



Annual Report on Quality Measures and Value-Based Payments

**As Required by
Texas Government Code
Section 536.008**

**Health and Human Services
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Executive Summary

Texas Government Code, Section 536.008, directs the Health and Human Services Commission (HHSC) to report annually on its efforts to develop quality measures and quality-based (or value-based) payment initiatives.^{1,2} This annual report presents information on HHSC's healthcare quality improvement activities for the Texas Medicaid program and the Children's Health Insurance Program (CHIP). It provides historical and current information on:

- Managed care value-based payment programs
- 1115 Healthcare Transformation Waiver
- Directed payment programs
- Trends in key quality measures

HHSC is charting a fundamental change in course away from paying for volume to paying for the value of healthcare services. This transformation aims to achieve better care for individuals, better health for populations and lower cost for the state.

To this end, HHSC has implemented contract requirements for managed care organizations (MCOs) to achieve minimum levels of alternative payment model (APM) agreements with providers and redesigned its medical and dental Pay-for-Quality (P4Q) programs. Calendar year 2018 was the first measurement year for these meaningful value-based payment (VBP) initiatives, and HHSC's MCOs and dental maintenance organizations (DMOs) performed well on both initiatives.

HHSC is also actively working to sustain a Texas Medicaid program that continues to advance value-based care and other effective delivery system reforms as funding for the Delivery System Reform Incentive Payment (DSRIP) program winds down (at the end of federal fiscal year 2022) under the current 1115 Healthcare Transformation Waiver. On September 30, 2019, HHSC submitted a draft DSRIP Transition plan to the Centers for Medicare & Medicaid Services (CMS), including goals and milestones that will help inform potential components of the post-DSRIP system. CMS formally approved this plan on September 2, 2020. The effort to successfully transition the DSRIP program is expected to yield new ideas for delivering value-based care to Texans.

¹ <https://statutes.capitol.texas.gov/Docs/GV/htm/GV.536.htm>

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

The Legislature continues to direct HHSC to advance value and transparency in the Medicaid program. The 2020-21 General Appropriations Act, H.B. 1, 86th Legislature, Regular Session, 2019 (Article II, HHSC, Rider 43) requires HHSC to implement an incentive program that automatically enrolls a greater percentage of Medicaid recipients who have not selected an MCO into a plan based on quality of care, efficiency and effectiveness of service provision and performance. Phase I of the new Value-Based Enrollment was implemented for MCO enrollments effective September 1, 2020.

H.B. 4533, 86th Legislature, Regular Session, 2019, requires HHSC to make available to the public on its website in an easy-to-read format data on the health care quality and health outcomes of Medicaid recipients. The Texas Healthcare Learning Collaborative (THLC) portal serves as a public reporting platform that enables users to compare performance across programs, MCOs, DMOs and service areas on process and outcome measures. HHSC has recently added P4Q results and member survey data to the THLC portal and continues to explore additional ways to leverage the THLC portal to support quality improvement and VBP programs.

Other legislation enacted by the 86th Legislature requires HHSC to develop initiatives for MCOs to improve the quality of maternal health care (Senate Bill [S.B.] 750), evaluate risk-adjustment methods for the Hospital Quality-Based Payment program in STAR Kids (S.B. 1207) and enhance quality monitoring for the Medically Dependent Children Program (S.B. 1207). The 2020-21 General Appropriations Act also includes several riders related to improving quality of care. HHSC has implemented and continues to implement initiatives from the 86th Legislature.

1. Introduction

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

Major Initiatives

Medicaid Managed Care Value-Based Payment Programs

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

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

- Medical and dental [P4Q programs](#)³
- [APM Thresholds](#)⁴ to promote MCOs and DMOs to increase APM contracts with providers
- [Hospital Quality-Based Payment \(HQBP\) program](#)⁵ targeting reductions in potentially preventable events

1115 Healthcare Transformation Waiver Program

Under the Medicaid 1115 Transformation Waiver, DSRIP funds locally-developed, innovative and value-based solutions for uninsured and Medicaid populations. DSRIP is funded with inter-governmental transfers (IGTs) from local governmental entities and federal matching funds. DSRIP funds flow directly to providers participating in DSRIP (not through the MCOs).

During the first six years of the waiver, DSRIP providers reported on process and outcome measures for specific projects that were selected based on regional assessments of community needs performed by each Regional Healthcare

³ P4Q information available at: <https://hhs.texas.gov/about-hhs/process-improvement/medicaid-chip-quality-efficiency-improvement/pay-quality-p4q-program>

⁴ MCO value-based contracting information available at: <https://hhs.texas.gov/about-hhs/process-improvement/medicaid-chip-quality-efficiency-improvement/value-based-contracting>

⁵ Hospital quality based payment program available at: <https://hhs.texas.gov/about-hhs/process-improvement/medicaid-chip-quality-efficiency-improvement/potentially-preventable-events>

Partnership (RHP). Beginning in Demonstration Year 7 (federal fiscal year 2018), DSRIP providers began reporting on achievement of health outcomes at their system level to measure the continued transformation of the Texas healthcare system related to the implementation of the 1115 Waiver.

Directed Payment Programs

Directed payment programs are permitted under federal Medicaid managed care regulations (42 CFR § 438.6(c)). They allow MCOs to make increased payments through adjustments to provider reimbursement rates or as incentive payments. The state develops the programs, specific to a type of provider, and directs MCOs to implement the associated provider payments. Directed payment programs must help HHSC advance its quality strategy and require approval from CMS to authorize federal matching funds. Annual CMS approvals are needed to continue the programs.

Directed payment programs that make additional payments for nursing facilities and hospitals, some of which are linked to measures of quality, include:

- [Quality Incentive Payment Program for Nursing Homes \(QIPP\)](#)⁶
- [Uniform Hospital Rate Increase Program \(UHRIP\)](#)⁷
- [Network Access Improvement Program \(NAIP\)](#)⁸

Key Quality Measures

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

⁶ QIPP information available at: <https://hhs.texas.gov/services/health/medicaid-chip/provider-information/quality-incentive-payment-program-nursing-homes>

⁷ Uniform Hospital Rate Increase Program (UHRIP) - information available at: <https://rad.hhs.texas.gov/hospitals-clinic/hospital-services/uniform-hospital-rate-increase-program>

⁸ NAIP information available at: <https://hhs.texas.gov/services/health/medicaid-chip/programs/medical-dental-plans>

2. Value-Based Care Strategy Background

The value-based care strategy for Texas Medicaid and CHIP encompasses: VBP reform (through P4Q, HQBP, and DSRIP programs) and regular evaluation and reporting of MCO performance on key quality measures.

As HHSC pursues VBP, it strives to adhere to the guiding principles outlined in its [VBP Roadmap](#):

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

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

The continued, evolutionary shift to value-based care requires collaboration between HHSC, MCOs, providers and other stakeholders. HHSC's [Value-Based Payment and Quality Improvement Advisory Committee](#) (VBPQI) plays an important role in supporting collaboration with all stakeholders in the system and advancing value-based care. In September 2020, the committee made recommendations on:

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

As recognized by the VBPQI Advisory Committee, data sharing, whether by an MCO, DMO or provider, is essential in a VBP environment. For example, managed care providers with APM contracts need regular information from MCOs on their

performance on agreed upon quality metrics. For HHSC, public reporting of MCO performance can be an effective strategy to accelerate improvement and establish a transparent and accountable system. With this approach in mind, HHSC provides information about VBP initiatives on its website, including payment arrangements between MCOs and their providers. HHSC is exploring additional ways to leverage its THLC portal⁹ to support MCOs, DMOs and providers to pursue APMs that improve outcomes and efficiency.

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

⁹ THLC portal accessed at: <https://thlcportal.com/home>

3. Managed Care Value-Based Payments Programs

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

1. P4Q program
2. APM Requirements for MCOs
3. HQBP program

Pay-for-Quality Program

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

Medical P4Q Program

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

Recouped capitation dollars from low performing MCOs for at-risk measures are redistributed to high performing MCOs. If there are any remaining funds after the collection and redistribution process, they form a performance bonus pool to reward high-performing MCOs on specific measures. Because there are significant capitation dollars for an MCO to lose or gain, this program incentivizes MCOs to collaborate with providers to develop VBP models that can help ensure their success. The at-risk measures and effective years for the medical P4Q program (for 2018 – 2021)¹⁰ are shown in Table 1. Table 2 lists the bonus pool measures and effective years for the same period. HHSC suspended the medical and dental P4Q programs for measurement year 2020 because of the COVID-19 pandemic. Tables 1 and 2 reflect this change.

¹⁰ Measures and associated benchmarks along with detailed methodology available at: <https://hhs.texas.gov/sites/default/files/documents/laws-regulations/handbooks/umcm/6-2-14.pdf>

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

Measures	STAR +PLUS	STAR	STAR Kids	CHIP
Potentially Preventable Emergency Room Visits (PPVs)	2018, 2019, 2021	2018, 2019, 2021	2021	2018, 2019, 2021
Appropriate Treatment for Children with Upper Respiratory Infection (URI)		2018, 2019, 2021		2018, 2019, 2021
Prenatal and Postpartum Care*		2018, 2021*		
Well Child Visits First 15 months of Life (W15)		2018, 2019, 2021		
Diabetes Control - HbA1c < 8% (CDC)	2018, 2019, 2021			
High Blood Pressure Controlled (CBP)	2021			
Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are using antipsychotics (SSD)	2018, 2019, 2021			
Cervical Cancer Screening (CCS)	2018, 2019, 2021			
Adolescent Well Care (AWC)			2021	2018, 2019
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (WCC)			2021* *	2018, 2019, 2021**
Follow-up After Hospitalization for Mental Illness (FUH)			2020	
Immunizations for Adolescents (IMA), Combination 2		2020		2020
Getting Specialized Services composite			2020	

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

** For 2021, only the counseling for nutrition sub measure is used.

Table 2. Bonus Pool Measures for the Medical P4Q Program

Bonus Pool Measures	STAR+ PLUS	STAR	STAR Kids	CHIP
Potentially preventable readmissions (PPR)	2018, 2019, 2021			
Potentially preventable admissions (PPA)		2018, 2019, 2021		
Prevention Quality Indicator (PQI) Composite	2018, 2019, 2021			
Potentially preventable complications (PPC)	2018, 2019, 2021			
Follow-up Care for Children Prescribed ADHD Medication (ADD) Initiation		2021		2021
Low Birth Weight		2018, 2019, 2021		
Childhood Immunization Status (CIS) Combination 10		2021		2018, 2019, 2021
Immunizations for Adolescents (IMA) Combination 2			2021	
Good access to urgent care	2018, 2019, 2021	2018, 2019		2018, 2019
Rating MCO a 9 or 10	2018, 2019	2018, 2019		2018, 2019
Rating Child's Personal Doctor a 9 or 10				2021
Getting care quickly composite		2021		2021
Transition to care as an adult			2021	
Help with care coordination			2021	

Table 3 presents the amounts recouped and distributed to each MCO for the measurement year 2018, the most recent year for which HHSC has complete results for Medical P4Q. For additional details on the Medical P4Q results, please refer to the THLC Portal.

Table 3 includes the amounts recouped or distributed per MCO in STAR and CHIP. In STAR+PLUS, all five MCOs performed well enough on the P4Q measures to earn a payment. However, none were subject to recoupment and no money was available to redistribute. Evaluation of STAR Kids MCOs for the medical P4Q program will begin with calendar year 2020.

