MCO Quality Meeting

MCS Quality & Program Improvement

February 16, 2022
Agenda

1. Welcome/Introductions
2. HB 2658 Increasing Disease Management Participation
3. Next Steps on the Road to Value-Based Care
   a. Annual Report on Quality Measures and VBP
   b. Future MCO Alternative Payment Model Requirements
   c. Policy Recommendations for Value-Based Committees
4. Nursing Facility Minimum Performance Standards
5. STAR Kids Screening and Assessment Instrument (SK-SAI)
6. Open Discussion
7. Close
HB 2658 Increasing Disease Management Participation

Pre-Implementation Discussion

Shelby Eidson, Quality Analyst, Quality Assurance
Background

H.B. 2658 passed in the 87th Legislature, effective September 1, 2021.

Disease management aims of H.B. 2658:

• HHSC shall study MCO disease management programs and identify factors influencing active participation by Medicaid recipients in disease management programs by examining variations in:
  a. Eligibility criteria for the programs; and
  b. Participation rates by health plan, disease management program, and year.

• Requires MCOs to develop approaches to increase active participation in disease management programs for high-risk recipients.
Implementation Plan

The External Quality Review Organization (EQRO) will conduct a study of MCO Disease Management Programs to understand factors that influence active participation in Disease Management programs.

Information from the study will provide better informed requirements for MCOs in these programs.

Recommendations made by the EQRO will be used to revise the UMCM.

After UMCM revisions are finalized, MCO notice of UMCM amendments will be posted via TexConnect.
Questions

• How can HHSC change the guidelines to support innovation in Disease Management programs?

• Are there any barriers to MCO innovation in Disease Management programs of which HHSC should be aware?

• What are your biggest success stories in Disease Management programs? These can be anecdotal or more quantifiable.
  • Have you been able to replicate or quantify that success?
  • What made it that story a success?
Thank You.

Shelby.Eidson@hhs.Texas.gov
Next Steps on the Road to Value-Based Care

Jimmy Blanton, Director, Value-Based Initiatives
Value-Based Care Next Steps: Key Inputs

• Annual Report on Quality Measures and Value-Based Payments
• Alternative Payment Model Contract Requirements
• Policy Recommendations for Value-Based Committees
Annual Report on Quality Measures and Value-Based Payments

Report Background

• Texas Government Code, Section 536.008, directs the Health and Human Services Commission to report annually on its efforts to develop quality measures and value-based payment initiatives.

• This annual report presents information on HHSC’s healthcare quality improvement activities for the Texas Medicaid program and the Children’s Health Insurance Program.

• 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
Medical Pay-for-Quality (P4Q) Program

Medical P4Q Program Background

• MCO Premiums at Risk (3% MCO)
• MCO performance is evaluated in three ways:
  1. Performance against self (comparison of an MCO's performance to its prior year performance)
  2. Performance against benchmarks (comparison of an MCO's performance against Texas and national peers)
  3. Bonus pool measures
• Each program (STAR, STAR+PLUS, CHIP) includes measures specific to the population

Link: HHSC MCS P4Q Program web page
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.
# STAR Performance Indicator Dashboard Results by MCO, Calendar Year 2019

<table>
<thead>
<tr>
<th>MCO NAME</th>
<th>Below Minimum Performance Standard</th>
<th>Meets Minimum Performance Standard</th>
<th>Above High Performance Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>57.35%</td>
<td>26.47%</td>
<td>16.18%</td>
</tr>
<tr>
<td></td>
<td>49.28%</td>
<td>23.19%</td>
<td>27.54%</td>
</tr>
<tr>
<td></td>
<td>46.15%</td>
<td>20.00%</td>
<td>33.85%</td>
</tr>
<tr>
<td></td>
<td>38.24%</td>
<td>29.41%</td>
<td>32.35%</td>
</tr>
<tr>
<td></td>
<td>26.09%</td>
<td>18.84%</td>
<td>55.07%</td>
</tr>
<tr>
<td></td>
<td>26.87%</td>
<td>23.88%</td>
<td>49.25%</td>
</tr>
<tr>
<td></td>
<td>32.26%</td>
<td>25.81%</td>
<td>63.24%</td>
</tr>
<tr>
<td></td>
<td>16.18%</td>
<td>41.94%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>44.12%</td>
<td>10.29%</td>
<td>63.24%</td>
</tr>
<tr>
<td></td>
<td>57.35%</td>
<td>14.71%</td>
<td>27.94%</td>
</tr>
<tr>
<td></td>
<td>46.38%</td>
<td>13.04%</td>
<td>40.58%</td>
</tr>
<tr>
<td></td>
<td>33.33%</td>
<td>23.19%</td>
<td>43.48%</td>
</tr>
<tr>
<td></td>
<td>33.33%</td>
<td>28.79%</td>
<td>37.88%</td>
</tr>
<tr>
<td></td>
<td>49.28%</td>
<td>20.29%</td>
<td>30.43%</td>
</tr>
<tr>
<td></td>
<td>37.68%</td>
<td>14.49%</td>
<td>47.83%</td>
</tr>
<tr>
<td></td>
<td>36.23%</td>
<td>24.64%</td>
<td>39.13%</td>
</tr>
</tbody>
</table>

