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DSRIP Transition Partner Engagement & Executive Waiver Committee Quarterly Meeting

June 22, 2021

Reminders

- To ensure the meeting runs smoothly, webinar attendees are muted
- 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

- 1115 Waiver Extension
- DSRIP Operational Update
- DSRIP Transition Plan Milestone Updates
- DPP Updates
- Differences between DPPs and DSRIP

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1115 Waiver Extension

Brittani Bilse, *Director of Healthcare Transformation Waiver Strategy*, Medicaid and CHIP Services

1115 Transformation Waiver Extension

- HHSC plans to submit a request to extend and amend the Texas Healthcare Transformation Quality Improvement Program waiver under section 1115 of the Social Security Act to CMS.
- The draft application reflects the same terms and conditions agreed to and approved by CMS on Jan. 15, 2021.
- Public notice was published in the May 28, 2021, issue of the Texas Register.
- Public hearings (in person and/or virtual) were held on June 2, June 10, and June 15.

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Public Comment

U.S. Mail

Texas Health and Human Services Commission

Attention: Basundhara Raychaudhuri, Waiver Coordinator, Policy Development Support

PO Box 13247

Mail Code H-600

Austin, Texas 78711-3247

Public Comment (cont.)

Email

- TX_Medicaid_Waivers@hhsc.state.tx.us

Telephone

- 512-487-3318

Fax

- Attention: Basundhara Raychaudhuri, Waiver Coordinator, at 512-206-3975

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DSRIP Operational Update

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April Reporting (DY10)

- 73% providers eligible to report Category B in April earned 100% achievement, many because of approved COVID-19 accommodations.
- In the Category C outcome measures, DSRIP participating providers reported Performance Year 3 for 95% of pay-for performance measures.
  - Of those measures that reported third year of performance data, 83% of measures received 100% payment, many because of approved COVID-19 accommodations.
- 86.4% of Category D metrics were reported in April; 97.82% earned 100% achievement.

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April Reporting (cont'd)

- Providers were approved for $2.48 billion in DSRIP payments for DY8-10. Actual payments will be based on IGT submitted in July 2021.
  - For April 2021 reporting, this will be the largest DSRIP payment to date.

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DSRIP Transition Plan Milestone Updates

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Transition Plan Milestones

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2021 Texas Legislative Session Begins

DY 11 (Oct 2021 – Sept 2022)

December 2020

- Identify and submit to CMS any proposals for new programs, including state-directed payment programs, to sustain key DSRIP initiative areas in DY 11 of current Waiver period
- Conduct a preliminary analysis of DY 7-8 DSRIP quality data and related core activities to outline lessons learned on health system performance measurement and improvement

March 2021

- Update the Texas Medicaid quality strategy and VBP Roadmap to address program goals and sustain key DSRIP initiatives
- Complete an assessment of which social factors are correlated with Texas Medicaid health outcomes

June 2021

- Assess Texas' current financial incentives for Medicaid MCOs and providers to enter into meaningful quality-based alternative payment models
- Identify options for the Regional Healthcare Partnership structure post-DSRIP
- Assess the current capacity and use of telemedicine and telehealth, particularly in rural areas of Texas, to inform next steps to address access gaps

September 2021

- Identify and submit to CMS any additional proposals for new programs, including potential new Medicaid benefits, to sustain key DSRIP initiative areas that would start when the current waiver expires.

Ongoing, Active Stakeholder Engagement

Completed Deliverables

Submitted in December 2020:

- **Report** on analysis of Demonstration Year (DY) 7-8 DSRIP quality data and related core activities.
- **Proposals** for new programs, including state-directed payment programs, to sustain key DSRIP initiative areas in DY 11

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Completed Deliverables

Submitted in March 2021:

- Updated **Texas Medicaid Managed Care Quality Strategy**
- **Value-Based Payment (VBP) Roadmap** and **report** of managed care organizations' alternative payment model achievement
- **Assessment of Social Factors impacting Health Care Quality in Texas Medicaid**
  - Texas Medicaid Managed Care SDOH **Focus Study** and **Addendum**

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Imminent Deliverables

Due to CMS June 30, 2021:

- Assessment of Incentives for Alternative Payment Models report and Guidance for MCOs on Quality Improvement Cost Reporting
- Assessment of Telemedicine and Telehealth report
- Options for the RHP Structure Post-DSRIP report

Due to CMS September 30, 2021:

- Summary of analysis of options for new benefits and programs for Demonstration Year 12 and beyond.

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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:

- Guidance for MCOs to encourage their use of Quality Improvement flexibilities in the MCO contract and a report assessing financial incentives for APMs are under final reviews.
- The deliverables are on schedule for submission to CMS by June 30, 2021.