Table 3. Medical Pay-for-Quality Program Recoupments and Distributions for 2018 by MCO and Program

MCO	STAR	CHIP	Sum of Dollars Recouped/ Distributed	Percentage Capitation Recouped/ Distributed
Aetna Better Health	\$ 97,683	\$ 629	\$ 98,312	0.0445%
Amerigroup	\$ 797,849	\$ 14,686	\$ 812,535	0.0287%
Blue Cross Blue Shield of Texas	\$ 26,416	\$ 428	\$ 26,844	0.0312%
Cigna-HealthSpring¹¹			\$ 0	0%
Community First Health Plans	\$ 24,278	\$ 761	\$ 25,039	0.0081%
Community Health Choice	\$ 668,516	\$ 9,792	\$ 678,308	0.0775%
Cook Children's Health Plan	\$ 58,666	\$ 6,337	\$ 65,003	0.0209%
Dell/Seton Health Plan	\$ 28,787	\$ 2,208	\$ 30,995	0.0540%
Driscoll Health Plan	\$ 394,520	\$ 2,238	\$ 396,758	0.0828%
El Paso Health	\$ 66,009	\$ 1,222	\$ 67,231	0.0364%
FirstCare	\$(3,689,445)	\$(19,950)	\$(3,709,395)	-1.4658%
Molina Healthcare of Texas, Inc.	\$ 140,023	\$(59,688)	\$ 80,335	0.0070%
Parkland Community Health Plan	\$ 210,880	\$ 5,246	\$ 216,126	0.0406%

¹¹ Cigna-HealthSpring only participates in the STAR+PLUS program.

MCO	STAR	CHIP	Sum of Dollars Recouped/ Distributed	Percentage Capitation Recouped/ Distributed
Baylor Scott & White Health Plan	\$ 43,363		\$ 43,363	0.0341%
Superior HealthPlan	\$ 614,780	\$ 6,963	\$ 621,743	0.0168%
Texas Children's Health Plan	\$ 331,706	\$ 26,779	\$ 358,485	0.0363%
UnitedHealthcare Community Plan	\$ 185,969	\$ 2,349	\$ 188,318	0.0105%

Dental P4Q Program

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

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

Measure	Description	Medicaid	CHIP
DQA Oral Evaluation, Dental Services	Percentage of enrolled children: <ul style="list-style-type: none"> who received a comprehensive or periodic oral evaluation within the reporting year 	2018 2019 2021 2022	2018 2019 2021 2022
DQA Topical Fluoride for Children at Elevated Caries Risk, Dental Health Services	Percentage of enrolled children: <ul style="list-style-type: none"> at "elevated" risk for cavities (i.e. "moderate" or "high") and who received at least 2 topical fluoride applications within the reporting year 	2018 2019 2021 2022	2018 2019 2021 2022

Measure	Description	Medicaid	CHIP
DQA Sealants for 6-9-year-old Children at Elevated Risk, Dental Services	Percentage of enrolled children: <ul style="list-style-type: none"> at "elevated" risk for cavities (i.e. "moderate" or "high") and who received a sealant on a permanent tooth within the reporting year 	2018	2018
DQA Sealants for 10-14-year-old Children at Elevated Risk, Dental Services	Percentage of enrolled children: <ul style="list-style-type: none"> at "elevated" risk for cavities (i.e. "moderate" or "high") and received a sealant on a permanent second molar tooth within the reporting year 	2018	2018
DQA Measure: Sealant Receipt on Permanent 1st Molars, One Sealant and All Four Sealants	Percentage of enrolled children, who have ever received sealants on permanent first molar teeth: <ul style="list-style-type: none"> at least one sealant all four molars sealed by the 10th birthdate 	2021 2022	2021 2022
DQA Measure: Sealant Receipt on Permanent 2nd Molars, One Sealant and All Four Sealants	Percentage of enrolled children, who have ever received sealants on permanent second molar teeth: <ul style="list-style-type: none"> at least one sealant all four molars sealed by the 15th birthdate 	2021 2022	2021 2022

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

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

DMO	CHIP	Medicaid	Sum of Dollars Recouped / Distributed	Percentage Capitation Recouped / Distributed
DentaQuest	\$0.00	\$0.00	\$0.00	0.00%
MCNA	(\$10,530.00)	(\$478,108.00)	(\$488,638.00)	-0.09%

Alternative Payment Model Requirements for MCOs

The medical and dental P4Q programs serve as a catalyst for MCOs and DMOs to pursue VBP arrangements with providers to achieve required P4Q outcomes. In addition, HHSC's MCO and DMO contracts require them to reach APM targets each year, beginning with calendar year 2018.

HHSC uses the [Healthcare Payment Learning and Action Network \(HCP LAN\) Alternative Payment Model \(APM\) Framework](#)¹² (Figure 1) to help guide this effort. This framework provides a menu of payment models from which MCOs could choose to develop APM contracts with their providers. Moving from one category to the next adds a level of risk to the payment model. MCOs can choose any of these models in their transition to a payment structure based on value.

In spring 2019, the HCP LAN developed a [Roadmap for Driving High Performance in Alternative Payment Models](#)¹³ (the "Roadmap"), an interactive, web-based implementation guide that public and private payers can use to work with providers, purchasers, patients, consumers and others. The Roadmap offers users a robust set of promising practices organized around three domains: APM Design, Payer-Provider Collaboration and Patient-Centered Care, which provide real-world guidance for organizations seeking to design, operate and scale APMs. The interactive design enables Roadmap users to access specific resources relevant to their own context and challenges.

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

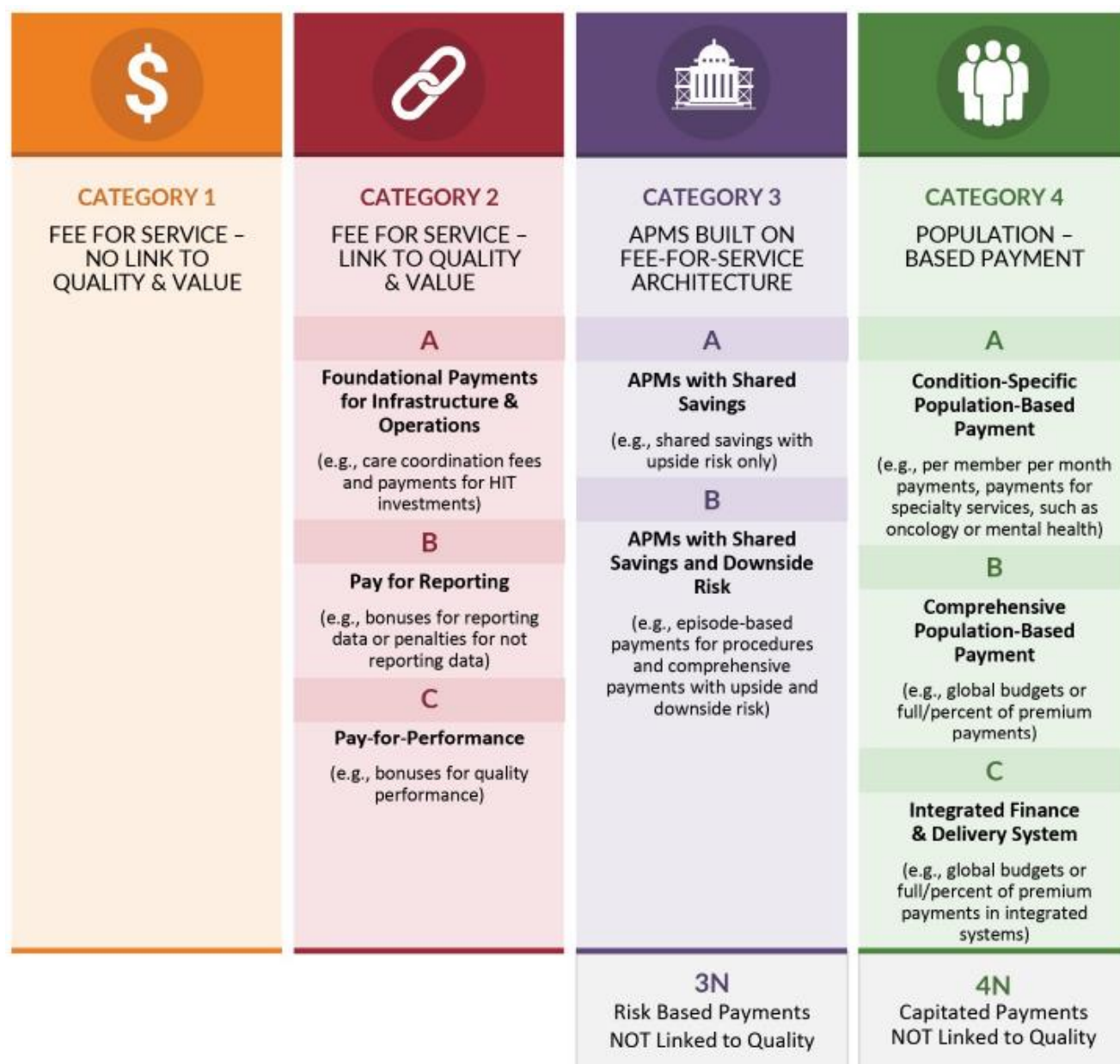
This framework represents payments from public and private payers to provider organizations (including payments between the payment and delivery arms of highly integrated health systems). It is designed to accommodate payments in multiple categories that are made by a single payer, as well as single provider organizations that receive payments in different categories—potentially from the same payer. Although payments will be classified in discrete categories, the Framework captures a continuum of clinical and financial risk for provider organizations as it moves from Category 1 to 4. Specifically, the risk models are considered by LAN starting with Category 3B up to 4C. The APMs are incentive-

¹² LAN Framework available at: <http://hcp-lan.org/workproducts/apm-framework-onepager.pdf>

¹³ <https://hcp-lan.org/apm-roadmap/>

based models that pay bonuses to providers that hit predetermined quality benchmarks, develop VBP infrastructure or report their quality data.

**Figure 1. Healthcare Payment Learning and Action Network (HCP LAN)
Alternative Payment Model (APM) Framework**



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

Effective in calendar year 2018, HHSC introduced contractual requirements for MCOs and DMOs to promote VBP, as follows:¹⁴

- *Establishment of MCO and DMO APM targets:* Overall and risk-based APM contractual targets were established for MCO expenditures on VBP contracts with providers relative to all medical and pharmacy expenses. For MCOs, the targets start at 25 percent of provider payments in any type of APM and 10

¹⁴ <https://hhs.texas.gov/sites/default/files/documents/services/health/medicaid-chip/programs/contracts/uniform-managed-care-contract.pdf> (page 8-95)

percent of provider payments in risk-based APMs for calendar year 2018. These targets increase over four years up to 50 percent overall and 25 percent risk-based by calendar year 2021. For DMOs, these targets were set at 25 percent overall and two percent risk-based in 2018. The targets for DMOs increase to 50 percent, with 10 percent risk-based by 2021.

- *MCOs and DMOs must submit inventories of their APM initiatives developed with providers every year:* These reports are used to calculate the accomplishment level of the targets and the negative or positive gap between accomplishment and targets.
- *Requirements for MCOs and DMOs to establish and maintain data sharing processes with providers:* MCOs and DMOs must share data and reports with providers and collaborate on common formats, if possible.
- *Requirements for MCOs and DMOs to adequately resource this activity:* MCOs and DMOs must dedicate sufficient resources for provider outreach and negotiation, provide assistance with data and/or report interpretation and initiate collaborative activities to support VBP and provider improvement.
- *Requirements for MCOs and DMOs to have a process in place to evaluate APM models:* MCOs and DMOs are required to evaluate the impact of APM models on utilization, quality, cost and return on investment.

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

In 2018, the first target year for HHSC's Medicaid MCO APM targets, MCOs reported that 40 percent of their payments to providers were in an APM, with about 22 percent in a risk-based APM.¹⁵ As a whole, the Texas Medicaid and CHIP programs performed at or above contractually-required thresholds and national goals in 2018, though performance varied somewhat by program (Figures 2 and 3).

¹⁵ 2018 APM targets include the STAR, STAR+PLUS, CHIP and STAR Health programs. STAR Kids requirements are effective beginning in 2019 and will be included in future calculations of these targets.

