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# **DSRIP Partner Engagement Quarterly Meeting**

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**December 11, 2020**

# Reminders

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- To ensure the meeting runs smoothly, webinar attendees are muted
- We will break after each topic to answer questions
- If an attendee has a question or comment during the webinar, please write your question in the webinar question box



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# Agenda

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- DSRIP Extension and 1115 Waiver Extension Requested
- Milestone Updates
  - Rider 38 Report Highlights
  - DY11 Program Options
  - Assessment of Social Factors
  - Telehealth Findings
  - Other Milestone progress



# 1115 Transformation Waiver Extension Requested

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- A “Fast Track” extension application for the Texas Healthcare Transformation Quality Improvement Program (THTQIP) 1115 waiver was submitted to CMS on November 30, 2020. The extension request is for 5 years, which will provide the 1115 waiver authority through September 30, 2027.
- There are no significant policy changes requested under this extension application.
- There is no DSRIP pool in the waiver extension request. DSRIP transition work will continue.



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# DSRIP Extension Requested

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- On October 16, 2020, HHSC submitted a request to CMS to extend the DSRIP program with \$2.49 billion in continued funding for the final demonstration year of the current 1115 Healthcare Transformation Waiver.
- HHSC is awaiting response from CMS.
- HHSC continues to work on DSRIP Transition Plan deliverables and plan for DY 11 new programs.



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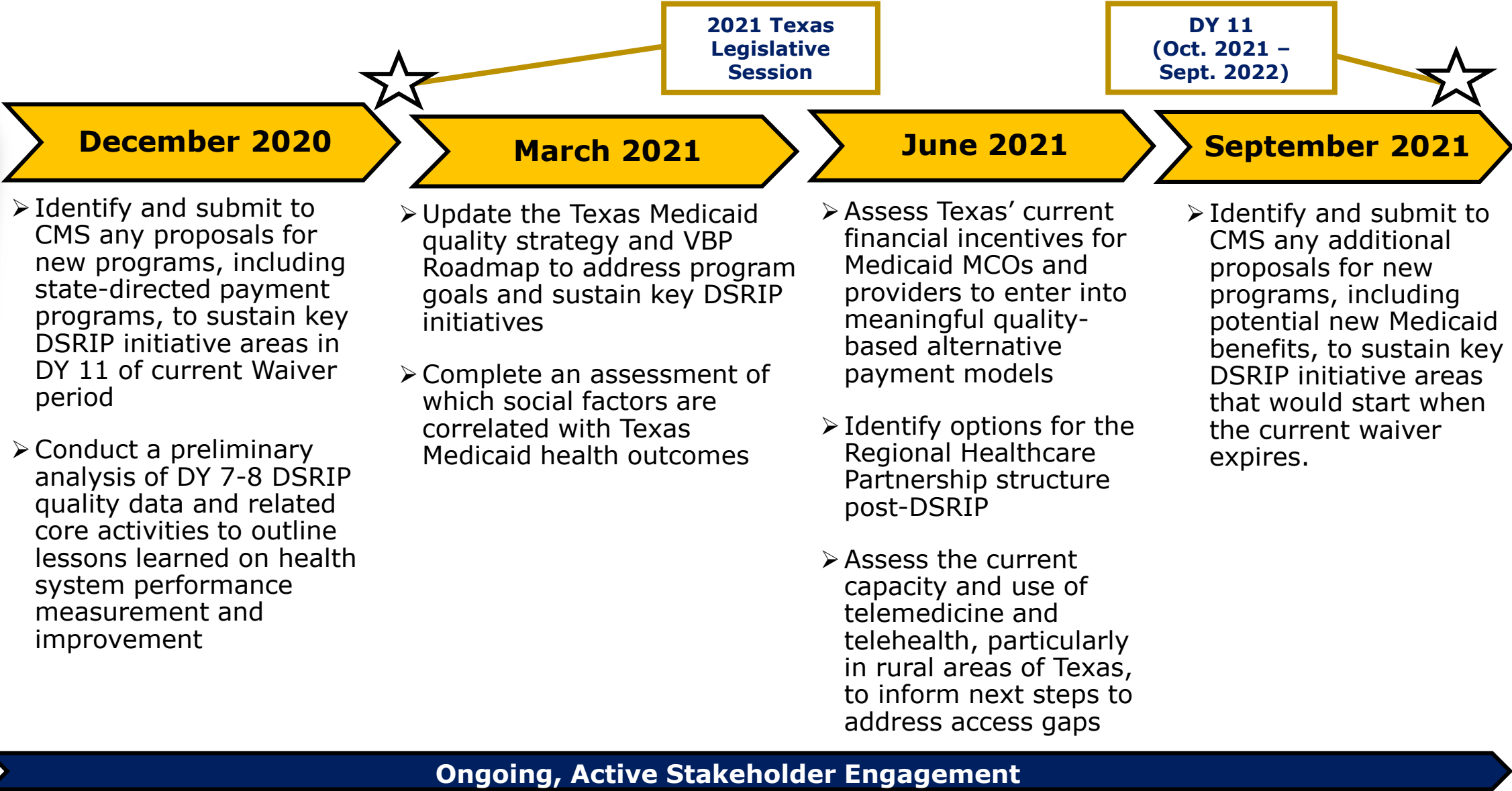