**PERCENTAGE OF MEASURES**

- Below Minimum Performance Standard
- Meets Minimum Performance Standard
- Above High Performance Standard
Value-Based Enrollment (VBE) (1 of 2)

- Implemented September 1, 2020.

**How it works**
MCOs with better performance than others on the factors listed below receive a higher share of default enrollments (Medicaid recipients that do not choose a health plan) than under the previous methodology.

**Criteria and Weighting**

40% Cost and Efficiency
Risk-Adjusted Ratio of Actual to Expected Spending

20% Cost and Quality
Risk-Adjusted Potentially Preventable Events (PPE) Ratios

40% Quality and Member Satisfaction
Composite MCO Report Card Scores

[Link: HHSC Value-Based Enrollment Incentive Program Report]
Value-Based Enrollment (VBE) (2 of 2)

• After implementation, HHSC assessed the effect of the VBE process based on six months of enrollment data for STAR, STAR+PLUS, and STAR Kids.

• For 17 participating MCOs across the programs from December 2020 to May 2021:
  • Five plans gained greater than 2.5 percent in auto-enrollments compared to the previous process
  • Five plans lost at least 2.5 percent
  • Seven plans saw changes of no greater than 2.5 percent
  • Overall enrollment based on the new methodology varied between over 12 percent gains to almost 12 percent losses in cumulative proportions across the programs
Hospital Quality-Based Payment Program (HQBP)

• HHSC administers the HQBP Program for all hospitals in Medicaid and CHIP in the managed care and FFS delivery systems.

• 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 Programs and CHIP, 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 2 percent for high rates of PPRs
  • 2.5 percent for PPCs

• Measurement, reporting and application of payment adjustments occur on an annual cycle.
Changes in hospital PPR performance for 2014-2020
Resources

Annual Report on Quality Measures and Value-Based Payments

Future MCO Alternative Payment Model Requirements
Revisions to Contract and Manual

Jimmy Blanton, Director, Value-Based Initiatives
## Current APM Targets

**Table 1 - The annual MCO targets established by HHSC by Calendar Year**

HHSC will require that MCOs increase their total APM and risk based APM ratios according to the following schedule*

<table>
<thead>
<tr>
<th>Period</th>
<th>Minimum Overall APM Ratio</th>
<th>Minimum Risk-Based APM Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calendar Year 1</td>
<td>&gt;= 25%</td>
<td>&gt;= 10%</td>
</tr>
<tr>
<td>Calendar Year 2</td>
<td>Year 1 Overall APM Ratio +25%</td>
<td>Year 1 Risk-Based APM Ratio +25%</td>
</tr>
<tr>
<td>Calendar Year 3</td>
<td>Year 2 Overall APM % + 25%</td>
<td>Year 2 Risk-Based APM % + 25%</td>
</tr>
<tr>
<td>Calendar Year 4</td>
<td>&gt;= 50%</td>
<td>&gt;= 25%</td>
</tr>
</tbody>
</table>

* An MCO entering a new program or a new service area, will begin on Calendar Year 1 of the targets as of the first day of its first calendar year in the program.