Figure 2. Overall APM Achievement by Program, CY 2018

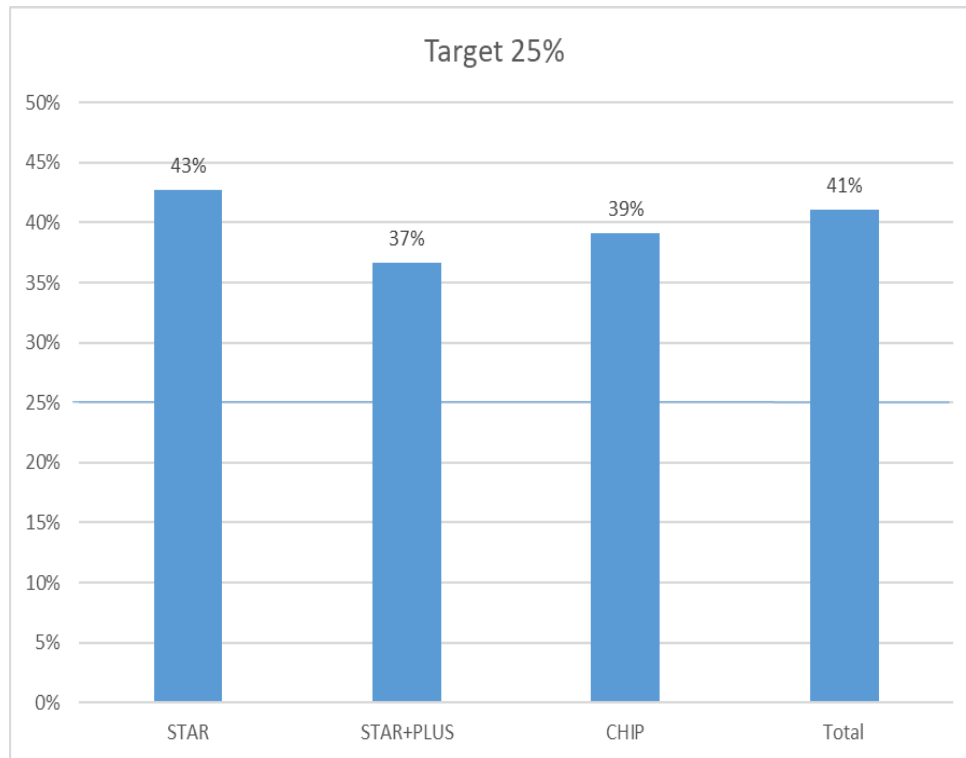
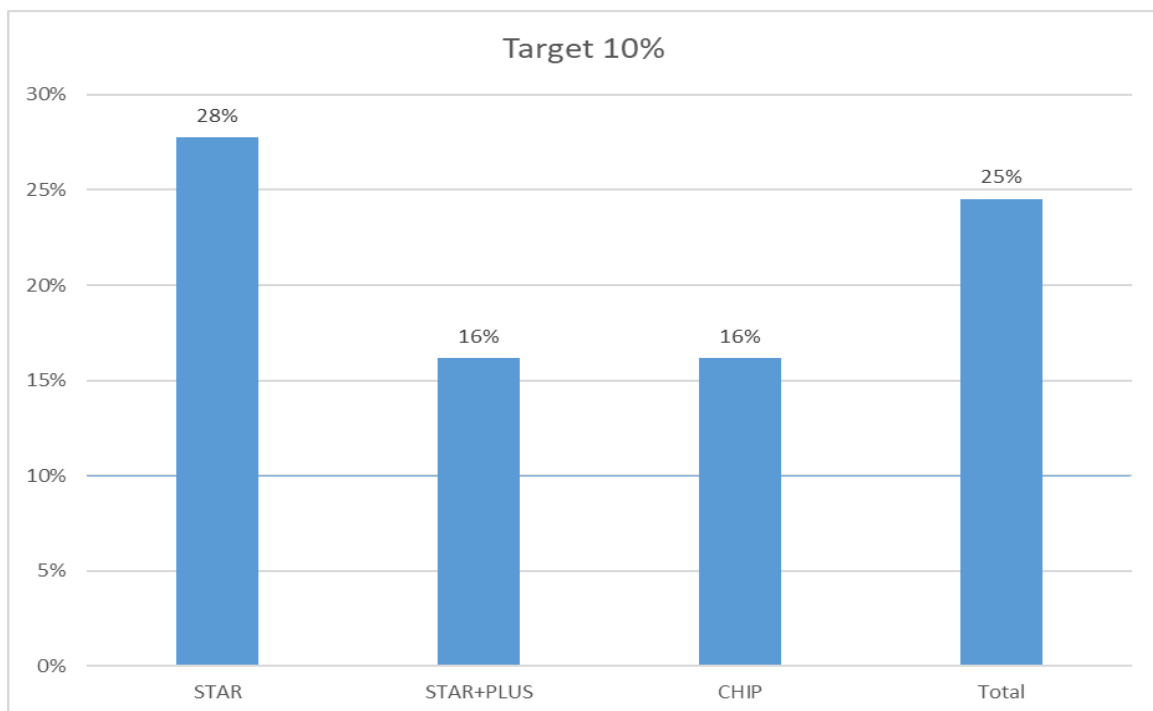


Figure 3. Risk-based APM Achievement by Program, CY 2018



Initial APMs established in Medicaid have tended to focus on primary care models, followed by hospitals and specialists/behavioral health providers (Table 6). For 2018, nearly three-fourths of all models are for those provider types, with over 40 percent in primary care alone. Mostly, APMs have yet to reach the long-term services and supports industry (nursing facilities/home care), an area with significant Medicaid expenditures. The VBPQI Advisory Committee has issued recommendations in both 2018 and 2020 to advance adoption of APMs in Texas Medicaid. These recommendations include prioritizing maternal and behavioral health models, promoting administrative simplification, and better leveraging available data to support value-based care.

Table 6. Distribution of APMs by Provider Type, CY 2018

Provider Type	Number of APMs	Percentage
Primary Care	143	41%
Hospitals	62	18%
Specialist and Behavioral Health	50	14%
Accountable Care Organization	36	10%
Obstetrics/Gynecology	27	8%
Pharmacy and Laboratory	17	5%
Nursing Facilities and Home Care	9	3%
Emergency and Urgent Care Services	7	2%
Total	351	100%

Hospital Quality-Based Payment Program

HHSC administers the HQBP Program for all hospitals in Medicaid and CHIP in both the managed care and FFS delivery systems.¹⁶ Hospitals are measured on their performance for risk-adjusted rates of potentially preventable hospital readmissions within 15 days of discharge (PPR) and potentially preventable inpatient hospital complications (PPC) across all Medicaid and CHIP programs, as these measures have been determined to be reasonably within hospitals' ability to improve. Hospitals can experience reductions to their payments for inpatient stays: up to two

¹⁶ HQBP program information available at: <https://hhs.texas.gov/about-hhs/process-improvement/medicaid-chip-quality-efficiency-improvement/potentially-preventable-events>

percent for high rates of PPRs and 2.5 percent for PPCs. Measurement, reporting and application of payment adjustments occur on an annual cycle.¹⁷

Hospital Performance: Potentially Preventable Readmissions

Changes in hospital performance on PPRs for 2014 to 2019 are shown in Figure 4. Decreases indicate better performance, while an increase means worse performance.

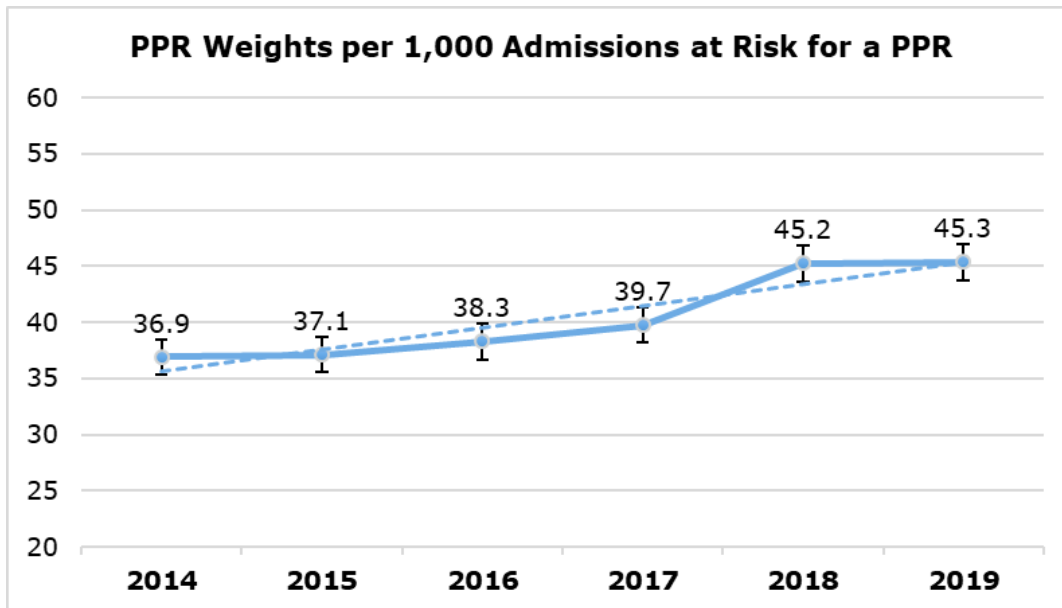
For each year, the “weight” per 1,000 admissions at risk for a PPR is shown for all hospitals measured. The “weight” captures changes in resources consumed by readmissions, rather than just changes in the rate of events. Not all readmissions are equal, and the use of weighted rates provides a standardized representation of relative costs. For example, if two hospitals have the same PPR rate, but the second hospital’s PPRs were costlier, it would have a higher “weighted” rate. From 2014 to 2019, there was a 23 percent increase in hospital PPR rates per 1,000 admissions at risk for a PPR, which indicates increasing total costs associated with PPRs.

As required by the 85th Legislature, HHSC conducted an evaluation of Medicaid managed care in Texas.¹⁸ The [report](#) identified the increasing PPR trends as an opportunity to integrate actuarial efficiency factors into the MCO rate setting process. In fiscal year 2020, HHSC reduced Medicaid and CHIP capitation rates with the expectation that MCOs will increase efforts to reduce their rates of PPRs by at least 10 percent. Implementation of this efficiency adjustment lowered fiscal year 2020 capitation rates by \$21.4 million.

¹⁷ [Texas Administrative Code, Title 1, Part 15, Chapter 354, Subchapter A, Division 35, Reimbursement Adjustments for Potentially Preventable Events.](#)

¹⁸ The 2018-19 General Appropriations Act, Senate Bill 1, 85th Texas Legislature, Regular Session, 2017 (Article II, HHSC, Rider 61)

