MCO Quality Meeting

Facilitated By The Office of Quality & Program Improvement

July,19 2022

Agenda

1. Welcome/Introductions
2. UTHSCSA Presentation
3. Directed Payment Program
4. QIPP Updates
5. Minimum Performance Standards
6. PPE Analysis
7. APM Requirements
8. Advisory Committee Recommendations
9. Updates from Quality Assurance
10. Upcoming Events
11. Open Discussion & Close

Welcome & Introductions

Emily Sentilles, *Deputy Associate Commissioner*

MCS Quality & Program Improvement

International Center of Excellence for Evidence Based Practices

Natalie Maples, DrPH, MA
UT Health San Antonio, Department of Psychiatry,
Division of Community Recovery, Research, and training

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The Basics

- Many different conditions are associated with difficulties in cognitive functioning (memory, attention, setting and maintaining goals)
- Cognitive functioning can predict how well we complete everyday independent tasks, and therefore, our overall recovery goals
- Helping someone build structure or habits decreases the amount of work for them to continue successfully completing their goals

Cognitive Functioning Predicts Real-World Outcomes

Executive Function

Attention

Memory

Psychomotor Speed

→

Independent/ Daily Living Skills

Social

Work

Cognitive Functioning Predicts Real-World Outcomes

Executive Function

Attention

Memory

Psychomotor Speed

Independent/ Daily Living Skills

Social Function

Work

Cognitive Adaptation Training (CAT)
Environmental Supports

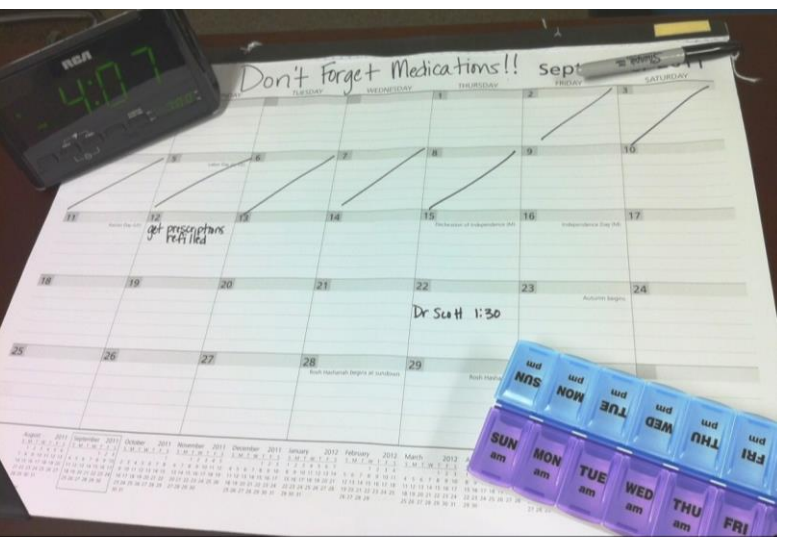
Cognitive Adaptation Training (CAT)

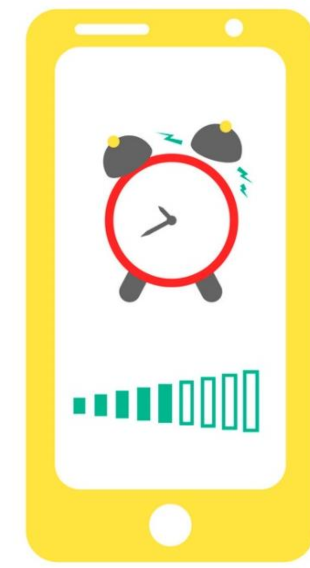
- CAT uses environmental supports such as signs, calendars, checklists and the reorganization of belongings designed to get around difficulties in cognitive functions and improve success in everyday behaviors
- Is completed in the individual's home environment
- Is evidence-based (20+ years), including MFP-BHP 10 years
- Uses a motivational strengths perspective to facilitate a person's initiatives and independence – overall goal of improved health
- Billable under psychosocial rehab

Areas of Intervention

Bathing	Laundry
Dressing	Grocery Shopping
Dental Hygiene	Transportation
Orientation	Leisure Skills
Work/Vocational Skills	Toileting
Social Skills, Communication and Telephone Use	Housekeeping/Care of Living Environment
Eating, Nutrition and Cooking	Money Management/Budgeting
Medication Management	Coping Skills

