Annual Report on Quality Measures and Value-Based Payments

As Required by
Texas Government Code
Section 536.008

Texas Health and Human Services
December 2023

TEXAS
Health and Human Services

Table of Contents

Executive Summary ... **1**

Introduction ... **3**

Managed Care Value-Based Payments Programs ... **5**
Pay-for-Quality Program ... 5
Alternative Payment Model Requirements for MCOs ... 6
Hospital Quality-Based Payment Program ... 9
Medicaid Value-Based Enrollment ... 10

Quality Improvement Programs ... **12**
Directed Payment Programs ... 12
Benchmarks for Managed Care Organizations ... 16

Trends in Key Quality Measures ... **18**
Trends in Potentially Preventable Events, 2016-2022 ... 18
HHSC Performance Indicator Dashboard ... 22
HIV Viral Load Suppression ... 24
Relocation to a Community-Based Setting ... 25

Conclusion ... **26**

List of Acronyms ... **27**

Appendix A. Supplemental Tables ... **A.1**

Appendix B. Statewide Initiatives to Improve Quality of Maternal Health Care ... **B.1**

Executive Summary ... **B.3**

Introduction ... **B.4**

Background ... **B.5**
State Landscape ... B.5
Texas Quality Initiatives ... B.5

Current Statewide Initiatives ... **B.9**
Pregnancy-Associated Outcome Measures ... B.9
Prenatal Appointment Availability Studies ... B.10
Maternal Measures in Medical P4Q ... B.12
Continuity of Care Performance Measures ... B.12
Maternal Health PIPs ... B.14
2022 PIPs: Prenatal & Postpartum Care and NMDOH for Pregnant Members ... B.14

Conclusion **B.16**

List of Acronyms **B.17**

Appendix B.1 Supplemental Data **B.1.1**

Appendix C. Quality Monitoring Program: Early Warning System for Long-Term Care Facilities **C.1**

Executive Summary **C.3**

Introduction **C.4**

Background **C.5**

Quality Monitoring Activities **C.7**
- Quality Monitoring Visits C.7
- Rapid Response Team Visits C.8
- Introductory and In-service Visits C.9

Conclusion and Next Steps **C.10**

List of Acronyms **C.11**

Executive Summary

Texas Government Code, Section 536.008, requires the Texas Health and Human Services Commission (HHSC) to report annually on efforts to develop quality measurement and quality-based (or value-based) payment initiatives.[1] Furthermore, Senate Bill (S.B.) 750, 86th Legislature, Regular Session, 2019, requires HHSC to develop or enhance statewide initiatives that 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 is the sixth annual submission of this report, which presents information on HHSC's healthcare quality improvement activities for Texas Medicaid programs and the Children's Health Insurance Program (CHIP). The report provides updates to previous sections and additional information related to new programs implemented since the publication of the prior report (2022). Specifically, it provides updates to the following sections:

- Managed Care Value-Based Payment Programs,
- Quality Improvement Programs,
- Trends in Key Quality Measures,
- Maternal Health Care, and
- Early Warning System for Long-Term Care Facilities.

HHSC has charted 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 contract requirements for MCOs and Dental Maintenance Organizations (DMOs) to achieve a minimum level of alternative payment model (APM) agreements with their providers. Furthermore, HHSC operates medical and dental Pay-for-Quality (P4Q) programs with MCOs and DMOs that hold them accountable for certain quality performance measures. The alignment between these two value-based payment programs (APM and P4Q), occurred in calendar year 2018, the first year of APM requirements and implementation of the redesigned P4Q programs. APM and P4Q were temporarily

[1] House Bill 1629, 85th Legislature, Regular Session, 2017, requires 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. Retrieved from https://capitol.texas.gov/BillLookup/Text.aspx?LegSess=85R&Bill=HB1629

paused during the federal COVID-19 public health emergency (PHE), when the goals of P4Q were recalibrated in response to the challenges posed by the PHE.

In state fiscal year 2022, HHSC implemented four new directed payment programs (DPPs) designed to advance goals and objectives of the Managed Care Quality Strategy and sustain supplemental funding levels earned under DSRIP, which ended September 2021. For state fiscal year 2024, HHSC received continued approval from the Centers for Medicare & Medicaid Services (CMS) for five directed payment programs: Comprehensive Hospital Increase Reimbursement Program (CHIRP), Directed Payment Program for Behavioral Health Services (DPP BHS), Quality Improvement Payment Program (QIPP), Rural Access to Primary and Preventive Services Program (RAPPS), and Texas Incentives for Physicians and Professional Services (TIPPS). These programs must advance at least one goal or objective of the Managed Care Quality Strategy.

This report also includes descriptions and implementation updates for key legislative initiatives (including from the 88th regular legislative session, 2023), as well as attachments covering legislative reporting requirements for statewide initiatives to improve the quality of maternal health care services and HHSC's Early Warning System for long-term care facilities.

Introduction

HHSC's Value-Based Care (VBC) strategy for Texas Medicaid and CHIP is centered on the Texas Managed Care Quality Strategy goals, using the 2021 VBP Roadmap for guidance. The VBC approach includes the VBP programs, the DPPs, and regular evaluation and reporting of MCO and DMO performance on key quality measures.

In accordance with Title 42, Code of Federal Regulations, Section 438.340, the state implements a quality strategy, which must be reviewed and updated as needed, but no less than once every three years. HHSC uses the Managed Care Quality Strategy (last updated in July 2021), to improve the quality of health care and services provided through the managed care system. More detailed information on specific goals and objectives is provided in the Texas Managed Care Quality Strategy.

The 88th Legislature directed HHSC to continue advancing value and transparency in the Medicaid program through a set of bills and riders. This recent legislation, described below, authorizes new approaches and builds on current quality improvement and value-based efforts:

- The 2024-25 General Appropriations Act (GAA), House Bill (H.B.) 1, 88th Legislature, Regular Session, 2023 (Article IX, General Provisions, Section 10.06), extends the requirement for cross-agency coordination of healthcare strategies and measures supported by the University of Texas Health Science Center (UTHSC)-Houston, Center for Health Care Data (CHCD). It requires a report that describes cross-agency coordination activities, efficiencies identified, and recommendations on ways to reduce cost and improve quality of care in the healthcare systems of the five participating agencies (HHSC, Teacher Retirement System of Texas, Employees Retirement System of Texas, Texas Department of Criminal Justice, and Department of State Health Services [DSHS]). The report will be submitted to the Legislature on September 1, 2024.
- H.B. 3414, 88th Legislature, Regular Session, 2023, revises provisions of the Texas Insurance Code pertaining to data and information collected by the Texas All Payor Claims Database (APCD), established in 2021 by H.B. 2090, 87th Legislature, Regular Session, 2021. The APCD, operated by CHCD, collects medical, dental, and pharmacy claims; provider files; and enrollment data from health insurance payors in the state, including Medicaid, for the purpose of supporting healthcare quality improvement and value-based analytics, research, and initiatives. Texas Medicaid is working with CHCD to

test data transmission to the APCD. Data transmission will be fully operational in early 2024.

- H.B. 1575, 88th Legislature, Regular Session, 2023, requires HHSC to adopt standardized screening questions that MCOs and Thriving Texas Families organizations will use to screen for certain non-medical drivers of health (NMDOH) needs of pregnant women and share the data with HHSC. H.B. 1575 requires STAR MCOs to use the NMDOH-related needs screening to determine if the client is eligible for service coordination or should be referred for program services. H.B. 1575 further directs HHSC to establish a separate provider type for both community health workers and doulas who provide case management services under the case management for children and pregnant women benefit.
- S.B. 1136, 87th Legislature, Regular Session, 2021 (Texas Government Code, Section 531.0862) requires ongoing reporting on the current state of emergency department (ED) use in Medicaid and information on initiatives to reduce ED use and improve health outcomes for the Medicaid population. Four reports have been submitted to the Legislature, with the two latest reports published in March 2023 and August 2023. These reports describe the current scope of potentially preventable ED visits (PPVs), current initiatives to reduce potentially preventable ED utilization by Medicaid recipients, ongoing and new efforts to improve Medicaid recipients' health outcomes, and updates on HHSC's work with stakeholders.

Managed Care Value-Based Payments Programs

The agency's primary drivers for advancing VBC in Medicaid managed care include:

- P4Q program,
- APM requirements for MCOs and DMOs,
- Hospital Quality Based Payment (HQBP) program, and
- Medicaid MCO Value-Based Enrollment (VBE).

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 that do not meet target performance thresholds for 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 any funds remain after the collection and redistribution process, they form a bonus pool to reward high-performing MCOs on specific measures. Because MCOs can lose or gain substantial capitation dollars, this program incentivizes MCOs to collaborate with providers to develop VBP models that can help ensure success. The at-risk measures and effective years for the medical P4Q program (for 2018–2025) are shown in Table 1 in Appendix A. Table 2 in Appendix A lists the bonus pool measures and effective years for the same period. HHSC suspended the medical and dental P4Q programs for measurement years 2020 and 2021 because of the federal COVID-19 PHE. Tables 1 and 2 reflect this change. For 2024-2025, the medical P4Q program will pause for CHIP MCOs. During the PHE, CHIP enrollment declined significantly due to Medicaid continuous enrollment requirements, impacting HHSC's ability to reliably calculate quality

measures for CHIP at the MCO level. P4Q for CHIP MCOs will be revisited for the 2026-2027 cycle.

The P4Q program was reinstated for Medicaid for 2022. The benchmarks are based on 2020 data and MCOs will also be compared to their own performance in 2021. P4Q data for 2022 will be available in March 2024.

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 one year 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 3 in Appendix A.

HHSC suspended the dental P4Q program for 2020 and 2021 because of the federal COVID-19 PHE. While Dental P4Q was reinstated for 2022, the benchmarks are based on 2020 data, and the DMOs are compared to their own performance in 2021. Dental P4Q data for 2022 will become available in March of 2024.

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. Thus, a second component of the VBP approach introduced in 2018 by HHSC requires MCOs to shift an increasing proportion of provider reimbursement into APMs that link a portion of provider payments to measures of value (quality and efficiency). These APMs may involve financial risk on providers or reward them for meeting performance standards based on measures of value. To guide this component, HHSC uses the Healthcare Payment Learning and Action Network (HCP LAN) Alternative Payment Model (APM) Framework which introduced a common pathway and vocabulary for pursuing and measuring these new payment models.[2] This framework, which describes four categories and eight subcategories of payment

[2] Health Care Payment Learning & Action Network (HCP-LAN) is a public-private partnership that developed the concept of alternative payment models (APM). Retrieved from https://hcp-lan.org/apm-framework/

models, has become the foundation for implementing APMs across the nation, capturing continuum of care arrangements and financial risks for provider organizations moving from Category 1 (fee-for-service) through Category 4 (population-based) models.

In the first phase of VBP implementation through APMs, MCOs were required to meet certain volumes of APM contracts with their providers, which were measured against annually increased targets over the six-year period (2018 – 2023).

Starting with calendar year 2024 reporting, HHSC will transition to an APM Performance Framework that recognizes MCO efforts beyond just meeting these payment targets. Initial data collection, planned for September 2024, will test the updated data collection tool. The new requirements will be fully in place for 2024 data collected in September 2025. Under the updated approach, MCOs will be encouraged to develop and field innovative models that address specific quality improvement priorities, including models that encourage improvements in maternal health outcomes, reductions to potentially preventable ED visits, address NMDOH, support home and community-based services workforce development, and incentivize the integration of primary and behavioral healthcare services.