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# Milestone Updates

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# Transition Plan Milestones



Ongoing, Active Stakeholder Engagement

# Goal: Support Further Delivery System Reform

## Deliverable:

Analysis of DY 7-8 DSRIP quality data.

## Progress:

- Report was submitted to the Legislature as the Rider 38 Report on December 1 and is available on the [HHS Reports and Presentations webpage](#).
- Report is on target to submit to CMS as the milestone deliverable.



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# Rider 38 Report Highlights I

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## Core Activities

Core Activities are implemented by providers to achieve their measure goals. The most commonly selected core activities were:

- Access to Primary Care Services - Provision of screening and follow-up services (56 selections);
- Chronic Care Management - Management of targeted patient populations with high risk for developing complications (45 selections); and,
- Chronic Care Management - Utilization of care management and/or chronic care management services (43 selections).



# Rider 38 Report Highlights II

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## Performance Measurement

The Category C measures most commonly selected by DSRIP providers for DYs 7-8 were:

- Tobacco screening and cessation intervention
- Diabetes foot exam
- Diabetes hemoglobin A1c (HbA1c) poor control
- Body Mass Index (BMI) screening and follow-up
- Diabetes blood pressure control
- Pneumonia vaccination status for older adults
- Documentation of current medications in the medical record



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# Rider 38 Report Highlights III

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## Performance Measurement

- Providers reported data for 2,364 pay-for-performance (P4P) measures for calendar year 2019. Of these, providers reported:
  - 100 percent achievement of the DY 8 goal for 77 percent of measures
  - Partial achievement for 9 percent of measures
  - No achievement for 14 percent of measures
- In 2019, most P4P measures showed an increase in the median performance rate reported by providers as compared to 2017, indicating improvement overall in provider performance on reported measures.



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# Rider 38 Report Highlights IV

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## Core Activities Associated with High Performance

The 5 Core Activities associated with the greatest number of high-performing P4P measures are:

- Provision of care aligned with the Certified Community Behavioral Health Clinic (CCBHC) model
- Provision of screening and follow-up services
- Utilization of care management and/or chronic care management services, including education in chronic disease self-management
- Management of targeted patient populations; e.g., patients with chronic disease



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# Rider 38 Report Highlights V

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## Core Activities Associated with High Performance

- Provision of services to individuals that address social determinants of health.



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# Rider 38 Report Highlights VI

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## Summary of Final Costs and Savings Analyses

In October 2019, providers with a valuation of \$1 million or more submitted their Cost and Savings analyses as required under Category A reporting. Of the 203 completed analyses:

- 86 percent showed that investment in Core Activities produced a positive return on investment (ROI) to the healthcare system
- 13 percent showed that investment in Core Activities did not produce a positive ROI
- 1 percent showed that the savings generated by Core Activities were equal to the costs associated with implementing it



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# Rider 38 Report Highlights VII

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## **Core Activities Associated with a Positive ROI**

The types of Core Activities that reported a positive ROI varied significantly among providers.

- At least 35 percent of Core Activities with a positive ROI provided care management and other services to individuals with chronic conditions, predominately diabetes;
- At a minimum, 16 percent of Core Activities with a positive ROI addressed individuals' behavioral health service needs; and,
- 13 percent managed the care of individuals who had frequent visits to emergency departments (EDs).