Figure 4. Changes in hospital PPR performance for 2014 - 2019

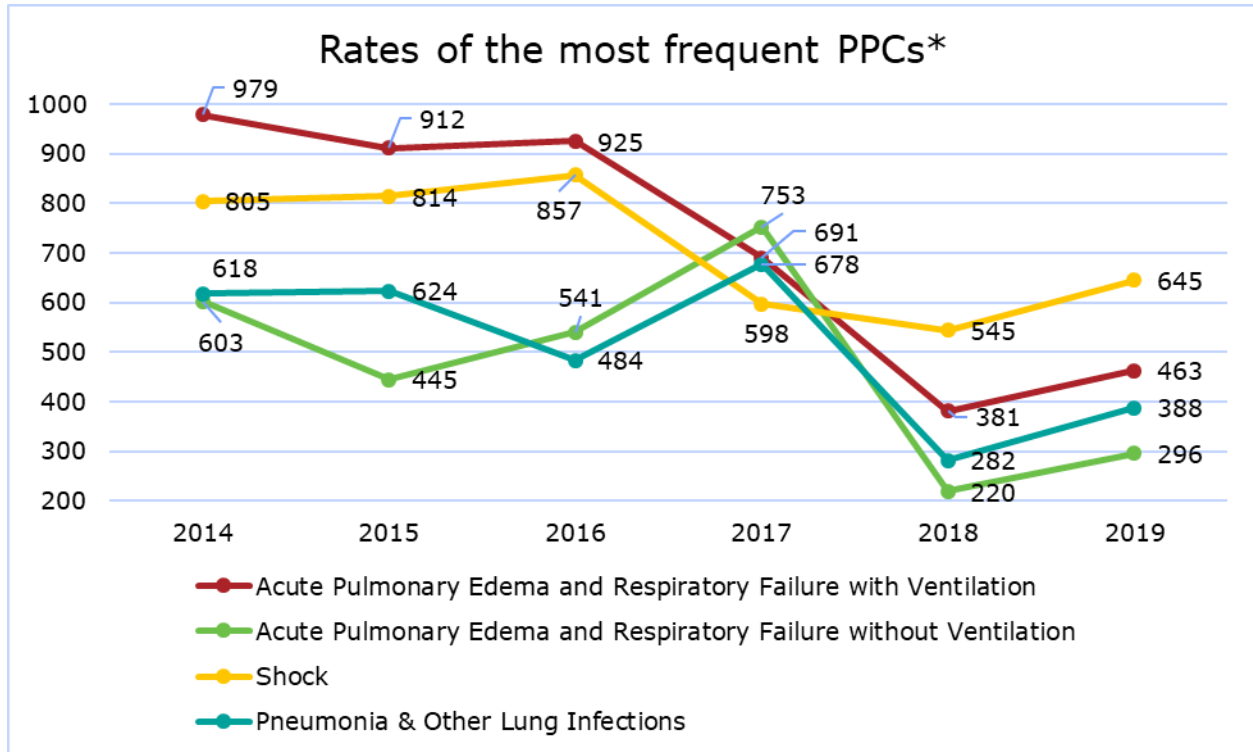


Hospital Performance: Potentially Preventable Complications

Beginning with the 2017 measurement period the state's PPC methodology changed,¹⁹ slightly reducing the number of complications considered potentially preventable. However, results for the most frequently occurring PPCs were largely unaffected by the methodology changes. Figure 5 shows the trends for the most frequent conditions from 2014 to 2019: Acute Pulmonary Edema and Respiratory Failure (with and without Ventilation), Pneumonia & Other Lung Infections, and Shock. Over the six years, all four PPCs show a decline, though rates for each have fluctuated over this time, with a slight increase for the 2018 – 2019 period. Data presented later in this report (Figures 13 and 14), for the full range of PPCs, indicate a relatively consistent improvement in performance over the years, particularly for the STAR+PLUS program.

¹⁹ <https://hhs.texas.gov/sites/default/files/documents/about-hhs/process-improvement/PPC-methodology-overview.pdf>

Figure 5. Changes in hospital PPC performance for 2014 - 2019



* *Weights for the most frequently occurring PPCs.*

Medicaid Value-Based Enrollment

Government Code Section 533.00511²⁰ 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:

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

At the time the statute was enacted, HHSC determined that there would be cost impacts to implement these requirements. To comply with the statute and to empower prospective enrollees to make informed choices about MCOs in their service area, HHSC created annual report cards of MCO performance. Report cards for CHIP, STAR, STAR+PLUS and most recently STAR Kids are posted on HHSC's [website](#) and mailed to prospective enrollees with their enrollment packets. HHSC's goals for report cards included lowering the percentage of candidates defaulted into a MCO by providing information about available MCOs.

Currently, when an individual is enrolled in Medicaid, they are encouraged to select an MCO using MCO report cards. If a Medicaid client does not select an MCO, HHSC assigns the client to an MCO and a primary care physician (PCP) using a default methodology. Under this process, the number of enrollments awarded to an MCO reflects the percentage of members in a service area who chose that MCO.

The 86th Legislature²¹ further directed HHSC to create an incentive program that automatically enrolls a greater percentage of Medicaid recipients who have not selected a MCO into a plan based on quality of care, efficiency and effectiveness of service provision and performance. Accordingly, HHSC developed a value-based enrollment methodology that incorporates results from key cost, quality and member satisfaction metrics into the existing method. MCOs with better performance than other MCOs on the factors listed below will receive a higher share of enrollments than under the current methodology:

²⁰ As added by Senate Bill 7, 83rd Legislature, Regular Session, 2013.

²¹ 2020-21 General Appropriations Act, H.B. 1, 86th Legislature, Regular Session, 2019, (Article II, HHSC, Rider 43)

- Risk-Adjusted Ratio of Actual to Expected Spending (Cost or Efficiency);
- Risk-Adjusted Potentially Preventable Events (PPE) Ratios (Cost and Quality);
- Composite Report Card Scores (Quality and Member Satisfaction):
 - ▶ Member experience with doctors and the MCO – derived from results of member surveys;
 - ▶ Staying healthy – MCO performance on preventive care measures; and
 - ▶ Controlling chronic diseases – MCO performance on important quality measures regarding care for asthma, Attention Deficit Hyperactivity Disorder, Chronic Obstructive Pulmonary Disease, depression, or diabetes, depending on the program.

HHSC used a phased approach to implement the program on September 1, 2020. In Phase I, HHSC reports to MCOs their monthly default enrollment under a value-based methodology. In Phase II, HHSC begins using the value-based methodology for default enrollments starting December 1, 2020. HHSC will release a report by January 15, 2021, on program status and metrics for the methodology.

4.1115 Healthcare Transformation Waiver

Delivery System Reform Incentive Payment (DSRIP) Program

CMS originally approved the Texas Healthcare Transformation and Quality Improvement Program 1115 Waiver as a five-year demonstration program from December 2011 to September 2016 (Demonstration Years [DY] 1-5).²² A subsequent one-year extension continued the waiver through DY 6 (October 2016 to September 2017). On December 21, 2017, CMS approved an additional five-year extension from October 2017 to September 2022 (DY 7-11).

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

The DSRIP program provides incentive payments to Texas hospitals, physician practices, community mental health centers and local health departments for investments in delivery system reforms. During DY2-6 (October 2012 to September 2017), approximately 300 DSRIP providers implemented over 1,450 locally driven projects to increase access to healthcare, improve the quality of care and enhance the health of patients and families served.

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

When CMS renewed the waiver in December 2017, it authorized DSRIP through September 30, 2021, and required Texas to submit a transition plan outlining how the state would sustain healthcare transformation without DSRIP funding. In September 2019, Texas submitted a draft DSRIP Transition Plan to CMS.²³ On September 2, 2020, CMS approved the state's revised DSRIP Transition Plan. The

²² <https://hhs.texas.gov/laws-regulations/policies-rules/waivers/medicaid-1115-waiver>

²³ <https://hhs.texas.gov/laws-regulations/policies-rules/waivers/medicaid-1115-waiver/dsrip-transition>

milestones included in this transition plan lay the groundwork to develop strategies, programs and policies to sustain successful DSRIP activities and for emerging areas of innovation in health care. The DSRIP Transition Plan contains the following goals for continued delivery system reform:

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

The transition plan outlines milestones with eight deliverables to be submitted to CMS. The deliverables are the product of analysis, review and stakeholder engagement which will inform new program and policy proposals for post-DSRIP.

DSRIP Success in Achieving Performance Goals

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

For P4P measures, providers that demonstrated improved performance on selected Category C outcome measures qualified for a partial incentive payment if they achieved at least 25 percent of the improvement goal. The improvement goal was set with a standard formula for each outcome measure that calculates improvement over a reported baseline relative to national benchmarks. The full incentive payment was earned if they met or exceeded 100 percent of the improvement goal.

The number of Category C P4P outcome measures for which performance was reported and the number of outcomes that earned a partial or full incentive payment based on the results are shown in Tables 7 and 8. As noted in the tables, most reported outcomes achieved at least 25 percent of their goal, and a high percentage achieved 100 percent of their goal, which is evidence of quality improvements across the state through DSRIP.

The following information summarizes the achievement of DSRIP providers on Category C P4P outcomes in DYs 7-8, both overall and for some of the most frequently reported measures.

Table 7. DSRIP Category C Achievement for All P4P Outcomes, DYs 7-8

Demonstration Year (DY)	Number of P4P Outcomes in DY²⁴	Percentage Goal Achievement
DY 7	2,581	86%
DY 8 ²⁵	2,581	77%

Table 8.i. DSRIP Category C Achievement for Selected P4P Outcomes Reported by Hospitals and Physician Practices in DY 8

Outcome Measure	Number of Providers Reporting Outcome	Greater than 25% Goal Achievement	Percentage Goal Achievement
Chronic Disease Management – Diabetes: HbA1c poor control (>9.0)	74	80%	76%
Chronic Disease Management - Heart Disease: Controlling High Blood Pressure	37	92%	78%
Rural Emergency Care: Documentation of Current Medications in Patient Medical Record	31	96%	92%
Improved Maternal Care: Post-Partum Follow-Up and Care Coordination	19	94%	83%

²⁴ This is the total number of pay-for-performance outcomes eligible to be reported per DY. There are approximately 300 DSRIP providers.

²⁵ Achievement data for DY8 only reflects results for outcomes that have reported Calendar Year 2019. Providers have reported CY2019 data for 91 percent of outcome measures. Provider have until October 2020 to report CY2019 data and have until CY2020 to achieve DY8 goals.

**Table 8. ii. DSRIP Category C Achievement for Selected P4P Outcomes
Reported by Community Mental Health Centers in DY 8**

Outcome Measure	Number of Providers Reporting Outcome	Greater than 25% Goal Achievement	Percentage Goal Achievement
Screening for Clinical Depression and Follow-Up Plan	20	100%	95%
Follow-Up After Hospitalization for Mental Illness	23	95%	91%

**Table 8.iii. DSRIP Category C Achievement for Selected P4P Outcomes
Reported by Local Health Departments in DY 8**

Outcome Measure	Number of Providers Reporting Outcome	Greater than 25% Goal Achievement	Percentage Goal Achievement
Latent Tuberculosis Infection Treatment Rate	8	100%	86%
Diabetes care: HbA1c poor control (>9.0%)	6	100%	100%

5. Directed Payment Programs

Directed payment programs allow MCOs to make increased payments through adjustments to provider reimbursement rates or as incentive payments. The state develops the programs, specific to a type of provider, and directs MCOs to implement the associated provider payments. Directed payment programs must help HHSC advance its quality strategy and require approval from CMS to authorize federal matching funds. Annual CMS approvals are needed to continue the programs.

HHSC operates three directed payment programs: The Nursing Home Quality Incentive Payment Program (QIPP), Uniform Hospital Rate Increase Program (UHRIP) and Network Access Improvement Program (NAIP). Each one is described below.

Nursing Home Quality Incentive Payment Program (QIPP)

QIPP is designed to incentivize nursing facilities to improve quality and innovation in the provision of nursing facility services.²⁶ The program began in state fiscal year 2018 and was approved for a fourth year that began on September 1, 2020.

QIPP Years One and Two (\$FY 2018 - 19) Performance

For year one, 514 nursing facilities participated in QIPP, including 430 non-state governmental owned (NSGO) nursing facilities and 84 private nursing facilities. The budget for year one was approximately \$400 million.

In program year two, 556 nursing facilities participated in QIPP, including 461 NSGO nursing facilities and 95 private nursing facilities. The budget for year two was \$446 million.

The program's structure included three components, each with performance requirements the providers must meet to qualify for incentive payments. Component One was exclusively available to NSGO nursing facilities and was triggered by the nursing facility's submission of a monthly Quality Assurance Performance Improvement Validation Report.