~ Targets started in CY 2018. HHSC will extend CY 2021 target through CY 2022.
Overall APM Achievement by Program CYs 2018 - 2019

Targets
Year 1 = 25% & Year 2 = 31.25%

<table>
<thead>
<tr>
<th>Program</th>
<th>2018</th>
<th>2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>STAR</td>
<td>43%</td>
<td>49%</td>
</tr>
<tr>
<td>STAR+PLUS</td>
<td>37%</td>
<td>44%</td>
</tr>
<tr>
<td>CHIP</td>
<td>39%</td>
<td>42%</td>
</tr>
<tr>
<td>STAR Kids (Year 1)</td>
<td></td>
<td>29%</td>
</tr>
</tbody>
</table>
Risk-Based APM Achievement by Program CYs 2018 - 2019

Targets
Year 1 = 10% &
Year 2 = 12.5%
Recommendation: HHSC should adopt a more comprehensive contractual APM framework to assess MCO achievement

- Move away from a specific focus on meeting APM targets
- Provide a menu of approaches to give MCOs credit for a broader range of work promoting value-based care
- Revise the current APM reporting tool to collect only needed data in as streamlined a format as possible
## Potential APM Menu Options Identified by VBPQIAC  (1 of 3)

<table>
<thead>
<tr>
<th>Example Menu</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Maintaining or improving on current APM benchmarks (total dollars involved in APMs)</td>
<td></td>
</tr>
<tr>
<td>• Meeting APM targets for challenging circumstances, e.g., APMs in rural areas (challenges can change over time)</td>
<td></td>
</tr>
<tr>
<td>• Improving APM rates for priority sectors with low APM participation, e.g., home-health or behavioral health (priority sectors can change over time).</td>
<td></td>
</tr>
<tr>
<td>• Increasing the amount of dollars providers earn or can earn through APMs</td>
<td></td>
</tr>
</tbody>
</table>
### Example Menu

<table>
<thead>
<tr>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Monitoring provider satisfaction or establishing other formal provider outreach mechanisms related to APMs <strong>OR</strong> processes for provider engagement</td>
</tr>
<tr>
<td>• Sharing data with providers through HIE (e.g., ADT data) or claims</td>
</tr>
<tr>
<td>• Sharing performance reports and best practices with providers</td>
</tr>
<tr>
<td>• Improving on quality measures <strong>or</strong> documenting processes that describe outcomes achieved and improvements that can be made in future years</td>
</tr>
</tbody>
</table>
## Potential APM Menu Options Identified by VBPQIAC (3 of 3)

<table>
<thead>
<tr>
<th>Example Menu</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Developing innovative approaches to address SDOH:</td>
<td></td>
</tr>
<tr>
<td>1. Leveraging VBP to incent the reduction of health disparities</td>
<td></td>
</tr>
<tr>
<td>2. Addressing SDOH as part of an APM?</td>
<td></td>
</tr>
<tr>
<td>• Developing a formal strategic plan for advancing APMs</td>
<td></td>
</tr>
<tr>
<td>• Collaborating with other MCOs within a service area (region) on standard measures and APM models</td>
<td></td>
</tr>
<tr>
<td>• Establishing formal APM evaluation criteria and reporting on evaluation results for key APMs</td>
<td></td>
</tr>
</tbody>
</table>
Timeline for Submitting Contract & Manual Changes

MCO/DMO Contract Amendment Process:
• Concept Phase: Complete
• Refinement Phase: Feb – Jun 2022
• Finalization Phase: Jun – Jul 2022
• Routing & Execution: Jul – Aug 2022

MCO/DMO Manual Amendment Process:
• Update current APM tool to be effective January 1, 2023
Policy Recommendations for Value-Based Committees

Jimmy Blanton, Director, Value-Based Initiatives
Palliative Care Interdisciplinary Advisory Council- Legislative Report Topics

• Improvement of pediatric supportive palliative care (SPC)
• Changes to Home Health licensing and regulations
• Proposed benefit: advance care planning
• Medical cannabis in the hospital setting
• Reimbursement for Child-Life Specialists
• Promoting education and awareness of SPC
Policy Council for Children and Families- Legislative Report Topics

- Applied Behavioral Analysis for kids with Autism Spectrum Disorder
- Workforce Needs
- Education and Employment- training on special needs populations
- Reduce Interest List (MDCP Interest List)
- Increase Medicaid Buy-In to 300 % FPL
- Transition Services:
  - Transition care from pediatric to adolescent care
  - Post-secondary transition for young adults with an Intellectual and Development Disability (IDD)
- Texas Early Hearing Detection and Intervention- hearing screening
- Accessibility issues with playgrounds and restrooms for special needs population
Value-Based Payment Quality Improvement Advisory Committee - Legislative Report Topics

