this report. These measures will be incorporated into the medical P4Q program in 2022.

3. 2021 Statewide Initiatives

Texas is on the forefront of quality performance measurement in SMM, as no other state has yet to develop a way to measure SMM at the MCO level. Texas will continue to monitor the progress of other states' initiatives and look for ways to incorporate lessons learned into managed care, as appropriate.

In coordination with DSHS, external partners and stakeholders, and informed by participation in the Centers for Medicare & Medicaid Services (CMS) Medicaid Innovation Accelerator Program, HHSC implemented the following initiatives in 2021 responsive to the requirements of S.B. 750.

Pregnancy-Associated Outcome Measures

HHSC implemented three custom measures inspired by the AIM bundles. While DSHS' TexasAIM initiative is geared toward hospitals, these measures focus on MCOs.

There are no national measures addressing SMM at this time, and research conducted by the Texas EQRO has indicated appropriate prenatal care has a significant impact on hemorrhage and preeclampsia rates. The measures capture:

- The proportion of SMM cases among all deliveries.
- The proportion of SMM cases among deliveries having hemorrhage.
- The proportion of SMM cases among deliveries with preeclampsia.

Results

The Pregnancy-Associated Outcome Measures' results were added to the Texas Healthcare Learning Collaborative portal[vv] in 2021. Table 2 below shows an overview of each MCO's performance on the percentage of all deliveries associated with SMM excluding cases identified only by transfusion in calendar years 2019 and 2020.

[vv] https://thlcportal.com/

Table 2. Pregnancy-Associated Outcome Measures – Percentage of All Deliveries Associated with SMM (excluding transfusion only)

STAR MCO	2019	2020
Aetna	1.37%	1.71%
Amerigroup	1.81%	1.64%
BCBSTX	2.36%	2.04%
Community First	1.45%	1.45%
Community Health Choice	2.15%	1.92%
Cook Children's	1.62%	1.34%
Dell Children's	2.71%	2.83%
Driscoll	1.30%	1.33%
El Paso Health	1.37%	1.63%
FirstCare	0.93%	1.43%
Molina	1.64%	1.55%
Parkland	1.96%	1.42%
Scott & White	2.10%	1.66%
Superior	1.56%	1.50%
Texas Children's	1.64%	1.66%
United Healthcare	1.71%	1.92%

The effects of COVID-19 on these performance measures in 2020 are hard to interpret, especially without several years' worth of data to identify 'normal' year-to-year change. HHSC will continue to report on these measures and track MCO performance until enough data is obtained to set benchmarks for improvement.

Prenatal and Postpartum Care PIPs

Background

The Texas Medicaid and CHIP EQRO evaluates PIPs from each MCO and dental maintenance organization (DMO) in accordance with state and federal regulations. Projects must be designed to achieve significant improvement, sustained over time, in health outcomes and enrollee satisfaction.

PIPs are an integral part of Texas Medicaid's 1115 waiver quality improvement strategy. The Balanced Budget Act of 1997 requires all states with Medicaid managed care to ensure MCOs and DMOs conduct PIPs.

To select the PIP topics, HHSC works with the EQRO to review MCO and DMO performance on quality measures and identify areas needing improvement. MCOs and DMOs are required to begin a two-year PIP each year for each Medicaid managed care program. As a result, plans have at least two PIPs in progress in any given year, and some plans may have many PIPs running concurrently.

At least one PIP must be conducted in collaboration with another MCO, DMO, Delivery System Reform Incentive Payment provider, or community-based organization. Collaborative PIPs address joint interventions, including member and provider communications and other strategies which may have a greater system-wide impact.

MCOs and DMOs must submit a PIP plan, annual progress reports, and a final report, all of which are evaluated by the EQRO.

2018 – 2019 PIP Topics

The 2018 PIP topic for all STAR plans, STAR Health, and three STAR+PLUS plans was improving the timeliness of prenatal care and/or the rate of postpartum care. These PIPs were implemented January 1, 2018, and concluded December 31, 2019, with final reports due in late 2020. Quality measure rates prior to the start of the PIP interventions (baseline) is compared to performance during the intervention period to determine whether the PIP has resulted in statistically significant improvement and whether that improvement is sustained throughout the intervention period.

Results

Four health plans achieved sustained improvement in at least one measure. Twelve health plans achieved a significant improvement from baseline to re-measurement in at least one measure. The EQRO noted abnormalities in the reported data and cautioned that data reliability of these 2018 PIPs cannot be verified due to measure specification changes in 2019 that HHSC was not aware of at the start of the PIP. NCQA changed the technical specifications for the postpartum measure to allow more time after delivery for the postpartum visit. Once HHSC became aware of the change, abnormalities were anticipated. Therefore, it cannot be said with

confidence that health plans would have achieved a significant improvement in the postpartum sub-measure without this change in the technical specifications. Despite changes in measure specifications, MCOs successfully implemented innovative interventions.

At the 2021 Annual Quality Forum, MCOs shared lessons learned, successes and challenges on the PIPs that targeted improving prenatal and postpartum care rates for African American members, and members with or at high risk of postpartum depression. An overview of the plans that achieved sustained improvement is below with a summary of the interventions used.

Table 3. MCOs with Sustained Improvement

MCO	Measure	Intervention
Amerigroup	Prenatal visits among African American women	• Provider level intervention: Nurse Practice Consultant team conducted outreach and education to providers. • Member level intervention: Identified new pregnant members, their needs and risk level, and conducted outreach.
BCBSTX	Prenatal visits among all women	• Educational intervention: Targeted members and providers to contact and incentivize unable to reach members to attend their postpartum appointment. • Call campaign intervention: Coordinated with local hospitals and members to provide timely member outreach to support with prenatal and postpartum care.
Parkland	Postpartum visits among members with depression	• Educational intervention: Hosted quarterly member advisory group meetings and quarterly provider luncheons where they utilized the time to provide education and materials to members and providers.
Superior	Postpartum visits among women in the Bexar Service Area	• Educational intervention: provided educational materials to members on the importance of timely prenatal visits. • Technology Intervention: Through the Wellframe application, offered members appointment reminders, educational videos, and direct communication with their OB Case Manager.

Prenatal Appointment Availability Studies

The Medicaid managed care contracts require that all members have access to all covered services on a timely basis, consistent with medically appropriate guidelines and accepted practice parameters. HHSC evaluated MCOs' compliance with OB-GYN prenatal appointment standards in 2015, 2016, 2018, and 2020.

Increased Prenatal Appointment Availability Thresholds

HHSC uses performance thresholds for contract oversight. These thresholds indicate the percent of providers in an MCO's network that HHSC expects to meet the contractual standard. The thresholds were developed based on MCOs' historic performance and in consideration of this vulnerable risk group and have been the same since 2015. MCOs with performance below the thresholds are subject to contract remedies, including corrective action plans (CAPs) and liquidated damages (LDs).

Table 4: Prenatal Appointment Availability Thresholds

Level/Type of Care	Contractual Standard: Time to Treatment (Calendar Days)	Current Threshold	Providers Meeting Threshold in 2018
Prenatal Care – Not High-Risk	Within 14 calendar days	85%	73%
Prenatal Care - High-Risk	Within 5 calendar days	51%	28%
Prenatal Care - New Members in the Third Trimester	Within 5 calendar days	51%	58%

Results

HHSC suspended CAPs and LDs for the appointment availability studies in 2020 and 2021 due to the COVID-19 public health emergency. During the public health emergency, telehealth visits increased greatly. Providers utilize telehealth visits to reduce patient exposure, making it problematic to assess MCOs on how quickly they could offer in-person appointments for members. Due to funding constraints, the prenatal care studies were not conducted in 2021, but are scheduled to be

conducted again in 2022. HHSC intends to revisit increasing the thresholds once the studies resume a normal cadence.

4. 2022 Statewide Initiatives

Maternal Measures in Medical P4Q

HHSC uses the medical P4Q program to communicate priorities to health plans by choosing measures that target areas of needed improvement. Maternal health continues to be a priority for HHSC, and the following measures will be added to the medical P4Q program for the STAR program for 2022-2023.

Table 5. STAR Medical P4Q Maternal Measures 2022-2023

Measure	Source	Description	Type
Prenatal and Postpartum Care (PPC)	HEDIS	Postpartum Care: The percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery	At-Risk
Cesarean Sections, Uncomplicated Deliveries	HHSC	Cesarean deliveries without a hysterotomy procedure per 1,000 deliveries. Excludes deliveries with complications (abnormal presentation, preterm delivery, fetal death, multiple gestation diagnoses, or breech procedure).	Bonus Pool
Pregnancy-Associated Outcomes	HHSC	The percentage of all deliveries associated with SMM excluding cases identified only by transfusion.	Bonus Pool
Low Birth Weight	CMS	Percentage of live births that weighed less than 2,500 grams (5.51 pounds)	Bonus Pool

Continuity of Care Performance Measures

Texas is one of nine states chosen to participate in the Center for Medicaid and CHIP Services (CMCS) Improving Postpartum Care Affinity Group, focused on improving the use and quality of postpartum care for Medicaid and CHIP beneficiaries who are high risk, including women with chronic medical conditions. As a part of this affinity group, quality improvement advisors and subject-matter experts provide technical assistance to Medicaid- and CHIP-led state quality improvement teams through individualized and group meetings, using quality improvement tools to identify, implement, and test postpartum care quality improvement change ideas. Participating state teams meet monthly from April 2021

through April 2022, with additional technical assistance available until October 2022.

HHSC planned to use this opportunity to develop and improve evaluation efforts to assess the quality of care received by the population served by the Healthy Texas Women (HTW) program, including HTW Plus, which includes services designed to treat conditions recognized as contributing to maternal mortality and morbidity in Texas. However, pursuant to federal law and subsequent federal guidance, HHSC has maintained clients' Medicaid coverage during the federal public health emergency as a condition of receiving enhanced federal funding. Therefore, clients who would normally transition from Medicaid for Pregnant Women to HTW remain in Medicaid.

Because clients are not transitioning from Medicaid to HTW during the public health emergency, HHSC has postponed affinity group activities targeting HTW utilization. As a member of the affinity group, Texas hopes to gain expertise on how to leverage the state's existing data sources and partnerships with MCOs to improve hypertension monitoring of pregnant and postpartum members, with particular emphasis on stratification by race/ethnicity to identify and address disparities in care.

Four Texas Medicaid MCOs have partnered with HHSC on this project. Each health plan has developed interventions to address hypertension management, or care coordination so that more eligible women in the postpartum period monitor high blood pressure and access services. The goal is to ensure continuity of care for women receiving these services as they transition from Medicaid for Pregnant Women to HTW in the future, to be efficiently referred forward to HTW and continue receiving hypertension management, substance use treatment, or postpartum depression services, as applicable.

2022 PIPs: Prenatal & Postpartum Care and SDOH for Pregnant Members

Healthy People 2020 defines SDOH as the conditions in the environments where people live, work, learn, and play with an emphasis on five areas of focus:

- Economic stability;
- Education;
- Health and Health Care;

- Neighborhood and Built Environment;
- Social and Community Context.

Additionally, a report[19] published in 2020 analyzing the associations of SDOH and pregnancy-related mortality and morbidity in the United States showed strong association between minority race and ethnicity, public or no insurance coverage, and lower education levels, with an increased incidence of maternal death and SMM. As more and more data show associations between maternal health outcomes and SDOH, many state Medicaid programs have started prioritizing initiatives to address SDOH.

The 2022 PIPs for STAR, STAR+PLUS, and STAR Health will focus on SDOH for pregnant members and reducing health disparities. In addition, MCOs with low prenatal and postpartum care rates will be required to target improvement on these measures in their 2022 PIPs.

5. Conclusion

HHSC is committed to improving the quality of maternal health care and outcomes in Texas Medicaid. HHSC is working toward this goal by including additional maternal measures in the medical P4Q program, developing measures to ensure quality care for women transitioning from Medicaid for Pregnant Women to the Healthy Texas Women program and incorporating a focus on SDOH and health disparities in PIPs for high-risk pregnancies.

List of Acronyms

Acronym	Full Name
AIM	The Alliance for Innovation on Maternal Health
CAPs	Corrective Action Plans
CHIP	Children's Health Insurance Program
CMCS	Center for Medicaid and CHIP Services
CMS	Centers for Medicare & Medicaid Services
COVID-19	Novel Coronavirus Public Health Emergency
DMO	Dental Maintenance Organization
DSHS	Texas Department of State Health Services
EQRO	External Quality Review Organization
HHSC	Health & Human Services Commission
HTW	Healthy Texas Women
LDs	Liquidated Damages
MCO	Managed Care Organization
MMMRC	Texas Maternal Mortality and Morbidity Review Committee
OB-GYN	Obstetric-Gynecological
P4Q	Pay for Quality
PIPs	Performance Improvement Projects
S.B.	Senate Bill
SDOH	Social Determinants of Health
SMM	Severe Maternal Morbidity
STAR	State of Texas Access Reform

References

1. Texas Department of State Health Services (DSHS). 2017. Maternal Mortality in Texas: Using Precision Pubic Health to Improve Maternal Outcomes. Available at: https://www.dshs.texas.gov/mch/Maternal-Mortality-and-Morbidity-Review- Committee.aspx.
2. Peahl AF, Kozhimannil KB, Admon LK. 2019. "Addressing the US Maternal Health Crisis: Policies of 2020 Presidential Candidates." Health Affairs (Blog), June 26, 2019.
3. Kaiser Family Foundation (KFF). 2020. "Analysis of Federal Bills to Strengthen Maternal Health Care." Available at: https://www.kff.org/womens-health- policy/fact-sheet/analysis-of-federal-bills-to-strengthen-maternal-health-care/.
4. Office of Disease Prevention and Health Promotion (ODPHP). 2020a. Healthy People 2020 – Maternal, Infant, and Child Health. Available at: https://www.healthypeople.gov/2020/topics-objectives/topic/maternal-infant- and-child-health.
5. CDC. 2020a. "Pregnancy Mortality Surveillance System." CDC, Division of Reproductive Health, National Center for Chronic Disease Prevention and Health Promotion. Available at: https://www.cdc.gov/reproductivehealth/maternal- mortality/pregnancy-mortality-surveillance-system.htm.
6. CDC 2020b. "Severe Maternal Morbidity in the United States." CDC, Division of Reproductive Health, National Center for Chronic Disease Prevention and Health Promotion. Available at: https://www.cdc.gov/reproductivehealth/maternalinfanthealth/severematernalmo rbidity.html.
7. The American College of Obstetricians and Gynecologists (ACOG). 2015. Racial and Ethnic Disparities in Obstetrics and Gynecology. ACOG Committee Opinion, Number 649, February 2015. Available at: https://www.acog.org/clinical/clinical- guidance/committee-opinion/articles/2015/12/racial-and-ethnic-disparities-in- obstetrics-and-gynecology.
8. ACOG. 2014. Health Disparities in Rural Women. ACOG Committee Opinion, Number 586, February 2014. Available at: https://www.acog.org/-/media/project/acog/acogorg/clinical/files/committee-opinion/articles/2014/02/health-disparities-in-rural-women.pdf.

9. Singh GK. 2010. Maternal Mortality in the United States, 1935-2007: Substantial Racial/Ethnic, Socioeconomic and Geographic Disparities Exist. A 75th Anniversary Publication. Health Resources and Services Administration, Maternal Health Bureau. Rockville, Maryland: U.S. Department of Health and Human Services. Available at: https://www.hrsa.gov/sites/default/files/ourstories/mchb75th/mchb75maternalmortality.pdf.
10. HHSC Financial Services, information received from Forecasting November 2021. These figures are influenced by the COVID Public Health Emergency Maintenance of Eligibility policy.
11. Texas Health and Safety Code, Section 34.001, related to Texas Maternal Mortality and Morbidity Review Committee definitions.
12. 2019 Healthy Texas Mothers and Babies Data Book, p. 50.
13. Texas Maternal Mortality and Morbidity Review Committee and Department of State Health Services Joint Biennial Report. 2020. thttps://www.dshs.texas.gov/legislative/2020-Reports/DSHS-MMMRC-2020.pdf.
14. Texas Health and Human Services (HHS). 2018. Maternal Mortality and Morbidity Task Force and Department of State Health Services Joint Biennial Report. September 2018. Available at: https://dshs.texas.gov/mch/maternal_mortality_and_morbidity.shtm.
15. Institute for Child Health Policy (ICHP). 2018. Texas Medicaid Managed Care – Quarterly Topic Report 3: Estimating Severe Maternal Morbidity Among Women Enrolled in Texas Medicaid and CHIP. August 2018.
16. Texans Care for Children (TCC). 2019. Report: Central TX Must Address Maternal Health. Available at: https://txchildren.org/posts/2019/6/24/report-central-tx- must-address-maternal-health.
17. Wang, E., Glazer, K. B., Howell, E. A., & Janevic, T. M. (2020). Social determinants of pregnancy-related mortality and morbidity in the United States: A systematic review. Obstetrics & Gynecology, 135(4), 896-915.
18. Department of Health Care Finance, Government of the District of Columbia. 2018. DC Healthy Families: Fully executed emergency contract Amerigroup. Contract no. DCHT-2018-C-0087-A01.
19. Minnesota Department of Human Services (DHS). 2019. Contract for prepaid medical assistance and MinnesotaCare (families and children). https://mn.gov/dhs/assets/2019-fc-model-contract_tcm1053-370132.pdf .