²⁶ <https://hhs.texas.gov/services/health/medicaid-chip/provider-information/quality-incentive-payment-program-nursing-homes>

Components two and three were available to all participating QIPP facilities and were triggered by meeting the national benchmark or by demonstrating minimum improvement (Component Two) or strong improvement (Component Three) on the following CMS long-stay nursing facility quality metrics:

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

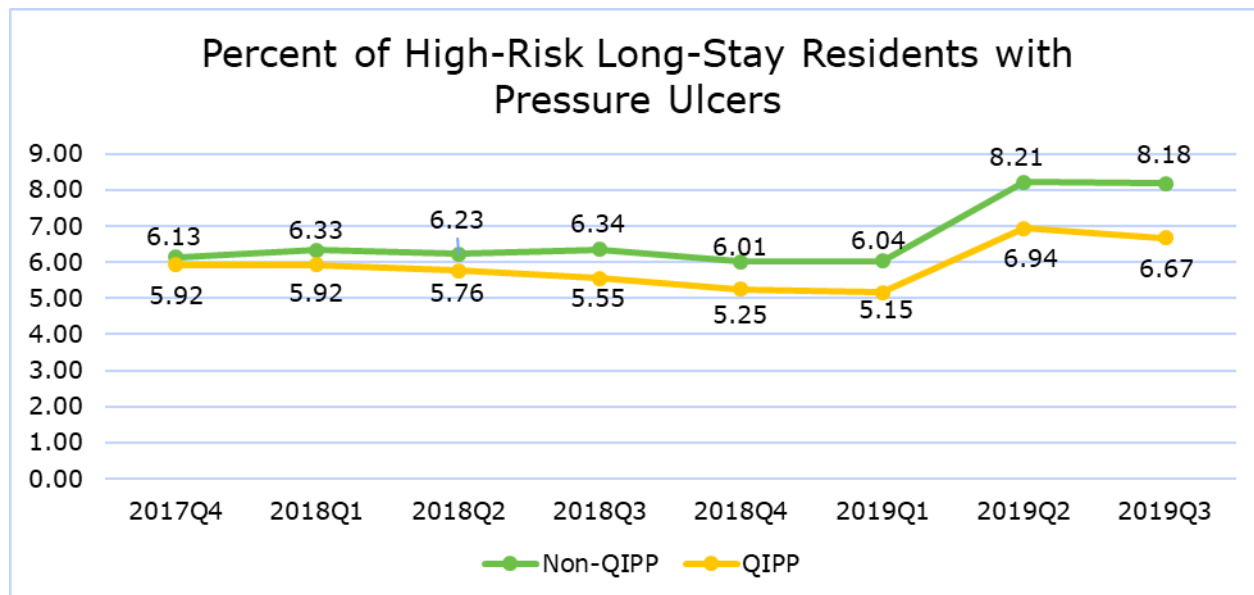
HHSC evaluates nursing facility performance on the quality measures on a quarterly basis.

After the two full years of data became available on Nursing Home Compare,²⁷ HHSC compared the performance of facilities enrolled in QIPP and facilities not enrolled in QIPP. Nursing Home Compare is a key source of information on all Medicare- and Medicaid-certified nursing facilities in the country. Through Nursing Home Compare, CMS publishes quarterly data in areas such as health inspection results, staffing ratios and certifications, and minimum data set (MDS) quality measures. The site hosts the “Five-Star Rating System,” which assigns star ratings to nursing facilities in individual categories and overall quality. In all, 17 of the 30 MDS measures reported on the site contribute to the quality of care star rating. Quality measure data are taken from this site each year to set QIPP performance measure baselines.

Active facilities with non-suppressed data available on the CMS website during the reporting periods most closely aligning with QIPP quarters (2017 Q4 – 2019 Q3) were tracked retrospectively as QIPP or non-QIPP facilities based on QIPP year one enrollment. In Figures 6 through 9, below, each trend line displays the average score per quarter for the four QIPP quality measures in Years 1 – 2. Lower scores are better.

²⁷ Nursing Home Compare provides information on nursing homes certified by Medicare and Medicaid, including inspection results and their performance certain CMS quality of care measures. <https://www.medicare.gov/nursinghomecompare/search.html>

Figure 6. Percent of High-Risk Long-Stay Residents with Pressure Ulcers



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

Figure 7. Percent of Long-Stay Residents Who Were Physically Restrained

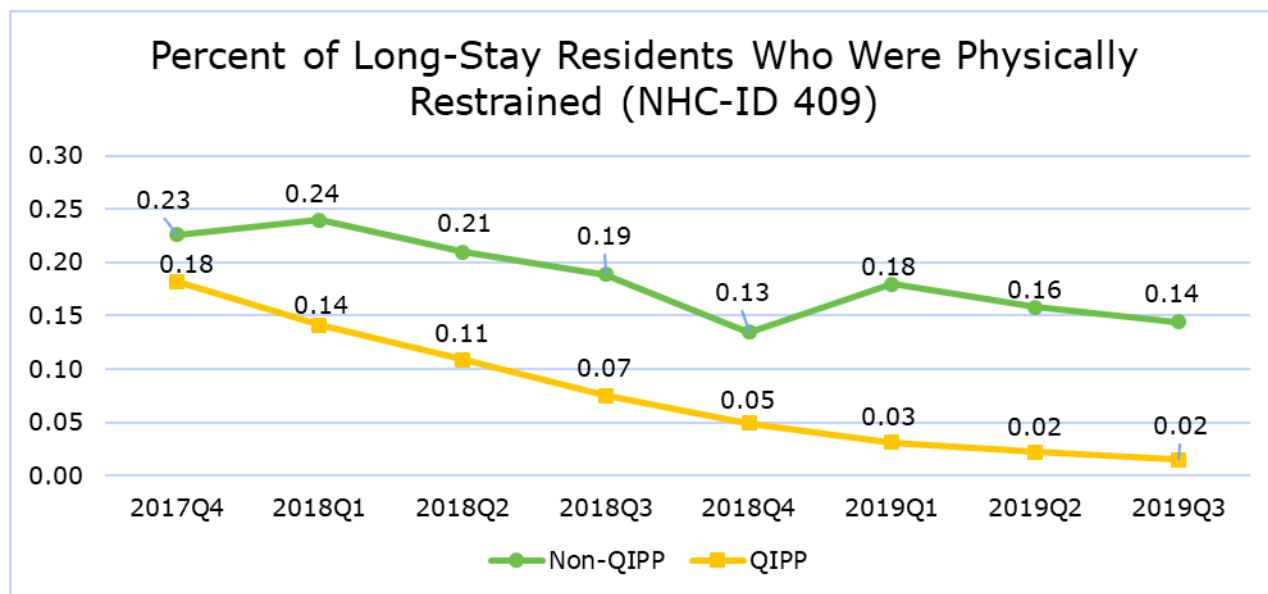


Figure 8. Percent of Long-Stay Residents Experiencing One or More Falls with Major Injury

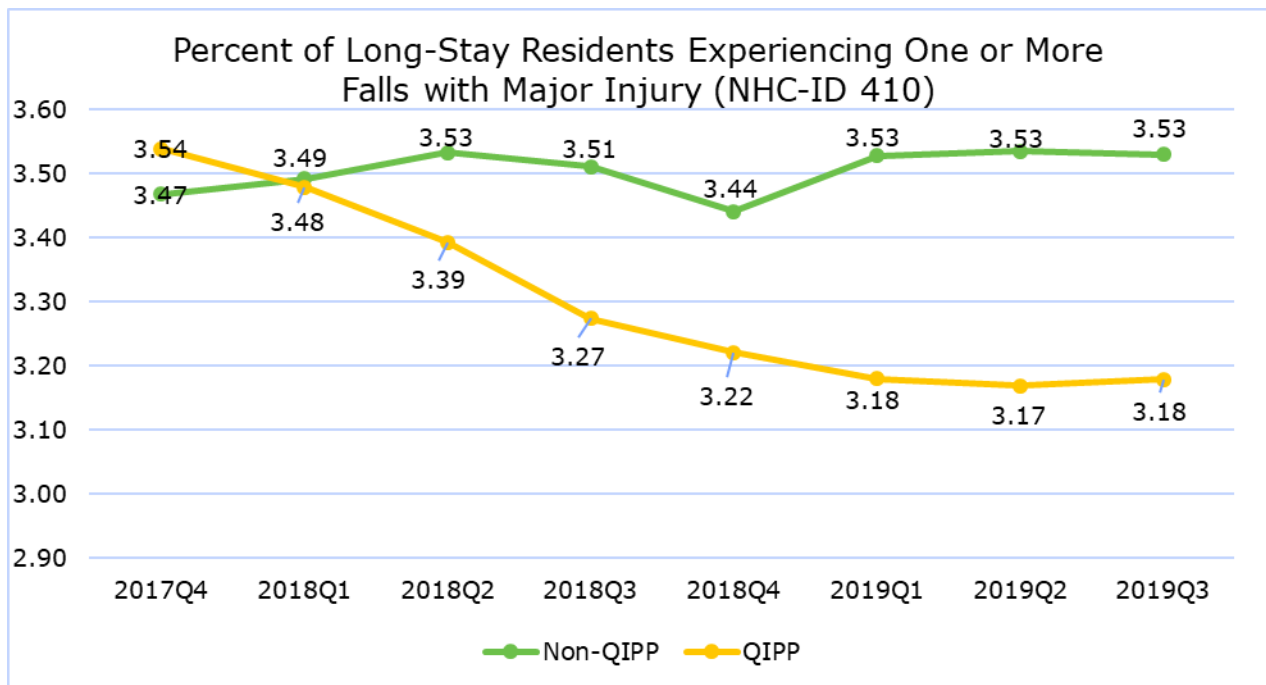
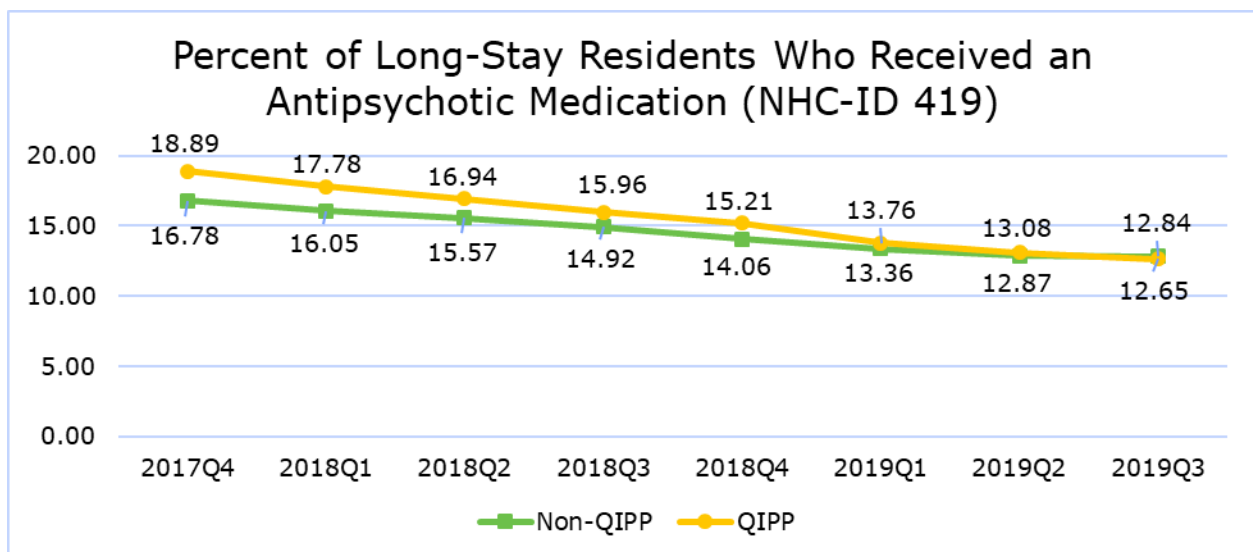


Figure 9. Percent of Long-Stay Residents Who Received an Antipsychotic Medication



In summary, results indicate that QIPP was successful in achieving significant performance gains by participating facilities on key measures of residents' health and safety. Associated payments to QIPP facilities for Years One and Two are presented in Table 9.

Table 9. Total QIPP Payments per Component, Years 1 and 2

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

QIPP Year Three (SFY 2020) Design

To continue incentivizing nursing facilities to improve quality and innovation in the provision of nursing facility services, HHSC adopted new quality measures, eligibility requirements and financing components for QIPP to begin in program Year Three (state fiscal year 2020) and continue through Year Four. The new measures were developed by a workgroup comprised of stakeholders and HHSC staff and were approved by CMS.

For fiscal year 2020, MCOs received QIPP funds through STAR+PLUS nursing facility MCO capitation rates. MCOs distributed the funds to enrolled nursing facilities based on each facility's performance on the quality measures in four program components, as follows.²⁸

²⁸ Details for QIPP Year Three Quality Metrics are available on the HHS site at: <https://hhs.texas.gov/sites/default/files/documents/services/health/medicaid-chip/programs/qipp/qipp-final-quality-metric-packet-fy-2020.pdf>

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

Funds in this Component are distributed monthly on a “Met” or Not Met” basis, contingent upon proper submission of the QAPI Validation Report.