HHSC MCO Contract on APMs

MCOs must report annually to HHSC on the volume of contracts they implemented with their providers in the prior calendar year, employing APMs. These reports include a detailed description of the APMs and the expense amounts associated with them. If the MCO's APM reports do not meet HHSC contractual requirements as stated in the Uniform Managed Care Contract, are not submitted by the required deadline, or if an MCO does not demonstrate acceptable progress within the APM Performance Framework, the MCO shall be subject to contractual remedies, up to and including liquidated damages.

Prior to 2022, improvements generally have been noted across the years in both the quality of MCO reports and the volume of APMs developed by MCOs with their providers. Using the data from these reports, HHSC calculates the annual level of APM target achievement for each MCO by program type.[3] Under current requirements, MCOs must make 50 percent of their provider payments through an APM with at least 25 percent through an APM involving financial risk for providers, by 2023. In the aggregate, MCOs had been on track to meet these goals. However,

---

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

for 2022, the most recent year for which data are complete, the percentage of overall MCO payments to providers in an APM declined across all programs from 2021 to 2022 (Figure 1). In contrast, APM's with financial risk, thought by most experts to have the greatest incentive on provider performance, remained at or above expectations in 2022 (Figure 2). Table 4 in Appendix A shows the number of MCOs meeting APM achievement targets for 2022. The decline in overall APM achievement reached by MCOs could be linked to several factors, including changing enrollment patterns associated with the federal COVID-19 PHE's continuous enrollment requirements, MCO decisions to scale back one or more large scale APMs, and MCOs prioritization of risk-based models. HHSC plans to collect more information from MCOs regarding their experience with APMs for 2022. Initial APMs established in Medicaid tended to focus on primary care, followed by hospitals, specialists, and behavioral health providers. More recently, APMs involving home and community-based services have become a greater share of the models (see Table 5 in Appendix A).

Figure 1. Overall APM Achievement by Program, Calendar Years (CY) 2017–2022

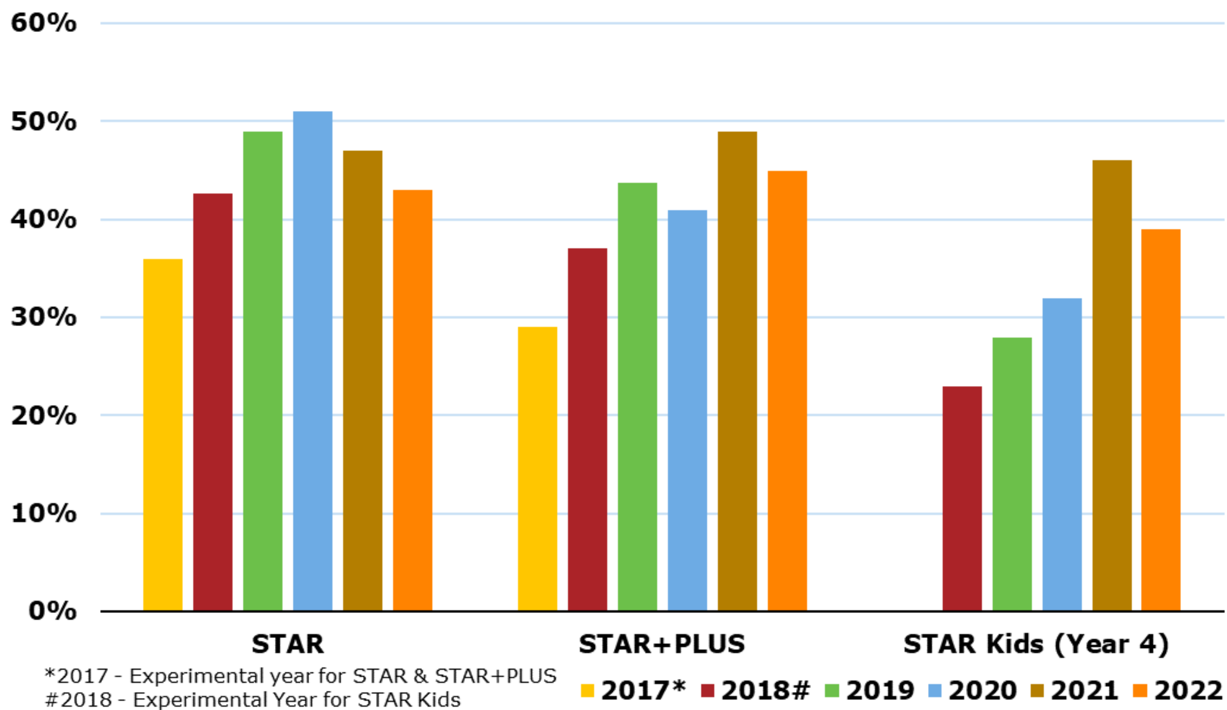
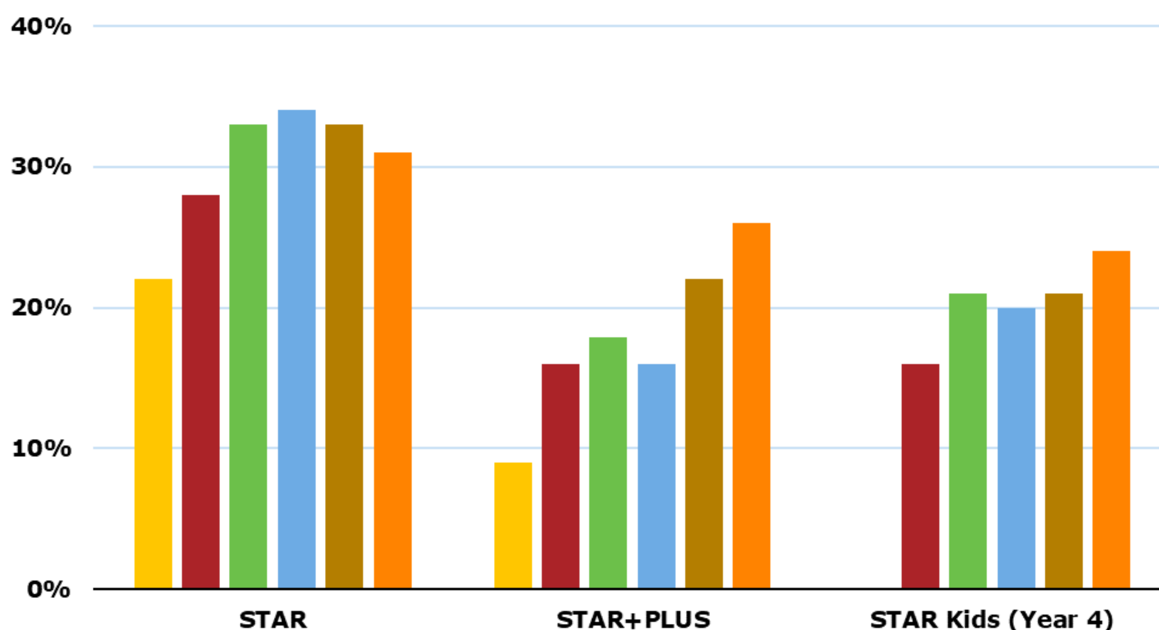


Figure 2. Risk-based APM Achievement by Program, CYs 2017–2022



Hospital Quality-Based Payment Program

HHSC administers the HQBP program for all hospitals in Medicaid and CHIP in both the managed care and fee-for-service delivery systems. Hospitals are measured on their performance for risk-adjusted rates of potentially preventable hospital readmissions (PPR) within 15 days of discharge and potentially preventable inpatient hospital complications (PPC) across all Medicaid programs and CHIP, as these measures have been determined to be reasonably within a hospital's 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.[4] Changes in the number of hospitals receiving a reimbursement adjustment under HQBP is not itself evidence of statewide performance on PPRs or PPCs, though it may indicate that variation across hospitals has narrowed.

[4] The measurement, reporting, and application of payment adjustments is described in the Texas Administrative Code, Title 1, Part 15, Chapter 354, Subchapter A, Division 35, Reimbursement Adjustments for Potentially Preventable Events. Retrieved from https://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=5&ti=1&pt=15&ch=354&sch=A&div=35&rl=Y

34Hospital Performance: Potentially Preventable Readmissions

Sixty-eight hospitals received a reimbursement reduction for PPR performance for the state fiscal year 2022 report cycle, factored into MCO rate setting for state fiscal year 2024. This number is lower than the previous report cycle for state fiscal year 2021, where 73 hospitals were issued a reimbursement adjustment.

Starting with state fiscal year 2020, HHSC began to use "unweighted" risk-adjustment methods for evaluating individual hospital performance on PPRs, to ensure that providers serving a high volume of patients with medical complexity are not unfairly penalized. As a result, HHSC also began using the "unweighted" method for the state fiscal year 2022 HQBP reimbursement reductions. Furthermore, after receiving input from stakeholders that neonatal jaundice readmissions may not reflect a systemic quality of care issue for hospitals, this diagnosis was removed from the PPR analysis starting with the state fiscal year 2021 report cycle (2023 MCO rate setting).

Reducing PPRs is a state Medicaid priority. As required by Rider 61: Evaluation of Medicaid and CHIP Managed Care by the 85th Legislature, HHSC evaluated Medicaid managed care in Texas in 2018. The evaluation report identified the increasing PPR trends as an opportunity to integrate actuarial efficiency factors into the MCO rate setting process. In state 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 state fiscal year 2020 capitation rates by $21.4 million.

Hospital Performance: Potentially Preventable Complications

Seventy-nine hospitals received a reimbursement reduction for PPC performance for the state fiscal year 2022 report cycle, effective for MCO rates in state fiscal year 2024. This is lower than the previous report cycle for state fiscal year 2021, where 90 hospitals were issued a reimbursement adjustment for PPC performance.

5Medicaid Value-Based Enrollment

Texas Government Code, Section 533.00511, directed HHSC to develop an incentive program that automatically enrolls a greater percentage of recipients who did not actively choose their managed care plan, into a plan that provides higher quality of

care, shows ability to provide services efficiently and effectively, and exceeds performance with respect to achieving appropriate outcome and process measures identified by HHSC.[5] In response, HHSC designed a VBE methodology, described in the 2021 iteration of this report.

HHSC periodically assesses the effect of the VBE process based on enrollment data for STAR, STAR+PLUS, and STAR Kids. Table 6 in Appendix A shows the impact of VBE on MCOs based on the model's data update from May 2023, both cumulative and for each program. Statewide, for 16 participating MCOs across the STAR, STAR+PLUS, and STAR Kids programs combined, six plans gained two percent or more in auto-enrollments compared to the previous process that did not account for value, six plans lost at least two percent, and four plans saw changes of no greater than two percent. Overall, enrollment changes based on VBE varied between around six percent gains to almost nine percent losses across the three Medicaid programs. Although changes are generally modest when aggregated statewide, within the specific program and service areas where MCOs compete, MCOs lost up to 23 percent or gained up to 18 percent default enrollment due to VBE.

[5] "Potentially preventable event" means potentially preventable admission, potentially preventable complication, potentially preventable emergency department visit, potentially preventable readmission. Described in the Texas Government Code, Section 536.001: https://texas.public.law/statutes/tex._gov't_code_section_536.001

Quality Improvement Programs

HHSC has pursued quality improvement programs over the last ten years with a large value-based component. These well-established initiatives included the Delivery System Reform Incentive Payment program (DSRIP), (part of the 1115 Waiver) and QIPP (DPP). DPPs like CHIRP, TIPPS, RAPPS, and DPP BHS are structured for quality improvement consistent with Medicaid Managed Care Quality Strategy goals. The quality and cost efficiency benchmarks for MCOs is another recent VBC related initiative established in 2022.