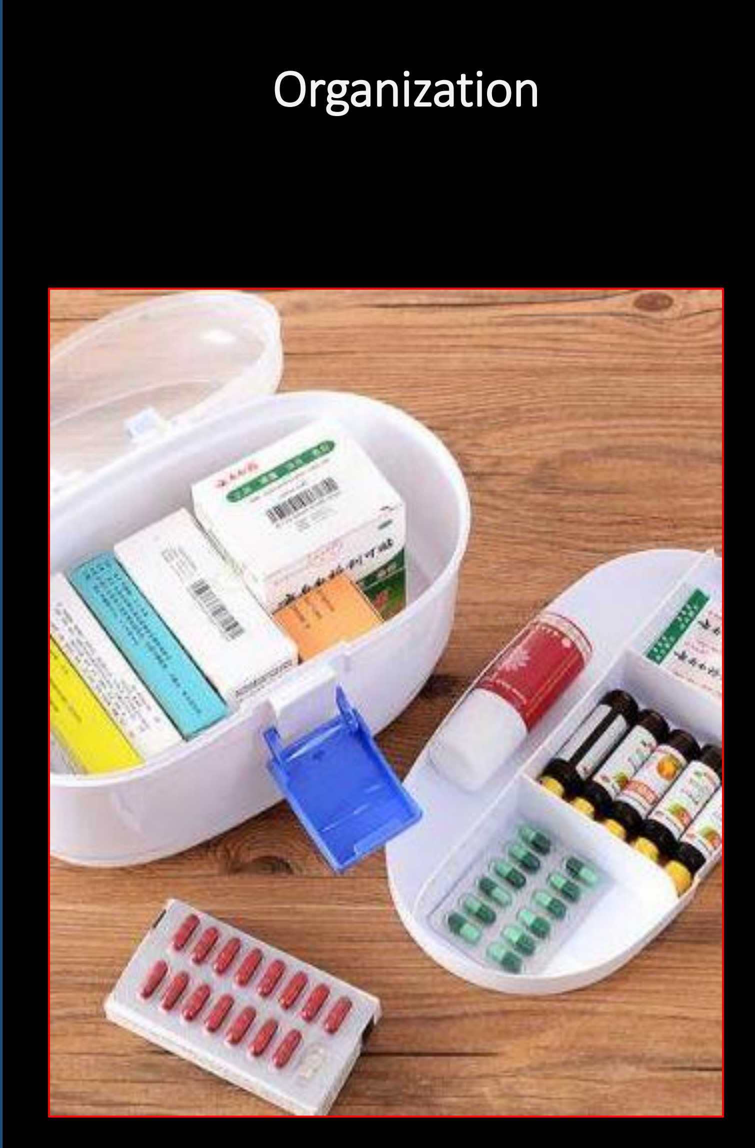
Orientation



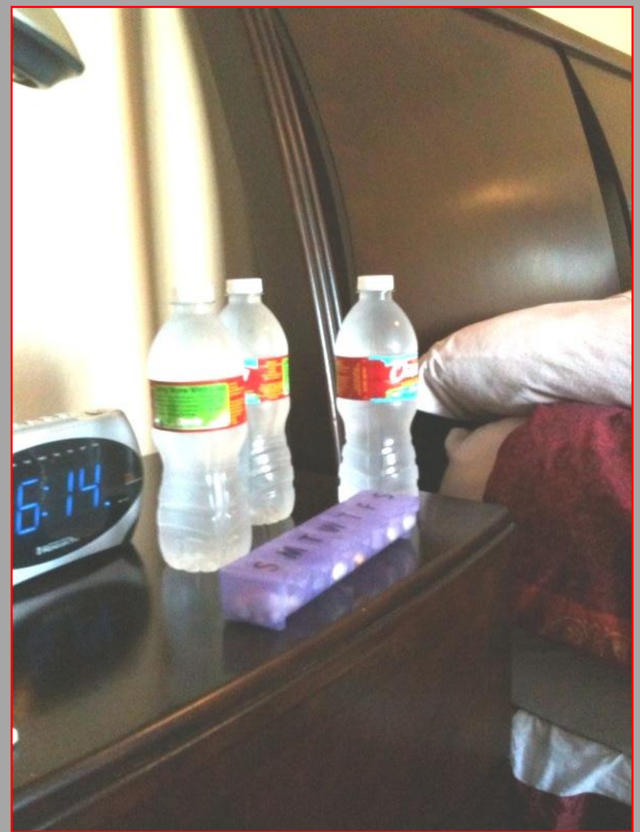


Medication

Organization



Decreasing the number of steps



Prompting

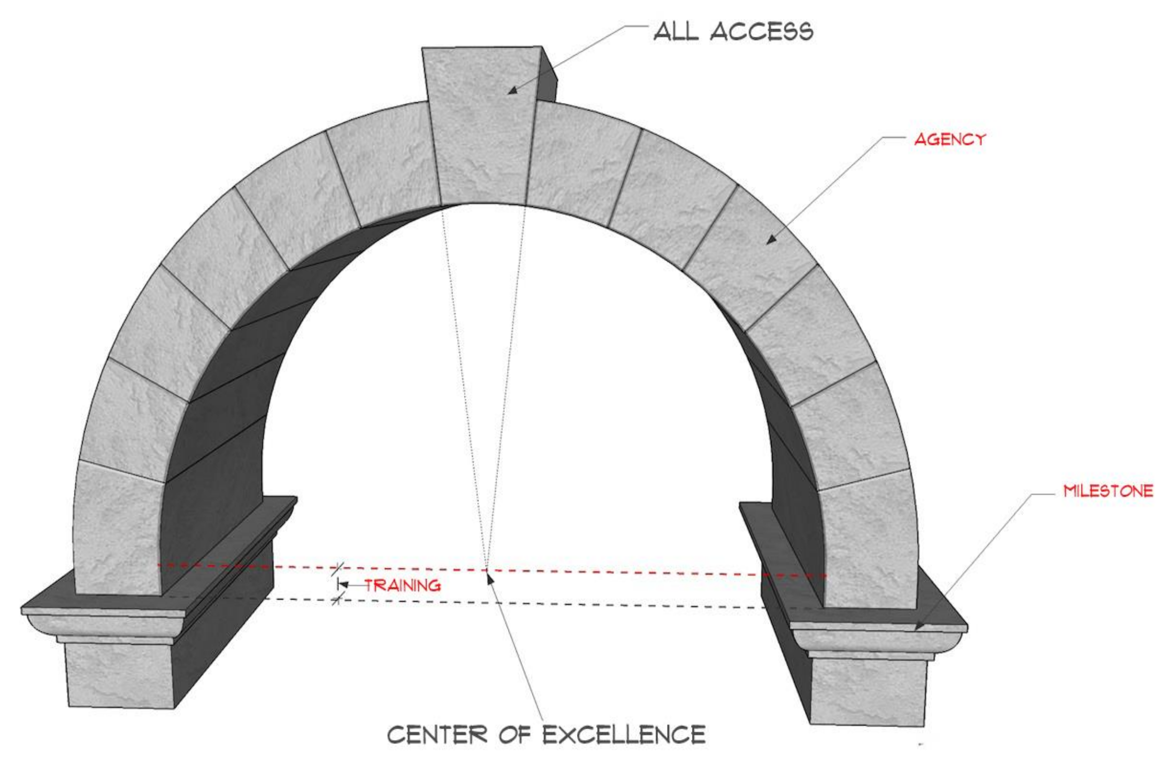
Medications – Before and After

Promoting healthy lifestyles to address medical comorbidities

Enhancing CAT with Motivational Interviewing

- CAT uses environmental & behavioral techniques to activate behavior
    - Less skilled CAT therapists may appear “pushy”
- CAT does not address values and motives that underlie motivation
- Definition: Collaborative, person-centered form of guiding to elicit and strengthen motivation for change
- Motivational Interviewing optimizes peoples’ psychological commitment to CAT goals
- Motivational Interviewing can be applied efficiently to each patient goal
    - “Every goal needs commitment”

Center of Excellence



- Established a Center of Excellence in 2018 to offer training and sustainability of best practices for helping individuals with serious & persistent mental health conditions
- Access for all agencies participating in the Texas Promoting Independence Initiative
- Free training available to MCOs, LM/BHAs, and other behavioral health affiliates
- www.iceebp.com

iceebp.com

INTERNATIONAL CENTER OF EXCELLENCE FOR EVIDENCE BASED PRACTICES

Home About Us

Trainings for Evidence Based Psychotherapies to Promote Mental Health

A multi-disciplinary team of world-renowned practitioners and researchers devoted to training the broader community in the use of evidence-based psychotherapies to keep providers on the cutting edge of treatment delivery for individuals with mental health challenges.