- Payments are only available to the NSGO providers.
- Federal law requires nursing facilities to develop QAPI programs and review them quarterly. Payments for Component 1 are based on the nursing facility’s submission of an attestation of a monthly QAPI review.

Component Two: Workforce Development

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

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

- All participating facilities are eligible to earn Component Three payments.
- QIPP features three quality measures, below, computed MDS information Nursing facilities are required to report to CMS. Facilities are measured against fixed and facility-specific targets. The measures are also used by CMS in their [Five-Star Quality Rating System](#).
 - Metric 1: Percent of high-risk residents with pressure ulcers.
 - Metric 2: Percent of residents who received an antipsychotic medication.
 - Metric 3: Percent of residents whose ability to move independently has worsened.

Component Four: Infection Control Program

- HHSC designates three equally weighted quality measures for Component Four. Component Four is open only to NSGO providers.

- ▶ Metric 1: Percent of residents with a urinary tract infection. This is a Five-Star MDS quality metric and is measured against quarterly targets.
- ▶ Metric 2: Percent of residents whose pneumococcal vaccine is up to date.
- ▶ Metric 3: Facility has an infection control program that includes antibiotic stewardship. The metric encompasses a list of nine infection control elements that each facility must incorporate into its infection control program.

QIPP Year Three (SFY20) Mid-Year COVID-19 Response

In response to the COVID-19 public health emergency, CMS waived certain reporting requirements for nursing facilities effective March 1, 2020, including timeframe requirements for MDS assessments and transmission.

To account for the lack of sufficient MDS data, HHSC waived the following performance requirements connected to QIPP MDS-based quality measures, effective March 1, 2020, and for the rest of state fiscal year 2020:²⁹

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

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

QIPP Year Three Performance to Date

For Year Three, 807 nursing facilities participated in QIPP, including 507 NSGO nursing facilities and 300 private nursing facilities. The budget for year three was \$600 million.

HHSC evaluates facility performance on the quality metrics on a monthly and quarterly basis. Table 10 includes performance results and payments for quarters one through three.

²⁹ <https://hhs.texas.gov/about-hhs/communications-events/news/2020/06/qipp-performance-reporting-requirement-adjustments-due-covid-19>

**Table 10. QIPP Year 3 NF Performance by Component and Metric
Quarters 1 - 3**

Component/Metric	Percentage of Nursing Facilities Achieved Metric	Total Payments
Component 1		\$188,666,733
<i>QAPI Program</i>	99%	
Component 2		\$41,724,957
<i>+4 RN Hours</i>	82%	
<i>+8 RN Hours</i>	78%	
<i>Workforce Plan</i>	93%	
Component 3		\$101,498,172
<i>Pressure Ulcers*</i>	72%	
<i>Antipsychotic Medication*</i>	81%	
<i>Move Independently*</i>	72%	
Component 4		\$65,168,123
<i>Urinary Tract Infection*</i>	88%	
<i>Pneumococcal Vaccine</i>	87%	
<i>Infection Control Program</i>	95%	
Total Paid Year 3 to date		\$397,057,985
Total Not Earned Year 3		\$35,228,666

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

QIPP Year Four (SFY 2021)

Year Four began on September 1, 2020. Initial participation increased to 865 nursing facilities, including 547 NSGO nursing facilities and 318 privately-owned nursing facilities. The budget for year four is almost \$1.1 billion. The Year Four program structure and quality measures are the same as for Year Three.

Uniform Hospital Rate Increase Program (UHRIP)

UHRIP³⁰ is an HHSC directed-payment program in which local taxpayer funds are used to match federal Medicaid funds to increase payments to hospitals. Funds are built into MCO capitation payments and are then paid out to eligible hospitals. Directed payment programs are required by federal statute³¹ to advance at least one of the goals and objectives in the state's Medicaid quality strategy. HHSC is working with stakeholders to revise this program for state fiscal year 2022.

Network Access Improvement Program (NAIP)

NAIP is also an HHSC directed-payment program in which local taxpayer funds are used to match federal Medicaid funds. These funds are built into MCO capitation rates and are designed to increase the availability and effectiveness of primary care for Medicaid beneficiaries by incentivizing health-related institutions and public hospitals to provide quality, well-coordinated, and continuous care. HHSC is working with stakeholders to replace this program with a new program for physician practices in state fiscal year 2022.

³⁰ Information on the UHRIP program is available at: <https://hhs.texas.gov/doing-business-hhs/provider-portals/medicaid-supplemental-payment-directed-payment-programs/directed-payment-programs>

³¹ 42 CFR §438.6(c)(2)

6. HHS Quality Webpage and THLC Portal

Public reporting of measurement results can be an effective strategy to advance quality and efficiency in healthcare. HHSC continues to increase the information about quality initiatives and data available to MCOs, DMOs, providers and other stakeholders through the [HHS Quality webpage](#)³² and the THLC portal.

HHS Quality Webpage

In June 2014, HHSC launched a Medicaid and CHIP Quality and Efficiency Improvement webpage to increase transparency and public reporting. The Quality webpage serves as a one-stop information resource for Medicaid and CHIP quality improvement efforts. It aims to increase transparency and public reporting by providing easy to navigate information for the public and policymakers in one place. Regularly refreshed information on various HHSC quality improvement efforts is provided to the public. Several data files and technical details are available for more in-depth analysis by users. The webpage also houses quality reports, including the annual quality of care workbooks for all Medicaid and CHIP programs, and report cards.

Furthermore, it provides links to the latest information regarding the agency's APM initiative; the [VBPQI Advisory Committee](#); the [DSRIP Program Transition Plan](#); the [Value-Based Payment Roadmap](#); the [Texas Medicaid HIE Connectivity Project](#), a key part of the [Health Information Technology \(Health IT\) Strategic Plan](#) and the [THLC Data Portal](#).

Texas Healthcare Learning Collaborative (THLC) Portal

HHSC's [external quality review organization](#) (EQRO)³³ developed the THLC Portal ([THLCPortal.com](#)) originally as a tool to support and inform MCOs and DMOs on quality improvement activities. In collaboration with HHSC, the EQRO modified the THLC portal to serve as a public reporting platform that enables users to compare performance of programs, MCOs, DMOs and service areas across process and outcome measures and multiple time periods. Through expanded analytics and

³² Quality webpage available at: <https://hhs.texas.gov/about-hhs/process-improvement/medicaid-chip-quality-efficiency-improvement>

³³ Information about EQRO is available at: <https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html>

enhanced data visualizations, the portal allows users to better understand and compare performance and download data for customized analytics. The portal also helps providers understand opportunity areas for value-based contracting with MCOs and DMOs.

The public features of the portal include:

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

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

7. Trends in Key Quality Measures

This section presents MCO performance on critical quality measures across the Medicaid and CHIP programs. What follows is information about Potentially Preventable Events, the HHSC Performance Indicator Dashboard, HIV Viral Load Suppression³⁴ and Relocation to a Community-Based Setting.

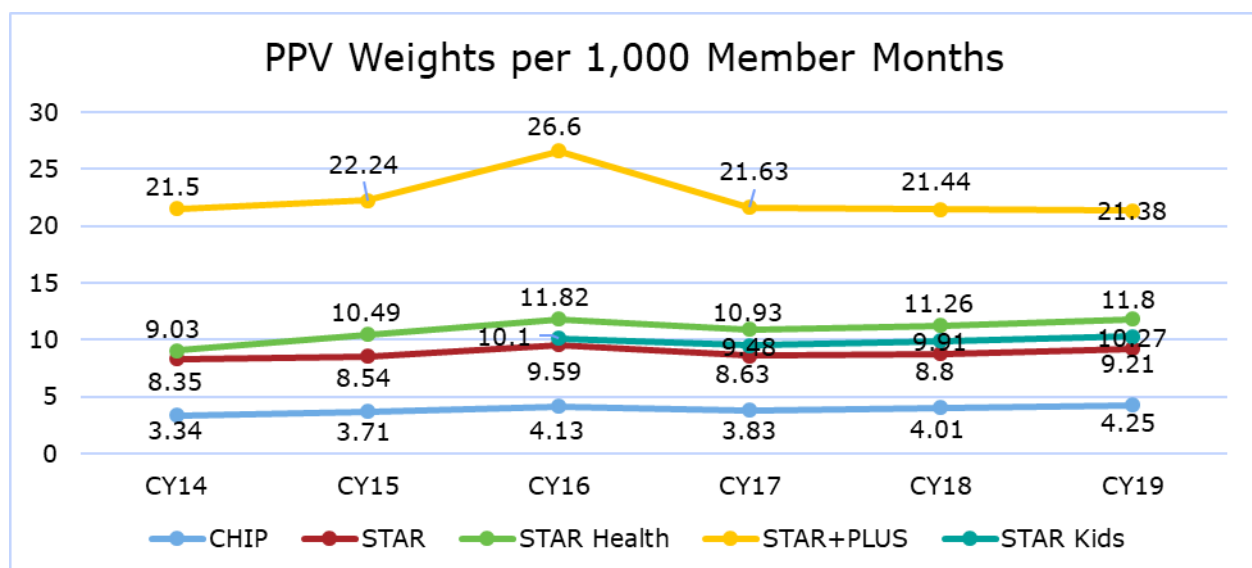
Trends in Potentially Preventable Events, 2014-2019

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

Potentially Preventable Emergency Department Visits (PPVs)

The graph below (Figure 10) shows the six-year trend for weighted rates of PPVs relative to how many people are enrolled in the program (member months). PPV is a medical P4Q measure applied across all programs. Results are presented below at the program level.

Figure 10. Six-Year Trends of PPV Weights per 1,000 Member Months - All Programs



³⁴ Per Section 536.003(g) (H.B. 1629, 85th Legislature, Regular Session, 2017) HIV Viral Suppression Rate (HIV) has recently been added to the suite of measures

Each PPV is assigned a relative weight reflecting the estimated resources needed to provide effective treatment (Y axis in graphs). National relative weights for calendar year 2019 were used to determine resource utilization.

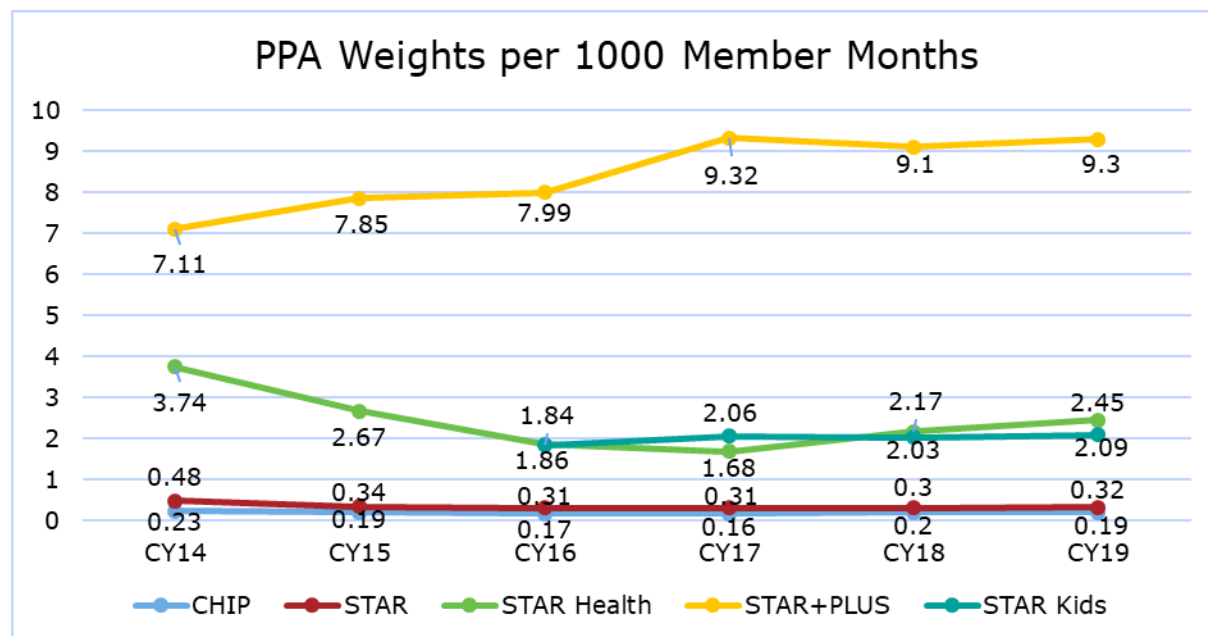
Between 2014 and 2019, PPV rates increased slightly across all programs except STAR+PLUS. Additionally, the STAR Kids Program PPV rate has remained nearly consistent since 2016. To help address PPV rates, many MCOs have instituted VBP models with providers that focus on reducing emergency department usage. Also, HHSC has included PPVs as a metric in its new value-based enrollment method to further increase accountability for MCOs.