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Goal: Strengthen Supporting Infrastructure

Deliverable:

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

Progress:

- The main themes and findings of the assessment were presented at the Statewide Medicaid Managed Care Advisory Committee Network Adequacy and Access to Care Subcommittee meeting on May 26.
- The assessment is on schedule for timely submission to CMS by June 30, 2021.

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Goal: Strengthen Supporting Infrastructure (cont)

Deliverable:

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

Progress:

- In DY11, DSRIP anchor entities will continue to support participating providers in completing DY10 reporting.
- DY11 will be a transition year for the function. HHSC is developing options for the scope of future regional coordinating entities focused on DY12 new program options.
- The deliverable is on schedule for submission to CMS by June 30, 2021.

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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:

- HHSC continues to explore options for DY12 and is on schedule for submission to CMS by September 30, 2021.

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Directed Payment Program Updates

DY 11 Programs

Proposed DY 11 New Directed Payment Programs

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

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Directed Payment Programs

- Texas submitted preprints to CMS requesting approval for all programs.
    - HHSC has received and is addressing questions from CMS on each program.
- Provider Enrollment: the application period has ended for all four programs and providers were notified of eligibility status.
- IGT: the IGT calls for the four programs have been completed.
- Implementation: HHSC is working with MCOs on implementation details for the programs.

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Directed Payment Programs (cont)

- Planning: HHSC will collaborate with stakeholders to discuss and propose future program year requirements, including goals for performance measures.

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Differences between DSRIP and DPPs

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DPP vs. DSRIP: Nuts and Bolts

Directed Payment Programs	DSRIP
Title 42 Code of Federal Regulations (CFR) § 438.6(c)	1115 Healthcare Transformation and Quality Improvement Waiver
Annual approval by CMS for rate enhancements. Multi-year approval for exclusively value-based DPP. Each new DPP for DY 11 requires annual approval.	One-time approval for a multi-year program.
Payments must be tied to Medicaid managed care service utilization. In TIPPS and DPP BHS, payments based on utilization are also triggered by quality achievement.	Payments are not reimbursements for services. Payments are based on demonstrated achievement of metrics and outcome measures.
Payments are tied to a rating period, which is the state fiscal year, and are made from the MCO to the provider.	Payments can be earned in the DY or carried-forward to be earned in the next DY. Payments are made directly from HHSC to the provider.

DPP vs. DSRIP: Nuts and Bolts (cont)

Directed Payment Programs	DSRIP
Unearned funds are unavailable to the provider and redistributed to other providers or may be kept by the MCO as part of their premium payment, depending on the program.	Unearned funds can be carried forward and the state share of recoupments are returned to the IGT entity.
Providers apply annually to participate in the program. In the first year of RAPPS and DPP BHS, there will be an opportunity for providers to apply to start participation mid-year.	Providers applied in the first year and participated for 10 years unless a region had additional funds for new providers to begin in the third or seventh year.
All providers within a provider class must be held to the same requirements.	Providers able to customize projects and measures based on an approved menu of activities and measures.

DPPs vs. DSRIP: Provider Type

CHIRP	TIPPS	RAPPS	DPP BHS	DSRIP
Hospitals: • Children's Hospitals • Rural Hospitals • State-owned Non-IMD Hospitals • Urban Hospitals • Non-state-owned IMDs • State-owned IMDs	**Physician Groups**: • Health-Related Institution (HRI) • Indirect Medical Education (IME) physician group • Other physician group (Other)	**Rural Health Clinics:** • Hospital-based RHCs (public & private) • Freestanding RHCs	**Behavioral Health Providers:** • Community Mental Health Center (CMHC)	**Various Providers:** • Hospitals (public and private) • Physician Practices, primarily associated with AHSCs • CMHCs • Local Health Departments

DPPs vs. DSRIP: Managed Care Programs & DPP Eligibility

CHIRP	TIPPS	RAPPS	DPP BHS	DSRIP
STAR, STAR+PLUS	STAR, STAR+PLUS, STAR Kids	STAR, STAR+PLUS, STAR Kids	STAR, STAR+PLUS, STAR Kids	NA
In SDA with IGT Entity	Served 250 Medicaid managed care members; in SDA with IGT Entity	30 Medicaid managed care encounters; in SDA with IGT Entity	NA	Must have IGT Entity for each DSRIP provider, project, and measure.

DPP vs. DSRIP: Available Funding Calculations

CHIRP	TIPPS	RAPPS	DPP BHS	DSRIP
Total potential funding amount is determined by available budget neutrality room AND the difference between the Medicaid reimbursement and a **comparison rate** that results in Medicaid reimbursement that is "reasonable and appropriate"				DSRIP's total funding pool was determined by available budget neutrality room and was based on CMS approval.
UHRIP Component: Medicare ACIA Component: Average Commercial Reimbursements	Average Commercial Reimbursement	Medicare	Cost-report based reimbursement established for the Certified Community Behavioral Health Clinic model	

DPPs vs. DSRIP: Size and State Share (Note 1)

CHIRP	TIPPS	RAPPS	DPP BHS	DSRIP
$5.0 billion	$600 million	$18.7 million	$165.6 million	$2.49 billion in final Demonstration Year. Max of $3.1 billion in previous years
IGT by SDA. Collected in advance of MCO premium rate setting.				IGT by provider and governmental entity affiliation in RHP. Collected at the time earned payment is calculated.

Note 1: amounts listed in the table reflect estimates included in the pre-print

DPPs vs. DSRIP: Program Structure & Quality Requirements (1 of 2)

CHIRP	RAPPS
Component 1: Uniform Hospital Rate Increase Program (UHRIP) • 2 structure measures reported as a condition of participation (RCP) semi-annually • Participating hospitals must participate in UHRIP and may opt to also participate in ACIA Component 2: Average Commercial Incentive Award (ACIA) – ACR gap • 6 modules based on hospital service type, measures RCP – max 4 structure measures, 7 data-based measures reported semi-annually • Hospitals that are not eligible for any ACIA measures based on volume are still eligible to participate in ACIA and no reporting will be required	Component 1: structure measures for primary and preventative services • 3 structure measures RCP semi-annually Component 2: reporting on process measures (setting baseline only in first year – no achievement required) • 2 Improvement Over Self (IOS) measures RCP baselines (6 months, CY2021)

DPPs vs. DSRIP: Structure and Quality Requirements (2 of 2)

TIPPS	DPP BHS	DSRIP
Component 1 for HRIs and IMEs: • 8 structure measures RCP Component 2: quality achievement for HRIs and IMEs • Reporting on process and outcome measures; payment increase tied to achievement on 75% benchmark measures for 100% payment, 50% for 75% payment, 25% for 50% payment Component 3: quality achievement for HRIs, IMEs, and Other • Reporting on process and outcome measures; payment tied to achievement on 50% of benchmark measures	Component 1: • 4 structure measures RCP Component 2: • 3 IOS measures RCP baselines; • 3 benchmark measures – CY2021 meet or exceed national benchmark (50th percentile for 2 measures, 25th percentile for 1 measure) for at least 1 benchmark measure for 100% payment	Category A: • RCP on Core Activities, Collaborative Activities, Costs & Savings, and Alternative Payment Models Category B: • Maintenance or increase in Medicaid and low-income or uninsured patient population Category C: • Reporting on and achievement of provider's selected outcome measure bundles or measures Category D: • Reporting on Statewide Reporting Measure Bundle

DPPs vs. DSRIP: Payment Structure

CHIRP	TIPPS	RAPPS	DPP BHS	DSRIP
Uniform rate increase paid out on adjudicated claims for inpatient and outpatient services	T1: Monthly lump sum based on historical utilization with reconciliation T2: Semi-annual lump sum based on historical utilization T3: Uniform rate increase on certain services paid on adjudicated claims, triggered by quality achievement	R1: Monthly lump sum based on historical utilization with reconciliation R2: Uniform rate enhancement paid on specific adjudicated claims.	B1: Monthly lump sum based on historical utilization with reconciliation B2: Uniform rate increase on certain services paid on specific adjudicated claims, triggered by quality achievement	Twice per year – January and July

DPPs vs. DSRIP: Rules

CHIRP	TIPPS	RAPPS	DPP BHS	DSRIP
Texas Administrative Code (TAC) §353.1305 - 353.1307	TAC §353.1309, §353.1311	TAC §353.1315, §353.1317	TAC §353.1320, §353.1322	TAC §355.8203-8206, §355.8216, §355.8218

Questions

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Thank you

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Appendix

TIPPS - Component 1 Measures

Measure ID	Measure Name	Measure Type
T1-101	Patient-Centered Medical Home (PCMH) Accreditation and Recognition Status	Structure
T1-102	Same-day, walk-in, or after-hours appointments in the outpatient setting	Structure
T1-103	Care team includes personnel in a care coordination role not requiring clinical licensure	Structure
T1-104	Pre-visit planning and/or standing order protocols	Structure
T1-105	Patient education focused on disease self-management	Structure
T1-106	Identification of pregnant women at-risk for Hypertension, Preeclampsia, or Eclampsia; treatment based and follow-up	Structure
T1-107	Health Information Exchange (HIE) participation	Structure
T1-108	Telehealth to provide virtual medical appointments and/or consultations for specialty services, including both physical health and behavioral health services	Structure

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TIPPS – Component 2 Measures

Measure ID	Measure Name	Measure Type
T2-109	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	Process
T2-110	Cervical Cancer Screening	Process
T2-111	Childhood Immunization Status	Process
T2-112	Immunization for Adolescents	Process
T2-113	Preventive Care and Screening: Screening for Depression and Follow-Up Plan	Process
T2-114	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) testing	Process
T2-115	Preventive Care and Screening: Influenza Immunization	Process
T2-116	Tobacco Use and Help with Quitting Among Adolescents	Process
T2-117	Chlamydia Screening in Women	Process
T2-118	Controlling High Blood Pressure	Outcome

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TIPPS – Component 3 Measures

Measure ID	Measure Name	Measure Type
T3-119	Food Insecurity Screening	Process
T3-120	Maternity Care: Post-Partum Follow-Up and Care Coordination	Process
T3-121	Behavioral Health Risk Assessment for Pregnant Women	Process
T3-122	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	Outcome
T3-123	Depression Response at Twelve Months	Outcome
T3-124	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	Process

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CHIRP Measures (Part I)

Measure ID	Measure Name	Measure Type
	UHRIP	
C1-101	HIE Participation	Structure
C1-102	SDA Learning Collaborative Participation	Structure
	ACIA Maternal Care	
C2-103	AIM Collaborative Participation	Structure
C2-104	Severe Maternal Morbidity	Outcome
C2-105	PC-02 Cesarean Section	Outcome
	ACIA Hospital Safety	
C2-106	Hospital Safety Collaborative Participation	Structure
C2-107	CAUTI Outcome Measure	Outcome
C2-108	CLABSI Outcome Measure	Outcome
C2-109	Facility-wide Inpatient Hospital-onset Clostridium difficile Infection Outcome Measure	Outcome
C2-110	Harmonized Procedure Specific Surgical Site Infection (SSI) Outcome Measure	Outcome

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CHIRP Measures (Part II)

Measure ID	Measure Name	Measure Type
	ACIA Pediatric	
C2-111	Hospital Safety Collaborative Participation	Structure
C2-112	Pediatric Adverse Drug Events	Outcome
C2-113	Pediatric CLABSI	Outcome
C2-114	Pediatric CAUTI	Outcome
C2-115	Pediatric SSI	Outcome
C2-116	Engagement in Integrated Behavioral Health	Process
	ACIA Psychiatric Care Transitions	
C2-117	Written transition procedures that include formal MCO relationship or EDEN notification/ADT Feed for psychiatric patients	Structure

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CHIRP Measures (Part III)

Measure ID	Measure Name	Measure Type
	ACIA Care Transitions	
C2-118	Written transition procedures that include formal MCO relationship or EDEN notification/ADT Feed for non-psychiatric patients	Structure
	ACIA Rural Hospital Best Practices	
C2-119	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	Process
C2-120	Preventive Care and Screening: Influenza Immunization	Process

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DPP BHS – Component 1 Measures

Measure ID	Measure Name	Measure Type
B1-101	Certified Community Behavioral Health Clinic (CCBHC) Certification Status	Structure
B1-102	Provide patients with services by using remote technology including audio/video, client portals and apps for the provision of services such as telehealth, assessment collection and remote health monitoring/screening	Structure
B1-103	Provide integrated physical and behavioral health care services to children and adults with serious mental illness	Structure
B1-104	Participate in electronic exchange of clinical data with other healthcare providers/entities	Structure

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DPP BHS – Component 2 Measures

Measure ID	Measure Name	Measure Type
B2-105	Preventive Care & Screening: Unhealthy Alcohol Use: Screening & Brief Counseling	Process
B2-106	Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment	Process
B2-107	Adult Major Depressive Disorder (MDD): Suicide Risk Assessment	Process
B2-108	Follow-Up After Hospitalization for Mental Illness 7-Day (discharges from state hospital)	Outcome
B2-109	Follow-Up after Hospitalization for Mental Illness 30-Day (discharges from state hospital)	Outcome
B2-110	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	Process

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RAPPS Measures

Measure ID	Measure Name	Measure Type
	Component 1	
R1-101	Telehealth to provide virtual medical appointments with a primary care or specialty care provider	Structure
R1-102	Use of electronic health record (EHR)	Structure
R1-103	Care team includes personnel in a care coordination role not requiring clinical licensure	Structure
	Component 2	
R2-104	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) testing	Process
R2-105	Preventive Care and Screening: Influenza Immunization	Process

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