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# Rider 38 Report Highlights VIII

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## Funding

- For DYs 1-5 (12/12/2011-9/30/2016) a total of \$11.4 billion was made available to approximately 300 providers.
- For DYs 6-10 (10/1/2016 through 9/30/2021), an additional \$14.7 billion dollars was made available to providers.
- As of July 2020, DSRIP providers received a total of approximately \$3.0 billion in DSRIP funds for DY 7 and \$2.6 billion for DY 8.



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# Goal: Support Further Delivery System Reform

## Deliverable:

Summary of analysis of options for new programs for DY11.

## Progress:

- Options for DY11 New Programs are on-track for December 31 submission to CMS.
- HHSC is finalizing fiscal estimates and drafting rules. Public comment period on rules will begin in January 2021.
- Intergovernmental Transfers (IGT) are assumed as the state match.
- Options are contingent on budget neutrality room.



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# DY 11 Program Options I

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## Potential DY 11 Program Proposals

1. Texas Incentives for Physician and Professional Services (TIPPS)
2. Comprehensive Hospital Increased Reimbursement Program (CHIRP)
3. Directed Payment Program for Behavioral Health Services
4. Rural Access to Primary and Preventive Services (RAPPS)
5. Local Health Department Participation in the Uncompensated Care Program
6. Public Health and Related Services (PHARS)



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# DY 11 Program Options II

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

<b>Target Beneficiaries</b>	Adults and children enrolled in STAR, STAR+PLUS, and possibly STAR Kids
<b>Participating Providers</b>	Physician practice groups
<b>Max Funding Estimate</b>	\$500 million annually in All Funds at estimated Average Commercial Rate; actual amount will be identified through the DPP approval process with CMS

The TIPPS program would be a new value-based DPP. Three classes of physician practice groups would be eligible to participate:



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# DY 11 Program Options III

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

- Physician groups affiliated with a health-related institution (HRI);
- Physician groups affiliated with a hospital receiving the indirect medical education add-on (IME); and
- Other physician practice groups that are not HRI or IME (Other).

Physician practice groups would need to serve a minimum volume of Medicaid Managed Care members to be eligible.



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# DY 11 Program Options IV

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

The program would have 3 components:

- Component 1: a per-member-per-month (PMPM) payment tied to requirements to implement quality improvement activities. HRIs and IMEs are eligible for Component 1.
- Component 2: a uniform rate enhancement based on achievement of quality metrics focused on primary care and chronic care. HRIs and IMEs are eligible for Component 2.



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# DY 11 Program Options V

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

- Component 3: a rate enhancement for certain outpatient services based on achievement of quality metrics focused on maternal health, chronic care, and social drivers of health. All physician practice groups are eligible for Component 3.



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# DY 11 Program Options VI

## Comprehensive Hospital Increased Reimbursement Program (CHIRP)

<b>Target Beneficiaries</b>	Adults and children enrolled in STAR and STAR+PLUS
<b>Participating Providers</b>	Hospitals
<b>Funding Estimate</b>	To be determined

- CHIRP is an update to the current Uniform Hospital Rate Increase Program (UHRIP).
- Component 1 (UHRIP): provides a uniform rate enhancement.



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# DY 11 Program Options VII

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## Comprehensive Hospital Increased Reimbursement Program (CHIRP)

- Component 2 (Average Commercial Incentive Award [ACIA]): allows participating providers to earn higher reimbursement rates based upon a percentage of the estimated average commercial reimbursement.



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# DY 11 Program Options VIII

## Directed Payment Program for Behavioral Health Services

<b>Target Beneficiaries</b>	Adults and children enrolled in STAR, STAR+PLUS, and STAR Kids
<b>Participating Providers</b>	Community Mental Health Centers (CMHCs)
<b>Funding Estimate</b>	Finalizing fiscal modeling based on CMS-approved CCBHC cost report rate methodology

This DPP would continue to support the state's CMHCs as they transition to the CCBHC model of care. This program would have two components:



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# DY 11 Program Options IX

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## Directed Payment Program for Behavioral Health Services

- Component 1: a uniform dollar increase issued in monthly payments to all CMHCs participating in the program, recognizing progress made toward certification or maintenance of CCBHC status and focusing on access and quality improvements.
- Component 2: a uniform percent increase on CCBHC services based on achievement of quality metrics that align with CCBHC measures and goals.



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# DY 11 Program Options X

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

<b>Target Beneficiaries</b>	Adults and children enrolled in STAR, STAR+PLUS, and STAR Kids
<b>Participating Providers</b>	Rural Health Clinics (RHCs)
<b>Max Funding Estimate</b>	\$18.7 million annually in All Funds at estimated Medicare rates



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The DPP for RHCs would incentivize primary and preventive services for Medicaid-enrolled individuals in rural areas. Two classes of RHCs would be eligible to participate:

# DY 11 Program Options XI

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

- Hospital-based RHCs, including non-state government owned and private RHCs, and
- Free-standing RHCs.

RHCs would apply for the program and must serve a minimum volume of Medicaid managed care members to participate.



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# DY 11 Program Options XII

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

There would be two program components:

- Component 1: a uniform dollar increase in the form of prospective, monthly payments to all participating RHCs to enhance structures that promote better access to primary and preventive services.
- Component 2: a uniform percent rate increase for certain services based on achievement of quality metrics focused on preventive care and screening and management of chronic conditions.
- Both classes of RHCs would be eligible for both components.



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# DY 11 Program Options XIII

## Local Health Department Participation in the Uncompensated Care Program

<b>Target Beneficiaries</b>	Individuals qualifying for charity care services at Local Health Departments
<b>Participating Providers</b>	Local Health Departments (LHDs)
<b>Max Funding Estimate</b>	Estimated unspent funding available in FFY 2022: \$100 million in All Funds

- The program would add LHDs as an eligible provider to the Uncompensated Care (UC) program.



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# DY 11 Program Options XIV

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## Local Health Department Participation in the Uncompensated Care Program

- LHDs would earn matching federal funds for eligible charity care expenses from the UC pool that reimburses providers for the cost of care to the uninsured.
- To participate, LHDs would create a Charity Care Policy and produce cost reports. Charity Care policies require assessing clients' insurance status and ability to afford services rendered.



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# DY 11 Program Options XV

## Public Health and Related Services (PHARS)

<b>Target Beneficiaries</b>	Individuals receiving Medicaid services at Local Health Departments
<b>Participating Providers</b>	Local Health Departments (LHDs)
<b>Funding Estimate</b>	To be Determined

- LHDs would certify expenditures for eligible Medicaid services provided to Medicaid-enrolled individuals. LHDs would submit cost reports and fulfill other program requirements based on the parameters developed by HHSC.





# DY 11 Program Options XVI

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## Public Health and Related Services (PHARS)

- The program would provide LHDs the federal share of the costs related to eligible Medicaid services provided to Medicaid-enrolled individuals.
- Payments under this program would not be made through Medicaid managed care organizations (MCOs). However, HHSC is simultaneously working to promote LHD participation in Medicaid managed care.



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# DY 11 Program Options XVII

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## Stakeholder Engagement

- HHSC has engaged stakeholders of the specific provider groups affected by the proposals over the past few months. Stakeholders have provided feedback on:
  - Quality Objectives
  - Program Structure
  - Feasibility
- Hearings specific to rules and potential measures for the DPP programs will occur in January.



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# Goal: Develop Cross-Focus Areas

## Deliverable:

Assessment of social factors correlated with Texas Medicaid health outcomes

## Progress:

- **SDOH Focus Study** - The contracted assessment of social determinants of health (SDOH) for Texas Medicaid children and adolescents, pregnant women, and adults is drafted and under review by HHSC.
- **SDOH Expert Panel Report** – The draft report, synthesizing SDOH Expert Panel discussions with evidence-based policy considerations for Texas Medicaid, is under review by HHSC.



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# SDOH Focus Study

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- The University of Texas School of Public Health (subcontractor of the Texas Medicaid EQRO) evaluated the association between a comprehensive set of **24 SDOH variables** and key health care quality measures for three Medicaid managed care populations in 2018:
  1. **Children and adolescents** (10 quality measures),
  2. **Pregnant women** (3 quality measures), and
  3. **STAR+PLUS adults** (11 quality measures).



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# SDOH Expert Panel Report

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- From August to October 2020, the Center for Health Care Strategies, with support from the Episcopal Health Foundation, convened an SDOH Expert Panel (9 members) to provide input on select SDOH topics:
  - screening
  - quality measures
  - VBP arrangements
  - managed care contracting
  - evidenced-based interventions



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# Goal: Strengthen Supporting Infrastructure

## Deliverable:

Assessment of telemedicine and telehealth capacity, particularly in rural areas of Texas

## Progress:

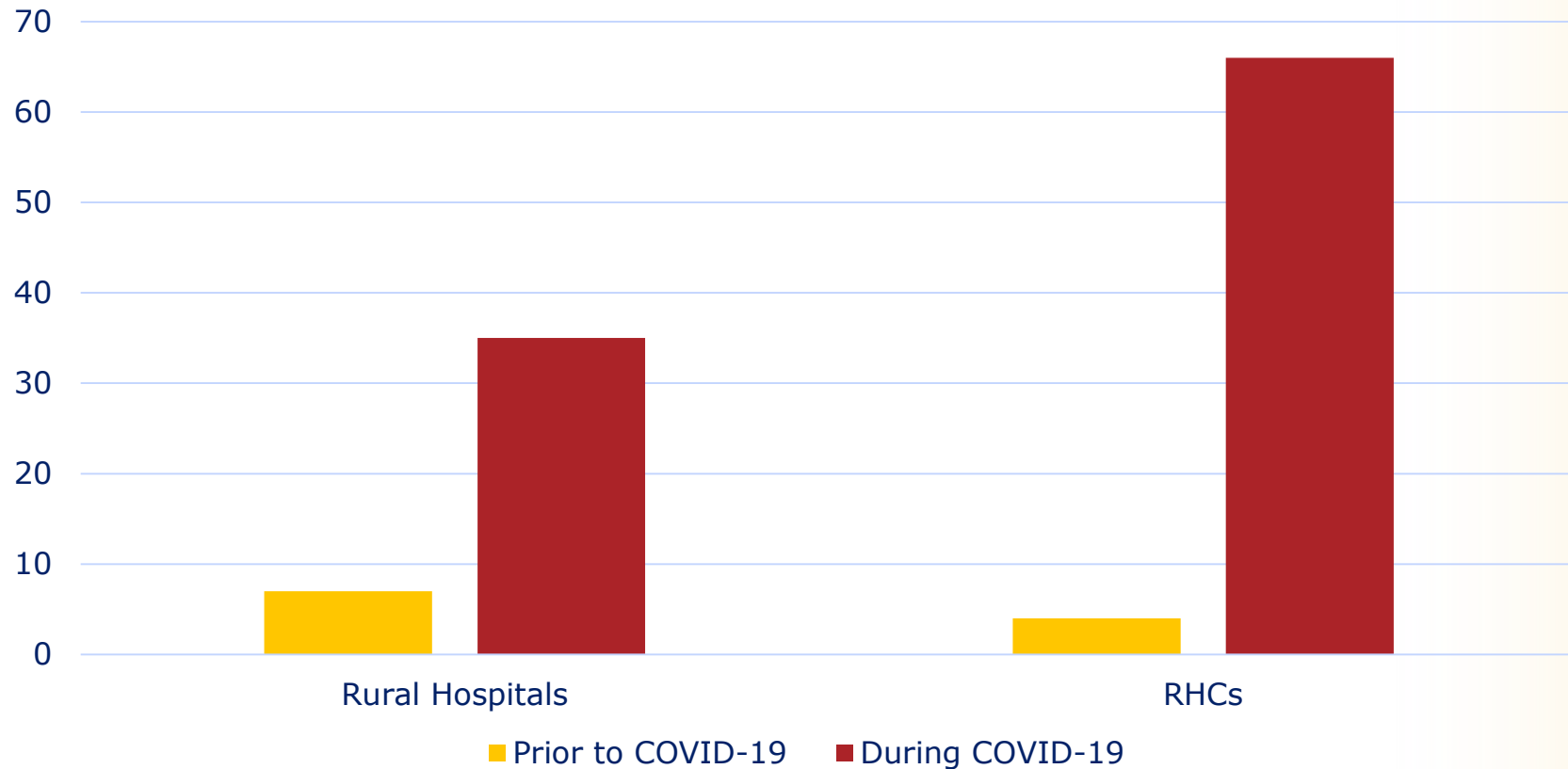
- HHSC is analyzing telemedicine utilization data in Medicaid and CHIP.
- HHSC presented the findings of the second survey at the State Medicaid Managed Care Advisory Committee (SMMCAC) Network Adequacy and Access to Care Subcommittee meeting and e-Health Advisory Committee meeting.



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# Telemedicine and Telehealth

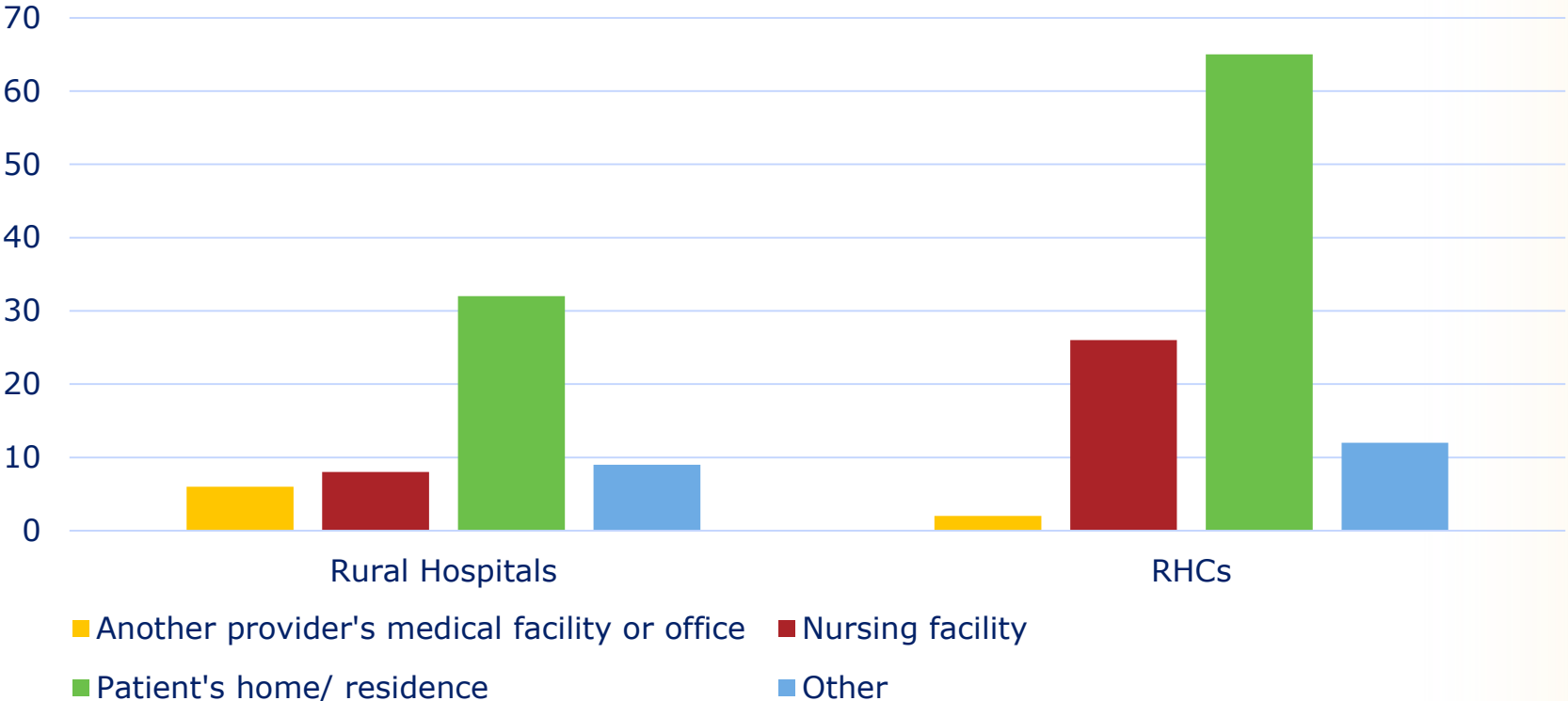
Rural Hospitals and RHCs Providing Telemedicine/  
Telehealth Services prior to COVID-19 and during  
COVID-19



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# Telemedicine and Telehealth

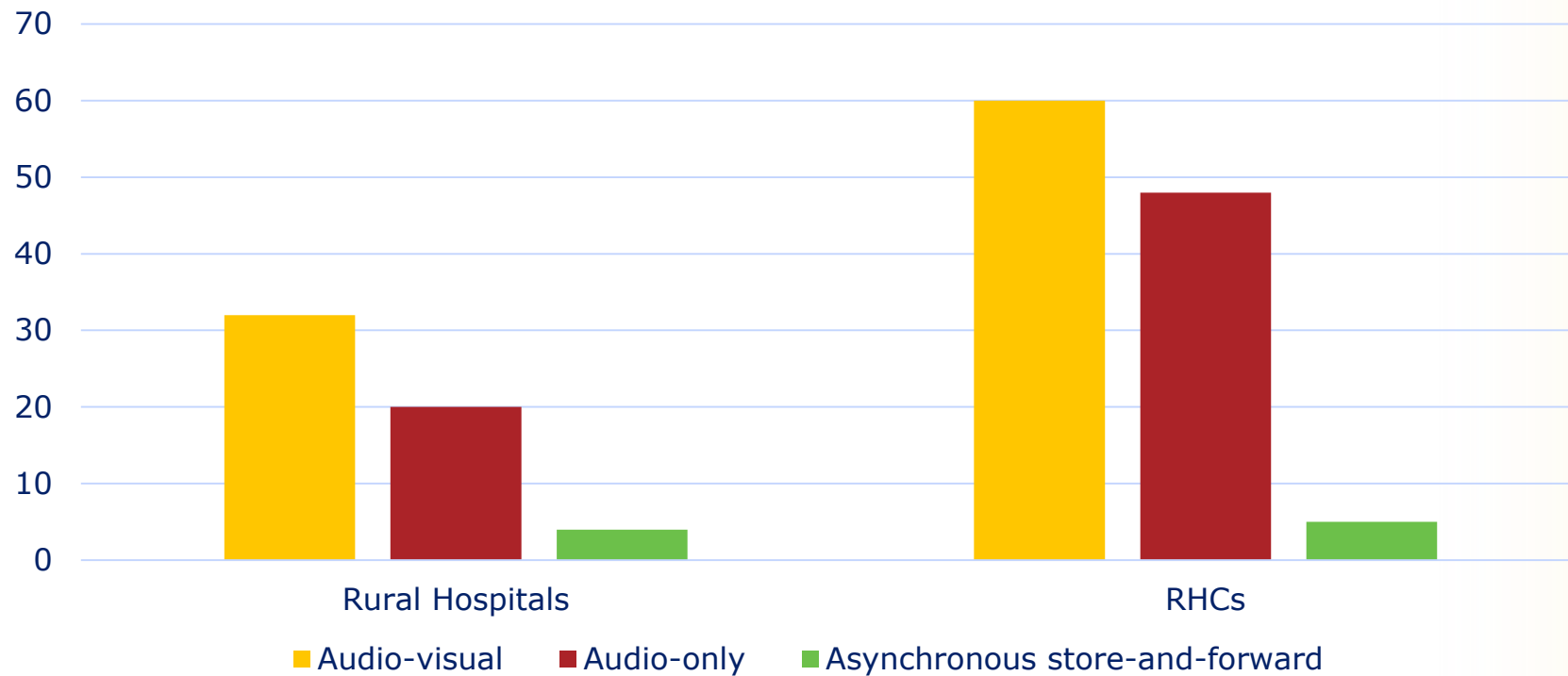
Rural Hospitals and RHCs Providing Telemedicine/  
Telehealth Services to Patients at Each Type of  
Patient Site during COVID-19



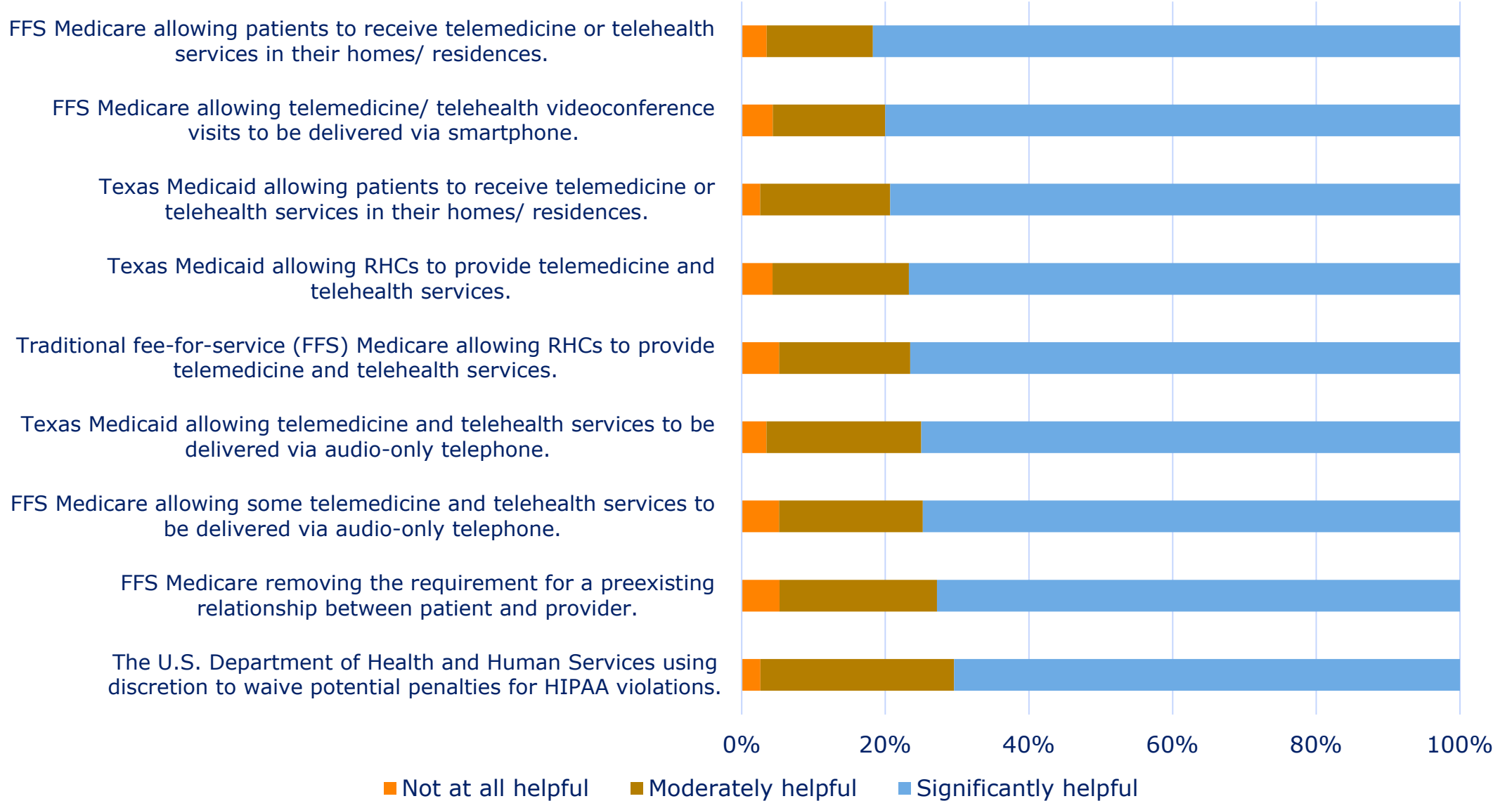


# Telemedicine and Telehealth

Rural Hospitals and RHCs Providing Telemedicine/  
Telehealth Services via Each Modality during  
COVID-19



# Telemedicine and Telehealth



# Goal: Advance APMs to Promote Healthcare Quality

## Deliverable:

Updated Texas Medicaid Quality Strategy, Texas VBP Roadmap, and MCO APM rates for each available measurement year

## Progress:

- The current Quality Strategy and an overview of planned changes were presented to the Medical Care Advisory Committee (MCAC) in November.
- A draft Quality Strategy will be posted for a 30-day public comment period.
- In the new year, a draft VBP Roadmap will be shared with the VBPQI Advisory Committee for feedback.



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# Goal: Explore Innovative Financing Models

## Deliverable:

Assessment of financial incentives for MCOs and providers in managed care, and additional guidance for allowable Quality Improvement (QI) costs.

## Progress:

- HHSC collected feedback from MCOs and DSRIP Providers regarding APMs and has analyzed the data and will synthesize the results and other research into the assessment.
- HHSC surveyed MCOs regarding their questions on QI costs and is drafting guidance to clarify federal code.



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# Goal: Strengthen Supporting Infrastructure

## Deliverable:

Options to maintain regional stakeholder collaboration for sustaining delivery system reform.

## Progress:

- Incorporating feedback from anchors and DSRIP providers, HHSC is assessing options for regional support structures that could be beneficial for collaboration and providing technical support for participants in the new proposed directed payment programs.



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# Goal: Support Further Delivery System Reform

## Deliverable:

Summary of analysis of options for new programs that could be implemented under an 1115 demonstration waiver or other authority.

## Progress:

- We are shifting focus and resources to developing options for when the current waiver expires. Ideas under exploration include targeted benefits for individuals served by DSRIP, regional-focused population health programs, Medicaid policy or benefit changes.



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# Questions and Feedback

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**Emily Sentilles, *Director, Healthcare Transformation Waiver Team***  
**Medicaid and CHIP Services**



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**Thank you**

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