Potentially Preventable Hospital Admissions (PPAs)

The graph below shows the six-year trend in weighted rates of PPAs relative to the number of enrollees (member months) per program. Each PPA is assigned a relative weight of the estimated resources needed to provide effective treatment. Figure 11 shows the PPA weights for all Medicaid programs and CHIP over the six-year observation period to facilitate relative comparisons between programs.

While there was a decrease in PPA in CHIP, STAR and STAR Health, PPA rates have increased in STAR+PLUS. The STAR Kids program (initiated in 2016) experienced a slight increase over the four-year period. HHSC has added PPAs to the value-based enrollment method to incentivize plans to take additional actions to improve performance.

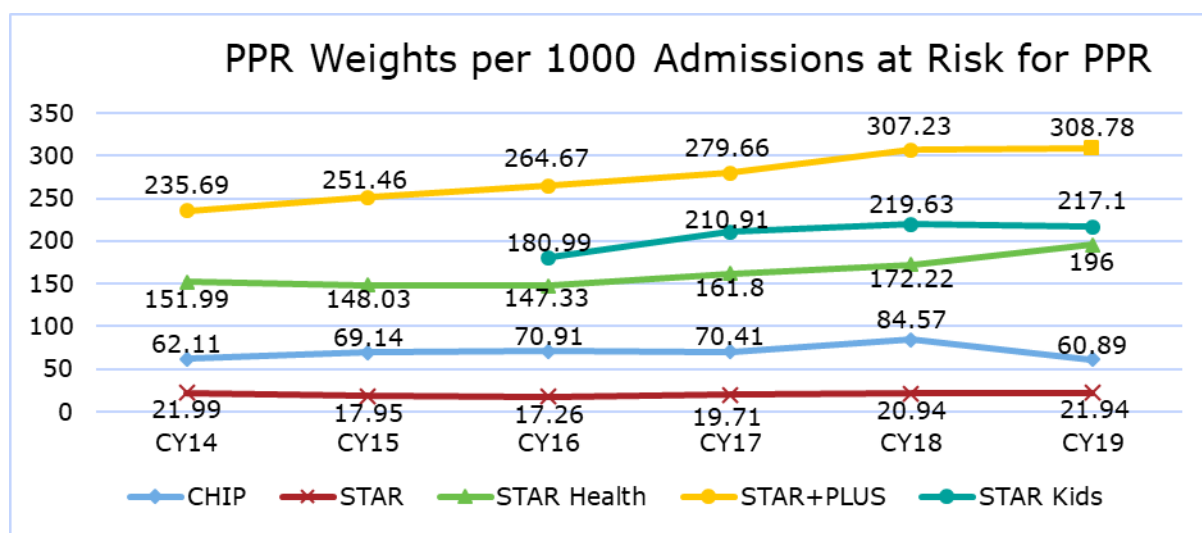
Figure 11. Six-Year Trends of PPA Weights per 1,000 Member Months - All Programs



Potentially Preventable Hospital Readmissions (PPRs)

The graph below (Figure 12) shows the six-year trend for weighted PPRs within 30 days of initial admission that were at-risk for readmission. Overall, PPRs have increased in Medicaid and CHIP, particularly in the STAR+PLUS and STAR Health program. As noted previously, in state fiscal year 2020, HHSC reduced Medicaid and CHIP capitation rates by approximately \$21.4 million with the expectation that MCOs will increase efforts to reduce their rates of PPRs by at least 10 percent. Also, for STAR+PLUS, PPRs will be included as a metric for value-based enrollment.

Figure 12. Six-Year Trends of PPR Weights per 1,000 Admissions at Risk for PPR - All Programs

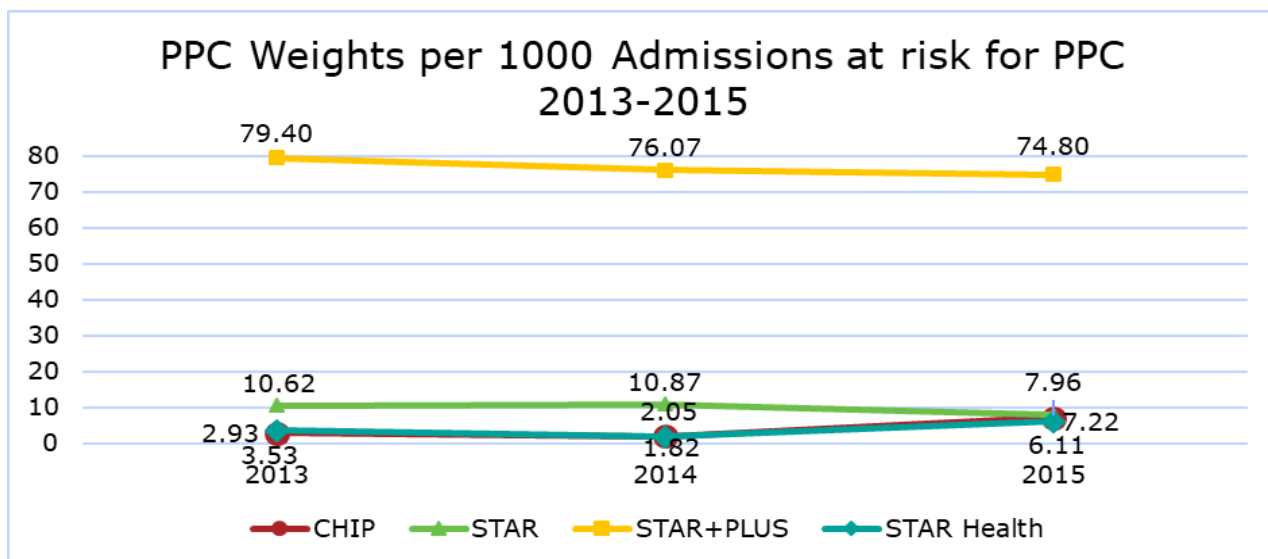


Potentially Preventable Complications (PPCs)

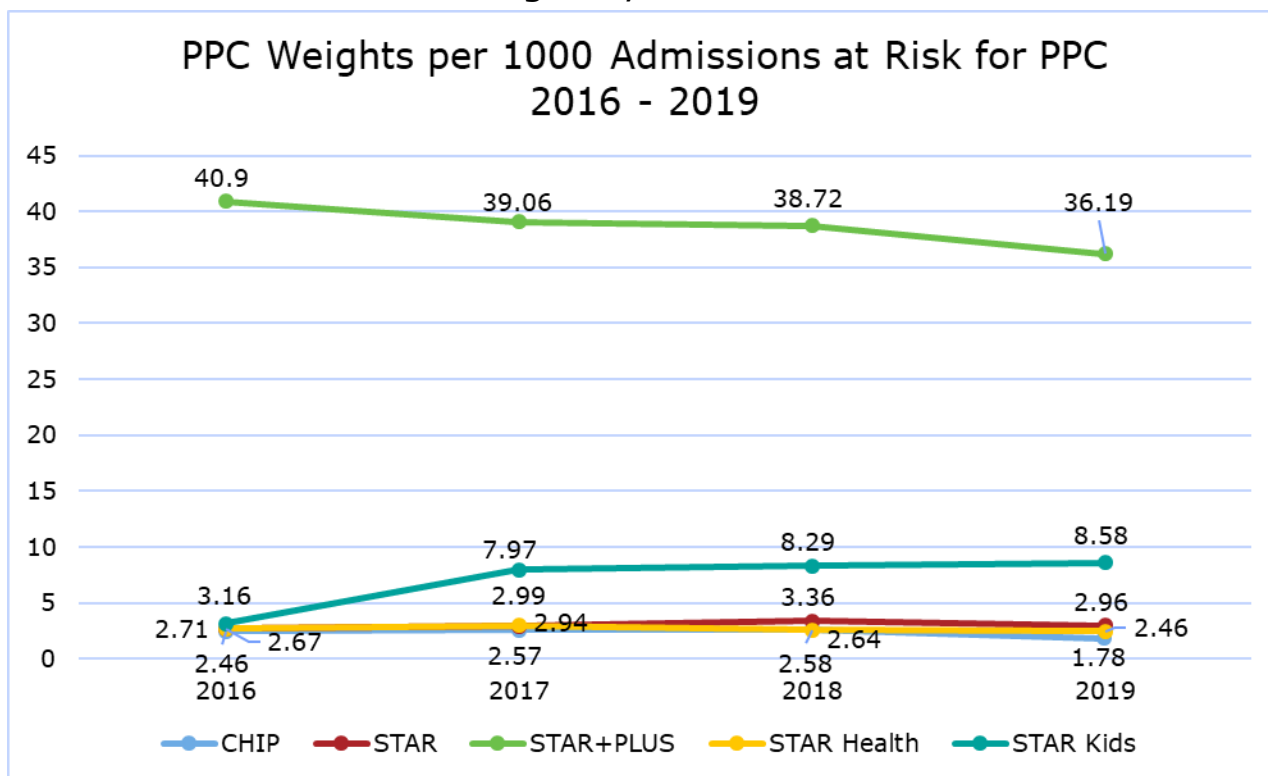
The graphs below show the six-year trends in weighted hospital inpatient PPCs for admissions that were at-risk for a complication.

As noted previously, the state's PPC methodology changed beginning with the 2017 measurement period. It is valid to conclude that overall PPC weights have declined over the six-year period, though PPC weights for calendar year 2013 through 2015 (Figure 13) should not be directly compared to PPC weights for 2016 – 2019 (Figure 14). However, the weights for 2013 – 2015 and 2016 - 2019 are comparable within each individual graph.