Texas Promoting Independence Learning Community

The target audience for our online behavioral health learning community includes designated Managed Care Organizations (MCO), their behavioral health affiliates and providers of long term services and supports (LTSS).

LEARN MORE

Trainings for Evidence Based Psychotherapies & Clinical Trial Support Services

We offer expert clinical trial consulting and trainings in multiple evidence-based psychotherapies to improve the treatment of behavioral health.

Click below for more information and to access the Evidenced Based Psychotherapies available for you and your agency.

LEARN MORE

Leave a message

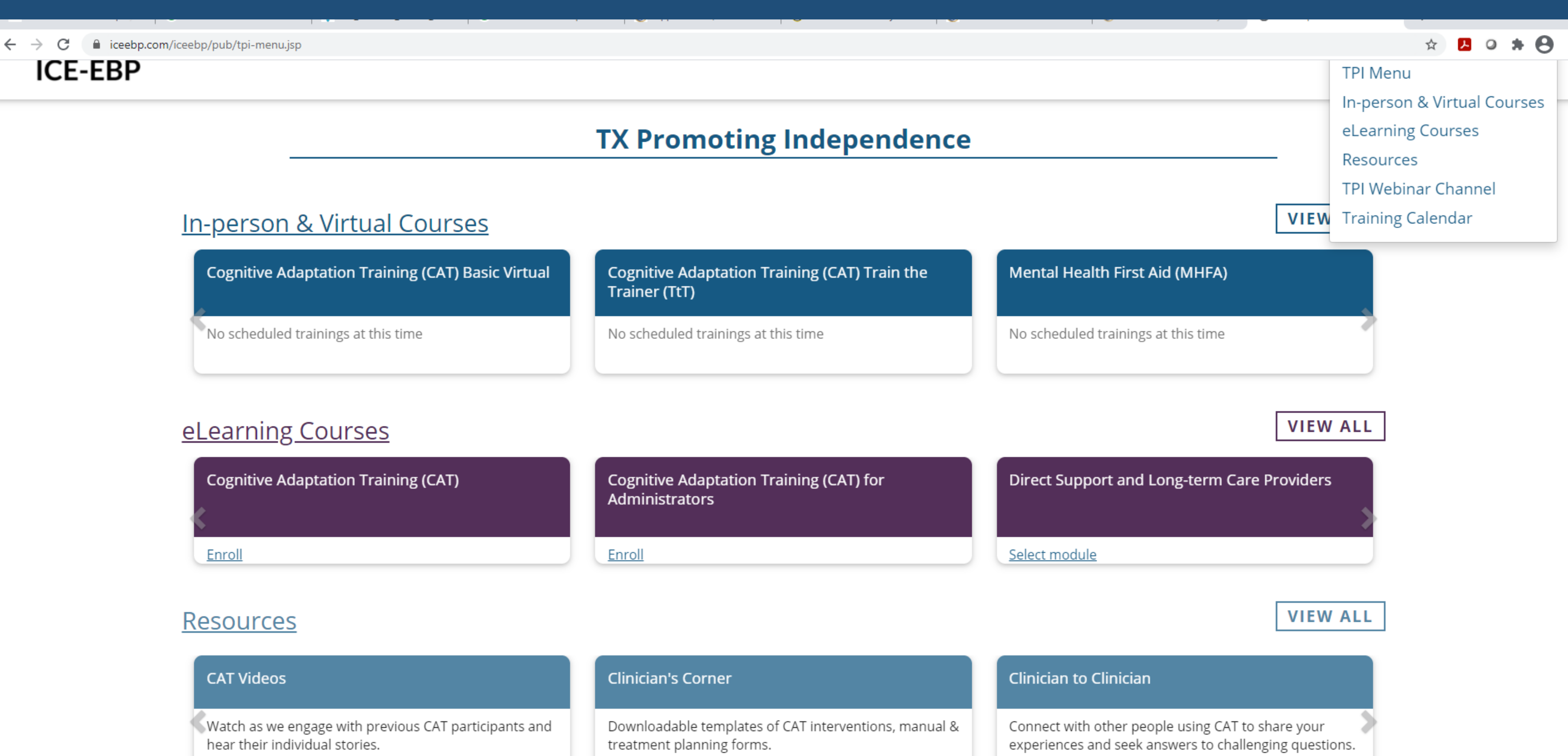
What We Offer

In Person or Virtual Workshops

- CAT Intro – 2.5 hour online, always available
- CAT Certification – in-person (or virtual) 2 days
- CAT Train the Trainer – in-person 4 days
- MI Intro – in-person or virtual 2 days
- MI Intermediate – in-person (or virtual) 2 days
- Coming soon!! 9 hour online CAT Certification Course

Specialty Trainings/Other

- CAT for Administrators
- 8 module eLearning series for Direct Support/Long-term Care Providers (NEW)
- CAT for Transition Aged Youth
- MI for Smoking Cessation
- MI Champion Calls
- CAT and MI Supervision Calls



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TPI Menu
In-person & Virtual Courses
eLearning Courses
Resources
TPI Webinar Channel
Training Calendar
TX Promoting Independence
In-person & Virtual Courses
VIEW
Cognitive Adaptation Training (CAT) Basic Virtual
No scheduled trainings at this time
Cognitive Adaptation Training (CAT) Train the Trainer (TtT)
No scheduled trainings at this time
Mental Health First Aid (MHFA)
No scheduled trainings at this time
eLearning Courses
VIEW ALL
Cognitive Adaptation Training (CAT)
Enroll
Cognitive Adaptation Training (CAT) for Administrators
Enroll
Direct Support and Long-term Care Providers
Select module
Resources
VIEW ALL
CAT Videos