- Advancing value-based payment:
  - Home Health
  - Pharmacy
- Addressing Social Driver’s of Health (SDOH) through in-lieu of services
- Next steps for Medicaid alternative payment models and HHSC contract language
- Improving the use of data for healthcare quality improvement
Thank You

Jimmy Blanton
Director, Office of Value-Based Initiatives
Jimmy.Blanton@hhs.texas.gov
Nursing Facility Minimum Performance Standards

Amber Campbell, Director, Quality Monitoring Program
Background (1 of 2)

Senate Bill 7 (83rd Regular Legislative Session, 2013) required HHSC to establish STAR+PLUS nursing facility (NF) credentialing and minimum performance standards (MPS).

• This allowed a STAR+PLUS MCO to refuse to contract, or terminate a contract, with a NF if the NF did not meet the MPS.

• HHSC amended the contracts to add STAR+PLUS NF credentialing requirements and a reference to MPS requirements.

• After discussions and workgroups with stakeholders, HHSC was ready to move forward with a July 2021 implementation date.
Background (2 of 2)

House Bill 2658 Sec. 2(h) (87th Regular Legislative Session, 2021) directed the executive commissioner to adopt rules establishing MPS applicable to nursing facility providers that participate in the program. The commission is responsible for monitoring provider performance in accordance with the standards and requiring corrective actions, as the commission determines necessary, from providers that do not meet the standards. The commission shall share data regarding the requirements of this subsection with STAR+PLUS Medicaid managed care organizations as appropriate.
Description

The goal is to address the problem of low and underperforming NFs delivering services to Texas Medicaid recipients by:

• Establishing a high-quality monitoring and corrective action process with MCOs and NFs.
• Creating UMCM requirements for MCOs.
• Drafting rules supporting HHSC's enforcement of the monitoring and corrective action process.
# Project Roadmap – Desired To-Be State Example

<table>
<thead>
<tr>
<th>CURRENT STATE</th>
<th>FUTURE STATE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MCOs</strong></td>
<td>• New requirements for MCOs &amp; new monitoring processes for QMP</td>
</tr>
<tr>
<td>• No monitoring or oversight processes are in place</td>
<td>• New monitoring processes for QMP</td>
</tr>
<tr>
<td><strong>NFs</strong></td>
<td>• New monitoring processes for QMP</td>
</tr>
<tr>
<td>• No corrective actions are in place</td>
<td>• UMCM requirements must be implemented</td>
</tr>
<tr>
<td><strong>HHSC</strong></td>
<td>• Expedited rules process will be used to prepare HHSC, MCOs, and NFs for implementation</td>
</tr>
<tr>
<td>• No monitoring or oversight processes are in place</td>
<td></td>
</tr>
<tr>
<td><strong>UMCM</strong></td>
<td></td>
</tr>
<tr>
<td>• No requirements are in place</td>
<td></td>
</tr>
<tr>
<td><strong>Rules</strong></td>
<td></td>
</tr>
<tr>
<td>• No rules are in place</td>
<td></td>
</tr>
</tbody>
</table>
Measures, Benchmarks & Results

- Percent of long-stay residents whose need for help with activities of daily living has increased.
- Percent of high-risk residents with pressure ulcers.
- Percent of residents assessed and appropriately given the seasonal influenza vaccine.
- Percent of residents assessed and appropriately given the pneumococcal vaccine.
- Percent of residents whose ability to move independently worsened.
Anticipated Outcomes

• Empower MCOs to address quality of care in nursing facilities.
• Ensure nursing facilities are performing efficiently.
• Create sustainable monitoring and corrective action processes to support continued improvements in the quality of care for residents living in Medicaid funded facilities.
Timeline of Project Completion Process

1/2/22
1. Create monitoring & communication plan for NFs and MCOs

2/1/22
2. Begin analysis of minimum performance standards 2021 CMS data

5/1/22
3. Obtain SMD approval to implement proposed plan

5/1/22
4. Propose UMCM changes

8/1/22
5. Expedited rules are effective

December 2022

December 2022
6. Begin expedited rules process

December 2022
7. Start MCO comment period for UMCM chapters

December 2022
8. Post MCO notice of UMCM amendments to TexConnect
Thank You!

Amber.Campbell03@hhs.texas.gov
STAR Kids Screening and Assessment Instrument (SK-SAI)

Soila Villarreal, Dr.PH, MPH, Quality Analyst, Quality Assurance
SK-SAI Background

Goals for using SK-SAI data to help evaluate quality:

• Fill gaps in the national standardized measure sets to ensure we are evaluating domains of care important to members and their families
• Fulfill EQRO recommendation in the STAR Kids implementation study report
• Responsive to SB 1207, 86th Regular Session, 2019 Sec. 531.06021 MDCP waiver program quality monitoring
• Responsive to STAR Kids Advisory Committee recommendation to utilize SK-SAI data for quality measures
# SK-SAI Measures

**Data Selection**

<table>
<thead>
<tr>
<th>Year</th>
<th>Health Plan</th>
<th>Service Area</th>
</tr>
</thead>
<tbody>
<tr>
<td>2020</td>
<td>ALL</td>
<td>ALL</td>
</tr>
</tbody>
</table>

**Sex**

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>AgeBand</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALL</td>
<td>ALL</td>
</tr>
</tbody>
</table>

**Measure Domain**

<table>
<thead>
<tr>
<th>Item Search</th>
</tr>
</thead>
<tbody>
<tr>
<td>(All)</td>
</tr>
</tbody>
</table>

Hover over links to see detailed description and all response options.
## SK-SAI Measures cont.

Hover over a rate to see detailed description and all response options.

<table>
<thead>
<tr>
<th>Domain</th>
<th>Measure</th>
<th>Rate</th>
<th>Plan Rank</th>
<th>SA Rank</th>
<th>SA x Plan</th>
<th>Peer Comparison</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caregiver</td>
<td>Caregiver Sleep Improvement</td>
<td>25.8</td>
<td>+</td>
<td>+</td>
<td>fi</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Caregiver Distress Improvement</td>
<td>32.6</td>
<td>+</td>
<td>+</td>
<td>fi</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Caregiver Burden Improvement</td>
<td>24.4</td>
<td>+</td>
<td>+</td>
<td>fi</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coordination</td>
<td>Person-centered Assessment (M04)</td>
<td>52.0</td>
<td>+</td>
<td>+</td>
<td>fi</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Care Goals Met</td>
<td>61.6</td>
<td>+</td>
<td>+</td>
<td>fi</td>
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<td></td>
</tr>
<tr>
<td></td>
<td>Service Coordinator Contact</td>
<td>94.0</td>
<td>+</td>
<td>+</td>
<td>fi</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tailored ISP</td>
<td>87.2</td>
<td>+</td>
<td>+</td>
<td>fi</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Functioning</td>
<td>ADL Improvement</td>
<td>12.0</td>
<td>+</td>
<td>+</td>
<td>fi</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>IADL Improvement</td>
<td>13.6</td>
<td>+</td>
<td>+</td>
<td>fi</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Integration</td>
<td>School Integration</td>
<td>85.6</td>
<td>+</td>
<td>+</td>
<td>fi</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Member Employment</td>
<td>8.5</td>
<td>+</td>
<td>+</td>
<td>fi</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Participation in Activities</td>
<td>77.5</td>
<td>+</td>
<td>+</td>
<td>fi</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Integration (Improvement)</td>
<td>Participation Improved</td>
<td>35.3</td>
<td>+</td>
<td>+</td>
<td>fi</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Services</td>
<td>Effective Medical Home</td>
<td>93.6</td>
<td>+</td>
<td>+</td>
<td>fi</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>PCP Refined</td>
<td>98.2</td>
<td>+</td>
<td>+</td>
<td>fi</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Unplanned Physician Visits (1+)</td>
<td>48.7</td>
<td>+</td>
<td>+</td>
<td>fi</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Unplanned Hospitalizations (1+)</td>
<td>8.4</td>
<td>+</td>
<td>+</td>
<td>fi</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social</td>
<td>Household Positivity</td>
<td>74.6</td>
<td>+</td>
<td>+</td>
<td>fi</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Peer Positivity</td>
<td>73.3</td>
<td>+</td>
<td>+</td>
<td>fi</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social (Improvement)</td>
<td>Household Positivity Improved</td>
<td>32.9</td>
<td>+</td>
<td>+</td>
<td>fi</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Peer Positivity Improved</td>
<td>31.6</td>
<td>+</td>
<td>+</td>
<td>fi</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Questions?

Soila.Villarreal@hhs.Texas.gov