Directed Payment Programs

In state fiscal year 2022, HHSC implemented four new DPPs designed to advance goals and objectives of the Managed Care Quality Strategy and sustain supplemental funding levels earned under DSRIP, that ended September 2021. CMS, under 42 Code of Federal Regulations § 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." The state develops the programs specific to a class of providers and directs MCOs to implement the associated provider payments. DPPs are expected to advance at least one of the goals and objectives in the state's Managed Care Quality Strategy and require approval from CMS to authorize federal matching funds.

For state fiscal year 2024, HHSC received approval from CMS on July 31, 2023 for year seven of its nursing facility (NF) QIPP DPP and year three of CHIRP, TIPPS, RAPPS, and DPP BHS.

Nursing Facility Quality Incentive Payment Program

The QIPP for nursing homes is designed to incentivize NFs to improve quality and innovation in the provision of NF services. The program began in state fiscal year 2018 and was approved by CMS for a sixth program year (state fiscal year 2023) on August 1, 2022, with an effective date of September 1, 2022. Program design and performance results for state fiscal year 2023 are summarized below.

QIPP Year Six (State Fiscal Year 2023) Design

HHSC adopted new quality measures, eligibility requirements, and financing components for QIPP that began in program year three (state fiscal year 2020) and continued through program year four (state fiscal year 2021).

In response to the federal PHE, HHSC made mid-year changes to QIPP year three effective March 1, 2020, that lasted through the third quarter of QIPP year four, ending June 1, 2021. Years three and four program design and the PHE response were described in the 2021 Annual Quality Report.

Building on the development in quality measures in year three and four, HHSC further developed program quality measures for QIPP year five (state fiscal year 2022). This led to an expansion of existing metrics in Components 1 and 2, from reporting on structure measures to tracking process measures in the form of performance improvement projects (PIPs), and an increase in the number of Minimum Data Sets (MDS)-based quality measures in component three, and a restructuring of the Infection Control Program that constitutes Component 4. As in previous years, the new measures were developed by a workgroup comprised of external stakeholders and HHSC staff.

Changes made to QIPP year five performance requirements continue through to QIPP years six and seven (state fiscal years 2023 and 2024). Beginning in QIPP year six (state fiscal year 2023), HHSC reduced the frequency of reporting requirements for PIPs required in Components 1 and 2 and for infection control policy documents in Component 4. However, quality measures and performance requirements remain the same across all three years.

For more information on the QIPP program components, please see the 2022 Annual Quality Report. For complete details of program components throughout all program years, see the Medicaid and CHIP services QIPP Overview & History website.

QIPP Year Six (State Fiscal Year 2023) Performance Summary

For program year six, 952 NFs participated in QIPP, representing 701 non-state government owned NFs and 251 private NFs. The estimated value for year six was $1.1 billion. HHSC evaluates facility performance/quality metrics on a monthly and quarterly basis.

MCOs received QIPP funds through STAR+PLUS capitation rates. MCOs distributed the funds to enrolled NFs based on each facility’s performance on the quality measures in four program components (Component 1: Quality Assurance and Performance Improvement (QAPI); Component 2: Workforce Development; Component 3: Core MDS Measures; Component 4: Infection Control) for state fiscal year 2023 as follows (see Table 7).

Table 7. QIPP Year Six NF Performance on Minimum Data Set (MDS) Long-Stay Measures

Long-Stay Measure	SFY 2023 Baseline	Q1 Average	Q2 Average	Q3 Average	Q4 Average
Percent of High-Risk Residents with Pressure Ulcers	7.20%	6.25	6.47%	6.00%	5.73%
Residents Who Received an Antipsychotic Medication	11.36%	9.07%	8.89%	8.29%	8.59%
Residents Whose Ability to Move Independently Worsened	15.45%	14.15%	13.78%	12.43%	12.08%
Residents with Urinary Tract Infections	1.29%	0.94%	0.87%	0.78%	0.77%
Residents Assessed and Appropriately Given the Pneumococcal Vaccine	96.01%	N/A	N/A	N/A	96.81%
Residents Assessed and Appropriately Given the Seasonal Influenza Vaccine	97.44%	N/A	N/A	N/A	98.19%

Associated payments to QIPP facilities for year six are presented in Tables 8.1 and Table 8.2. Total paid funds are equal to the actual funds paid to the facility through the component payment plus non-dispersed funds. Earned funds are funds the facility is eligible to receive when they have met the payment component requirements. Non-dispersed funds are funds left unearned by facilities not meeting requirements, which are then paid out among eligible facilities.

Table 8.1 QIPP Year Six NF Achievement by Component and Metric

Component	Metric	Percentage of Eligible Nursing Facilities Achieving Metric
Component One	QAPI Program & PIP	Condition of Participation
Component Two	+4 RN Hours	89%
Component Two	+8 RN Hours	86%
Component Two	Workforce Plan & PIP	Condition of Participation

Component	Metric	Percentage of Eligible Nursing Facilities Achieving Metric
Component Three	Pressure Ulcers	61%
Component Three	Antipsychotic Medication	69%
Component Three	Move Independently	78%
Component Three	Urinary Tract Infection	82%
Component Four	Infection Control Program	97%
Component Four	Infection Control Training	85%
Component Four	Pneumococcal & Influenza Vaccines	72%

Table 8.2 QIPP Year Six NF Payments

Component	Total Payments
Component One	$459,507,443
Component Two	$147,688,266
Component Three	$175,332,959
Component Four	$147,654,694
Total Earned Year Six	$930,183,363
Total Non-Dispersed Year Six	$143,691,449

QIPP Year Seven (State Fiscal Year 2024) Developments and Approval

CMS approved QIPP for a seventh program year (state fiscal year 2024) on July 31, 2023. HHSC made no changes to QIPP quality requirements for the 2024 fiscal year.

CHIRP, TIPPS, RAPPS and DPP BHS

In state fiscal year 2022, Texas HHSC received approval for four new Medicaid directed payment programs (DPPs). They are the:

- Comprehensive Hospital Increase Reimbursement Program (CHIRP)
- Texas Incentive for Physicians and Professional Services (TIPPS)
- Directed Payment Program for Behavioral Health Services (DPP BHS)
- Rural Access to Primary and Preventive Services (RAPPS)

The DPPs were designed to help advance the goals and objectives of the Managed Care Quality Strategy. DPPs must be evaluated annually to test whether the payment arrangement advances the goals of the Managed Care Quality Strategy.

As of state fiscal year 2024, the hospitals, physician groups, rural health clinics, and behavioral health centers that participate in these four programs have now

completed the second year of quality reporting and third year activities are underway. The first evaluation report includes final data from the first year of the DPPs, and preliminary data from the second year including provider-reported data and population-based data that reflects the health of the Medicaid managed care (MMC) clients. The evaluation shows the following:

1. Participants' ability to track and report data is improving, including the ability to isolate data for MMC clients. In the first year, participants were not able to report MMC data for approximately 30 percent of the measures that required it.
2. Providers participating in the DPPs serve Medicaid clients with higher rates of preventable hospital admissions and ED visits as compared to other Medicaid clients.
3. Some measures are not a good fit for the DPPs because performance rates are already high during the first year, or the measures have poor alignment with the Medicaid population.
4. Hospitals participating in CHIRP reported a 12 percent increase in the adoption of Health Information Exchange between the first and second year.
5. Challenges continue with evaluating the impact of the payment arrangement. The evaluation results are limited by initial delays in program approval, the impacts of the PHE, and annual changes in program enrollment.

Benchmarks for Managed Care Organizations

Texas Government Code, Section 536.052(b) required HHSC to develop quality of care and cost efficiency benchmarks for MCOs participating in Medicaid and CHIP by September 1, 2022. The required benchmarks were published by HHSC in August 2022 and complement existing initiatives to monitor and incentivize efficiency and quality of care in Medicaid and CHIP managed care.

HHSC provided MCOs with an initial round of performance reporting at the beginning of calendar year 2023. Based on feedback from the MCOs, HHSC continues to refine and improve the benchmarks. HHSC will continue to use the underlying data for MCO oversight, to assess potential new uses of the benchmarks, and to align quality initiatives.

The benchmarks address three broad areas that include five associated domains:

1. Cost efficiency (medical and administrative),
2. Quality of care (health-related measures), and

3. Experience of care (member experience and MCO operational performance).

For each domain, benchmarks categorize performance as exceptional, high, satisfactory, marginal, or low. This categorization provides more information about an MCO’s performance than a single benchmark and allows for greater differentiation between plans.

Trends in Key Quality Measures

This section presents MCO performance on critical quality measures across the Medicaid and CHIP programs, including information about Potentially Preventable Events (PPE), the HHSC Performance Indicator Dashboard, HIV Viral Load Suppression, and Relocation to a Community-Based Setting. [6]

Trends in Potentially Preventable Events, 2016-2022

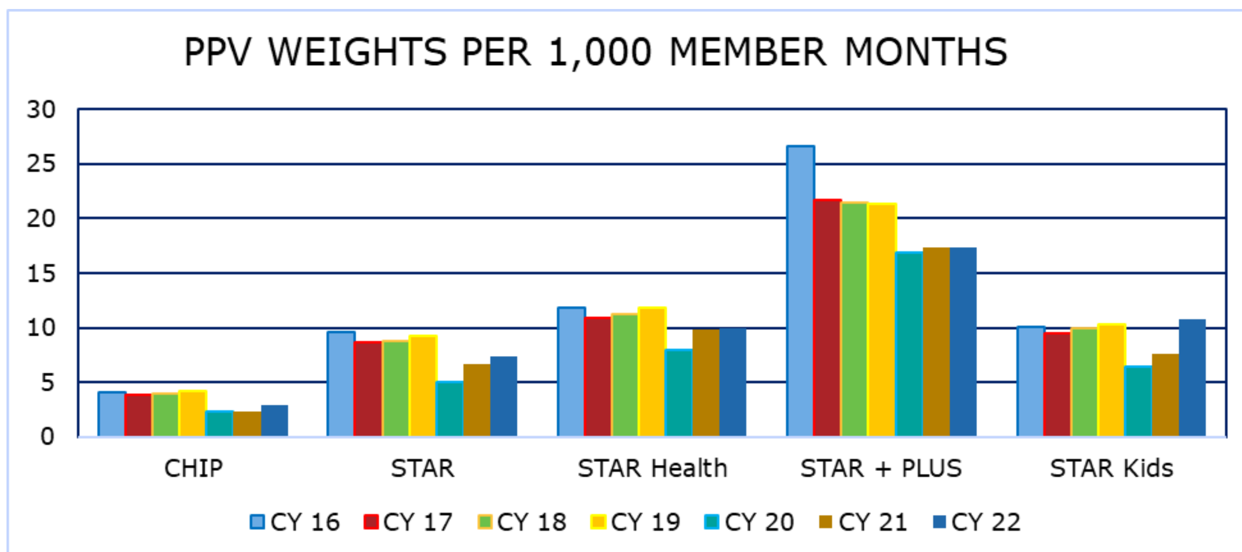
For tables included in this section, a decrease in the rate signifies improving performance and an increase signifies worsening performance, except as indicated. Each table is stratified by managed care program. Data presented are available on the Texas Healthcare Learning Collaborative (THLC) Portal and available publicly. The results presented in the following section show a seven-year trend by program.

Potentially Preventable Emergency Department Visits

The graph below (Figure 3) 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.

[6] 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 3. 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 the calendar year were used to determine resource utilization.

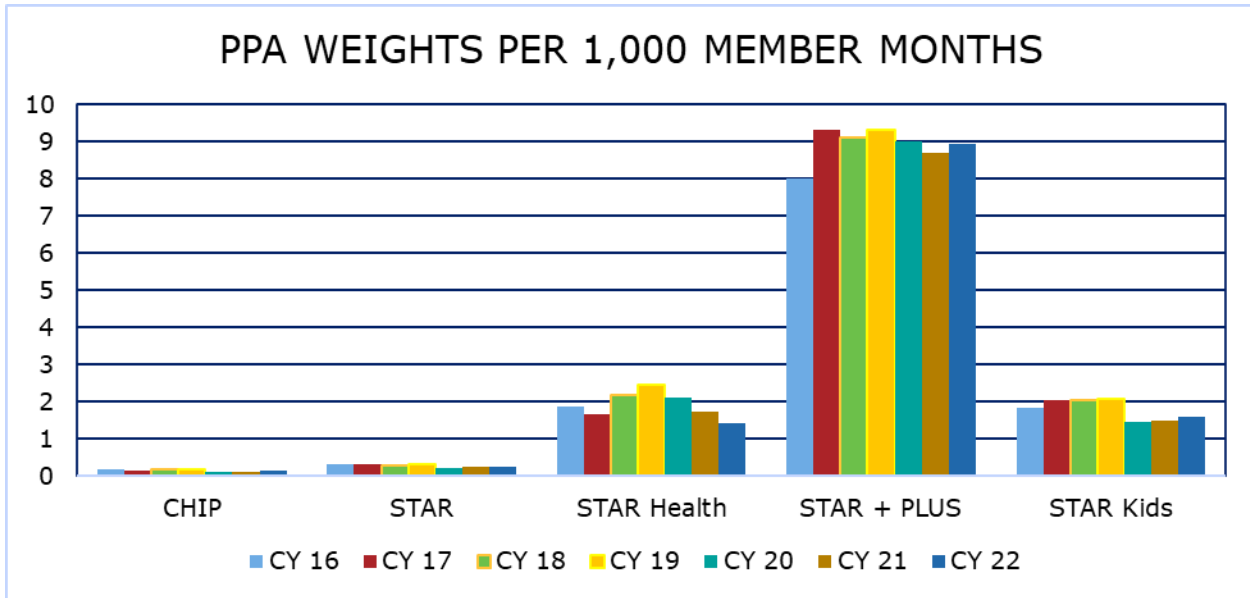
The calendar year 2021-2022 results generally show an increase across programs, suggesting that PPVs may track part way back to previous years. However, improvement achieved for STAR+PLUS, the program with the highest PPC rate, has remained relatively stable during the most recent two years. To help address PPV rates, many MCOs instituted VBP models that focus on reducing ED usage (including PPVs). Also, HHSC has included PPVs as a metric in value-based enrollment to further increase accountability for MCOs.

Potentially Preventable Hospital Admissions

The graph below (Figure 4) shows the seven-year trend in weighted rates of potentially preventable hospital admissions (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. The graph shows the PPA weights for all Medicaid programs and CHIP to facilitate relative comparisons between programs.

In 2022, there was a slight increase in PPAs from the prior year across all programs except STAR Health.

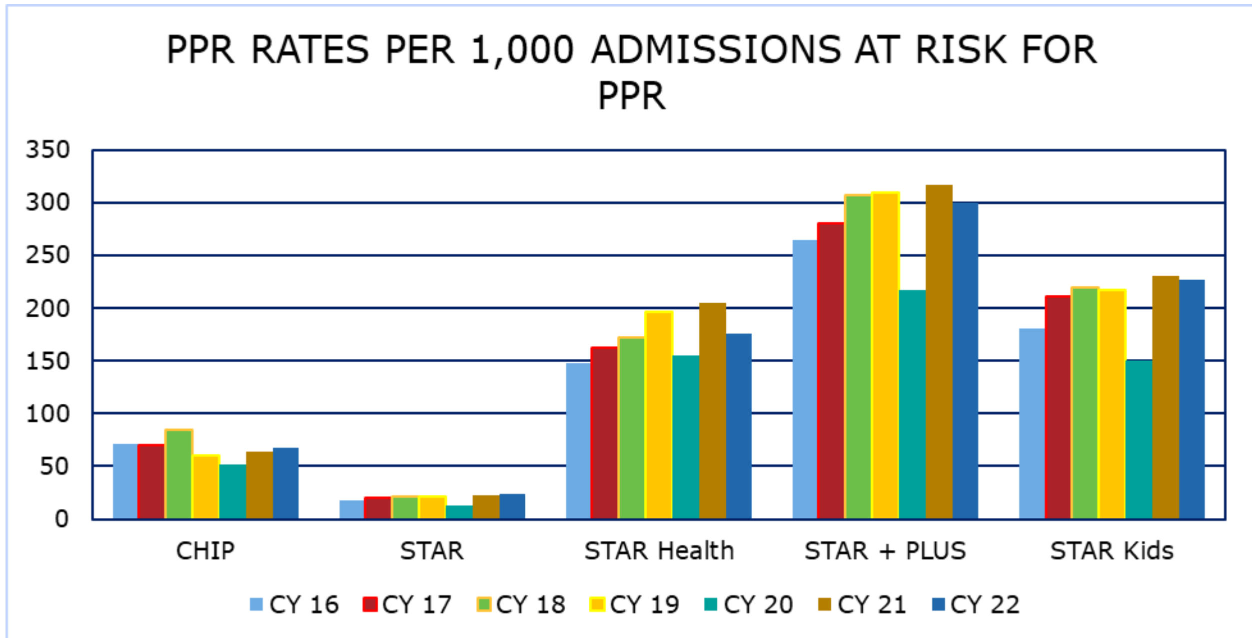
Figure 4. Seven-Year Trends of PPA Weights per 1,000 Member Months - All Programs



Potentially Preventable Hospital Readmissions

The graph below (Figure 5) shows the seven-year trend for weighted PPRs within 30 days of initial admissions that were at-risk for readmission. When compared to the prior year, in 2022, PPR rates decreased across the STAR Health, STAR+PLUS, and STAR Kids programs. However, the CHIP and STAR programs had a slight increase.

Figure 5. Seven-Year Trends of PPR Weights per 1,000 Admissions at Risk for PPR - All Programs

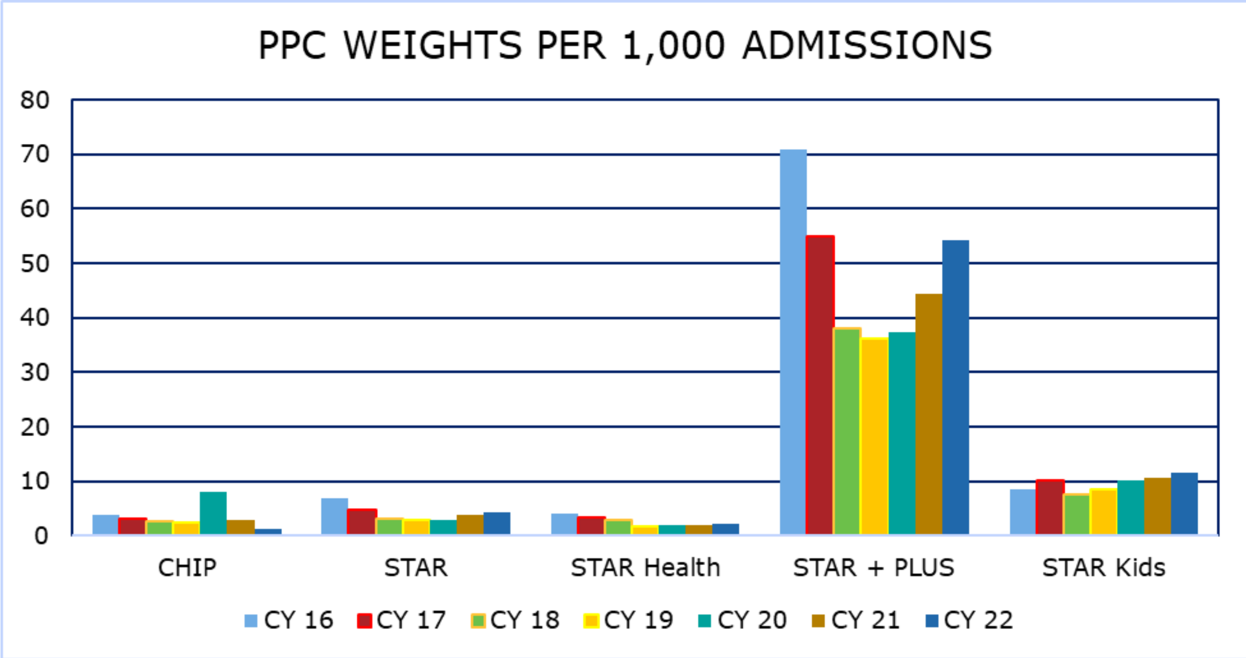


Potentially Preventable Complications

The graphs below show the seven-year trends in weighted hospital inpatient PPCs for admissions that were at-risk for a complication (Figure 6).

Overall, the PPC rates have declined in the last six years (2016–2022), most remarkably in the STAR+PLUS program that saw a notable drop in 2017 and 2018. However, for 2020-2021, PPCs increased in all programs, particularly STAR+PLUS. Like other PPEs presented in this report, federal PHE could have impacted the PPC trends for 2020-2021.

Figure 6. Seven-Year Trends of PPCs Weights Per 1,000 Admissions at Risk for PPC - All Programs



HHSC Performance Indicator Dashboard

MCO dashboard measures are scored and may fall below the minimum standard, meet the minimum standard, or achieve a high-performance standard. 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 measures selected for the dashboard are program-specific, align with state and federal health care quality initiatives and priorities, and impact a substantial number of members. The minimum standard is the program rate or the national average, whichever is lower, from two years prior to the measurement year. The high-performance standard is the upper bound of the national percentile published by the measure steward in which the state mean falls.

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 managed care contract, such as placement on a corrective action plan. For more information, please see Chapter 10.1.14 of the Uniform Managed Care Manual. Calendar year 2021 Performance Indicator Dashboard results for STAR are presented in Table 9 below. Additional detail for these and other programs is available on the THLC portal available for public access. STAR+PLUS calendar year 2021 data in Table 10 is the most recent publicly available data.

Table 9. STAR Level of Performance Standard met by MCOs in CY 2021

MCO	Below Minimum (Percent)	Met Minimum (Percent)	Above High (Percent)
Aetna Better Health	24.32%	28.38%	47.30%
Amerigroup	34.67%	18.67%	46.67%
Blue Cross Blue Shield of Texas	36.49%	10.81%	52.70%
Community First Health Plans	32.00%	16.00%	52.00%
Community Health Choice	25.68%	21.62%	52.70%
Cook Children's Health Plan	25.33%	13.33%	61.33%
Dell Children's Health Plan (formerly Seton)	31.08%	8.11%	60.81%
Driscoll Health Plan	22.97%	10.81%	66.22%
El Paso Health	33.78%	10.81%	55.41%
FirstCare Health Plans	56.16%	8.22%	35.62%
Molina Healthcare of Texas	36.49%	14.86%	48.65%
Parkland Community Health Plan	40.00%	17.33%	42.67%
RightCare from Scott & White Health Plan	47.95%	15.07%	36.99%
Superior HealthPlan	29.33%	17.33%	53.33%
Texas Children's Health Plan	29.33%	9.33%	61.33%
United HealthCare Community Plan	24.32%	27.03%	48.65%

Calendar year 2021 Performance Indicator Dashboard results for STAR+PLUS are presented in Table 10 below, and detail for these and other programs is available on the THLC portal for public access.

Table 10. STAR+PLUS Level of Performance Standard met by MCOs in CY 2021

MCO	Below Minimum (Percent)	Meets Minimum (Percent)	Above High (Percent)
Amerigroup	38.81%	37.31%	23.88%
Cigna-HealthSpring	43.28%	17.91%	38.81%
Molina	44.78%	23.88%	31.34%
Superior	23.88%	38.81%	37.31%
UnitedHealthcare	37.31%	32.84%	29.85%

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 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 the Performance Indicator Dashboard as an incentive for MCOs to continue to improve their performance. Table 11 shows the percentage of individuals with a suppressed HIV viral load by Medicaid program for calendar year 2021.

Table 11. Percentage of Individuals with a Suppressed HIV Viral Load by Program, CY 2021

Program	Total Individuals with HIV	Percent Virally Suppressed (Percent)
STAR	832	70%
STAR+PLUS	3689	70%

Detailed HIV measure results by MCO and service area in all Medicaid and CHIP managed care programs are published on the THLC portal for public access 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.

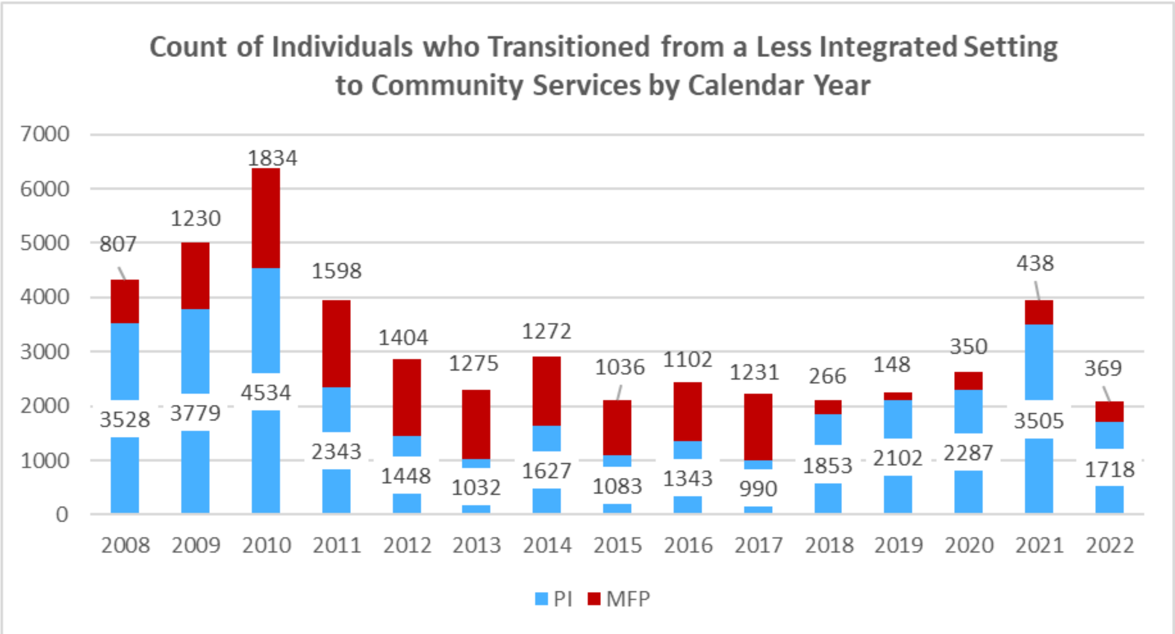
For calendar year 2021, there were five STAR MCOs that exceeded the high-performance standard, two that met the minimum standard, one was below minimum standards, and eight that did not have enough member volume to reliably assess their performance. Two STAR+PLUS MCOs met the minimum performance standards and three were below minimum standards.

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) and Money Follows the Person (MFP). 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.

As Figure 7 indicates, since 2008, 33,172 people have transitioned to the community under the PI initiative. MFP has helped another 14,360 individuals transition from institutional to community-based services. The combined total of transitions since 2008 is 47,532.

Figure 7. Promoting Independence and Money Follows the Person – Transitions from Less-Integrated Settings



Data Source: Department of Aging and Disability Services Quality Assurance and Improvement Data Mart. 10 MFP Demo Semi- Annual Newly Enrolled Participants by Target Population Report. Report Generated July 24, 2023.

Conclusion

Transforming the state's medical assistance programs into an accountable, value-based system requires ongoing coordination and improvement efforts spanning numerous contributors from the Medicaid program staff to MCOs, providers, patients and families, professional organizations, academic centers, faith and community-based organizations, and others.

This latest annual review of value-based payment programs finds the state meeting important milestones in the transition to VBC. The state's primary quality and value-based programs (Medical and Dental P4Q, MCO APM contract requirements, MCO VBE, NF QIPP, and the HQBP program) continue to incentivize MCOs and providers to achieve high results on key outcome measures.

DPPs (CHIRP, TIPPS, RAPPS, and DPP BHS) also advance the state's Managed Care Quality Strategy.

Along with these successes, challenges remain. Texas performs well on several key quality measures, but the state has not achieved sustained improvement at reducing certain PPEs (PPRs and PPCs).

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
APM	Alternative Payment Models
CY	Calendar Year
CHIP	Children Health Insurance Program
CHIRP	Comprehensive Hospital Increase Reimbursement Program
CMS	Centers for Medicare and Medicaid 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
ED	Emergency Department
H.B.	House Bill
HCP LAN	Healthcare Payment Learning and Action Network
HHSC	Health and Human Services Commission
HIV	Human Immunodeficiency Virus
HQBP	Hospital Quality-Based Payment
MCO	Managed Care Organization
MFP	Money Follows the Person
NCQA	National Committee for Quality Assurance
NF	Nursing Facility
P4Q	Pay-for-Quality
PHE	Public Health Emergency
PI	Promoting Independence
PPA	Potentially Preventable Hospital Admissions
PPC	Potentially Preventable Inpatient Hospital Complications
PPR	Potentially Preventable Hospital Readmissions
PPV	Potentially Preventable Emergency Department Visits
QAPI	Quality Assurance and Performance Improvement
QIPP	Quality Incentive Payment Program
RAPPS	Rural Access to Primary and Preventive Services
S.B.	Senate Bill
STAR	State of Texas Access Reform
STAR+PLUS	State of Texas Access Reform Plus
THLC	Texas Healthcare Learning Collaborative
TIPPS	Texas Incentives for Physicians and Professional Services
VBC	Value-Based Care
VBP	Value-Based Payment

Appendix A. Supplemental Tables

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 2024 2025	2018 2019 2022 2023 2024 2025	2022 2023 2024 2025	2018 2019 2022 2023
Potentially Preventable Hospital Admissions (PPAs)	-	2022 2023 2024 2025	-	-
Potentially Preventable Hospital Readmissions (PPRs)	2022 2023 2024 2025	-	-	-
Appropriate Treatment for Children with Upper Respiratory Infection	-	2018 2019	-	2018 2019 2022 2023
Prenatal and Postpartum Care (P&PC)*	-	2018 2022 2023 2024 2025	-	-
Well Child Visits in the First 30 Months of Life/First 15 Months of Life[7]	-	2018 2019	-	-
Diabetes Control - HbA1c < 8 percent [Centers for Disease Control and Prevention (CDC)]	2018 2019 2022 2023 2024 2025	-	-	-

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

Measures	STAR+ PLUS	STAR	STAR Kids	CHIP
Diabetes Screening for Members with Schizophrenia or Bipolar Disorder Who are Using Antipsychotics	2018 2019	-	-	-
Cervical Cancer Screening	2018 2019 2022 2023 2024 2025	-	-	-
Child and Adolescent Well-Care Visits[8]	-	-	-	2018 2019
Weight Assessment and Counseling for Nutrition and Physical Activity** for Children and Adolescents[9]	-	-	-	2018 2019 2022 2023
Follow-up After Hospitalization for Mental Illness 7 Days and 30 Days***	2022 2023 2024 2025	-	2022 2023	-
Follow-up After Hospitalization for Mental Illness 7 Days***	-	-	2024 2025	-
Childhood Immunization Status Combination 10	-	2022 2023 2024 2025	-	2022 2023
Follow-up Care for Children Prescribed ADHD Medication[10]	-	2022 2023	2024 2025	-
Getting Specialized Services Composite	-	-	2022 2023 2024 2025	-

[8] For Measurement Years 2018 and 2019, this measure was Adolescent Well Care.
[9] For 2018 and 2019, the counseling for nutrition and counseling for physical activity sub-measures are used. For 2022 and 2023, only the body mass index (BMI) percentile documentation sub-measure is used.
[10] For 2022 and 2023, only the initiation sub-measure is used.

Measures	STAR+ PLUS	STAR	STAR Kids	CHIP
Assistance with Care Coordination	-	-	2022 2023 2024 2025	-

** 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.*

**** For 2024-2025 only the 7 Day follow-up portion of the measure will be used for Star Kids.*

Table 2. Bonus Pool Measures for the Medical P4Q Program

Bonus Pool Measures	STAR+ PLUS	STAR	STAR Kids	CHIP
Potentially Preventable Hospital Readmissions (PPR)	2018 2019	-	-	-
Potentially Preventable Hospital Admissions (PPA)	-	2018 2019	-	-
Prevention Quality Indicator Composite	2018 2019 2022 2023 2024 2025	-	-	-
Potentially Preventable Complications (PPC)	2018 2019 2022 2023	-	-	-
Follow-up Care for Children Prescribed ADHD Medication - Initiation Sub-measure	-	-	2022 2023	-
Low Birth Weight	-	2018 2019 2022 2023 2024 2025	-	-

Bonus Pool Measures	STAR+ PLUS	STAR	STAR Kids	CHIP
Childhood Immunization Status Combination 10	-	-	-	2018 2019
Immunizations for Adolescents Combination 2	-	-	-	2022 2023
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Glucose and Cholesterol Combined, All Ages	-	2022 2023 2024 2025	-	-
Chlamydia Screening in Women	-	2022 2023 2024 2025	-	-
Cesarean Sections, Uncomplicated deliveries	-	2022 2023 2024 2025	-	-
Risk of Continued Opioid Use, Total Members Have ≥15 Days Coverage	2022 2023 2024 2025	-	-	-
Adherence to Antipsychotic Medications for Individuals with Schizophrenia, 80 percent Coverage	2022 2023 2024 2025	-	-	-
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	-	-	2022 2023 2024 2025	-
Breast Cancer Screening, Non-Medicare Total	2022 2023 2024 2025	-	-	-
Appropriate Treatment for Children with Upper Respiratory Infection – All Ages	-	-	2022 2023	-

Bonus Pool Measures	STAR+ PLUS	STAR	STAR Kids	CHIP
Appropriate Treatment for Children with Upper Respiratory Infection – Age 3 months-17 years	-	-	2024 2025	-
Pregnancy-Associated Outcomes	-	2022 2023 2024 2025	-	-
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 2024 2025	-
Access to Routine Care, Adult Survey	-	2022 2023 2024 2025	-	-
How Well Doctors Communicate Composite	2024 2025	-	-	2022 2023
Family-Centered Care: Personal Doctor Who Knows Child Composite			2024 2025	

Table 3. At-Risk 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 2022 2023	2018 2019 2022 2023

Measure	Description	Medicaid	CHIP
DQA Topical Fluoride for Children,, Dental or Oral Health Services	Percentage of enrolled children who received at least 2 topical fluoride applications within the reporting year as a dental or oral health service	2018 2019 2022 2023	2018 2019 2022 2023
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	2022 2023	2022 2023
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	2022 2023	2022 2023

Table 4. APM Achievement Targets for CY 2022 - Number of MCOs That Met Year 5 Overall Target of 50 percent and Risk-Based Target of 25 Percent.

Medicaid Program	Overall Target	Overall Percentage	Risk-Based Target	Risk-Based Percentage
STAR	5/16	31%	11/16	69%
STAR+PLUS	1/4	25%	2/4	50%
STAR Kids*	3/9	33%	3/9	33%
STAR Health	0/1	0%	1/1	100%

*STAR Kids is in APM Target Year 4. Overall target achievement was 50 percent and risk-based was 25 percent.

Table 5. Distribution of APMs by Provider Type, CYs 2018–2022

Provider Type	2018 APM Count	2019 APM Count	2020 APM Count	2021 APM Count	2022 APM Count	2018 Percent APMs	2019 Percent APMs	2020 Percent APMs	2021 Percent APMs	2022 Percent APMs
Primary Care	143	181	179	206	205	41%	45%	41%	38%	37%
Hospitals	62	60	78	93	90	18%	15%	18%	17%	16%
Specialist and Behavioral Health	50	51	61	53	73	14%	13%	14%	10%	13%
Accountable Care Organization	36	43	42	10	13	10%	11%	10%	2%	2%
Obstetrics/Gynecology	27	29	31	32	29	8%	7%	7%	6%	5%
Pharmacy and Laboratory	17	16	19	35	41	5%	4%	4%	6%	7%
Nursing Facilities and Home Care	9	13	19	82	88	2%	3%	4%	15%	16%
Emergency and Urgent Care Services	7	5	3	3	3	2%	1%	1%	1%	1%
Case Management	-	1	4	5	5	-	1%	1%	1%	1%
Total	**351**	**399**	**436**	**541**	**569**	**100%**	**100%**	**100%**	**100%**	**100%**

Table 6. Statewide Auto-Enrollment Pool Percent Changes Compared to "Choice" Only, May 2023

Health Plan	Cumulative (Percent)	STAR (Percent)	STAR+PLUS (Percent)	
Aetna Better Health	-3.4	-3.4	-	-2.5
Amerigroup	1.1	1.5	-0.4	1.9
Baylor Scott & White	6.0	6.3	-	-
Blue Cross Blue Shield	-2.3	-2.7	-	-1.1
Community First	6.1	7.3	-	-1.2
Community Health Choice	-4.1	-3.9	-	-
Cook Children's	-3.9	-5.3	-	11.8
Dell Children's	4.6	4.8	-	-
Driscoll Health	-0.2	-0.3	-	1.5
El Paso First	2.0	2.1	-	-
FirstCare	-3.5	-3.4	-	-
Molina	-8.5	-12.7	-1.6	-
Parkland Community	2.0	2.1	-	-
Superior	0.4	0.4	0.6	0.2
Texas Children's	3.9	4.4	-	-0.1
UnitedHealthcare	0.2	-0.2	1.0	-0.5

Note: Health Plans with no data in a cell means they don't offer that product.

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

As Required by Texas Health and Safety Code, Section 32.155.

Page intentionally left blank

As Required by Texas Health and Safety Code, Section 32.155

Texas Health and Human Services
December 2023

TEXAS
Health and Human Services

B-2
Revised: 12/2023

Executive Summary

Texas Health and Safety Code, Section 32.155, 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 statute also encourages MCOs to incorporate their own initiatives to improve maternal healthcare services.

The statute lists potential topics the initiatives may address, including prenatal and postpartum care rates, maternal health disparities for minority and high-risk women, non-medical drivers of health (NMDOH), or other agency priorities. HHSC implemented the following statewide managed care initiatives in 2022 to improve the quality of maternal health care services, which are detailed in this report:

- Pregnancy-Associated Outcome Measures, focusing on MCOs;
- MCO performance thresholds for prenatal appointment availability studies;
- Additional maternal measures in the Pay-for-Quality (P4Q) program;
- Performance measures to ensure quality of care for women transitioning from Medicaid for Pregnant Women to the Healthy Texas Women (HTW) program;
- Collaboration with MCO partners on Postpartum Care Affinity group; and
- Implementing 2022-2023 Performance Improvement Projects on improving maternal health by focusing on NMDOH and reducing health disparities.

In addition, HHSC was granted funding by the Center for Medicare & Medicaid Innovation to implement the Maternal Opioid Misuse (MOM) Model in 2021. The MOM Model is a service delivery model designed to improve quality of care and reduce costs for Medicaid-eligible pregnant and postpartum women with opioid use disorder. In Houston, MOM Model beneficiaries are served at Harris Health System's Ben Taub Hospital, and provided with additional services such as counseling, inpatient treatment, and pharmacotherapy through partnerships with Baylor College of Medicine and Santa Maria Hostel. The hospital's Maternal Perinatal Addiction Treatment Clinic helps treat women both during and after pregnancy; the clinic receives referrals from private obstetric-gynecological (OB-GYN) practices, local substance use disorder treatment providers and Houston emergency medical services (EMS). To date, 54 Medicaid members have enrolled, and as a result of meeting the Centers for Medicare and Medicaid Services (CMS) enrollment and milestone benchmarks, the project was granted additional funding in early 2023.

Introduction

Maternal mortality and severe maternal morbidity (SMM) continue to be a concern, both in Texas and nationally. National studies indicate inequities in maternal health outcomes are evident among under-insured and publicly-insured women, particularly among racial/ethnic minorities, women living in rural areas where availability of OB-GYN care is low, and women living in poverty. [1,2,3] 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. Section 32.155 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 their 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; and
- NMDOH 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.

---

[1] More detailed information on federal bills that aimed to improve maternal health care was retrieved from https://www.kff.org/womens-health-policy/fact-sheet/analysis-of-federal-bills-to-strengthen-maternal-health-care/.

[2] Information on trends in pregnancy-related mortality ratios in the United States were retrieved from https://www.cdc.gov/reproductivehealth/maternal-mortality/pregnancy-mortality-surveillance-system.htm.

[3] A detailed article of information on health disparities in rural women was retrieved from https://www.acog.org/-/media/project/acog/acogorg/clinical/files/committee-opinion/articles/2014/02/health-disparities-in-rural-women.pdf.

Background

State Landscape

SMM is maternal morbidity that constitutes a life-threatening condition.[4] HHSC continues to work toward improving the environment for mothers and babies. The data enclosed in the 2022 Joint Biennial Texas Maternal Mortality and Morbidity Review Committee (MMMRC) report, the enhanced maternal mortality ratio, which measures the number of identified maternal deaths per 100,000 live births in a given year, remained relatively stable from 2013-2017, fluctuating from 18.3 percent to 20.7 percent.[5]

The Joint Biennial MMMRC report found that there was at least some chance of preventability in 90 percent of the maternal death cases reviewed for 2019. According to the report, the leading causes of maternal death in the Texas for calendar year 2019 cases examined were obstetric hemorrhage, mental health conditions, non-cerebral thrombotic embolism, injury, as well as cardiovascular conditions and infection. The Joint Report and the Texas Department of State Health Services (DSHS) found that disparities persist in maternal mortality with Non-Hispanic Black women being most disproportionately impacted. Preeclampsia-associated SMM rates increased 37 percent between 2017 and 2020. From 2019 to 2020, rates remained stable among Non-Hispanic White populations, declined in Non-Hispanic Other populations, and increased among Non-Hispanic Black and Hispanic populations. Additionally, the report identified that sepsis-associated SMM rates more than doubled between 2019 and 2020.

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, Cesarean section (C-section) rates, pregnancy associated outcomes, and access to contraception. These metrics are

---

[4] Texas Health and Safety Code, Section 34.001, related to Texas Maternal Mortality and Morbidity Review Committee definitions. Retrieved from https://statutes.capitol.texas.gov/Docs/HS/htm/HS.34.htm.

[5] The enhanced method is different from methods used by others to calculate maternal mortality rates or ratios. Therefore, calculated enhanced maternal mortality ratios cannot be compared with other maternal mortality rates or ratios. DSHS researchers will continue to apply the refined four-step enhanced methodology to confirm maternal deaths and calculate enhanced maternal mortality ratios for trend analysis.

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 to hold MCOs accountable for performance.

The majority of measures that HHSC uses for assessing maternal care have shown positive achievement gains since 2018. Due to the federal COVID-19 public health emergency (PHE), the 2020 measurement year saw performance decreases in many measures. Beginning with the 2021 measurement year, most measures related to maternal health quality have shown improvement, nearly exceeding pre-PHE attainment.

Table 1. Maternal Health Measures[6]

Measure	Steward	Definition	Uses
Prenatal and Postpartum Care	National Committee for Quality Assurance-Healthcare Effectiveness Data and Information Set (NCQA – HEDIS)	Timeliness of Prenatal and postpartum care	State of Texas Access Reform (STAR) MCO report cards, Pay for Quality Program (P4Q), Performance Improvement Projects, and CMS Core Measure reporting
Low Birthweight	Center for Disease Control and Prevention (CDC)	The percentage of live births weighing less than 2,500 grams	STAR P4Q and CMS Core Measure reporting
Potentially Preventable Complications	3M Health Information Systems	An in-hospital complication—not present on admission—during an obstetric related hospital stay	STAR+PLUS P4Q
Cervical Cancer Screening	NCQA HEDIS	The percentage of women 21–64 years of age who were screened for cervical cancer	STAR+PLUS P4Q and HTW measure

[6] *Detailed specifications for HHSC's maternal health measures are provided in Appendix B.1*

Measure	Steward	Definition	Uses
Contraceptive Care - All women	CDC	Women ages 15 to 44 at risk of unintended pregnancy who received an effective form of contraception	CMS Core Measure reporting and HTW measure
Contraceptive Care – postpartum	CDC	Women ages 15 to 44 who had a live birth and received an effective form of contraception during the postpartum period	CMS Core Measure reporting
Chlamydia Screening in Women	NCQA HEDIS	Women 16–24 years of age identified as sexually active with at least one test for chlamydia during the measurement year	STAR P4Q and CMS Core Measure reporting
Cesarean Sections	N/A	The percentage of deliveries by Cesarean Section	STAR P4Q
Pregnancy Associated Outcomes	N/A	The percentage of deliveries associated with SMM	STAR P4Q

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

Appointment Availability Study

Texas Government Code, Section 533.007 directs 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' External Quality Review Organization (EQRO) conduct appointment availability studies that use a "mystery shopper" methodology to examine member experience in scheduling appointments. The study evaluates appointment wait-times 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 and liquidated damages. Results are included in the Prenatal Appointment Availability Studies section of this report.

Performance Improvement Projects

To ensure compliance with Title 42, Code of Federal Regulations, Section 438.330, HHSC requires that MCOs conduct two, two-year Performance Improvement Projects (PIPs) per program. One PIP must be completed in collaboration with another MCO, dental maintenance organization (DMO), or a community-based organization. The 2022-2023 PIPs are focused on improving maternal health by addressing NMDOH. MCOs will submit the final 2022 PIP reports to the State in October 2024. The 2024 PIPs for all STAR and CHIP plans will focus on a maternal health related topic. More information about current PIPs can be found on the HHSC website.

Medical Pay-for-Quality Program

The medical P4Q program creates financial incentives and disincentives for MCOs based on their performance on a set of quality measures. Three percent of each MCO's capitation is at-risk based on their performance on several 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 federal PHE, the medical P4Q program was suspended for 2020 and 2021. The 2022-2025 STAR P4Q at-risk measures include HEDIS prenatal and postpartum care. The 2023-2025 STAR P4Q bonus pool measures include low birth weight, low-risk C-sections, and pregnancy associated outcomes.

Texas Senate Bill 17

As required by Section 8, Senate Bill 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 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 the Current Statewide Initiatives section of this report. HHSC incorporated these measures into the medical P4Q program in 2022.

Current Statewide Initiatives

Texas continues to monitor and measure its maternal health quality measurement initiatives. In coordination with DSHS, external partners and stakeholders, and informed by participation in the CMS Medicaid Innovation Accelerator Program, HHSC implemented the following initiatives in 2023 responsive to the requirements of Section 32.155.

Pregnancy-Associated Outcome Measures

HHSC continued to track and monitor the State's 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 in 2021. Table 2 below shows an overview of each MCO's performance on the percentage of all deliveries associated with SMM in 2020 and 2021. Improvements on SMM measures are reflected by a lower rate. The effects of the federal PHE on these performance measures in 2020 and 2021 are not fully known. HHSC will continue to report on these measures and track MCO performance until enough data is obtained to set benchmarks for improvement.

Table 2. Pregnancy-Associated Outcome Measures – Percentage of All Deliveries Associated with SMM[7]

STAR MCO	2020 (Percent)	2021 (Percent)
Aetna	1.71	2.08
Amerigroup	1.64	2.28
BCBSTX	2.04	2.52
Community First	1.45	2.38
Community Health Choice	1.92	2.35
Cook Children's	1.34	2.16
Dell Children's	2.83	2.85
Driscoll	1.33	1.62
El Paso Health	1.63	1.91
FirstCare	1.43	0.97
Molina	1.55	1.97
Parkland	1.42	1.96
Scott & White	1.66	2.15
Superior	1.50	1.78
Texas Children's	1.66	2.18
United Healthcare	1.92	2.28
All MCOs	1.60	2.03

Prenatal Appointment Availability Studies

The Medicaid managed care contracts require that all members have access to all covered services in a timely manner, consistent with medically appropriate guidelines and accepted practice parameters. HHSC evaluated MCO compliance with OB-GYN prenatal appointment standards in 2015, 2016, 2018, 2020, 2022, and 2023.

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

[7] Excluding cases associated only with transfusion. Please note that for the Pregnancy Associated Outcomes measure, a lower rate indicates better performance during the measurement period.

contractual standard. The thresholds (Table 4) were developed based on historic MCO performance with consideration of this vulnerable population and have been the same since 2015. MCOs with performance below the thresholds are subject to contract remedies, including corrective action plans and liquidated damages.

Results

The following are the results from the 2022 and 2023 Appointment Availability prenatal care study (Table 3). Table 3 reflects the overall availability of appointments within the appropriate standard time.

Table 3. Results of the Appointment Availability Prenatal Care Study

Prenatal Care Standard	2022 (Percent)	2023 (Percent)
Low-risk: Appointment available within 14 days	65.3%	63.1%
High-risk: Appointment available within five days	21.5%	22.1%
Third Trimester: Appointment available within five days	37.3%	37.0%

In Table 4, the MCO's Meeting Threshold in 2023 column is the percentage of MCOs who met the contractual time to treatment standards for each prenatal care category. In this example, 12.5 percent of MCOs met the 85 percent threshold standard for a low-risk prenatal care appointment within 14 calendar days.

Table 4. Prenatal Appointment Availability Thresholds

Level/Type of Care	Contractual Standard: Time to Treatment (Calendar Days)	Current Threshold (Percent)	MCOs Meeting Threshold in 2023 (Percent)
Prenatal Care –Low-Risk	Within 14 calendar days	85%	12.5%
Prenatal Care - High-Risk	Within 5 calendar days	51%	0%
Prenatal Care - New Members in the Third Trimester	Within 5 calendar days	51%	31%

Increasing after-hour, holiday, and weekend appointments could help meet the requirements, especially for high risk and third trimester pregnant women. HHSC is working with the EQRO and MCOs to identify effective approaches for improving

appointment availability for new-member prenatal care. HHSC held one-on-one meetings with each MCO to understand their efforts to improve the appointment availability rates and reemphasize the criticality of pregnant women receiving timely services. HHSC required each MCO to submit a plan of action to include a root-case analysis identifying reasons for performance gaps and strategies for improving results. HHSC provided recommendations for enhancements and identified additional best practices to improve rates. HHSC will continue to hold routine meetings with the MCOs to discuss their progress and identify whether additional technical assistance or contract remedies are needed. Finally, HHSC is in the process of assessing increased liquidated damages for 2022 and 2023 results.

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 were added to the medical P4Q program for the STAR program for 2022-2025 (Table 5).

Table 5. STAR Medical P4Q Maternal Measures 2022-2025

Measure	Source	Description	Type
Prenatal and Postpartum Care (PPC)	HEDIS	Postpartum Care: The percentage of deliveries that had a postpartum visit on or between 7-84 days after delivery.	At-Risk
Cesarean - Section, Uncomplicated Deliveries	HHSC	C-section 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 Improving Postpartum Care Affinity Group, focused on improving the use and quality of postpartum care for Medicaid and CHIP beneficiaries who are considered high risk, including women with chronic medical conditions. Participating

state teams met monthly from April 2021 through April 2022, with Texas participating in the additional technical assistance available through April 2023. This is discussed in detail in the 2022 report.

Texas used the affinity group to gain expertise on how to leverage the state's existing data sources and partnerships with MCOs to improve hypertension management in pregnant and postpartum members, with particular emphasis on stratification by race/ethnicity to identify and address disparities in care.

MCO Postpartum Affinity Care Group Results

MCO partners (Aetna, Dell Children's, El Paso Health and Texas Children's Health Plan) developed interventions to address hypertension management and to improve perinatal care and maternal outcomes for women covered by STAR and CHIP who have hypertension by improving hypertension management and increasing the postpartum visit rate (Note: small sample sizes and the cessation of one MCO program affected data collection regarding interventions).

Aetna focused on increasing member engagement as a means to affect postpartum PPC and Controlling High Blood Pressure (CBP) rates. To accomplish this, Aetna started with small sample sizes and direct outreach. Aetna later began using the PYX app for outreach, an application that assists people dealing with loneliness. Aetna reports engagement with the PYX app directly correlated with improved scores for the PPC measure.

Dell Children's focused on improving hypertensive outcomes. Dell Children's provided members a blood pressure cuff for at-home monitoring and consultation with a doula. Participation in this study was limited, however, Dell Children's learned how to better partner with provider offices and identify patients who could benefit from intervention.

El Paso Health focused on health outcomes after delivery for high-risk pregnant members diagnosed with hypertension. El Paso Health increased case management engagement during pregnancy. Also, the increased engagement continued for either two weeks after the member's delivery date or one week after improved blood pressure readings were noted. As a result, El Paso Health improved their communication with providers, their provision of blood pressure cuffs, and their protocols for identifying at-risk members.

Texas Children's Health Plan (TCHP) focused on reducing Emergency Room (ER) visits and readmissions within two weeks of delivery through provision of at home

blood pressure cuffs to CHIP Perinate (CHIP-P) members with hypertension (pre-, intra- or post-partum). One challenge TCHP noted was blood pressure cuffs are not a covered item for CHIP-P mothers since CHIP-P offers a limited-benefit package.

Maternal Health PIPs

Background

The Texas Medicaid and CHIP EQRO evaluates PIPs from each MCO and DMOs 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 & CHIP's Managed Care Quality 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, 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.

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

Texas HHS Medicaid and CHIP Services Non-Medical Drivers of Health Action Plan defines NMDOH as the conditions in the place where people live, learn, work, and play that affect a wide range of health risks and outcomes. The primary identified priorities include: food insecurity, housing and transportation.

A recent systematic review of the literature published by the National Institutes of Health examined the associations of NMDOH and pregnancy-related mortality and

morbidity in the United States consistently finding 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.[8] One study included in the review found women delivering in a rural hospital to be at elevated risk for readmission. As more data show associations between maternal health outcomes and NMDOH, many state Medicaid programs have started prioritizing initiatives to address NMDOH.

The 2022 PIPs for STAR, STAR+PLUS, and STAR Health focused on improving maternal health by addressing NMDOH and reducing health disparities. These PIPs were implemented in January 2022 and will conclude in December 2023. Results from the 2022 PIPs will be made available in 2024.

The 2024 PIPs for all STAR and CHIP plans will center around improving maternal health. These PIPs will be implemented in January 2024 and will conclude in December 2025. Results of the 2024 PIPs will be available in 2026.

[8] Social Determinants of Pregnancy-Related Mortality and Morbidity in the United States: A Systematic Review. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7104722/

Conclusion

HHSC is committed to improving the quality of maternal health care and outcomes in Texas Medicaid. HHSC continues to include maternal measures in the medical P4Q program and monitoring existing quality measures to ensure better care for pregnant and postpartum women. Additional efforts that reflect this commitment include partnering directly with MCOs, the extended HHSC participation in the Improving Postpartum Care Affinity Group, requiring that 2022 and 2024 PIP topics address maternal health, and working with MCOs to address prenatal appointment availability. Preliminary data shows performance on maternal health quality measures has been negatively affected by the federal PHE. While the full impact of the federal PHE on maternal health outcomes is not yet known, HHSC will continue to prioritize initiatives to improve maternal health and health outcomes.

List of Acronyms

Acronym	Full Name
AIM	The Alliance for Innovation on Maternal Health
CBP	Controlling High Blood Pressure
CDC	Centers for Disease Control and Prevention
CHIP	Children’s Health Insurance Program
CHIP-P	Children’s Health Insurance Program Perinatal
CMS	Centers for Medicare & Medicaid Services
DMO	Dental Maintenance Organization
DSHS	Texas Department of State Health Services
EMS	Emergency Medical Services
EQRO	External Quality Review Organization
ER	Emergency Room
HEDIS	Healthcare Effectiveness Data and Information Set
HHSC	Health and Human Services Commission
HTW	Healthy Texas Women
MCO	Managed Care Organization
MMMRC	Texas Maternal Mortality and Morbidity Review Committee
MOM	Maternal Opioid Misuse
NCQA	National Committee for Quality Assurance
NMDOH	Non-Medical Drivers of Health
OB-GYN	Obstetric-Gynecological
P4Q	Pay-for-Quality
PHE	Public Health Emergency
PIPs	Performance Improvement Projects
SMM	Severe Maternal Morbidity
STAR	State of Texas Access Reform
TCHP	Texas Children’s Health Plan

Appendix B.1 Supplemental Data

Below is a detailed description of Table 1. Maternal Health Measures.

Measure: Prenatal and Postpartum Care

- **Measure Steward**: NCQA - HEDIS
- **Definition**: 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.
- **Use**:
  - State of Texas Access Reform (STAR) MCO report cards: 2018-2021
  - STAR Medical P4Q At-Risk Measure: 2018, 2022-2025
  - PIPs: 2018-2019 and 2022-2023
  - CMS Core Measure reporting

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

Measure: Low Birthweight

- **Measure Steward**: CDC
- **Definition**: The percentage of live births that weighed less than 2,500 grams.
- **Use**:
  - STAR Medical P4Q Bonus Pool Measure: 2018-2019 and 2022-2025
  - CMS Core Measure reporting

Measure: Potentially Preventable Complications

- **Measure Steward**: 3M
- **Definition**: 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.