Watch as we engage with previous CAT participants and hear their individual stories.
Access resource
Clinician's Corner
Downloadable templates of CAT interventions, manual & treatment planning forms.
Access resource
Clinician to Clinician
Connect with other people using CAT to share your experiences and seek answers to challenging questions.
Access resource
Technical Assistance Webinars
Leave a message

Questions?

Thank you!

Natalie Maples
maplesn@uthscsa.edu

Directed Payment Program Quality Update

Noelle Gaughen and Jennifer Quereau

Delivery System Quality & Innovation

Medicaid/CHIP Services

What is a State Directed Payment?

- Directed Payment Programs (DPPs) are designed to advance at least one goal of the Texas Medicaid Managed Care Strategy.
- Specifically, a state is permitted to direct Medicaid managed care organizations (MCOs) to make certain payments to enrolled healthcare providers.
- In Texas DPPs, intergovernmental transfers provide the non-federal share to draw down federal funds.
- These programs must be approved annually by the Centers for Medicare and Medicaid Services (CMS).

Texas Medicaid DPPs

Quality Incentive Payment Program (QIPP)
$1.1 Billion
Nursing Facilities
Started SFY18

Comprehensive Hospital Increased Reimbursement Program (CHIRP)
$4.7 Billion
Hospitals
Started as UHRIP SFY18
CHIRP started SFY22

Directed Payment Program for Behavioral Health Services (DPP BHS)
$176 Million
CMHCS, LBHAs
Started SFY22

Texas Incentive for Physicians and Professional Services (TIPPS)
$600 Million
Physician Groups
Started SFY22

Rural Access to Primary and Preventive Services (RAPPS)
$11 Million
Rural Health Clinics
Started SFY22

DPPs and the Medicaid Quality Strategy (1 of 2)

- Texas must demonstrate that each directed payment arrangement advances at least one of the goals and objectives in the Texas Managed Care Quality Strategy.
- Texas expects the five DPPs to advance the objectives of the following quality strategy goals.

DPPs and the Medicaid Quality Strategy (2 of 2)

Quality Strategy Goal	CHIRP	QIPP	TIPPS	BHS	RAPPS
Promoting optimal health for Texans	X		X	X	X
Keeping patients free from harm	X	X			
Promoting effective practices for people with chronic, complex, and serious conditions	X	X	X	X	X
Attracting and retaining high-performing Medicaid providers, including medical, behavioral health, dental, and long-term services and supports providers to participate in team based, collaborative, and coordinated care	X	X			

Performance Criteria

QIPP Year 5:

- Some payments are tied to a participating nursing facilities performance on specific quality measures or metrics.

CHIRP, TIPPS, RAPPS, and DPP BHS Year 1:

- Payment is not tied to performance on quality metrics. Reporting is required as a condition of participation.

Evaluation Criteria

- All DPPs will have performance targets for evaluation purposes.
- Texas DPPs require participants to submit quality reports to HHSC.
  - The type and frequency of data submitted varies by program.
  - Participant reporting may be in the form of:
    - Structure measures like:
      - Health Information Exchange participation
      - Staffing hours
    - Process or outcome measures like:
      - Screening for food insecurity
      - Diabetes control
- Other data sources will also be used to evaluate the program, such as managed care claims and CMS Care Compare.

How quality reporting will be used

- Annual evaluations will be sent to CMS as part of the annual application and approval process.
  - CMS will use evaluation findings to make decisions about future program years.
  - CMS expects states to demonstrate year over year improvement through annual evaluations.
- HHSC will publish public information on performance, so that providers know how they are doing compared to their peers.
- HHSC and MCOs may also use the data to provide technical assistance or develop possible policy or program changes to drive quality improvement.

DPP Quality Data Analysis Example

Electronic Exchange of Clinical Data

Electronic Exchange of Clinical Data

- Each program has at least one measure that asks providers to report on their status regarding electronic exchange of clinical data.
- The goal of improving clinical data sharing and care coordination aligns with the:
  - HHSC Health IT Strategic Plan
  - 2020-2025 Federal Health IT Strategic Plan
  - DSRIP Transition Plan
- Providers are not required to implement any activities discussed in the measures in order to receive payment, only to report on their status and answer the questions from HHSC.

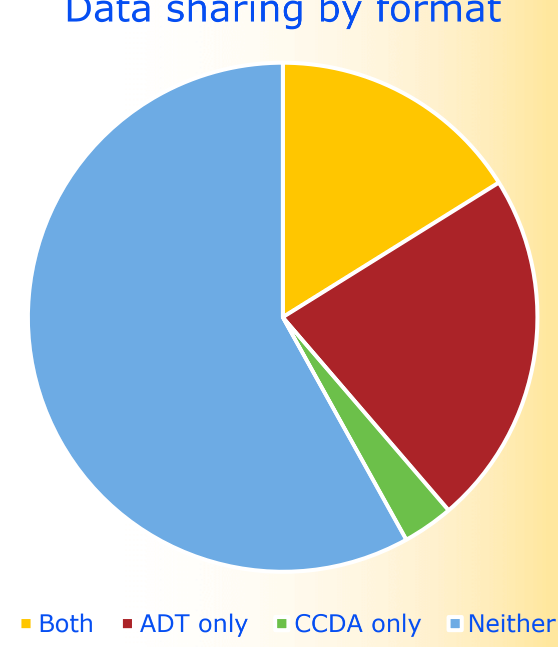
Program	Measure ID	Measure Name
RAPPS	R1-144	Use of Electronic Health Record (EHR)
DPP BHS	B1-148	Participate in electronic exchange of clinical data with other healthcare providers/entities
TIPPS	T1-105	HIE Participation
CHIRP	C1-105	HIE Participation
CHIRP	C2-141	Written transition procedures that include formal MCO relationship or EDEN notification/ADT Feed for **psychiatric** patients
CHIRP	C2-142	Written transition procedures that include formal MCO relationship or EDEN notification/ADT Feed for **non-psychiatric** patients

Use of EHRs by Rural Health Clinics

- 100% Rural Health Clinics in RAPPS reported using an EHR (n=169), based on preliminary data.

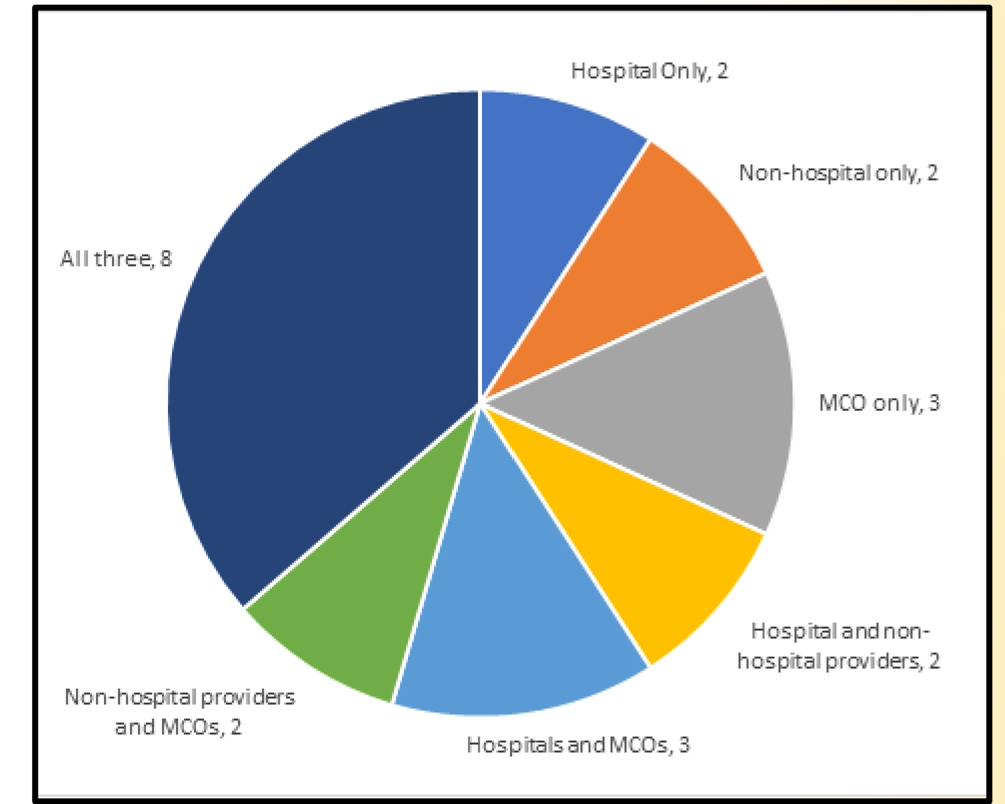
- All 39 of the CMHCs reported using electronic health records.
- 9 are not electronically exchanging clinical data by any means and are not planning to by the end of Year 1.
- Of the 30 CMHCs that report electronically exchanging clinical data, most are not using either ADT feeds or C-CDA formats.
- None of the organizations that electronically exchange data do so through a direct connection to HIETexas EDEN, and only one reported sending any data to HIETexas, which is via a public HIE.

Data sharing by format



CMHC Clinical Data Sharing Recipients

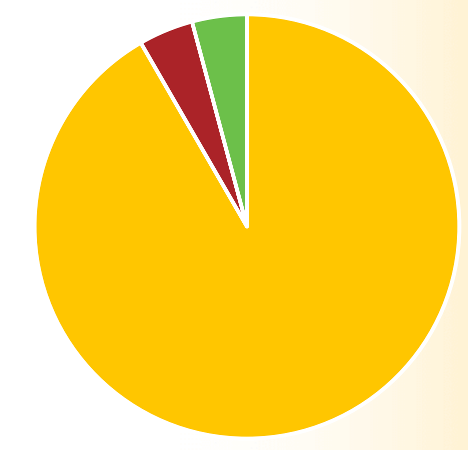
- 15 organizations send data to hospitals, 14 send data to non-hospital providers, and 16 send data to MCOs.
- The combinations of these three types of recipients varies:



HIE Participation by Physician Groups

- Almost all the TIPPS participants eligible to report this measure (n=24) connected with a public HIE, or an EHR with HIE capabilities, prior to enrolling in TIPPS.
  - The one that did not cited cost as the reason.
- However, most of those organizations (65.2%) are not sending their data to HIETexas EDEN, which is a goal of the HHSC Health IT Strategic Plan.