**Figure 13. Three-Year Trends of PPCs Per 1,000 Admissions at Risk for PPC
- All Programs, 2013 - 2015**



**Figure 14. Four-Year Trends of PPCs Per 1,000 Admissions at Risk for PPC -
All Programs, 2016 - 2019**



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

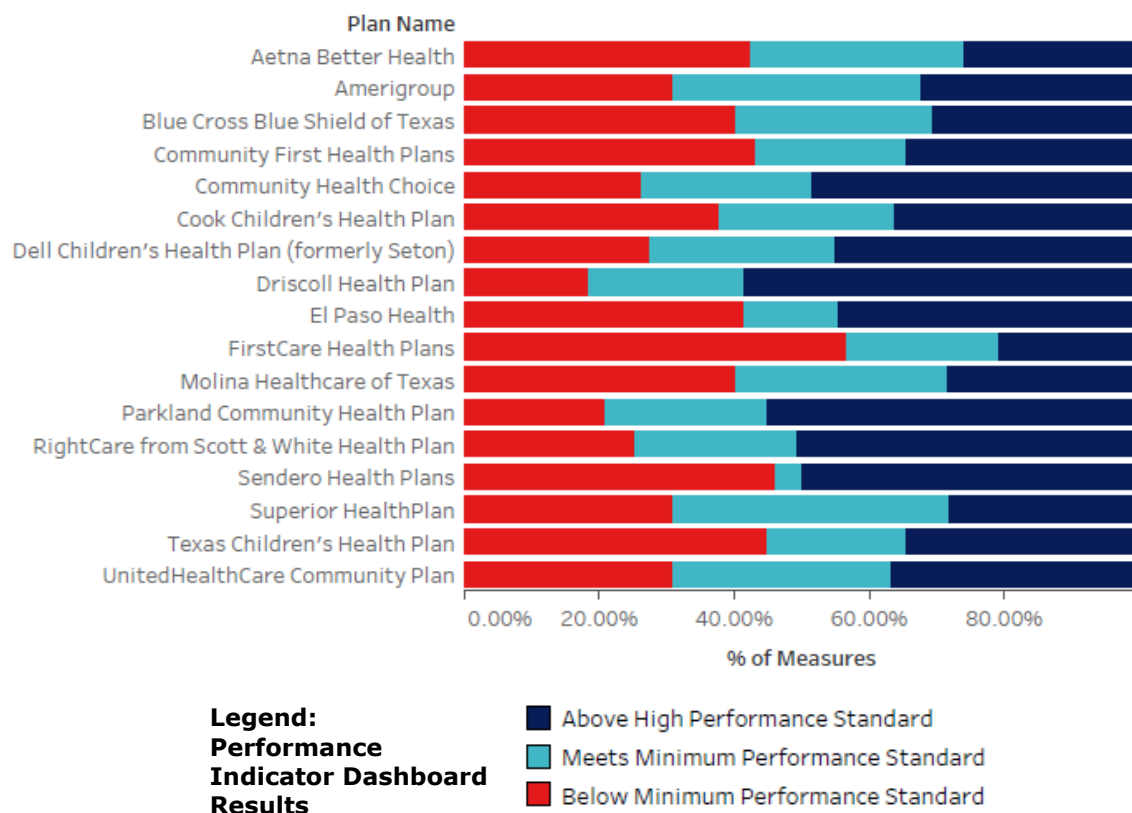
Additional Measurement Activities

HHSC Performance Indicator Dashboard

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

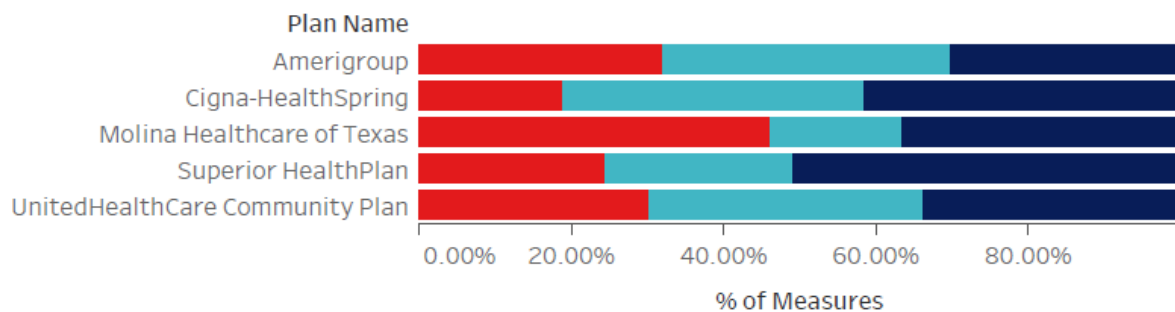
Beginning with the measurement year 2018, an MCO whose per program performance is below the minimum standard on more than 33 percent of the measures on the dashboard is subject to remedies under the contract, such as placement on a corrective action plan (CAP). For more information, please see Chapter 10.1.14 of the Uniform Managed Care Manual.³⁵ Calendar year 2018 Performance Indicator Dashboard results for STAR and STAR+PLUS, are presented in Figures 15 and 16, below, and added detail for these and other programs is available on the THLC portal.

Figure 15. STAR Performance Indicator Dashboard Results by MCO, CY 2018



³⁵ <https://hhs.texas.gov/sites/default/files/documents/laws-regulations/handbooks/umcm/10-1-14.pdf>

Figure 16. STAR+PLUS Performance Indicator Dashboard Results by MCO, CY 2018



HIV Viral Load Suppression

H.B. 1629, 85th Legislature, Regular Session, 2017, requires HHSC to coordinate with the Texas Department of State Health Services (DSHS) to develop a quality-based outcome measure for individuals with human immunodeficiency virus (HIV) in the CHIP and Medicaid programs. To fulfill this requirement, HHSC is monitoring MCO performance using the HIV viral load suppression measure (HIV measure) from CMS. Beginning with calendar year 2018, HHSC added the measure to its Performance Indicator Dashboard.

The HIV measure is defined as the percentage of patients, regardless of age, with a diagnosis of HIV, with a HIV viral load less than 200 copies/mL at their last HIV viral load test, during the measurement year (Table 11).

Table 11. Percentage of individuals meeting the HIV viral suppression standard, CY 2018

Program	Total Individuals with HIV	Total number Virally Suppressed	Percentage Virally Suppressed
STAR	1,002	679	68%
STAR+PLUS	5,677	3,986	70%
CHIP	95	78	82%

Source: HIV Surveillance Data, Electronic Lab Records linked to Medicaid Claims Data, 2018.

Relocation to a Community-Based Setting

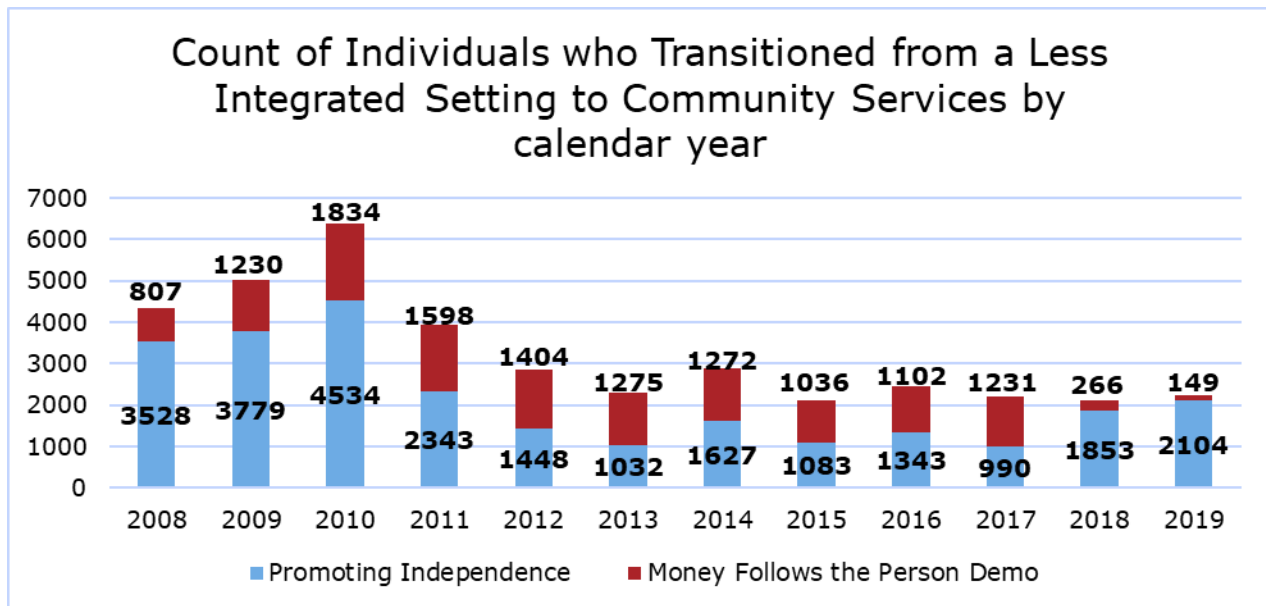
Senate Bill 7, 83rd Legislature, Regular Session, 2013, requires HHSC, as appropriate, to report the number of recipients who relocated to a community-based setting from a less integrated setting. The two initiatives analyzed are [Promoting Independence \(PI\)](#)³⁶ and [Money Follows the Person \(MFP\)](#).³⁷

The data in this section provides a snapshot over time of the progress made in moving individuals from institutional care to community-based settings. The PI and MFP initiatives combined have had an important impact in Texas. The 81st, 82nd, 83rd and 84th Legislatures appropriated a significant amount of general revenue (GR) to community-based programs to reduce Medicaid 1915(c) long-term services and supports waiver interest lists and support individuals transitioning from institutional to community-based settings. HHSC has been able to meet the transition needs of all who ask and are qualified to transition. HHSC fulfills these requests by filling attrition slots. As Figure 17 indicates, since its implementation in 2003, 25,332 people transitioned to the community under the Promoting Independence Initiative. MFP has helped another 13,000 individuals transition from institutional to community-based services. The combined total of transitions since 2003 is 38,332. An MFP evaluation by Mathematica found that Texas led all 44 MFP states in the cumulative number of transitions at 11,433 at the time of the 2016 final report. In 2019, the total number of transitions was 2,176, compared with 2,120 the previous year.

³⁶ Information regarding Promoting Independence available at <https://hhs.texas.gov/doing-business-hhs/provider-portals/resources/promoting-independence-pi>

³⁷ Information regarding Money Follows the Person available at <https://hhs.texas.gov/doing-business-hhs/provider-portals/resources/promoting-independence/money-follows-person-demonstration-project>

Figure 17. Promoting Independence and Money Follows the Person Programs – Transitions from Less-Integrated Settings



Data Source: DADS QAI Data Mart. 10 MFP Demo Semi- Annual Newly Enrolled Participants by Target Population Report. Report Generated August 17, 2020.

8. Conclusion

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

This latest annual review of quality measures and APMs finds the state meeting important milestones in its transition to value-based care. The state's primary quality and value-based incentive programs (Medical and Dental P4Q, MCO APM contract requirements, Nursing Home QIPP and the HQBP program) continue to reward MCOs and providers that achieve high results on key outcome measures.

New, quality-based initiatives are coming online in state fiscal years 2021 and 2022. HHSC is incorporating quality and value-based metrics into MCO enrollment allocations. Through the DSRIP program, HHSC and its stakeholders are working on ideas to sustain and deepen value-based reforms, while providing needed funding for locally administered quality improvement initiatives. And, increasingly, dollars in the state's directed payment programs will be linked to achievement of quality improvement goals.

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

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

List of Acronyms

Acronym	Full Name
AHRQ	Agency for Healthcare Research and Quality
APM	Alternative Payment Models
AWC	Adolescent Well Care
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CAP	Corrective Action Plan
CBP	Blood Pressure Controlled
CCS	Cervical Cancer Screening
CDC	Center for Disease Control
CHIP	Children Health Insurance Program
CIS	Childhood Immunization Status
CMS	Centers for Medicare and Medicaid Services
DADS	Department of Aging and Disability Services
DMO	Dental Maintenance Organization
DQA	Dental Quality Alliance
DSHS	Department of State Health Services
DSRIP	Delivery System Reform Incentive Payment
DY	Demonstration Year
ED	Emergency Room
FFS	Fee-For-Service
HB	House Bill
HCP LAN	Healthcare Effectiveness Data and Information Set
HHS	Health and Human Services
HHSC	Health and Human Services Commission
HIV	Human Immunodeficiency Virus

Acronym	Full Name
HQBP	Hospital Quality-Based Payment
LAN	Learning and Action Network
MFP	Money Follows the Person
NAIP	Network Access Improvement Program
NCQA	National Center for Quality Assurance
NF	Nursing Facility
NSGO	Non-State Government Owned
P4Q	Pay-for-Quality
PI	Promoting Independence
PMPM	Per Member Per Month
PPA	Potentially Preventable Hospital Admissions
PPC	Potentially Preventable Hospital Complications
PPR	Potentially Preventable Hospital Readmissions
PPV	Potentially Preventable Emergency Room Visits
QAI	Quality Assurance and Improvement
QIPP	Quality Incentive Payment Program
S.B.	Senate Bill
SSD	Screening for People with Schizophrenia or Bipolar Disorder
STAR	State of Texas Access Reform
STAR+PLUS	State of Texas Access Reform Plus
THLC	Texas Healthcare Learning Collaborative
UHRIP	Uniform Hospital Rate Increase Program
URI	Upper Respiratory Infection
VBP	Value-Based Payment
WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents