

# **Biannual Report on Initiatives to Reduce Avoidable Emergency Room Utilization and Improve Health Outcomes in Medicaid**

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**As Required by  
Senate Bill 1136, 87th Legislature,  
Regular Session, 2021**

**Texas Health and Human Services  
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**TEXAS**  
Health and Human  
Services

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# Executive Summary

In compliance with Senate Bill (S.B.) 1136, 87th Legislature, Regular Session, 2021, this report provides an overview of the Health and Human Services Commission's (HHSC's) efforts to coordinate with hospitals and other providers to:

- Identify and implement initiatives designed to reduce Medicaid recipients' use of emergency room services as a primary means of receiving health care benefits, and
- Encourage Medicaid providers to continue implementing effective interventions and best practices that were developed and achieved under the Delivery System Reform Incentive Payment (DSRIP) program.

In 2020, there were approximately 880,000 potentially preventable emergency room (or department)<sup>1</sup> visits (PPVs) in Texas Medicaid and CHIP programs, resulting in Medicaid expenditures of approximately \$378 million.<sup>2</sup> If these visits had occurred in primary care settings instead of the emergency department or been prevented, it is assumed some of these expenditures could have been reduced or avoided.

Data analysis indicates that while the number of PPVs per 1,000 member months decreased from 37.8 in 2013 to 32 in 2019, indicating a 15.5 percent decrease in the rate adjusted for caseload, the resource use or prices of the remaining PPVs increased enough to increase total PPV expenditures over this time period. Several factors may contribute to PPVs, including that patients cannot or do not access timely health care for preventative services or to manage chronic conditions. Reasons for this may include health professional shortages, limited availability of appointments, and other challenges such as lack of transportation.

This report includes information on current and proposed initiatives for addressing potentially preventable emergency department (ED) utilization and for implementing effective interventions and best practices associated with improvements in the health outcomes of Medicaid recipients:

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<sup>1</sup> For the purposes of this report, emergency room and emergency department are used interchangeably.

<sup>2</sup> DSRIP Report of PPE for 2020 Medicaid+CHIP Data, Texas-EQRO Programming core

- In addition to rate caps on non-emergent ED services, directed by the legislature in 2013, HHSC implemented several initiatives designed to reduce ED utilization as a primary means of receiving healthcare by Medicaid recipients, including:
  - Medical Pay-for-Quality (P4Q) Program
  - Performance Improvement Projects (PIPs)
  - HHSC Performance Indicator Dashboard
  - Medicaid Value-based Enrollment (VBE)
- HHSC implemented and is proposing additional initiatives to encourage Medicaid providers to continue implementing effective interventions and best practices associated with improving Medicaid recipients' health outcomes accomplished under the DSRIP program, including:
  - Directed Payment Programs (DPPs)
  - Medicaid Benefit Changes
  - Alternative Payment Model Requirements for Medicaid managed care organizations (MCOs)
  - Proposed Value Based Purchasing Arrangements to Address Social Determinates of Health (SDOH)

S.B. 1136 requires HHSC to coordinate with hospitals and other providers to identify and implement initiatives. This initial report includes a discussion of HHSC's plan for engaging with providers and other stakeholders. HHSC plans to leverage available data and hold meetings and conduct surveys with stakeholders to identify challenges, discuss best practices and potential solutions, and develop next steps. HHSC will convene a workgroup consisting of external stakeholders, including providers, associations, and MCOs.

This report describes data analysis of the current scope of PPVs, current initiatives to reduce potentially preventable ED utilization by Medicaid recipients, current and proposed initiatives to improve Medicaid recipients' health outcomes, and HHSC's stakeholder engagement plan. Future reports, required by S.B. 1136 to be submitted biannually, will provide updates on these programs and other new initiatives.

# 1. Introduction

In compliance with S.B. 1136, 87th Legislature, Regular Session, 2021, HHSC must report biannually on the agency's efforts to implement initiatives and measures designed to reduce costs and improve recipient health outcomes under Medicaid. The report must provide updates on the agency's efforts to coordinate with hospitals and other providers that receive uncompensated care (UC) pool payments to identify and implement initiatives based on best practices and models designed to reduce Medicaid recipients' use of hospital ED services as a primary means of receiving health care benefits. The report must also provide updates on HHSC's efforts to encourage Medicaid providers to continue implementing effective interventions and best practices associated with improvements in the health outcomes of Medicaid recipients that were accomplished under the DSRIP program. The bill directs HHSC to encourage these best practices through existing provider incentive programs, the creation of new provider incentive programs, the terms of contracts with Medicaid MCOs, use of alternative payment models (APMs), and other cost-effective measures.

In December 2011, the Centers for Medicare & Medicaid Services (CMS) approved Texas' request for a new Medicaid demonstration waiver entitled "Texas Healthcare Transformation and Quality Improvement Program" in accordance with section 1115 of the Social Security Act. This waiver authorized the establishment of the DSRIP program. The initial waiver was approved through September 30, 2016. An initial extension was granted through December 31, 2017. When CMS renewed the Waiver in December 2017, it authorized DSRIP funding through September 30, 2021 with a Waiver end date of September 2022. The 2017 Waiver required HHSC to plan for a DSRIP transition. In January 2021, CMS renewed the waiver again, with the understanding that the funding aspect of DSRIP transition would rely heavily on new and expanded directed-payment programs.<sup>3</sup>

The DSRIP program provides incentive payments to performing providers to support enhanced access to healthcare, quality of care, and the health of patients and families served. DSRIP is locally driven, based on community needs, and as an incentive payment program, offers flexibility to: innovate to deliver better care and

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<sup>3</sup> CMS acted to rescind the January 2021 Waiver approval. However, HHSC and CMS are currently operating under the January 2021 due to a court order.

improve health outcomes and deliver services not traditionally billable to insurance, but that can improve health. Major DSRIP focus areas include the following.

- Behavioral health
- Primary care
- Patient navigation, care coordination, and care transitions especially for complex populations
- Chronic care management
- Health promotion and disease prevention

The DSRIP pool benefits Texans and the Texas healthcare delivery system. Texas providers earned over \$22 billion in DSRIP funds from 2012 to July 2021, served 11.7 million people, and provided 29.4 million encounters from October 1, 2013 to September 30, 2017.<sup>4</sup> DSRIP participating providers include hospitals, community mental health centers (CMHCs), physician groups primarily associated with academic health science centers, and local health departments (LHDs).

The Special Terms and Conditions of the Waiver renewal in 2017 included a requirement to submit a DSRIP Transition Plan to CMS.<sup>5</sup> The milestones included in the transition plan provided the framework for developing strategies, programs, and policies to sustain successful DSRIP activities and for emerging areas of innovation in health care and contained specific goals for next steps in delivery system transformation. From December 2020 through September 2021, HHSC submitted to CMS deliverables required by the DSRIP Transition Plan.

During the DSRIP transition period, as well as over the course of the DSRIP program, numerous best practices were identified. HHSC published analyses of

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<sup>4</sup> The number of people served and encounters provided are for demonstration years (DYs) 3-6 (October 1, 2013 to September 30, 2017) and are not unduplicated counts.

<sup>5</sup> Texas Health & Human Services Commission. *Delivery System Reform Incentive Payment (DSRIP) Transition Plan*. August 2020.  
<https://www.hhs.texas.gov/sites/default/files/documents/laws-regulations/policies-rules/Waivers/medicaid-1115-waiver/dsrip-transition-plan.pdf>

DSRIP data in the *Provider Performance in the DSRIP Program, DYs 7 and 8 Report*<sup>6</sup> and the *DSRIP Transition Plan Milestone: Support Further Delivery System Reform*.<sup>7</sup> In January 2020, HHSC established the DSRIP Transition Best Practices Workgroup, comprised of 84 DSRIP provider representatives, DSRIP anchor organization representatives (public hospitals and local governmental entities who act as coordinators for providers in their regions), and Executive Committee Waiver members (a workgroup that provides HHSC with feedback on Waiver implementation). The workgroup convened to support the sustainability of delivery system reform best practices and the development of the next phase of delivery system reform in Texas. The Workgroup prioritized DSRIP outcome measures and practices, which were identified as key to driving improvements in the health status of clients.

Through data analysis and stakeholder engagement, the following DSRIP best practices were identified.

- Improving patient navigation and care coordination through practices such as pre-visit planning and providing culturally and linguistically appropriate care.
- Sustaining and expanding access to critical health care services, including through telehealth.
- Integration or co-location of primary care with specialty care and psychiatric services.
- Care teams that include a care coordination role such as community health workers and social workers.

Key DSRIP quality measures for driving improvements in the health status of clients included measures related to maternal health, screenings for health promotion and

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<sup>6</sup> Texas Health & Human Services Commission. *Provider Performance in the DSRIP Program, DYs 7 and 8 Report*. December 2020  
<https://www.hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2020/hb1-provider-perf-dsrip-dy7and8-dec-2020.pdf>

<sup>7</sup> Texas Health & Human Services Commission. *DSRIP Transition Plan Milestone: Support Further Delivery System Reform*. December 2020.  
<https://www.hhs.texas.gov/sites/default/files/documents/laws-regulations/policies-rules/Waivers/medicaid-1115-waiver/dsrip-support-delivery-system-reform.pdf>

disease prevention, chronic care management, especially diabetes, and follow-up after hospitalization for mental illness.

With the DSRIP program scheduled to end in September 2021, S.B. 1136 directed HHSC to continue implementing effective interventions and beneficial practices, informed by the DSRIP program, in the Texas Medicaid program.

## 2. Data Analysis – Avoidable Use of Emergency Rooms in Medicaid

### Potentially Preventable Emergency Department Visit (PPV) Rates

Some patients go to hospital emergency departments (ED) for conditions that are not emergencies, and others go for conditions that are emergencies at the time of the visit but could have been treated before becoming emergent with appropriate primary or urgent care. A PPV is emergency treatment for a condition that could have been treated or prevented by a physician or other health care provider in a nonemergency setting.<sup>8</sup> PPVs can result in avoidable healthcare costs, as ED visits are generally more expensive than primary care visits for comparable conditions.<sup>9</sup> According to Texas' contracted External Quality Review Organization (EQRO), approximately 880,000 PPVs in Texas Medicaid and Children's Health Insurance Program (CHIP) programs occurred in 2020, costing approximately \$378 million.<sup>10</sup> If these visits had occurred in primary care settings instead of the emergency department or been prevented, it is assumed some of these expenditures could have been reduced or avoided.

HHSC operates several initiatives intended to reduce PPVs, as discussed in the next section. The number of PPVs per 1,000 member months decreased significantly from 37.8 in 2013 to 32 in 2019, as shown in Figure 1, indicating a 15.5 percent decrease in the rate adjusted for caseload. However, the PPV weight per 1,000 member months did not significantly decrease (it was 9.2 in 2013 and 9.2 in 2019),

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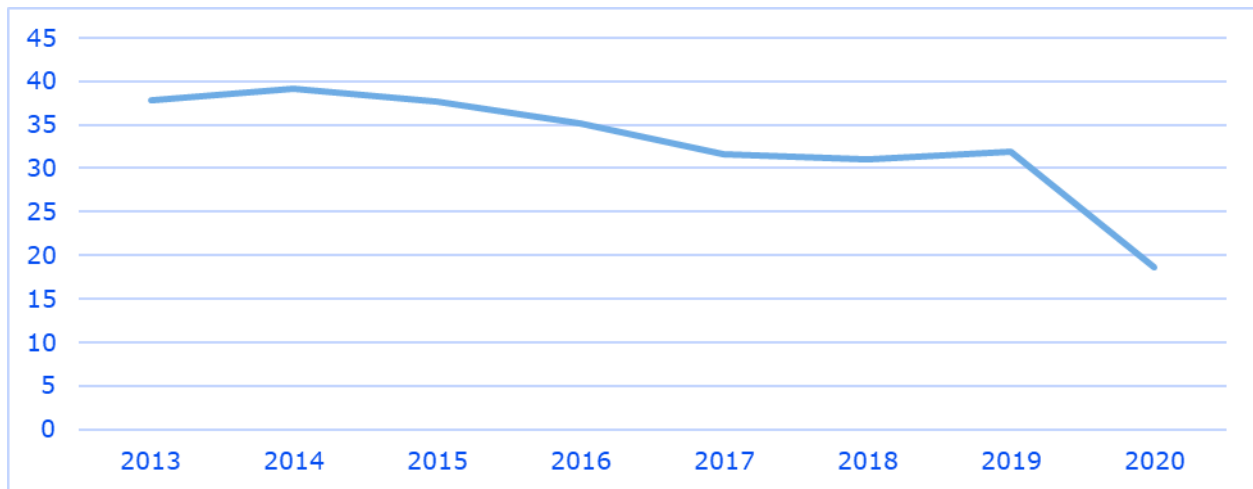
<sup>8</sup> [Potentially Preventable Events](#). There are various methodologies to determine and measure which ED visits could have been prevented. Texas Medicaid and its External Quality Review Organization (EQRO) use the methodology from 3M to measure PPVs.

<sup>9</sup> [Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health & Human Services. Trends in the Utilization of Emergency Department Services, 2009-2018. 2021.](#)

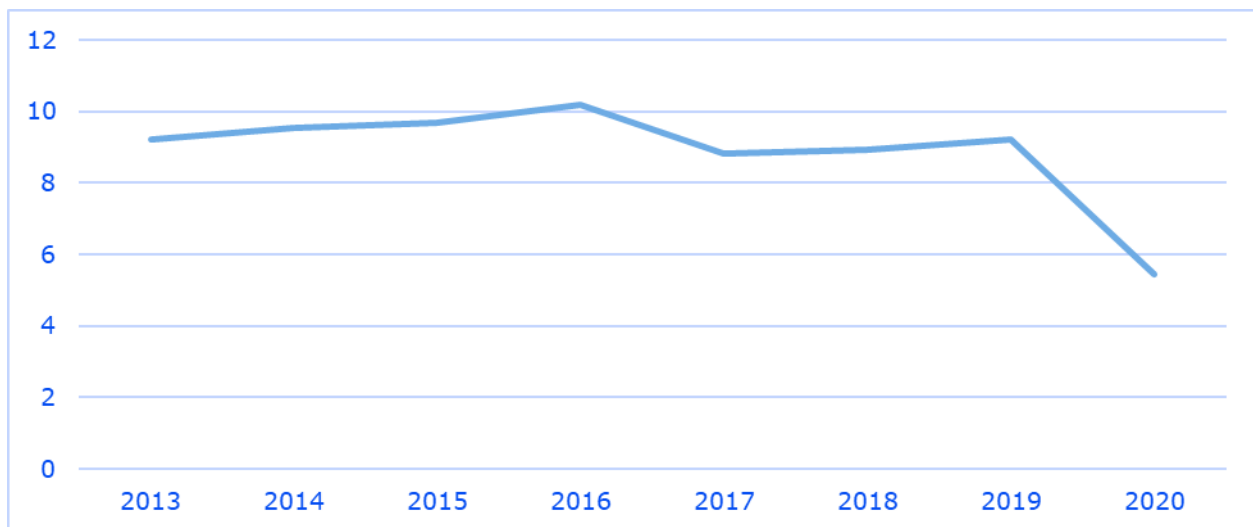
<sup>10</sup> DSRIP Report of PPE for 2020 Medicaid+CHIP Data, Texas-EQRO Programming core.

as shown in Figure 2.<sup>11</sup> PPV weight reflects the estimated intensity of resource costs needed to provide effective treatment for a visit, based on national data. Total PPV weight reported is the sum of weights and thus accounts for both volume and resource use.<sup>12</sup>

**Figure 1: Number of PPVs Per 1,000 Member Months, All Programs, 2013-2020**



**Figure 2: PPV Weight Per 1,000 Member Months, All Programs, 2013-2020**



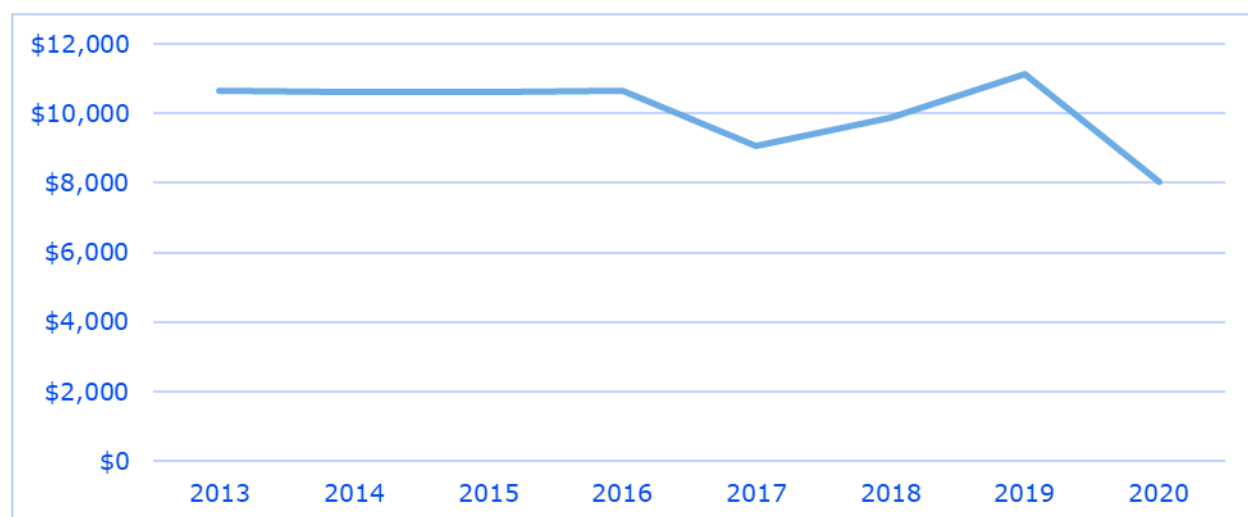
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<sup>11</sup> DSRIP Report of PPE for 2013-2020 Medicaid+CHIP Data, Texas-EQRO Programming core.

<sup>12</sup> [DSRIP PPV CY2017 Technical Notes EQRO.](#)

PPV expenditures per 1,000 member months increased from \$10,665 in 2013 to \$11,120 in 2019, as shown in Figure 3. Total expenditures associated with PPVs in Medicaid and CHIP increased from approximately \$444 million in 2013 to \$492 million in 2019. To summarize, while the number of PPVs decreased, the resource use or prices of the remaining PPVs increased enough to increase total PPV expenditures.

**Figure 3: PPV Expenditures Per 1,000 Member Months, All Programs, 2013-2020**



All three measures declined in 2020, which could represent changes from the novel coronavirus (COVID-19) public health emergency (PHE). Research suggests the decrease in ED visits was likely caused by several factors related to the PHE: restricting social interactions except for essential activities, fear of exposure to COVID-19 at hospitals, increased childcare needs, hospital policy changes, and concerns about long wait times. The increase in telehealth availability may have also diverted some inappropriate ED visits, but the reduction in face-to-face urgent care may also have prevented some patients from receiving appropriate recommendations to go to the ED for evaluation.<sup>13</sup>

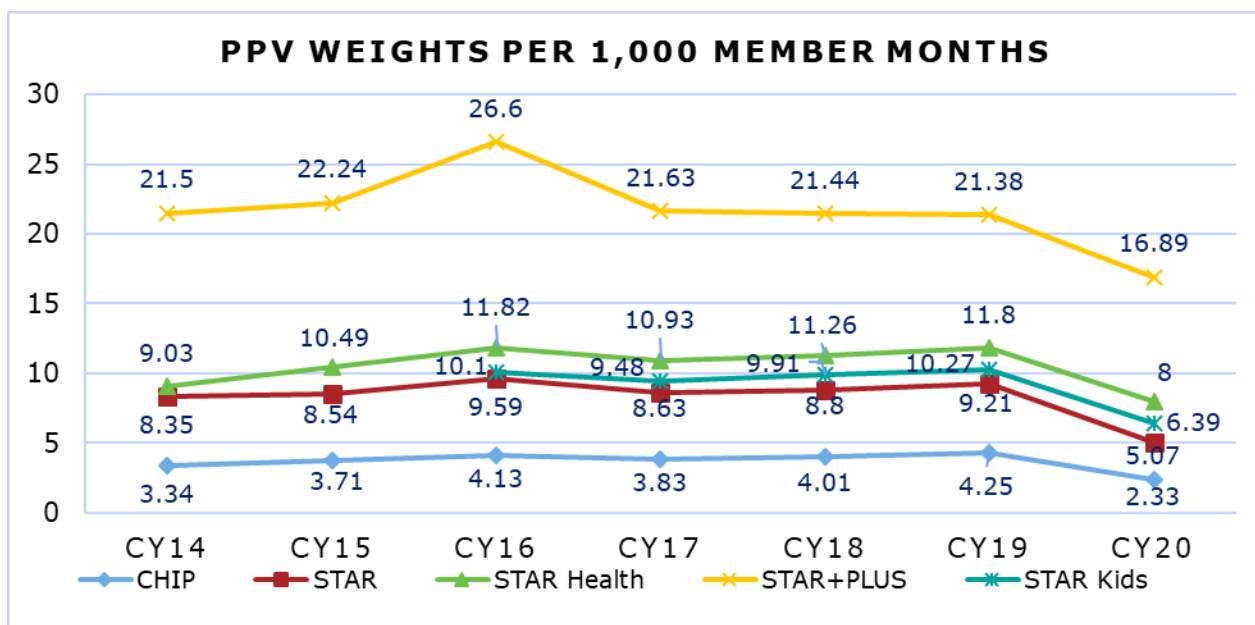
The PPV weights vary by program within Medicaid. The PPV weight in STAR+PLUS was more than twice as high as the overall rate across other programs,<sup>14</sup> as shown

<sup>13</sup> [Yu, et. al. "Changes In Non-COVID-19 Emergency Department Visits By Acuity And Insurance Status During The COVID-19 Pandemic" Health Affairs, June 2021.](#)

<sup>14</sup> [External Quality Review of Texas Medicaid and CHIP Managed Care Summary of Activities, State Fiscal Year 2020.](#)

in Figure 4.<sup>15</sup> While the population in STAR+PLUS is generally older than in other programs and more likely to have complex healthcare needs, STAR Kids also serves a population with complex healthcare needs but has about half the rate of PPVs.

**Figure 4: Seven-Year Trends of PPV Weights per 1,000 Member Months - All Programs**



While HHSC does not know the cause of these differences, they could reflect differences between the populations in healthcare related social needs, behavioral health conditions, tobacco use, or in age leading to more disabilities and comorbidities. For example, the EQRO found that the rate of adult smoking was significantly associated with higher ED utilization among STAR+PLUS adults.<sup>16</sup>

PPV rates also vary geographically within programs, as does the actual-to-expected ratio, which adjusts for the case mix of a given population. Figures 5-8 in [Appendix A](#) show the actual-to-expected ratio of PPVs for 2020 by service area (SA) in STAR,

<sup>15</sup> [Texas Health & Human Services Commission. Annual Report on Quality Measures and Value-Based Payments. December 2021.](#)

<sup>16</sup> [External Quality Review of Texas Medicaid and CHIP Managed Care Summary of Activities, State Fiscal Year 2020.](#)

STAR Health, STAR+PLUS, and STAR Kids respectively.<sup>17</sup> Across the four programs, the Medicaid Rural Service Area (MRSA) Northeast area had higher or much higher PPVs than expected, and the Hidalgo SA had much lower PPVs than expected. Interventions to decrease PPVs could initially target SAs with higher than expected PPVs to have the greatest impact.

## Types of PPVs

The most common medical reasons for PPVs from 2019 are shown in Table 1.

**Table 1: Top Medical Reasons for PPVs in Texas Medicaid and CHIP, 2019**

<b>EAPG Description<sup>18</sup></b>	<b>Number of PPVs</b>	<b>Percent of Total PPVs</b>	<b>Percent of Total PPV Weights</b>	<b>PPV Expenditures</b>	<b>Percent of Total PPV Expenditures</b>
Infections of Upper Respiratory Tract (URTI) & Otitis Media	344,611	24.4%	18.4%	\$77.47M	15.7%
Non-Bacterial Gastroenteritis, Nausea & Vomiting	107,758	7.6%	9.8%	\$43.18M	8.8%
Viral Illness	80,792	5.7%	7.3%	\$21.16M	4.3%
Contusion, Open Wound & other Trauma to Skin & Subcutaneous Tissue	80,891	5.7%	6.6%	\$23.64M	4.8%
Abdominal Pain	68,426	4.8%	6.4%	\$42.95M	8.7%

The EQRO found that co-occurring behavioral health and physical health conditions accounted for the vast majority of all potentially preventable events in STAR+PLUS in 2018.<sup>19</sup> Additionally, about 1 percent of Medicaid and CHIP pediatric ED visits

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<sup>17</sup> <https://thlcportal.com/ppe/ppvprogramwide>.

<sup>18</sup> EAPG stands for Enhanced Ambulatory Patient Group. [External Quality Review of Texas Medicaid and CHIP Managed Care Summary of Activities, State Fiscal Year 2020](#).

<sup>19</sup> [EQRO Summary of Activities 2018 \(May 2019\)](#).

from 2013 to 2017 were related to Non-Traumatic Dental Conditions and resulted in expenditures of approximately \$44 million.<sup>20</sup>

## Factors Contributing to PPVs

Some patients use the ED for visits that could have been managed in physician offices or clinics.<sup>21</sup> Some of these patients visit the ED because they cannot, or do not, access timely primary, dental, or behavioral health care for preventive services or to manage chronic conditions.<sup>22</sup> Without preventative services and timely treatment, conditions can develop, worsen, or lead to additional complications that may have otherwise been avoided with routine care.

Several factors may potentially contribute to Medicaid members visiting the ED instead of accessing timely primary or preventive care or appropriate urgent care. Many counties in Texas are designated as Health Professional Shortage Areas for Primary Care, Mental Health, and Dental, as shown in Appendix B. These shortages affect appointment availability for all Texans, not just those in Medicaid.

MCOs are required to maintain adequate networks with sufficient capacity to provide timely access to all covered services according to contract standards.<sup>23</sup> HHSC monitors managed care network adequacy with distance and travel standards. The results of these monitoring initiatives show MCOs continue to perform well in meeting requirements related to providing access to preventive care, with nearly all MCOs compliant with access standards for primary care providers (PCPs) and main dentists for all Medicaid programs. However, specialty provider shortages, particularly in rural areas of the state, continue to present

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<sup>20</sup> [External Quality Review of Texas Medicaid and CHIP Managed Care Summary of Activities, State Fiscal Year 2020.](#)

<sup>21</sup> Weinick, et. al. "How Many Emergency Department Visits Could be Managed at Urgent Care Centers and Retail Clinics?", Health Affairs, September 2010. <https://www.healthaffairs.org/doi/10.1377/hlthaff.2009.0748>

<sup>22</sup> [Trends in the Utilization of Emergency Department Services, 2009-2018, U.S. Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation, March 2021.](#)

<sup>23</sup> [Medicaid and CHIP Managed Care Services RFP, Uniform Managed Care Contract Terms and Conditions Section 8.1.3.2.](#)

challenges to member access. Details on network adequacy data and standards can be found in the [Report on Medicaid Managed Care Provider Network Adequacy](#).<sup>24</sup>

In a report to Congress on trends in ED utilization, the United States Department of Health and Human Services stated that research indicates “access and convenience play an important role in the choice to seek care in an ED.” The report also cited research showing that doctors sometimes refer their patients to the ED if they need care outside of office hours or if an appointment is not available when needed.<sup>25</sup>

A member’s regular provider may not have appointments available at certain times, or some members may have work or caregiving schedules that conflict with the clinic hours or when appointments are available. Between 2016 and 2020, Medicaid member surveys for STAR and STAR+PLUS indicated that 44 to 57 percent of members or their caregivers reported appointment delays due to limited availability, and 28 to 44 percent of members reported visiting an ED due to limited appointment availability, as shown in Appendix C.<sup>26</sup> According to the EQRO, “lack of weekend and after-hours appointments limits member access to vital services for prenatal, preventive, and behavioral health care.”<sup>27</sup> Table 2 shows the percentage of PCPs with any appointments available that offer weekend appointments for fiscal years 2016 and 2018.<sup>28</sup>

**Table 2: PCPs with appointments that offered weekend appointments, by program**

State Fiscal Year (SFY)	STAR	CHIP	STAR+PLUS	STAR Health	STAR Kids
SFY 2016	37.4%	34.2%	35.2%	-	-
SFY 2018	41.7%	41.4%	33.0%	29.4%	34.1%

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<sup>24</sup> Report on Medicaid Managed Care Provider Network Adequacy, HHSC December 2020.

<sup>25</sup> [Trends in the Utilization of Emergency Department Services, 2009-2018, U.S. Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation, March 2021.](#)

<sup>26</sup> Texas Healthcare Learning Collaborative Experience of Care Surveys.

<sup>27</sup> [External Quality Review of Texas Medicaid and CHIP Managed Care Summary of Activities and Value Added Services, State Fiscal Year 2018.](#)

<sup>28</sup> [External Quality Review of Texas Medicaid and CHIP Managed Care Summary of Activities, State Fiscal Year 2019.](#)

Even when patients can and do access timely preventative care, they may still need access to urgent care for acute illness or injury. For some of these conditions, patients may have difficulty determining the severity without diagnostic procedures and medical expertise.<sup>29</sup> If they do not have convenient alternatives for urgent care or cannot distinguish whether a condition is urgent or emergent, they may visit an ED for treatment.

MCOs participated in performance improvement projects (PIPs) in 2016 and 2017 related to reducing PPVs related to upper respiratory tract infections. Two STAR MCOs achieved a sustained statistically significant improvement for two years. Their initiatives included member outreach to provide after hour nurse lines to redirect care to appropriate settings, increasing contracts with walk-in and urgent care clinics, and notifying members' PCPs when they visited the ED.<sup>30</sup>

HHSC will continue to analyze data from MCO and provider performance reports and member surveys to understand the factors contributing to PPVs. HHSC also has several ongoing and new initiatives designed to reduce PPVs and improve health outcomes overall, which are discussed in the next section. HHSC will provide updates on these programs, progress on reducing PPVs, and other initiatives to improve member health outcomes in subsequent reports.

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<sup>29</sup> [Trends in the Utilization of Emergency Department Services, 2009-2018, U.S. Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation, March 2021.](#)

<sup>30</sup> [External Quality Review of Texas Medicaid and CHIP Managed Care Summary of Activities and Value Added Services, State Fiscal Year 2018.](#)

### **3. Initiatives to Reduce Potentially Preventable Emergency Department Utilization in Medicaid**

Section 1 of S.B. 1136 requires HHSC to coordinate with hospitals and other providers that receive UC payments to identify and implement initiatives to reduce Medicaid recipients' use of hospital ED services as a primary means of receiving health care benefits, including initiatives to improve recipients' access to and use of primary care providers.

To meet these requirements, HHSC will leverage available data, conduct surveys, and convene a workgroup consisting of various external stakeholders to identify current issues that contribute to the preventable use of EDs and to identify effective solutions and potential next steps. Additional details related to this upcoming work are included in Section 5 of this report, Stakeholder Engagement Plan.

In addition, HHSC has already implemented initiatives, which are meant to incentivize and hold MCOs accountable for their management of non-emergent ED utilization.

#### **P4Q Program**

The P4Q program is required for all MCOs and dental maintenance organizations (DMOs) and uses financial penalties and rewards, coupled with performance measures, to improve outcomes.

#### **Medical P4Q Program**

For the medical P4Q program, MCOs are evaluated based on their performance against benchmarks and on their performance improvement/decline from the prior year (performance against self). MCOs not meeting target performance thresholds for the P4Q measures could lose capitation dollars that are at-risk.<sup>31</sup> Recouped capitation dollars from low performing MCOs for at-risk measures are redistributed

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<sup>31</sup> For more information on the medical P4Q program, see the [Annual Report on Quality Measures and Value Based Payments 2021](#).

to high-performing MCOs. Funds remaining after the collection and redistribution process form a bonus pool to reward high-performing MCOs on specific measures.

The at-risk measures and effective years for the medical P4Q program (for 2018–2023)<sup>32</sup> are included in Table 1 on pages 10-11 of the [Annual Report on Quality Measures and Value Based Payments 2021](#). Table 3 shows key at-risk measures related to avoidable ED utilization, including access to and use of primary care providers, and how long each measure has been tracked in the medical P4Q Program. Table 3 also includes PPVs and Potentially Preventable Admissions (PPAs), which are hospital admissions that may have been prevented with access to ambulatory care or health care coordination.

HHSC suspended the medical P4Q program for measurement years 2020 and 2021 because of the PHE. The addition of STAR Kids was planned for January 2020; however, due to the PHE was delayed to 2022.

**Table 3. Key At-Risk Measures for the Medical P4Q Program related to Avoidable ED Utilization, Including Access to and Use of Primary Care Providers**

Measure	STAR+PLUS	STAR	STAR Kids
Potentially Preventable Emergency Department Visits (PPVs)	2018 2019 2022 2023	2018 2019 2022 2023	2022 2023
Potentially Preventable Admissions (PPAs)		2022 2023	

Table 2 on pages 12-13 of the [Annual Report on Quality Measures and Value Based Payments 2021](#) lists the bonus pool measures and effective years for the same period. Table 4 below includes the key bonus pool measures related to avoidable emergency room utilization, including access to and use of primary care providers.

**Table 4. Key Bonus Pool Measures for the Medical P4Q Program related to Avoidable ED Utilization, Including Access to and Use of Primary Care Providers**

Measure	STAR+PLUS	STAR	STAR Kids
Potentially Preventable Admissions (PPAs)		2018 2019	

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<sup>32</sup> Details of measures and methodology available at: <https://hhs.texas.gov/sites/default/files/documents/laws-regulations/handbooks/umcm/6-2-14.pdf>

Measure	STAR+PLUS	STAR	STAR Kids
Prevention Quality Indicator (PQI) Composite	2018 2019 2022 2023		
Access to Routine Care, adult survey		2022 2023	

The Texas Healthcare Learning Collaborative (THLC) Portal was established to strengthen public reporting, increase transparency, and improve accountability of services and care provided under the Texas Medicaid system.<sup>33</sup> The Medical P4Q Performance Dashboard on the THLC Portal shows rewards or losses the MCOs earned or incurred for 2018 and 2019 for PPV performance by MCO and program. Rewards and losses are categorized as:

1. Maximum or Bonus Reward (the most an MCO could earn)
2. Minimum Reward (MCO earned some, but not the maximum)
3. No Reward or Loss (MCO performance did not warrant a reward or recoupment)
4. Minimum Loss (MCO lost some, but not the maximum)
5. Maximum Loss (the most an MCO could lose)

MCOs are evaluated two ways for each measure: performance against national benchmarks and performance against their prior year results (against self).

While two years of data are insufficient to determine any trends, overall program-level performance on PPVs improved in STAR+PLUS, but declined in STAR and CHIP. For STAR PPVs in 2018, of the 16 STAR MCOs:

- Five MCOs received the maximum reward for performance against a benchmark.
- Five MCOs incurred the maximum loss for performance against a benchmark and one MCO incurred the maximum loss for performance against self.

For STAR PPVs in 2019, of the 16 STAR MCOs:

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<sup>33</sup> <https://thlcportal.com/home>.

- Three MCOs received the maximum reward for performance against a benchmark.
- Five MCOs incurred the maximum loss for performance against a benchmark and one MCO incurred the maximum loss for performance against self.

For STAR+PLUS PPVs in 2018 and 2019, none of the five STAR+PLUS MCOs received the maximum reward or incurred the maximum loss.

## Performance Improvement Projects (PIPs)

The Texas EQRO evaluates PIPs from each MCO and DMO in accordance with state and federal regulations. PIPs are projects that MCOs and DMOs are required to implement that must be designed to achieve significant improvement, sustained over time, in health outcomes and enrollee satisfaction.

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

One of the topics for the 2018 two-year PIPs was PPVs for URTI.<sup>34</sup> URTI was the most common medical reason for PPVs in 2018 and 2019. The MCOs completed their 2018 PIPs in December 2019 and submitted final PIP reports in November 2020. The EQRO will include final and overall results for the 2018 PIPs in the fiscal year 2021 Summary of Activities report.

For 2019, all MCOs focused on the statewide PIP topic, improving care for beneficiaries with complex needs.<sup>35</sup> Specifically, the focus was on ED utilization or preventable admissions for this population. Many of these individuals have co-occurring behavioral and physical health conditions, as discussed above in the Types of PPVs section. As a result, selected measures for the PIP included the following.

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<sup>34</sup> Texas External Quality Review Organization, [External Quality Review of Texas Medicaid and CHIP Managed Care Summary of Activities, State Fiscal Year 2020](#), p. 19.

<sup>35</sup> Texas External Quality Review Organization, [External Quality Review of Texas Medicaid and CHIP Managed Care Summary of Activities, State Fiscal Year 2020](#), p. 19.

- The percentage of members with depression and/or anxiety who had high utilization, defined by three or more ED visits or two or more inpatient stays in one measurement year.
- The rate of members with anxiety and/or depression who had any PPV during the measurement year.
- The rate of members with anxiety and/or depression who had any Potentially Preventable Admission (PPA) during the measurement year.

The two DMOs both established a collaborative data-sharing agreement with an MCO with the aim of reducing dental-related PPVs.

For 2021, both DMOs have PIP topics to reduce dental-related PPVs.

## HHSC Performance Indicator Dashboard

The Performance Indicator Dashboard provides a comprehensive view of overall quality of healthcare provided to Medicaid members by MCOs. It includes a set of measures for each managed care program. The measures assess different aspects of healthcare quality that HHSC has determined to be of greatest importance. PPV is one of the dashboard measures.

HHSC expects Medicaid MCOs to meet or surpass the HHSC-defined minimum standard on more than two-thirds of the measures on the Performance Indicator Dashboard. The minimum standard is the program rate or the national average, whichever is lower, from two years prior to the measurement year. The Performance Indicator Dashboard is publicly available on the THLC Portal providing transparency of monitoring of MCO performance to HHSC, CMS, and the public at large.

Beginning with measurement year 2018, an MCO whose per-program performance is below the minimum standard on more than 33.33 percent of the measures on the dashboard is subject to remedies under the contract. Remedies include placement on a corrective action plan (CAP).<sup>36</sup> Measures for which the plan has a low denominator are excluded from the CAP calculation. For 2019, 10 STAR MCOs, one

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<sup>36</sup> For more information, please see Chapter 10.1.14 of the Uniform Managed Care Manual <https://hhs.texas.gov/sites/default/files/documents/laws-regulations/handbooks/umcm/10-1-14.pdf>

STAR+PLUS MCO, and six STAR Kids MCOs did not meet the minimum standard on more than 33.33 percent of the dashboard measures and were placed on CAPs.

## **Medicaid Value-based Enrollment (VBE)**

Government Code, Section 533.00511 directed HHSC to create an incentive program to automatically enroll a greater percentage of recipients who did not actively choose a managed care plan into a plan based on:

- The quality of care provided through the MCO offering that managed care plan.
- The organization's ability to efficiently and effectively provide services, taking into consideration the acuity of populations primarily served by the organization.
- The organization's performance with respect to exceeding, or failing to achieve, appropriate outcome and process measures developed by the commission, including measures based on PPVs.

When an individual enrolls in Medicaid, they are encouraged to select an MCO using MCO report cards and other information sent to the individual. If a Medicaid client does not select a health plan, HHSC uses a default assignment methodology to enroll the client in an MCO. Beginning in fiscal year 2021, HHSC began incorporating measures of quality and efficiency into this auto assignment process. Under the new VBE, plans that perform better on key risk adjusted cost and quality measures and have higher member satisfaction, receive a greater share of these enrollments. Measures included in VBE align with the state's Managed Care Quality Strategy and the dimensions of the Triple Aim framework developed by the Institute for Healthcare Improvement.

Under the new VBE, HHSC or its administrative services contractor (enrollment broker) equitably distributes beneficiaries who do not select an MCO to qualified MCOs, using an automated procedure with two main steps:

1. A target default number is calculated for each plan in an SDA based on the proportion of individuals in the SDA who actively chose that MCO during the most recent three-month period.
2. Specific members are allocated to plans, up to approximately the amount of the target default number, based on criteria such as whether the member has other family enrolled with an MCO, a member has previous experience

with the MCO or a member has a prior relationship with a primary care provider in that MCO's network. All default enrollments occur at an SDA level.

VBE, as implemented by HHSC, does not change step two of the process described above but does modify the calculation of the target default number (step 1). Under VBE, results from key cost, quality and member satisfaction dimensions are consolidated into a single value score and then combined with data on member choice to produce a new target default number for each MCO in an SDA. Thus, MCOs with better performance than others, as measured using the criteria listed below in Table 5 receive a higher share of enrollments than under the previous approach.

**Table 5. VBE Methodology Criteria**

<b>Dimension</b>	<b>Weight</b>	<b>VBE Enrollment Criteria</b>
Cost and Efficiency	40%	Risk-adjusted actual to expected spending ratio
Cost and Quality	20%	Risk-adjusted actual to expected PPEs ratios: PPAs, PPRs, and PPVs
Quality and Member Satisfaction	40%	<p>Composite Report Card Scores (Quality and Member Satisfaction), which include:</p> <ul style="list-style-type: none"> <li>• Member experience with doctors and the health plan – derived from results of member surveys;</li> <li>• Staying healthy – MCO performance on preventive care measures; and</li> <li>• Controlling chronic diseases – MCO performance on important quality measures regarding care for asthma, Attention Deficit Hyperactivity Disorder, Chronic Obstructive Pulmonary Disease, depression, or diabetes, depending on the program.<sup>37</sup></li> </ul>

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<sup>37</sup> The Composite Scores are included in the report cards.

Detailed information on VBE is available in the *Value-based Enrollment Incentive Program* report<sup>38</sup> released in January 2021 and the *Annual Report on Quality Measures and Value-based Payments*<sup>39</sup> released in December 2021.

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<sup>38</sup> <https://www.hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2020/hb1-value-based-enrollment-incentive-program-jan-2021.pdf>.

<sup>39</sup> <https://www.hhs.texas.gov/sites/default/files/documents/annual-report-on-quality-measures-and-vbp-dec-2021.pdf>

## 4. Initiatives to Improve Medicaid Recipients' Health Outcomes

Section 2 of S.B. 1136 requires HHSC to encourage Medicaid providers to continue implementing effective interventions and best practices associated with improvements in the health outcomes of Medicaid recipients that were developed and achieved under DSRIP. HHSC has already implemented initiatives to encourage Medicaid providers to continue implementing these types of interventions and best practices. HHSC is also proposing several new initiatives to this end. These current and proposed initiatives are summarized below.

### Directed Payment Programs (DPPs)

CMS, under 42 C.F.R. § 438.6(c), allows states to direct MCO expenditures "... to assist states in achieving their overall objectives for delivery system and payment reform and performance improvement."<sup>40</sup> The state develops the programs, specific to a class of provider, and directs MCOs to implement the associated provider payments. DPPs must help the state advance its Quality Strategy. HHSC uses its Quality Strategy to assess and improve the quality of health care and services provided through the managed care system.<sup>41</sup> DPPs require annual approval from CMS to authorize federal matching funds and continue the programs.

HHSC proposed four new DPPs for fiscal year 2022:

- Comprehensive Hospital Increased Reimbursement Program (CHIRP),
- Texas Incentives for Physician and Professional Services (TIPPS),
- Rural Access to Primary and Preventive Services (RAPPS), and
- Directed Payment Program for Behavioral Health Services (DPP BHS).

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<sup>40</sup> CMS State Medicaid Director Letter (SMD# 21-001), January 8, 2021, <https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/smd21001.pdf>

<sup>41</sup> For more information, please see <https://www.hhs.texas.gov/about/process-improvement/improving-services-texans/medicaid-chip-quality-efficiency-improvement/quality-strategy>.

On November 15, 2021, HHSC received CMS approval for DPP BHS effective September 1, 2021. On March 25, 2022, HHSC received CMS approval for CHIRP, TIPPS, and RAPPS. Each program is described in the next section.

## **Comprehensive Hospital Increase Reimbursement Program (CHIRP)**

CHIRP is a DPP for hospitals that provides increased Medicaid payments for inpatient and outpatient services to children and adults enrolled in the STAR and STAR+PLUS Medicaid programs. The program began as the Uniform Hospital Rate Increase Program (UHRIP) in fiscal year 2018. UHRIP was then renewed annually in fiscal years 2019, 2020, and 2021. For fiscal year 2022, HHSC is implementing a new program, CHIRP, comprised of UHRIP and a new component, the Average Commercial Incentive Award (ACIA).

CHIRP replaces UHRIP for fiscal year 2022 as a statewide DPP that provides increased Medicaid payments for inpatient and outpatient services to participating hospitals. To continue incentivizing hospitals to improve access, quality, and innovation in the provision of hospital services, HHSC developed new eligibility requirements, hospital classes, and financing components for the program. HHSC also implemented new quality measures for evaluating the program and new reporting requirements as a condition of participation.

Hospitals must report as a condition of participation on measures that were chosen based on best practices from DSRIP. They include process measures, clinical outcome measures, and structure measures. Structure measures are a type of measure that help indicate a provider's capacity, infrastructure, and strategy for delivering evidence-based best practices for high quality care. For example, all hospitals must report on health information exchange (HIE) connectivity, as data exchange enhances providers' and MCOs' ability to coordinate care. Measures that support activities known to improve care transitions and provide preventive screenings were also chosen for inclusion in the program, including adoption of written care transition procedures, and screenings for influenza and tobacco use.

The provider-reported measures will be used for evaluating the program's efficacy at advancing the Quality Strategy goals and objectives. CMS approved CHIRP in March 2022, with an effective date of September 1, 2021.

## Texas Incentives for Physicians and Professional Services (TIPPS)

TIPPS is a DPP for certain physician groups providing health care services to children and adults enrolled in the STAR, STAR+PLUS, and STAR Kids Medicaid programs. HHSC created the TIPPS program as a part of an effort to replace funding provided under the Texas DSRIP program and the Network Access Improvement Program (NAIP). Three classes of physician groups are eligible to participate: Health-Related Institution (HRI) physician groups, Indirect Medical Education (IME) physician groups, and other physician groups.

TIPPS aligns with the focus areas identified in the DSRIP Transition Plan including:

- Primary care
- Pediatric care
- Chronic care management
- Maternal health and birth outcomes including in rural areas of the state
- Behavioral health
- Social determinants of health (SDOH)

TIPPS is designed to improve access, quality, and timeliness of outpatient care - providing the right care in the right place at the right time, a focus of physician practices' DSRIP activities. TIPPS incorporates best practices identified in DSRIP and requires providers to report status on interventions known to drive quality outcomes, including:

- Patient-centered medical homes
- Same-day, walk-in, or after-hours appointments
- Care teams that include personnel in a care coordination role
- Pre-visit planning and/or standing order protocols
- Self-management classes
- SDOH screening
- Participation in local health information exchange
- Telehealth

Providers will report on outcome measures and HHSC will evaluate the efficacy of the program in driving improvement in primary care, chronic disease management, maternal health, and behavioral health screenings measures. Measures selected for inclusion in the program were identified by DSRIP stakeholders, including the Best Practices Workgroup<sup>42</sup>, as key for improving the health status of clients, including the following.

- Tobacco screening
- Cervical cancer screening
- Immunization status
- Behavioral health screening
- Diabetes hemoglobin A1c testing and control
- Prenatal and post-partum care

Physician groups must report all required quality measures as a condition of participation. The provider-reported measures will be used for evaluating the program's efficacy at advancing the Quality Strategy goals and objectives. CMS approved TIPPS in March 2022, with an effective date of September 1, 2021.

## **Rural Access to Primary and Preventive Services (RAPPS)**

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

HHSC developed the RAPPS program to help continue funding for key activities started under DSRIP. DSRIP improved access to care in rural areas through increased primary and specialty care capacity (direct staff or telemedicine). However, access to necessary services in rural areas continues to be a challenge. A prospective payment included in Component 1 of the RAPPS program is intended to provide some budget stability for rural providers.

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<sup>42</sup> Texas Health & Human Services Commission. *Provider Performance in the Delivery System Reform Incentive Payment Program, Demonstration Years 7 and 8*, p. 17-18.

RHCs were integrated into the region provided DSRIP patient services. RHCs provided primary and preventive care services measured for quality improvement in DSRIP program. RHCs help avoid PPVs by providing access to primary and preventative care and chronic disease management to rural residents.

RAPPS' required quality measures are supported by the results from the Best Practices Workgroup that found diabetes control, cancer screening, high blood pressure control, and immunization measures were among the top seven measures for driving improvements in the health status of clients.

The participating RHC must report all quality measures as a condition of participation in the program. The provider-reported data will be used for the evaluation of the program. CMS approved RAPPS in March 2022, with an effective date of September 1, 2021.

## **Directed Payment Program for Behavioral Health Services (DPP BHS)**

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

DPP BHS aligns with the following focus areas identified in the DSRIP Transition Plan.

- Behavioral health
- Patient navigation, care coordination, and care transitions, especially for patients with high costs and high utilization
- Sustaining access to critical healthcare services

The program also builds on the following core activities CMHC providers implemented during DSRIP.

- Implementing a provision of care aligned with the CCBHC model
- Utilizing telehealth/telemedicine

This program uses quality measures identified by stakeholders as key for improving the health of clients. This includes the top three key behavioral health measures identified through the Best Practices Workgroup:

- Follow-up after hospitalization for mental illness
- Age-appropriate screening for clinical depression/suicide risk
- Behavioral health conditions, ED visits rate

Participating CMHCs must report all required quality measures as a condition of participation in the program. CMS approved DPP BHS in November 2021, with an effective date of September 1, 2021.

## **Medicaid Benefits**

The 87th Legislature passed additional bills, such as S.B. 672 and House Bill (H.B.) 2658 described below, that will incorporate DSRIP best practices into the Medicaid program. The legislation provides the opportunity to advance frequently implemented and best practices of DSRIP, such as enhanced care coordination and chronic disease management. Based on the legislation, best practices, and additional research, HHSC is exploring other Medicaid benefit changes.

## **Collaborative Care Model**

S.B. 672, 87th Legislature, Regular Session, 2021 requires HHSC to provide Medicaid reimbursement for the provision of behavioral health services that are classified as collaborative care management services. The Collaborative Care Model (CoCM) is a systematic approach to the treatment of behavioral health conditions in primary care settings. The model integrates the services of behavioral health care managers and psychiatric consultants with PCP oversight to proactively manage behavioral health conditions as chronic diseases. These services include care plans developed and driven by evidence-based practice guidelines. The use of a team that integrates physical and behavioral health care can improve care coordination and care transitions, and thereby improve health outcomes. CoCM services will be a benefit in Texas Medicaid for persons of all ages who have a mental health or substance use condition, as determined by the PCP.

The collaborative care management services benefit was chosen by DSRIP providers in a survey conducted by HHSC in May 2020 as one of the most effective interventions for positively impacting their clients' health. The addition of this benefit to the Medicaid program will facilitate the continuation of this best practice. The benefit is anticipated to be added in Summer 2022.

## **Social Determinants of Health (SDOH)**

### **Screening and Referral**

Social determinants of health (SDOH) are "the conditions in the place where people live, learn, work, and play that affect a wide range of health risks and outcomes,"<sup>43</sup> and within SDOH, there are health-related social needs, which are "the individual-level, adverse social conditions that can negatively impact a person's health or health care."<sup>44</sup> In February 2020, HHSC received a recommendation that screening and intervention to address food insecurity be designated as a reimbursable benefit at Texas Health Steps (THSteps) checkups for children birth through 20 years old enrolled in Medicaid. HHSC continues to analyze this potential policy change.

SDOH is a focus area of the DSRIP Transition. Based on an analysis of DSRIP provider performance in DYs 7-8 (October 1, 2017 through September 30, 2019), DSRIP providers that reported quality measures with the highest performance rates for Medicaid and CHIP beneficiaries were more likely to have implemented screening for food insecurity.<sup>45</sup>

## **Diabetes Self-Management Education and Support (DSMES)**

H.B. 2658, 87th Legislature, Regular Session, 2021, requires HHSC to study the cost-effectiveness and feasibility of providing diabetes self-management education

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<sup>43</sup> <https://www.cdc.gov/socialdeterminants/about.html>

<sup>44</sup> <https://innovation.cms.gov/media/document/ahcm-screeningtool-companion>

<sup>45</sup> Texas Health & Human Services Commission. Provider Performance in the Delivery System Reform Incentive Payment Program, Demonstration Years 7 and 8. December 2020. Available at <https://www.hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2020/hb1-provider-perf-dsrip-dy7and8-dec-2020.pdf>

and medical nutrition therapy services to people with diabetes in Medicaid. If these services are found to improve health outcomes and lower costs for Medicaid, the bill requires HHSC to develop a program to provide the benefits and seek prior approval from the Legislative Budget Board. These evidence-based services could potentially reduce unnecessary ED use by supporting members with diabetes to self-manage their condition to prevent or delay diabetes complications. The study will be submitted to the legislature by September 1, 2022.

Chronic care management is a focus area of the DSRIP Transition, and the Best Practices Workgroup identified diabetes-related performance measures as the two most important key measures for driving improvements in health status for clients. Education in chronic disease self-management was one component of chronic care management services, which was one of the Core Activities most commonly associated with improvement on certain diabetes quality measures in DSRIP.<sup>46</sup>

## **Alternative Payment Model (APM) Requirements for MCOs**

S.B. 1136 requires HHSC to encourage Medicaid providers to continue implementing effective interventions and best practices associated with improvements in the health outcomes of Medicaid recipients that were developed and achieved under DSRIP. It specifies that this can be done in a number of ways, including through the terms included in contracts with MCOs and through implementation of Alternative Payment Models (APMs). APMs are the specific payment arrangements and methods used in Value-Based Payment (VBP) programs, which hold providers or MCOs accountable for the cost and quality of care.<sup>47</sup> Some examples of APMs include providers receiving bonuses for achieving quality or reaching goals on performance measures, sharing savings for delivering services at a lower cost, or incurring financial losses for not meeting specified quality and cost benchmarks.

HHSC's MCO and DMO contracts require them to reach escalating APM targets each year, from calendar year 2018 through 2022. Revised contract language is being

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<sup>46</sup> [Texas Health & Human Services Commission. \*Provider Performance in the Delivery System Reform Incentive Payment Program, Demonstration Years 7 and 8\*. December 2020](#)

<sup>47</sup> <https://www.medicaid.gov/medicaid/downloads/accel-adoption-vp-pay.pdf>

considered for future years following the recommendations made by the Value-Based Payment and Quality Improvement (VBPQI) Advisory Committee. The VBPQI Advisory Committee plays an important role in supporting collaboration between Medicaid stakeholders to advance value-based care.

During its August 2021 meeting, the VBPQI Advisory Committee recommended HHSC adopt a more comprehensive contractual framework to assess MCO and DMO achievement on APMs that will include a set of qualitative measures in addition to the more quantitative measures. The VBPQI Advisory Committee suggested HHSC policies should also encourage ongoing evaluation of the APMs, development of innovative models, sharing of key data and best practices, administrative simplification, and deeper engagement between MCOs/DMOs and providers. The Committee recommended MCOs and DMOs should be credited for successes on a set of activities designed to advance value-based care in Texas Medicaid, rather than just the APM targets.

The following recommendations were added to those made previously by the VBPQI Advisory Committee in September 2020<sup>48</sup>:

- Align APMs and performance metrics for maternal and newborn care in Medicaid managed care.
- Adopt VBP methodologies that address social drivers of health to lower healthcare costs and improve outcomes.
- Leverage multi-payer data to advance collaboration on VBP and quality improvement initiatives across major payers of healthcare.
- Develop strategies to increase adoption of effective APMs by Medicaid MCOs and providers, including by reducing administrative barriers.
- Identify lessons learned during the PHE to strengthen care delivery and value-based care in Medicaid, such as through the increased deployment of teleservices.

The original APM targets established in the managed care contracts for calendar year 2021 were maintained for calendar year 2022 because of the PHE and will be assessed for subsequent years. The recommendations made by the VBPQI Advisory

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<sup>48</sup> <https://www.hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2020/value-based-payment-qual-improvement-recommendations-dec-2020.pdf>

Committee, MCOs and DMOs, and other stakeholders will inform future HHSC decisions on APM measurement and reporting processes. The update of APM contractual requirements provides an opportunity to encourage adoption of best practices informed by DSRIP.

Initial APMs established by MCOs/DMOs in Medicaid focused on primary care models, followed by hospitals, and specialists/behavioral health providers as seen in Table 6 below. In 2018, nearly three-fourths of all APM models were for the primary care, hospital, and specialists/ behavioral health provider types, with over 40 percent in primary care alone. That proportion was maintained in calendar year 2019, with an increase in primary care APMs, a decrease in hospital representation, and a slight decrease in specialists, including behavioral health APMs.

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

**Table 6. Distribution of APMs by Provider Type, Calendar Years 2018–2019<sup>49</sup>**

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

HHSC's goals on the future development and expansion of its VBP strategy through APMs can be found in deliverables published as part of the DSRIP Transition Plan.

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<sup>49</sup> Due to rounding, the total percentages may be a little higher or lower than 100%.

The following are summaries of the information detailed in these Transition Plan deliverables published as [Transition Milestone Updates](#).

- The "*Value Based Payment (VBP) Roadmap*"<sup>50</sup> (March 2021), while centered on HHSC healthcare quality goals, describes how the state plans to move forward with VBP, the status of its current programs, along with its guiding principles for success.
- The "*Alternative Payment Models in Texas Medicaid*"<sup>51</sup> (March 2021), which accompanied the VBP Roadmap, includes a report of managed care organizations' APM achievement to that point in time. This document highlights the role of APMs in managed care, along with other aspects of the state's VBP strategy that are helping to transform Texas Medicaid from a volume-based to a value-based system.
- An "*Assessment of Financial Incentives for Alternative Payment Models*"<sup>52</sup> (June 2021) and "*Quality Improvement Cost Guidance*"<sup>53</sup> supplemented the VBP Roadmap and the APM report (above). The assessment demonstrated the effectiveness of financial incentives to improve quality as evidenced by better MCO performance on quality measures associated with a financial incentive than on measures without an incentive.

HHSC plans to continue its support for the APM initiative and work with stakeholders to facilitate new and more advanced arrangements as directed by S.B.

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<sup>50</sup> Texas Health & Human Services Commission. *Value-Based Payment Roadmap*. March 2021. Available at <https://www.hhs.texas.gov/sites/default/files/documents/laws-regulations/policies-rules/Waivers/medicaid-1115-waiver/value-based-payment-roadmap.pdf>

<sup>51</sup> Texas Health & Human Services Commission. *Alternative Payment Models in Texas Medicaid*. March 2021. Available at <https://www.hhs.texas.gov/sites/default/files/documents/laws-regulations/policies-rules/Waivers/medicaid-1115-waiver/alternative-payment-models-texas-medicaid.pdf>

<sup>52</sup> Texas Health & Human Services Commission. *Assessment of Financial Incentives for Alternative Payment Models*. June 2021. Available at <https://www.hhs.texas.gov/sites/default/files/documents/laws-regulations/policies-rules/Waivers/medicaid-1115-waiver/assessment-financial-incentives-apm.pdf>

<sup>53</sup> Texas Health & Human Services Commission. *Quality Improvement Cost Guidance*. June 2021. Available at <https://www.hhs.texas.gov/sites/default/files/documents/laws-regulations/policies-rules/Waivers/medicaid-1115-waiver/quality-improvement-cost-guidance.pdf>

1136 and recommended by the Healthcare Payment Learning and Action Network (HCP-LAN)<sup>54</sup>.

## VBP Arrangements to Address SDOH

Since 2018, MCOs have been required to increasingly transition a percentage of their provider payment methodologies into VBP arrangements.<sup>55</sup> VBP arrangements that address SDOH would support the continuation of best practices identified during the DSRIP program to be associated with improvements in the health outcomes of Medicaid recipients. For example, according to an analysis of DSRIP provider performance in DYs 7-8 (October 1, 2017 – September 30, 2019), DSRIP providers that reported quality measures with the highest performance rates for Medicaid and CHIP beneficiaries were more likely to have implemented screening for food insecurity and screening for housing needs.<sup>56</sup> Moreover, the *Assessment of Social Factors impacting Health Care Quality in Texas Medicaid*, a DSRIP Transition Plan milestone deliverable submitted to CMS in March 2021, found statistically significant associations between SDOH variables and quality measures for children, adolescents, pregnant women, and adults with disabilities and age 65 or older in Texas Medicaid.<sup>57</sup> Additionally, the Best Practices Workgroup identified the inclusion

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<sup>54</sup> The HCP-LAN was established as a collaborative network of public and private stakeholders, including health plans, providers, patients, employers, consumers, states, federal agencies, and other partners within the health care community to drive alignment in payment approaches across the public and private sectors of the U.S. health care system. To advance the goal of aligning payment approaches, the HCP-LAN created an APM Framework that could be used to track progress toward payment reform. LAN Framework available at: <http://hcp-lan.org/workproducts/apm-framework-onepager.pdf>

<sup>55</sup> The contractual MCO provision related to APMs with providers is outlined in the HHSC Uniform Managed Care Contract (PDF) in Section 8.1.7.8.2 "MCO Alternative Payment Models with Providers", and the contractual targets for APMs are listed on pg. 519. Available at <https://www.hhs.texas.gov/sites/default/files/documents/services/health/medicaid-chip/programs/contracts/uniform-managed-care-contract.pdf>

<sup>56</sup> Texas Health & Human Services Commission. *Provider Performance in the Delivery System Reform Incentive Payment Program, Demonstration Years 7 and 8*. December 2020. Available at <https://www.hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2020/hb1-provider-perf-dsrip-dy7and8-dec-2020.pdf>

<sup>57</sup> Texas Health & Human Services Commission. *Assessment of Social Factors impacting Health Care Quality*. March 2021. Available at <https://www.hhs.texas.gov/sites/default/files/documents/laws-regulations/policies-rules/Waivers/medicaid-1115-waiver/assessment-social-factors.pdf>

of community health workers (CHWs) or promotor(a)s in a care coordination role on care teams as the second most impactful key practice (out of 40 total surveyed practices) from the DSRIP program.<sup>58</sup>

While some MCOs have already begun implementing a variety of SDOH initiatives, HHSC encourages MCOs and providers to voluntarily adopt VBP arrangements that use evidence-based interventions and standardized models to address SDOH. The following three examples of SDOH VBP arrangements were presented to Medicaid MCOs at a recent MCO Quality meeting.

Recognizing there may be varying degrees of readiness and capability among MCOs and providers to adopt a VBP arrangement, HHSC recommends stepwise advancement of APM arrangements over time using the HCP-LAN Framework, as outlined in Tables 15, 16, and 17 in Appendix D.

## **SDOH VBP Arrangement 1: Integrating CHWs/Promotor(a)s into Care Teams**

This SDOH VBP arrangement aims to leverage the effective use of CHWs/promotor(a)s by integrating them into care teams through an evidenced-based intervention, known as Individualized Management for Patient Centered Targets (IMPACT), which is a “theory-based intervention using specially hired and trained CHWs to provide tailored social support for high-risk patients.”<sup>59</sup> This evidence-based intervention has been evaluated by physician researchers at the Perelman School of Medicine at the University of Pennsylvania using a randomized

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<sup>58</sup> Top Ten DSRIP Key Practices from the DSRIP Transition Best Practices Workgroup Best Practices Workgroup Survey 2 Final Results\_20200710 includes:

- Care team includes personnel in a care coordination role not requiring clinical licensure (e.g. non-clinical social worker, community health worker, medical assistant, etc.)

<sup>59</sup> Kangovi, et. al. “Evidence-Based Community Health Worker Program Addresses Unmet Social Needs and Generates Positive Return on Investment”. Health Affairs 39, No 2 (2020) 207-213

control trial<sup>60</sup> and an economic analysis to determine its cost effectiveness to a Medicaid payer.

The IMPaCT intervention is highly structured, lasts six months, and includes recommended caseloads, supervision ratios, hiring algorithms, training courses, and software for documentation, reporting, and quality control. In IMPaCT, CHWs are trained to use interviewing techniques to understand patients' social needs and preferences to inform tailored, patient-driven action plans. The CHWs communicate weekly with patients, support the execution of action plans, and convene weekly support groups to foster social support networks among high-risk patients with shared experiences. The CHWs are closely integrated with outpatient primary care practices, including having workspace in the practice, access to the electronic medical records of their patients, and the ability to communicate with clinical staff regularly.

## **SDOH VBP Arrangement 2: Standardized SDOH Screening Initiative**

This SDOH VBP arrangement aims to standardize the identification of health-related social needs among Medicaid clients through mutual engagement between MCOs and providers to use one of the following standardized SDOH screenings. For example, based on existing research and the new user guide by CMS,<sup>61</sup> for food insecurity, the recommended standardized screening tool is the 2-question Hunger Vital Sign™.<sup>62</sup> For additional health-related social needs, the Accountable Health Communities screening tool is recommended.

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<sup>60</sup> Shreya Kangovi, Nandita Mitra, David Grande, Hairong Huo, Robyn A. Smith, and Judith A. Long, 2017: Community Health Worker Support for Disadvantaged Patients With Multiple Chronic Diseases: A Randomized Clinical Trial. *American Journal of Public Health* 107, 1660\_1667, <https://doi.org/10.2105/AJPH.2017.303985>

<sup>61</sup> <https://innovation.cms.gov/media/document/ahcm-screeningtool-companion>

<sup>62</sup> <https://childrenshealthwatch.org/public-policy/hunger-vital-sign/>

## SDOH VBP Arrangement 3: Targeting Food Insecurity

This SDOH VBP arrangement aims to use a “screen and intervene” framework to identify clients facing food insecurity during a clinical encounter and actively refer eligible clients into an appropriate intervention to address food insecurity and improve health outcomes. The “screen” component uses a validated, standardized screening question to identify food insecurity among clients seen in the clinical setting (see also SDOH VBP Arrangement #2 for Standardized SDOH Screening Initiative). The “intervene” component refers eligible clients identified with food insecurity to an appropriate intervention such as Supplemental Nutrition Assistance Program (SNAP) assistance,<sup>63,64</sup> medically tailored meals,<sup>65,66,67,68</sup> or a food prescription (Rx) program.<sup>69,70</sup>

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<sup>63</sup> <https://www.cbpp.org/research/food-assistance/snap-is-linked-with-improved-nutritional-outcomes-and-lower-health-care>

<sup>64</sup> [https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2653910?amp%3Butm\\_source=JAMA%20Intern%20MedPublishAheadofPrint&utm\\_campaign=25-09-2017](https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2653910?amp%3Butm_source=JAMA%20Intern%20MedPublishAheadofPrint&utm_campaign=25-09-2017)

<sup>65</sup> <https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2730768>

<sup>66</sup> <https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2017.0999>

<sup>67</sup> <https://journals.sagepub.com/doi/full/10.1177/2150131913490737>

<sup>68</sup> <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6676759/>

<sup>69</sup> <https://www.tfah.org/story/produce-rx-using-prescriptions-to-improve-affordability-of-healthy-foods/>

<sup>70</sup> [https://ajph.aphapublications.org/doi/abs/10.2105/AJPH.2018.304528?url\\_ver=Z39.88-2003&rfr\\_id=ori%3Arid%3Acrossref.org&rfr\\_dat=cr\\_pub%3Dpubmed](https://ajph.aphapublications.org/doi/abs/10.2105/AJPH.2018.304528?url_ver=Z39.88-2003&rfr_id=ori%3Arid%3Acrossref.org&rfr_dat=cr_pub%3Dpubmed)

## 5. Stakeholder Engagement Plan

S.B. 1136 requires HHSC to coordinate with hospitals and other providers that receive supplemental payments under the UC payment program to identify and implement initiatives designed to reduce Medicaid's recipients use of hospital ED services as a primary means of receiving health care benefits. To meet these requirements, HHSC will convene a workgroup consisting of external stakeholders that receive UC payments, including UC hospitals, RHCs that work with UC hospitals, Texas Medical Association (TMA), MCOs, and CMHCs.

HHSC will leverage available data and also survey members of the workgroup to identify challenges for accessing health care that contribute to use of ED for primary care services, collect information on how stakeholders are overcoming these challenges, and find which solutions appear to be effective. HHSC will share with stakeholders DSRIP best practices aimed at reducing avoidable ED services.

HHSC will share the results of the survey with workgroup members and elicit their recommendations for potential next steps to develop and implement initiatives. Future reports will include identified challenges, effective solutions, and potential next steps.

## 6. Conclusion

This report describes data analysis of the current rates of PPVs, summarizes HHSC's efforts to reduce potentially non-emergent ED utilization in Medicaid, summarizes HHSC's efforts to improve Medicaid recipients' health outcomes and continue effective interventions and best practices achieved under the DSRIP program, and HHSC's plan for engaging with stakeholders. Future reports will be submitted biannually and will provide updated PPV rates, as they become available, and updates on HHSC's initiatives and activities.

PPVs are the key metric HHSC uses to measure the rates of avoidable ED visits in each Medicaid managed care program. From 2013 to 2019, the number of PPVs per 1,000 member months decreased 15.5 percent, but the resource use or prices of the remaining PPVs increased enough to increase total PPV expenditures. HHSC will determine whether reductions in 2020 were attributable to the PHE.

HHSC has implemented multiple initiatives to reduce avoidable ED use, evaluate and communicate each MCO's performance, and incentivize MCOs to reduce PPV rates, including the Medical P4Q program, PIPs, the HHSC Performance Indicator Dashboard, and Medicaid VBE. HHSC also developed initiatives to improve Medicaid recipients' health outcomes and continue effective best practices achieved under the DSRIP program through provider incentive programs, the terms of contracts with MCOs, implementation of APMs, and other cost-effective measures. Initiatives include four new DPPs, Medicaid benefit changes, and recommendations for APM requirements in the contracts for MCOs. HHSC is also proposing new initiatives, including three VBP arrangements that address SDOH.

HHSC will continue to leverage available data and assess current programs and other promising practices from the DSRIP program, Medicaid stakeholders, and national experts to reduce ED use as a primary means of health care. HHSC is committed to developing effective interventions and best practices associated with improvements in the health outcomes of Medicaid recipients that were accomplished under the DSRIP program.

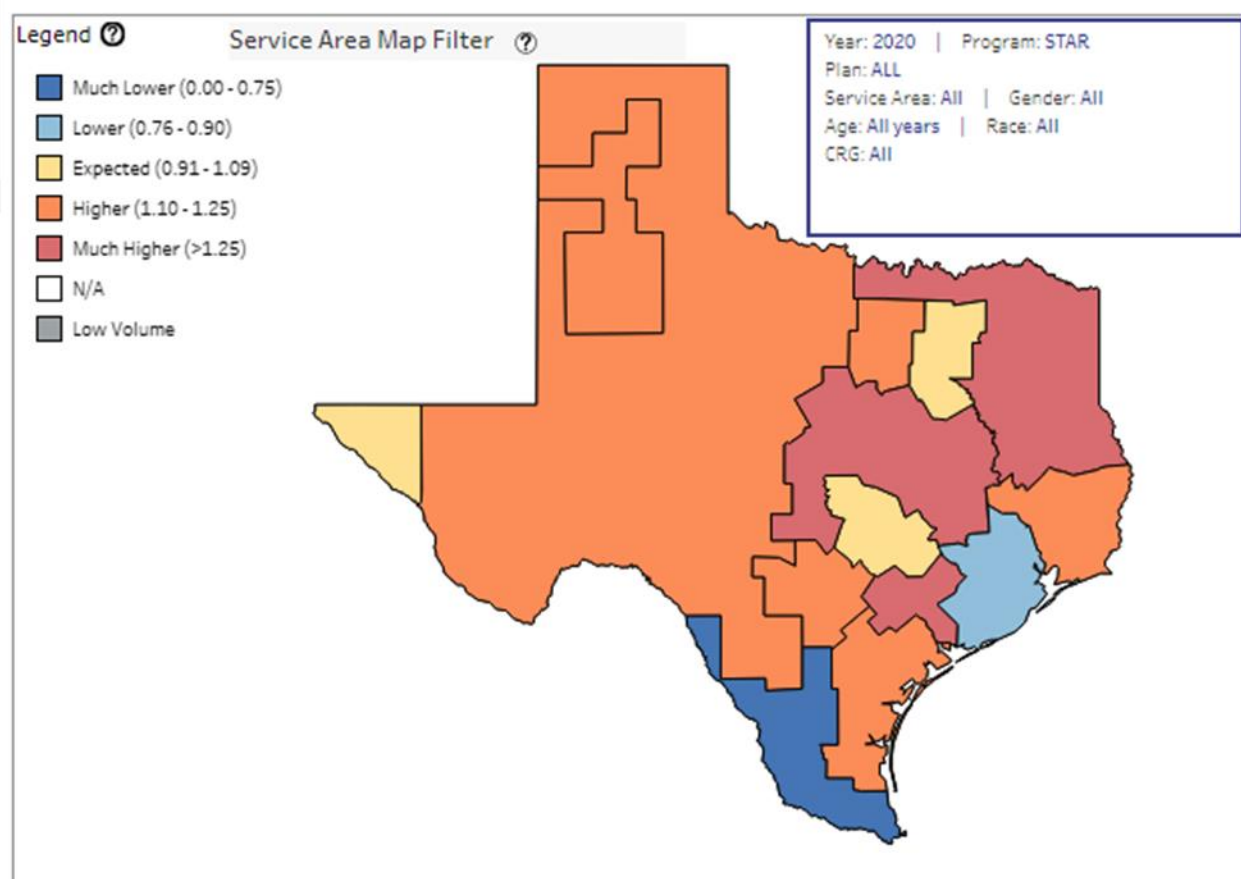
## List of Acronyms

Acronym	Full Name
ACIA	Average Commercial Incentive Award
APM	Alternative Payment Model
CAP	Corrective action plan
CCBHC	Certified Community Behavioral Health Clinic
CHIP	Children’s Health Insurance Program
CHIRP	Comprehensive Hospital Increased Reimbursement Program
CHW	Community health worker
CMHC	Community mental health center
CMS	Centers for Medicare & Medicaid Services
DMO	Dental maintenance organization
DSMES	Diabetes Self-Management Education and Support
DSRIP	Delivery System Reform Incentive Payment
DPP	Directed Payment Program
DPP BHS	Directed Payment Program for Behavioral Health Services
DY	Demonstration year
ED	Emergency department
EQRO	External Quality Review Organization
FFS	Fee for Service
HCP-LAN	Healthcare Payment Learning and Action Network
HIE	Health information exchange
HHSC	Health and Human Services Commission
HPSA	Health Professional Shortage Area
HRI	Health-Related Institution
IME	Indirect Medical Education
IMPACT	Individualized Management for Patient Centered Targets
LHD	Local health department
MCO	Managed care organization
MRSA	Medicaid Rural Service Area

<b>Acronym</b>	<b>Full Name</b>
NAIP	Network Access Improvement Program
P4P	Pay-for-Performance
P4Q	Pay-for-Quality
P4R	Pay-for-Reporting
PCP	Primary Care Physician
PIP	Performance Improvement Project
PMPM	Per Member Per Month
PPA	Potentially Preventable Admission
PPV	Potentially Preventable Emergency Room Visit
PQI	Prevention Quality Indicator
RAPPS	Rural Access to Primary and Preventive Services
RHC	Rural health clinic
SA	Service area
SDOH	Social determinates of health
SFY	State fiscal year
SNAP	Supplemental Nutrition Assistance Program
THSteps	Texas Health Steps
THLC	Texas Healthcare Learning Collaborative
TIPPS	Texas Incentives for Physician and Professional Services
TMA	Texas Medical Association
UC	Uncompensated care
UHRIP	Uniform Hospital Rate Increase Program
URTI	Upper respiratory tract infection
VBE	Value-based Enrollment
VBP	Value Based Payment
VBPQI	Value-Based Payment and Quality Improvement Committee

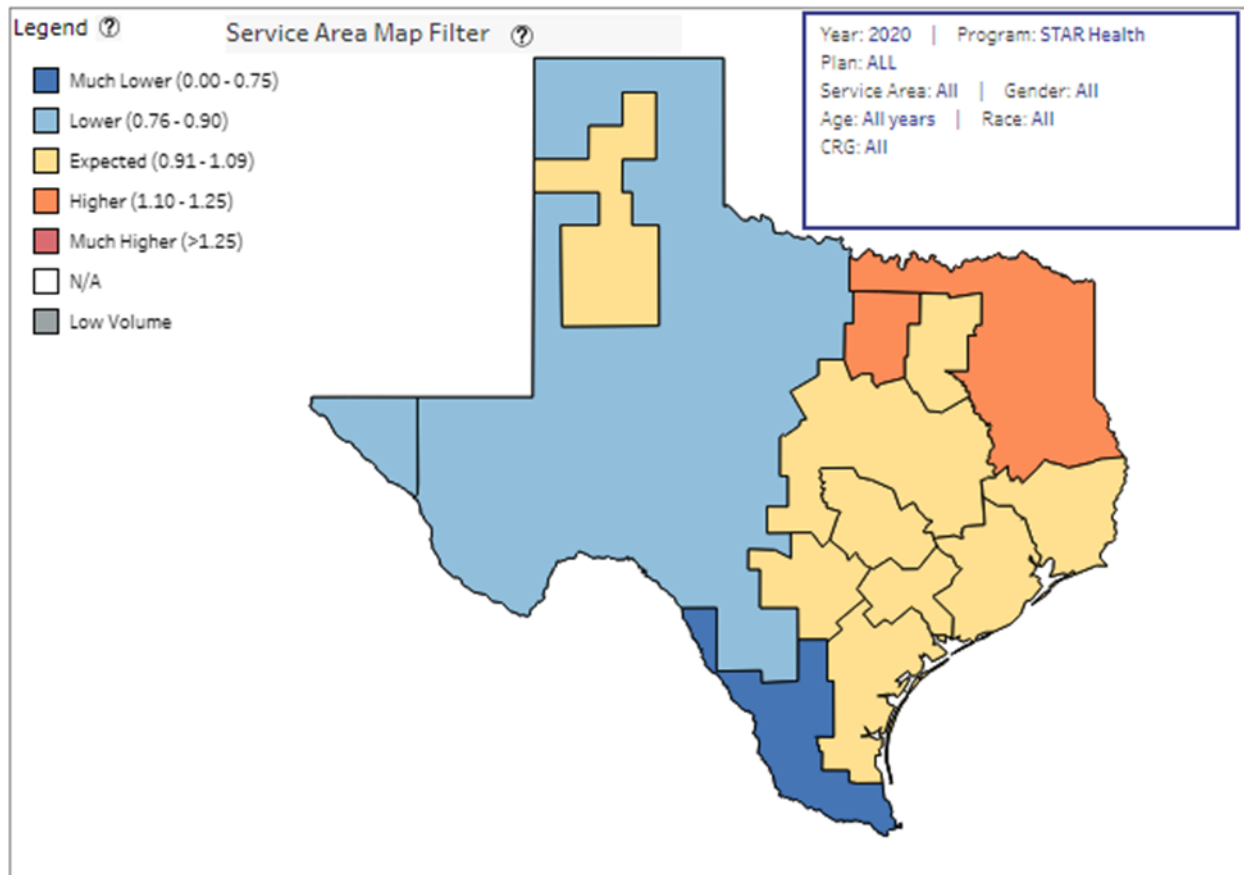
## Appendix A. Actual to Expected Ratios of PPVs by Medicaid Program and Service Area, 2020<sup>71</sup>

**Figure 5: Actual to Expected Ratio of Potentially Preventable Emergency Department Visits in STAR, 2020**

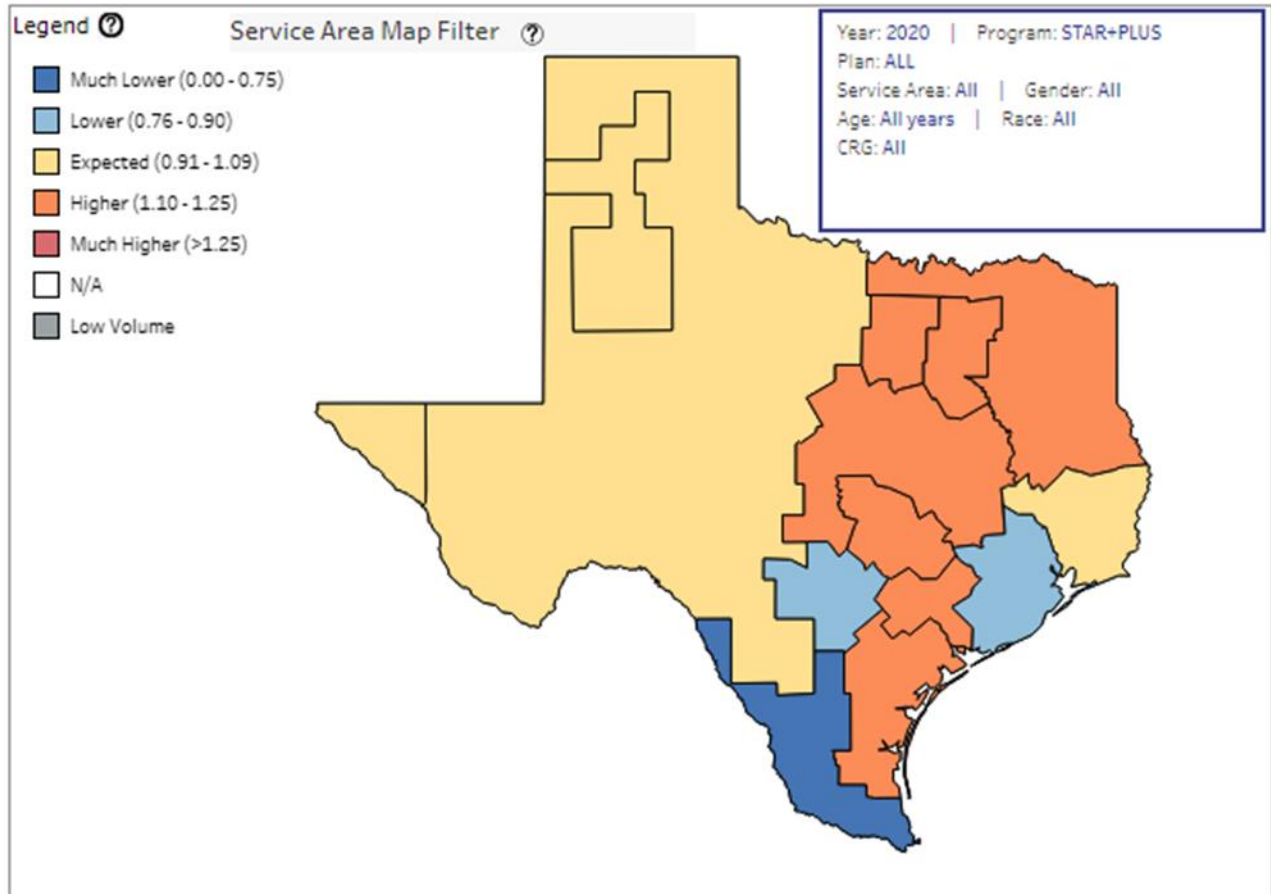


<sup>71</sup> [Texas Healthcare Learning Collaborative, Potentially Preventable Emergency Department Visits Program Level](#)

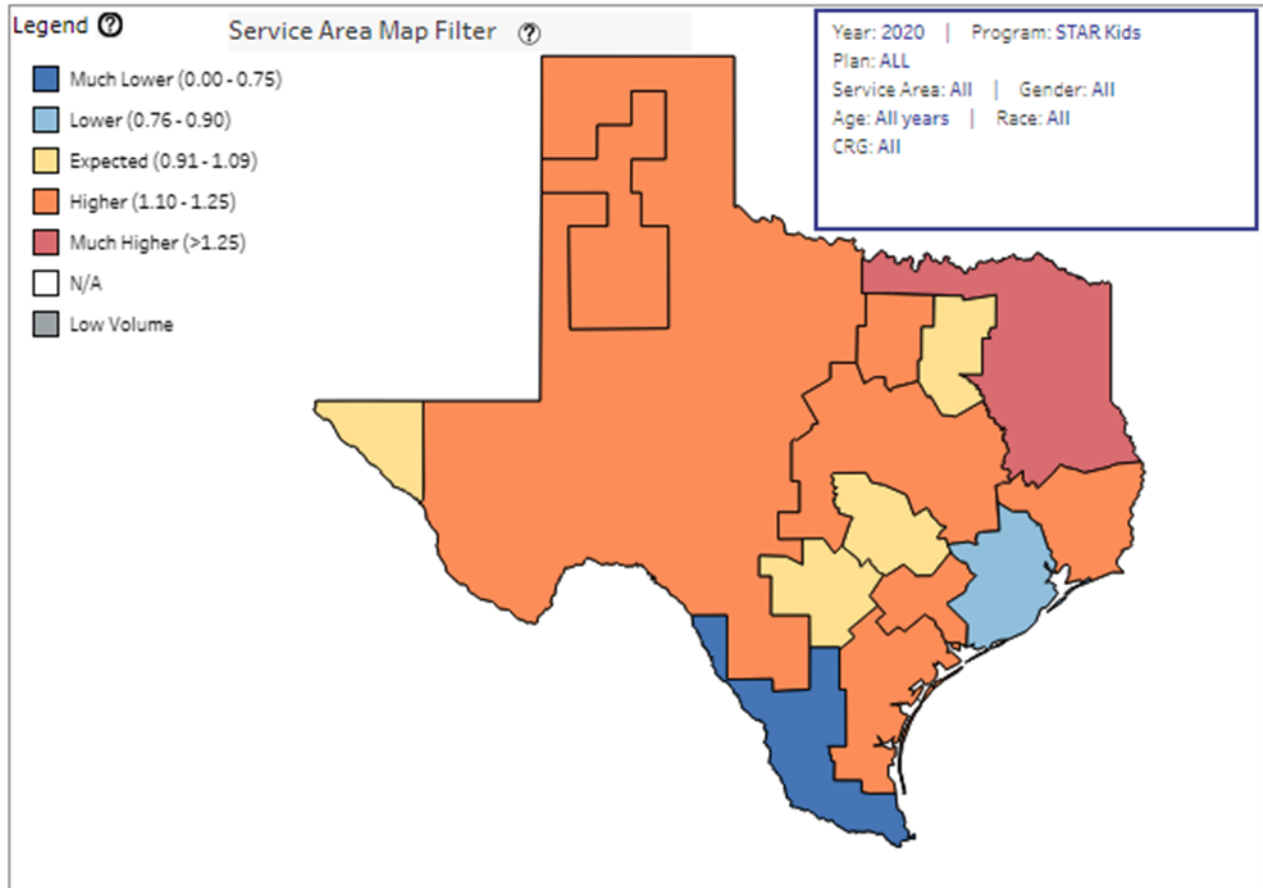
**Figure 6: Actual to Expected Ratio of Potentially Preventable Emergency Department Visits in STAR Health, 2020**



**Figure 7: Actual to Expected Ratio of Potentially Preventable Emergency Department Visits in STAR+PLUS, 2020**

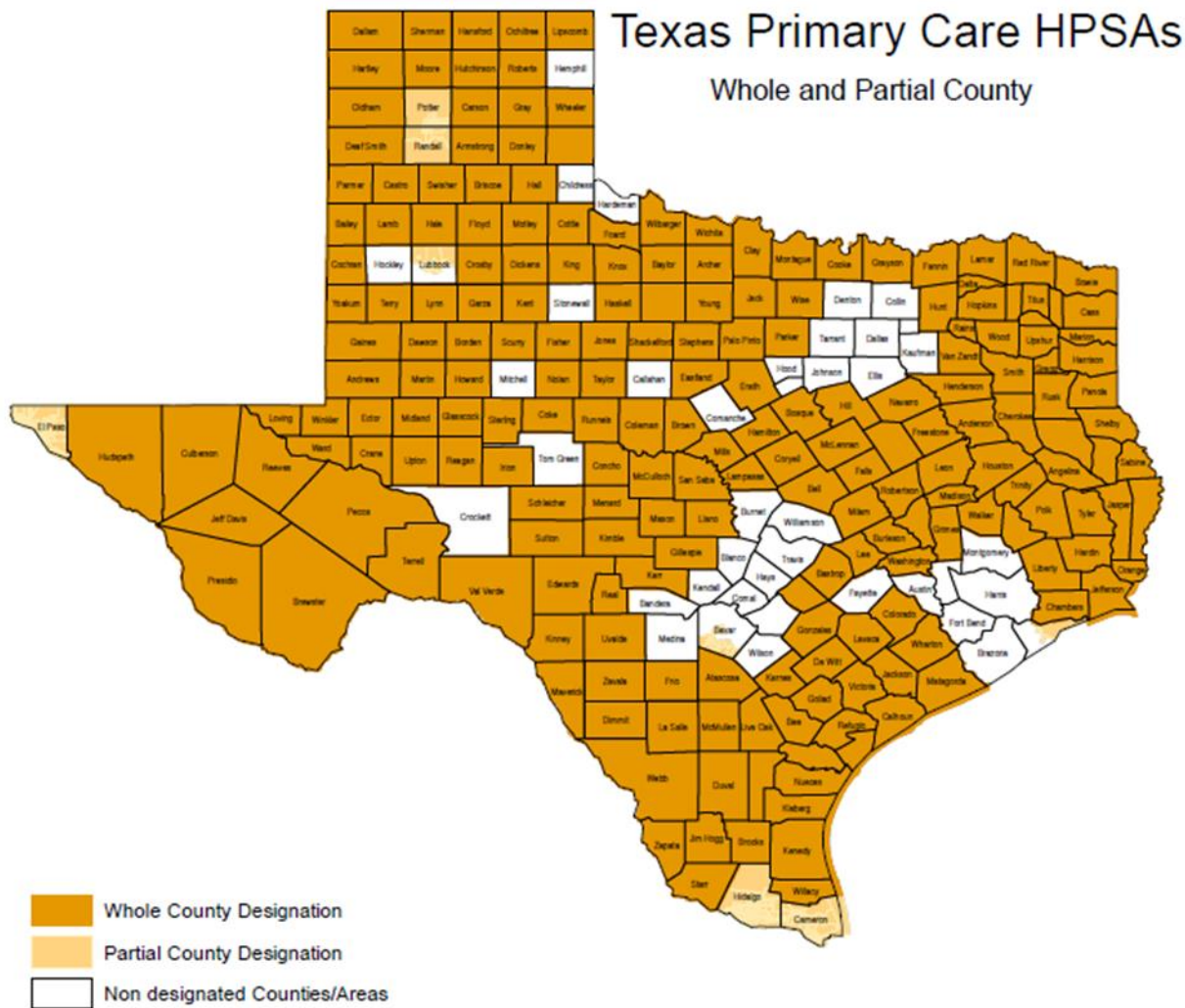


**Figure 8: Actual to Expected Ratio of Potentially Preventable Emergency Department Visits in STAR Kids, 2020**



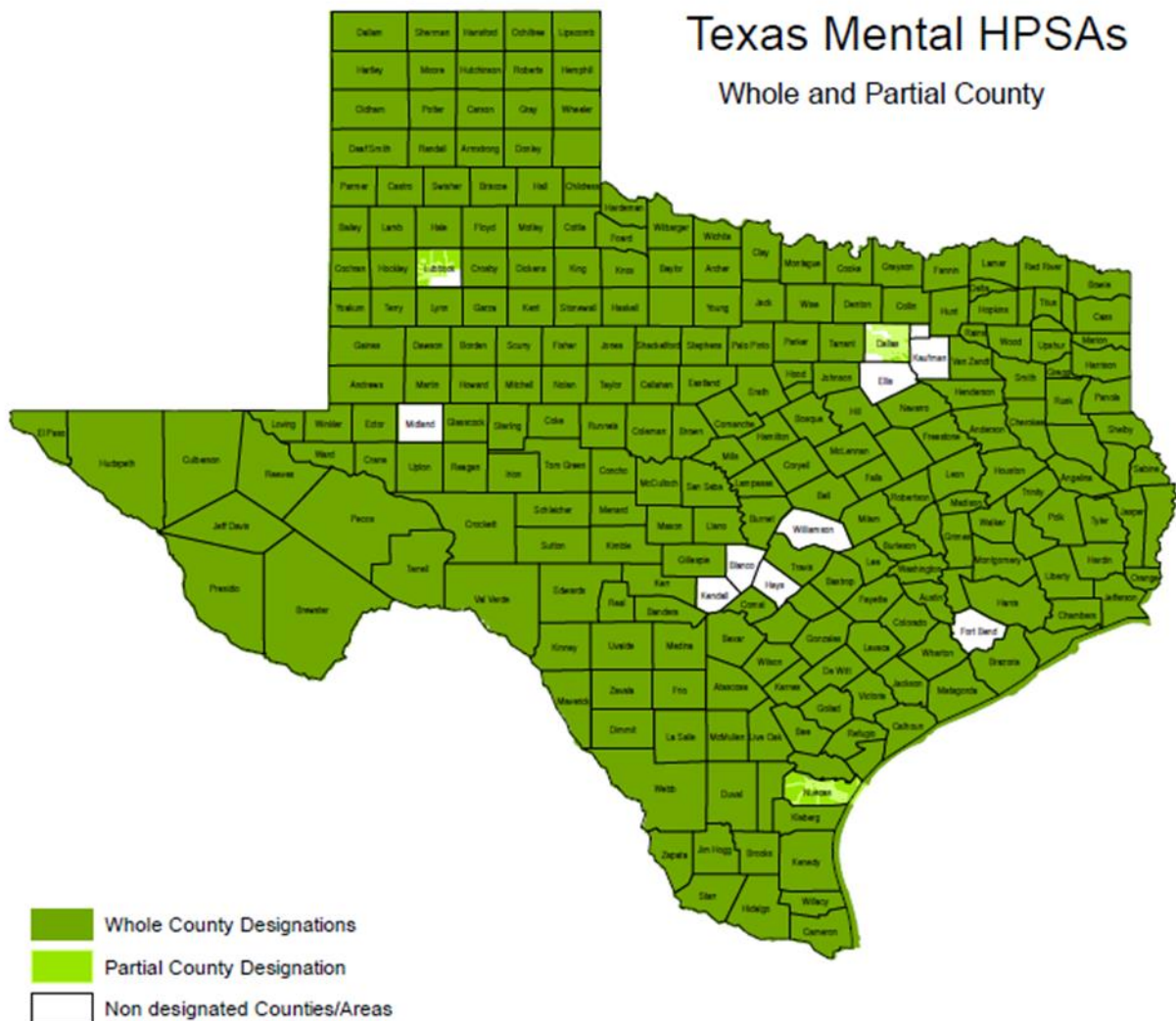
# Appendix B. Health Professional Shortage Areas (HPSAs)

**Figure 9: Map of Primary Care Health Professional Shortage Areas, November 2021**



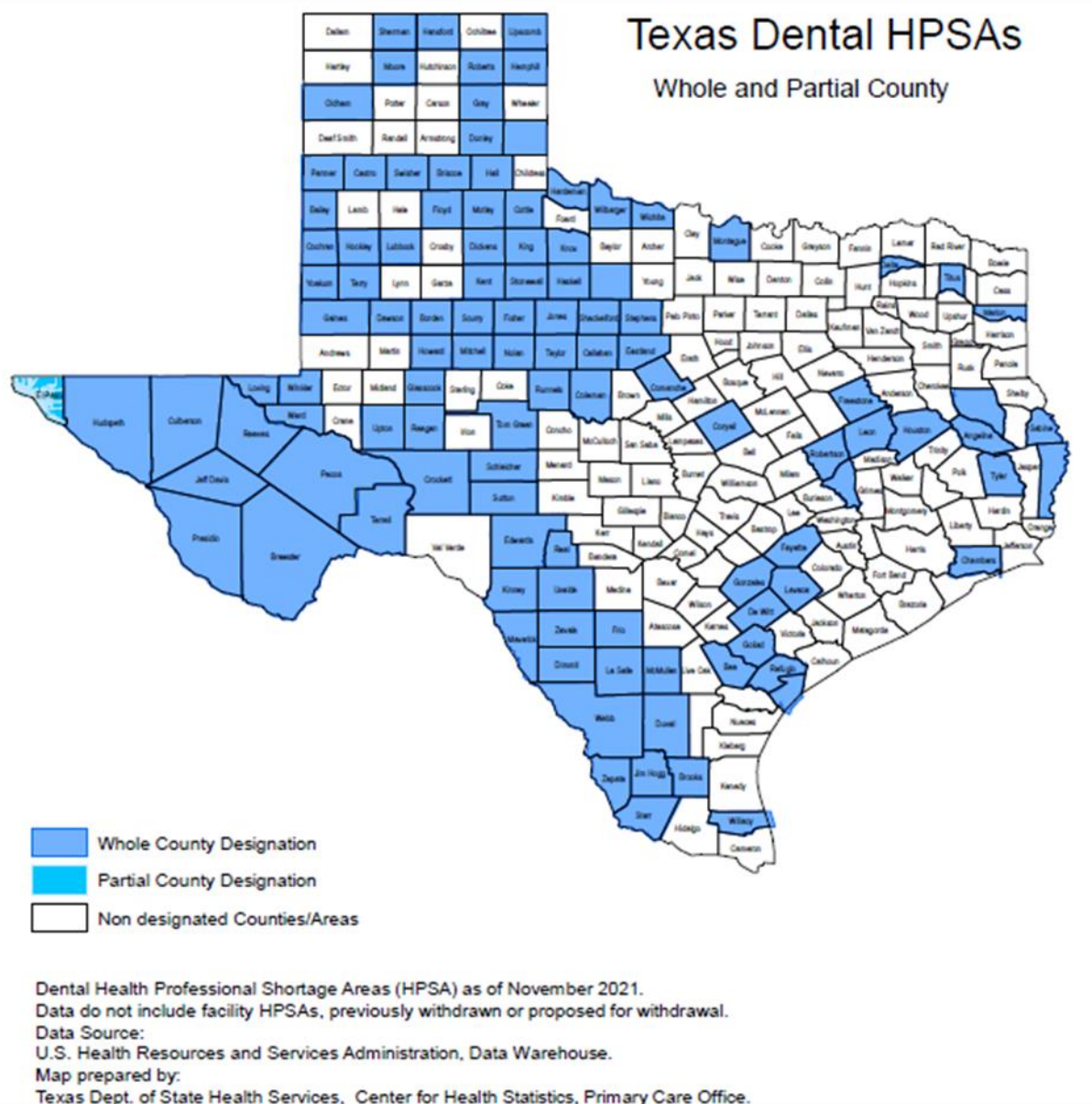
Primary Care Health Professional Shortage Areas (HPSA) as of November 2021.  
 Data do not include facility HPSAs, previously withdrawn or proposed for withdrawal.  
 Data Source:  
 U.S. Health Resources and Services Administration, Data Warehouse.  
 Map prepared by:  
 Texas Dept. of State Health Services, Center for Health Statistics, Primary Care Office.

**Figure 10: Map of Mental Care Health Professional Shortage Areas, November 2021**



Mental Health Professional Shortage Areas (HPSA) as of November 2021.  
Data do not include facility HPSAs, previously withdrawn or proposed for withdrawal.  
Data Source:  
U.S. Health Resources and Services Administration, Data Warehouse.  
Map prepared by:  
Texas Dept. of State Health Services, Center for Health Statistics, Primary Care Office.

**Figure 11: Map of Dental Health Professional Shortage Areas, November 2021**



## Appendix C.

### Select Measures from Experience of Care Survey Results, 2016-2020

The EQRO for Texas Medicaid conducts annual member surveys. The Experience of Care surveys measure member and caregiver experience getting care through their or their child's health plan. These surveys use the Consumer Assessment of Healthcare Providers and Systems survey instruments, adding items relevant to the population. The full Experience of Care surveys is fielded in alternate years and an abbreviated version of the survey is fielded annually. Results are available at the THLC Portal.<sup>72</sup>

#### Select Measures from Experience of Care Survey Results, 2016-2020<sup>73,74,75</sup>

**Table 7: Good Access to Routine Care (percent responding "Always")**

Survey respondents	2016	2017	2018	2019	2020
STAR Caregiver	68.9	70.7	70.2	71.9	68.9
STAR Member	53.2	54.1	52.6	53.6	53.2
STAR Kids Caregiver	*	*	70.4	72.2	69.5
STAR+PLUS Member	60.8	62.6	65.6	60.1	59.4

Note: Answer options were "Always", "Usually", "Sometimes", or "Never".

**Table 8: Good Access to specialist appointment (percent responding "Always")**

Survey respondents	2016	2017	2018	2019	2020
STAR Caregiver	NA	52.6	NA	56.6	NA
STAR Member	55.7	54.9	50.9	51.8	55.7
STAR Kids Caregiver	*	*	59.2	60.7	59.8
STAR+PLUS Member	54.5	58.2	58.3	54.7	56.5

Note: Answer options were "Always", "Usually", "Sometimes", or "Never".

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<sup>72</sup> <https://thlcportal.com/survey>

<sup>73</sup> STAR Kids surveys began in 2018.

<sup>74</sup> NA indicates question was not asked. Not all questions appear on all member surveys, and some questions only appear on alternating year surveys.

<sup>75</sup> STAR Health member survey is not included as several questions had low denominators that impacted the validity of the rates.

**Table 9: Appointment delay due to limited availability (percent responding “Never”)**

Survey respondents	2016	2017	2018	2019	2020
STAR Caregiver	NA	48.9	NA	44.1	NA
STAR Member	50.6	NA	49.9	NA	50.6
STAR+PLUS Member	56.2	NA	57.4	NA	54.0

Note: Answer options were “Always”, “Usually”, “Sometimes”, or “Never”.

**Table 10: Easy to get after hours care (percent responding “Always”)**

Survey respondents	2016	2017	2018	2019	2020
STAR Caregiver	NA	53.5	NA	59.5	NA
STAR Member	44.0	NA	47.4	NA	44.0
STAR+PLUS Member	40.1	NA	39.2	NA	47.1

Note: Answer options were “Always”, “Usually”, “Sometimes”, or “Never”.

**Table 11: Got help with transportation from health plan (of those who called their health plan, percent responding “Always”)**

Survey respondents	2016	2017	2018	2019	2020
STAR Caregiver	NA	50.6	NA	64.8	NA
STAR Member	51.1	NA	48.2	NA	51.1
STAR Kids Caregiver	*	*	61.9	NA	56.0
STAR+PLUS Member	65.0	NA	69.6	NA	66.8

Note: Answer options were “Always”, “Usually”, “Sometimes”, or “Never”.

**Table 12: Need for urgent care (percent responding “Yes”)**

Survey respondents	2016	2017	2018	2019	2020
STAR Caregiver	16.9	26.6	30.1	23.9	16.9
STAR Member	28.9	34.8	34.1	35.5	28.9
STAR Kids Caregiver	*	*	26.3	26.4	17.9
STAR+PLUS Member	47.5	46.0	46.5	46.6	39.0

Note: Answer options were “No” or “Yes”.

**Table 13: Good Access to urgent care (percent responding “Always”)**

Survey respondents	2016	2017	2018	2019	2020
STAR Caregiver	78.0	80.3	78.8	80.4	78.0
STAR Member	65.7	63.2	62.7	66.7	65.7
STAR Kids Caregiver	*	*	81.0	85.7	80.4
STAR+PLUS Member	64.4	66.2	65.6	64.4	65.8

Note: Answer options were “Always”, “Usually”, “Sometimes”, or “Never”.

**Table 14: Visited ED due to limited appointment availability (percent responding “Yes”)**

<b>Survey respondents</b>	<b>2016</b>	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>
STAR Caregiver	NA	43.7	NA	42.7	NA
STAR Member	28.4	NA	32.1	NA	28.4
STAR+PLUS Member	34.3	NA	35.6	NA	31.3

Note: Answer options were “No” or “Yes”.

## **Appendix D. VBP Arrangements to Address SDOH: Evidence-based Interventions or Standardized Models**

Recognizing there may be varying degrees of readiness and capability among MCOs and providers to adopt a VBP arrangement, HHSC recommends a stepwise advancement of APM Categories using the HCP-LAN Framework<sup>76</sup> over a projected time horizon (i.e., progressing over time from APM Category 2, to Category 3, to Category 4 as the payment model for the identified SDOH VBP arrangement). The HCP-LAN APM categories are:

- **APM Category 2:** Fee for Service (FFS) - Link to Quality and Value
  - **2A:** Foundational Payments for Infrastructure and Operations
  - **2B:** Pay-for-Reporting (P4R)
  - **2C:** Pay-for-Performance (P4P)
- **APM Category 3:** APMs built on FFS Architecture
  - **3A:** APMs with Shared Savings
- **APM Category 4:** Population-based Payment
  - **4A:** Condition-Specific Population-based Payment
  - **4B:** Comprehensive Population-based Payment

### **Table 15. SDOH VBP Arrangement 1: IMPaCT CHW Intervention for High-Risk Patients**

In SDOH VBP Arrangement 1, the SDOH evidence-based intervention is the IMPaCT CHWs and Promotor(a)s. MCOs would hire and manage the staff operating the evidence-based intervention. The following table outlines potential examples of APMs associated with this SDOH evidence-based intervention advancing across Categories 2-4 and over a time horizon.

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<sup>76</sup> <https://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf>

<b>APM Subcategory</b>	<b>SDOH Evidence-based Intervention or Standardized Model</b>	<b>Time Horizon</b>
<b>2A:</b> Foundational Payments for Infrastructure and Operations	MCOs pay a “care coordination” fee to the provider to integrate the CHW intervention staff with provider’s care team, including access to provider’s medical records, physical space in the clinical setting as needed, and communication and collaboration with clinical staff.	1-2 Years
<b>2B:</b> P4R	MCOs provide P4R bonuses to providers based on reporting of quality measure data such as SDOH screening process measures, SDOH appropriate action/referrals completion rates, and/or SDOH incidence rates.	1-2 Years
<b>2C:</b> P4P	MCOs provide P4P bonuses to providers based on quality performance such as SDOH screening process measures, SDOH appropriate action/referrals completion rates, ED rates, and/or inpatient hospitalization rates.	1-2 Years
<b>3A:</b> APMs with Shared Savings	Providers share in any realized savings by the MCO based on reduced ED and/or inpatient hospitalization and quality performance such as SDOH screening process measures, SDOH appropriate action/referrals completion rates, and/or SDOH incidence rates.	1-2 Years
<b>4A:</b> Condition-Specific Population-based Payment	MCOs pay a capitated payment (per member per month (PMPM) or global) to Provider to manage care for eligible clients using the evidence-based intervention.	1+ Years
<b>4B:</b> Comprehensive Population-based Payment	MCOs pay a capitated payment (global) or percentage/full premium to Provider to manage care for eligible clients using the evidence-based intervention.	1+ Years

**Table 16. SDOH VBP Arrangement 2: Standardized SDOH Screening**

In SDOH VBP Arrangement 2, the SDOH standardized model is implementation of recommended SDOH screenings for each type of health-related social need. The provider would implement the SDOH screening initiative. The following table outlines potential examples of APMs associated with this SDOH standardized model advancing across Categories 2-4 and over a time horizon such that future steps towards capitation may include social risk adjustments based on the standardized data collected regarding health-related social needs among clients.

<b>APM Subcategory</b>	<b>SDOH Evidence-based Intervention or Standardized Model</b>	<b>Time Horizon</b>
<b>2A:</b> Foundational Payments for Infrastructure and Operations	MCOs would pay a “data infrastructure OR other foundational” fee to the provider to implement the SDOH screening initiative infrastructure and operations.	1-2 Years
<b>2B:</b> P4R	MCOs would provide P4R bonuses to providers based on reporting of quality measure data such as SDOH screening process measures, SDOH appropriate action/referrals completion rates, and/or SDOH incidence rates.	1-2 Years
<b>2C:</b> P4P	MCOs would provide P4P bonuses to providers based on quality performance such as SDOH screening process measures, SDOH appropriate action/referrals completion rates, ED rates, and/or inpatient hospitalization rates.	1-2 Years
<b>3A:</b> APMs with Shared Savings	Providers would share in any realized savings by the MCO based on reduced ED and/or inpatient hospitalization and quality performance such as SDOH screening process measures, SDOH appropriate action/referrals completion rates, and/or SDOH incidence rates.	1-2 Years

<b>APM Subcategory</b>	<b>SDOH Evidence-based Intervention or Standardized Model</b>	<b>Time Horizon</b>
<b>4A:</b> Condition-Specific Population-based Payment	MCOs would pay a capitated payment (PMPM or global) to Provider to manage care for eligible clients incorporating social-risk adjustments using the standardized model.	1+ Years
<b>4B:</b> Comprehensive Population-based Payment	MCOs would pay a capitated payment (global) or percentage/full premium to Provider to manage care for eligible clients incorporating social-risk adjustments using the standardized model.	1+ Years

**Table 17. SDOH VBP Arrangement 3: Food Insecurity – Screen and Intervene**

In SDOH VBP Arrangement 3, the SDOH standardized model is the “screen and intervene” framework for food insecurity. The provider would implement the screening for food insecurity, while MCOs would hire and manage the staff operating appropriate intervention(s) to address identified food insecurity. The following table outlines potential examples of APMs associated with this SDOH standardized model advancing across Categories 2-4 and over a time horizon.

<b>APM Subcategory</b>	<b>SDOH Evidence-based Intervention or Standardized Model</b>	<b>Time Horizon</b>
<b>2A:</b> Foundational Payments for Infrastructure and Operations	MCOs pay a “care coordination” fee to the provider to integrate the appropriate intervention staff with provider’s care team, including access to provider’s medical records, physical space in the clinical setting as needed, and communication and collaboration with clinical staff.	1-2 Years
<b>2B:</b> P4R	MCOs provide P4R bonuses to providers based on reporting of quality measure data such as food insecurity screening process measures, appropriate action/referral completion rates, and/or food insecurity incidence rates.	1-2 Years

<b>APM Subcategory</b>	<b>SDOH Evidence-based Intervention or Standardized Model</b>	<b>Time Horizon</b>
<b>2C:</b> P4P	MCOs provide pay-for-performance bonuses to providers based on quality performance such as food insecurity screening process measures, appropriate action/referral completion rates, ED rates, inpatient hospitalization rates, and/or disease-specific clinical outcomes and intermediate outcomes.	1-2 Years
<b>3A:</b> APMs with Shared Savings	Providers share in any realized savings by the MCO based on reduced ED and/or inpatient hospitalization and quality performance such as food insecurity screening process measures, appropriate action/referral completion rates, food insecurity incidence rates, and/or disease-specific clinical outcomes and intermediate outcomes.	1-2 Years
<b>4A:</b> Condition-Specific Population-based Payment	MCOs pay a capitated payment (PMPM or global) to Provider to manage care for eligible clients incorporating food insecurity-risk adjustments using the standardized model.	1+ Years
<b>4B:</b> Comprehensive Population-based Payment	MCOs pay a capitated payment (global) or percentage/full premium to Provider to manage care for eligible clients incorporating food insecurity-risk adjustments using the standardized model.	1+ Years