- **Use**:
  - STAR+PLUS Medical P4Q Bonus Pool Measure: 2018-2019 and 2022-2025

Measure: Cervical Cancer Screening

- **Measure Steward**: NCQA HEDIS
- **Definition**: 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.
- **Use**:
  - STAR+PLUS Medical P4Q At-Risk Measure: 2019-2019 and 2022-2025
  - Healthy Texas Women Measure: 2020-2022

Measure: Contraceptive Care – All Women

- **Measure Steward**: CDC
- **Definition**: 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).
- **Use**:
  - CMS Core Measure reporting
  - Healthy Texas Women Measure: 2020-2022

Measure: Contraceptive Care – Postpartum

- **Measure Steward**: CDC

- **Definition**: Among women ages 15-44 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).
- **Use**:
  - CMS Core Measure reporting

Measure: Chlamydia Screening in Women

- **Measure Steward**: NCQA HEDIS
- **Definition**: 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.
- **Use**:
  - STAR Medical P4Q Bonus Pool Measure: 2022-2025
  - CMS Core Measure reporting

Measure: Cesarean Sections

- **Measure Steward**: N/A
- **Definition**: 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.
- **Use**:
  - STAR Medical P4Q Bonus Pool Measure: 2022-2025

Measure: Pregnancy Associate Outcomes

- **Measure Steward**: N/A
- **Definition**: 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.

- **Use**:
  - STAR Medical P4Q Bonus Pool Measure: 2022-2025

Appendix C. Quality Monitoring Program: Early Warning System for Long-Term Care Facilities

As required by Health and Safety Code, Section 255.005

Page intentionally left blank

Quality Monitoring Program: Early Warning System for Long-Term Care Facilities

As Required by
Health and Safety Code
Section 255.005

Texas Health and Human Services
December 2023

TEXAS
Health and Human Services

C-2
Revised: 12/2023

Executive Summary

Texas Health & Safety Code, Section 255.005 requires the Texas Health and Human Service Commission (HHSC) to establish an Early Warning System (EWS) to identify long-term care facilities at risk for a poor inspection (survey or complaint investigation). Section 255.005 directs HHSC to evaluate the effectiveness of the EWS and report its findings annually to the governor, lieutenant governor, and speaker of the house of representatives.

The EWS is a statistical model that has been used since 2003 to predict the risk (high or low) that a nursing facility's (NF) next regulatory inspection (survey or complaint investigation) will have a poor outcome. The current model uses data from sources such as HHSC Long-Term Care Regulation and resident assessments submitted by NFs to establish their EWS scores; the higher the score, the greater the risk for poor outcomes on a regulatory inspection.

The EWS is an effective tool used to prioritize the Quality Monitoring Program's (QMP) visits to the NFs in most need of improvement. The current model successfully predicts facility risk levels 70 percent of the time. The model is evaluated at least annually, and NF EWS scores are updated at least quarterly.

During a quality monitoring (QM) visit, quality monitors (nurses, dietitians, and pharmacists) evaluate the overall quality of care and quality of life in the NF to identify opportunities for quality improvement, then provide facility staff with education and resources promoting evidence-based best practices. QMP is not regulatory and does not cite deficiencies but rather works with NFs in a collaborative manner to improve quality of care and quality of life for their residents.

Introduction

HHSC implemented the EWS in 2003, and the system uses statistical data to predict which NFs may have conditions that could be detrimental to the health, safety, and welfare of residents. The EWS is required to identify NFs as low or high risk. Every NF is assigned an EWS score; the higher the EWS score, the higher the facility's risk of a poor outcome on the next regulatory inspection or survey.

The QMP has a team of quality monitors comprised of nurses, pharmacists, and dietitians. Quality monitors use the EWS scores to prioritize visits to NFs and conduct initial and follow-up QM visits for higher risk facilities and facilities with a history of resident care deficiencies. During the initial QM visit, quality monitors evaluate the overall quality of care and quality of life in the facility. Quality monitors partner with facility staff and provide educational and technical assistance to improve quality of care and resident outcomes.

QMP staff promote evidence-based best practices by working collaboratively with providers to identify opportunities for quality improvement beyond minimal compliance with state and federal regulatory standards. QMP is not a regulatory program.

Background

The QMP continues to use the EWS model developed in 2003, which was revamped in 2022. It accurately predicts NF risk levels 70 percent of the time, an improvement over the previous model (63 percent). The model compiles information from multiple sources to forecast the level of risk (the EWS score) that an NF will perform poorly upon inspection. In general, the highest risk facilities (NFs with the highest EWS scores) are scheduled for QM visits. The risk calculation for any given NF may change upon updates of survey and complaint investigations, as well as minimum data set (MDS) data.[1] The model receives data from the following sources to determine a facility's EWS score:

- Findings from a facility's annual survey and complaint investigations, including the total number of selected deficiencies cited in the previous three years;[2] and
- Quality measures from MDS resident care assessments.

No financial indicators have been identified as strong enough predictors to be included in the model.

In addition to QM visits scheduled according to EWS scores, other types of information may trigger a visit from QMP staff, including:

- Preadmission Screening and Resident Review referrals from within HHSC or a local intellectual and developmental disability authority;
- Referrals from the Texas Department of State Health Services regarding outbreaks of infectious illnesses or cases of multi-drug resistant organisms in NFs; and/or
- Medicaid managed care organization referrals.

EWS scores for each NF are updated at least quarterly to determine the priority of QM visits for the following quarter.

HHSC reassesses EWS scoring criteria at least annually and compares predictions to actual outcomes. Possible data sources and variables from those sources are

[1] The MDS is a federally mandated, standardized clinical assessment of each resident's functional capabilities and health needs.
[2] HHSC Long-term Care Regulation conducts annual surveys and complaint or incident investigations in NFs to ensure compliance with state licensure and federal certification regulations.

identified. Examples of data sources are previous deficiencies or quality measures from the Centers for Medicare and Medicaid Services. Variables are combined and tested in models predicting performance of NFs as defined by the number, scope, and severity of federal deficiencies. The model that does the best job of predicting NF performance is retained.

The Centers for Medicare and Medicaid Services implemented changes to the MDS process in October 2023 that may impact the variables chosen for the next EWS model.

Quality Monitoring Activities

Quality monitors perform the following types of in-person support and technical assistance to NF staff:

- QM Visits
- Rapid Response Team (RRT) Visits
- In-Service visits

Quality Monitoring Visits

Quality monitors – nurses, pharmacists, and dietitians – conduct initial and follow-up QM visits for higher risk NFs, or those with a history of resident care deficiencies. QM visits are not a regulatory activity. During the initial QM visit, quality monitors evaluate the overall quality of care and quality of life in the NF. Specific clinical areas are addressed during the visit; the selection of a particular clinical area may be based on a facility request or the quality monitor's review of recent quality measure reports for the facility. Based on this evaluation, quality monitors partner with facility staff and provide educational and technical assistance to improve quality of care and resident outcomes. Quality monitors schedule a follow-up visit within 45 calendar days to ensure progress toward improvements. If a facility's EWS score continues to put it among the top 25 percent highest risk after the 45-day follow-up visit, the facility will continue to receive regular QM visits, often quarterly, until the EWS score drops below that threshold.

Facilities can also request a QM visit, but QMP cannot help NFs prepare for a Long-term Care Regulation survey or be included as part of a plan of correction to address deficiencies cited during a survey or investigation.

In fiscal year 2023, QMP field staff vacancies continued to affect the number of visits conducted. Currently, one dietitian and one pharmacist position are vacant. In addition, nine registered nurse positions are vacant, approximately 43 percent of all field staff registered nurse positions. HHSC has experienced challenges attracting and retaining sufficient numbers of clinical staff to conduct all planned visits due to position classifications and salary levels. However, HHSC implemented some changes in state fiscal year 2024 to address these recruitment and retention challenges.

In state fiscal year 2023, most of the visits were carried out on-site; however, occasional telephonic visits were also conducted. Tables 1 and 2 provide data on initial and follow-up QM visits, including on-site and telephonic visits.

Table 1. On-Site QM Visits - September 2022 through August 2023

Visit Type	Number of Visits	Number of Unduplicated Facilities
Initial QM Visits	358	358
45-Day Follow-Up On-Site Visits	369	369
QM On-Site Visits	531	326
QM Follow-Up On-Site Visits	11	10
Total On-Site Visits	**1269**	**N/A**[3]

Table 2. Telephonic QM Visits - September 2022 through August 2023

Visit Type	Number of Visits	Number of Unduplicated Facilities
Initial QM Telephone Visits	-	-
45-Day Follow-Up Telephone Visits	5	5
QM Telephone Visits	6	3
QM Follow-Up Telephone Visits	5	2
Total Telephonic Visits	**16**	**N/A**[21]

Rapid Response Team Visits

For facilities with EWS scores that indicate the highest risk, QMP sends RRTs. Facilities at high risk include those that have three deficiency citations in a 24-month period related to abuse and/or neglect that constitute an immediate threat to health and safety. Once an RRT is triggered, QMP will conduct a series of visits, typically over a period of six months.

Unlike a QM visit, a full team of quality monitors (one from each discipline) conducts the initial RRT visit. Staffing an RRT is a more complex undertaking and requires assembling a team from offices across the state to visit a single NF. When

[3] The number of unduplicated NFs is by visit type only. A facility may have had multiple visits within this timeframe, but of different visit types.

an RRT goes on-site, the facility must also make more administrative and clinical staff available than on a QM visit to assist and learn from the state staff.

Because of the greater need for improvement and the extra effort required from HHSC and NF staff, the RRT visit is more comprehensive. The team conducts a broader review and provides more education and assistance than during a regular QM visit. Follow-up RRT visits are conducted by one or more team members and are more focused, depending on the identified needs.

Table 3 provides data on initial, follow-up, and final RRT visits, including on-site and telephonic visits.

Table 3. RRT Visits - September 2022 through August 2023

Visit Type	Number of Visits	Number of Unduplicated Facilities
Initial RRT Visits	72	18
RRT On-Site Follow-Up Visits	281	20
RRT Telephonic Follow-Up Visits	1	1
RRT Final Visits	17	5
Total Visits	**371**	**N/A[4]**

Introductory and In-service Visits

Introductory visits introduce new facilities to the QMP, helping NF staff understand the purpose of the program and the resources available to assist with quality improvement activities. QMP staff often combine introductory visits with an initial QM visit. In state fiscal year 2023, introductory visits were conducted in two NFs.

During in-service visits, quality monitors provide educational presentations to NF staff, offering evidence-based information in an interactive manner. The information provided supports quality improvement in multiple areas, such as dementia care, fall prevention, and reducing the use of anti-psychotic medications. In state fiscal year 2023, Quality Monitors conducted 32 in-service visits in 26 NFs. In addition, in-services may be conducted during QM and RRT visits, but would not be counted separately from those visits.

[4] The number of unduplicated NFs is by visit type only. A facility may have had multiple RRT visits within this timeframe, but of different visit types.

Conclusion and Next Steps

The QMP team continues to evaluate the NF EWS model by examining and statistically analyzing potential changes designed to improve the accuracy and quality of its predictions. HHSC is also addressing recruitment and retention to improve staffing levels to conduct QM functions. HHSC continues investigating opportunities to modernize QM Visit to allow for more automated scheduling, enhanced reporting functionality, and provide robust information for data-driven decision making.

List of Acronyms

Acronym	Full Name
EWS	Early Warning System
HHSC	Health and Human Services Commission
MDS	Minimum Data Set
NFs	Nursing Facilities
QM	Quality Monitoring
QMP	Quality Monitoring Program
RRT	Rapid Response Team