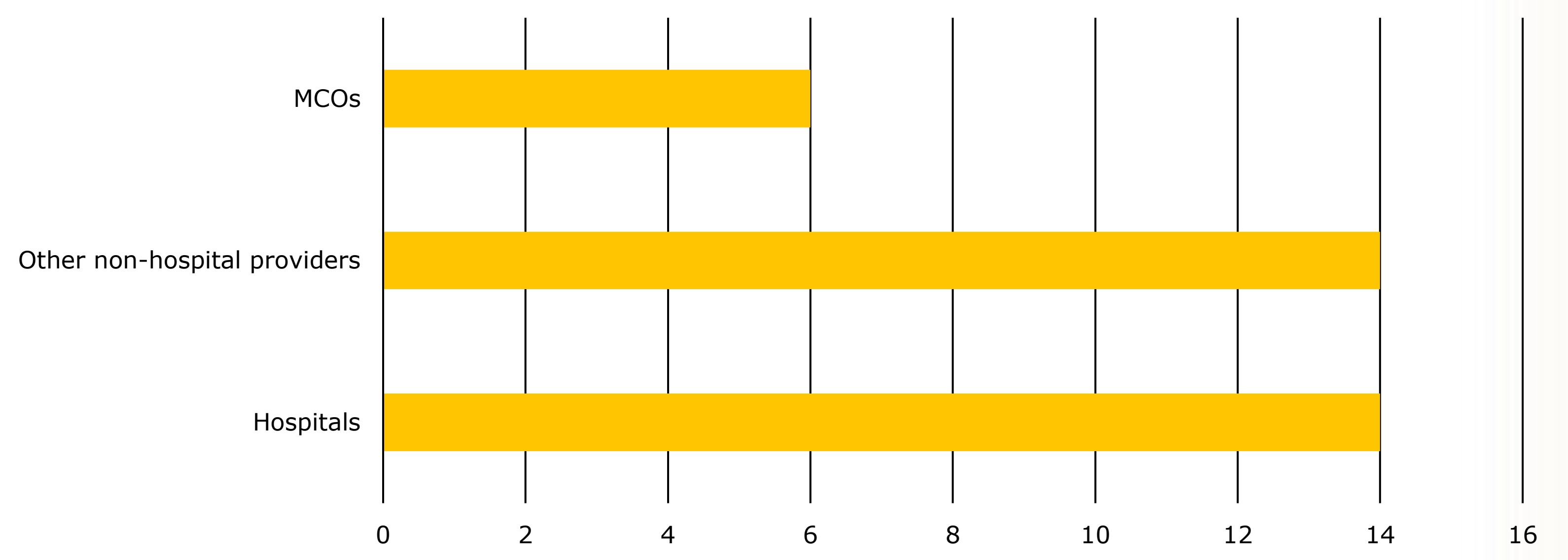
Public HIE Participation among IMEs and HRIs, as of August 31, 2021



- Yes
- No, but planning to by August 21, 2022
- No, and not planning to by August 31, 2022

HIE Participation by Physician Groups, II

Those not sending data to HIETexas EDEN are less likely to send data via an HIE to MCOs than to other providers or hospitals.



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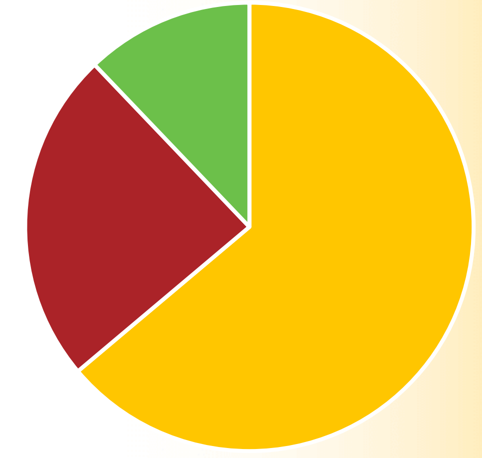
HIE Participation by Hospitals

- About 64% of the CHIRP hospitals connected with a public HIE, or an EHR with HIE capabilities, prior to enrolling in CHIRP. Another 24% planned to start participating during Year 1.
- However, most of those organizations (69%) are not sending their data to HIETexas EDEN.

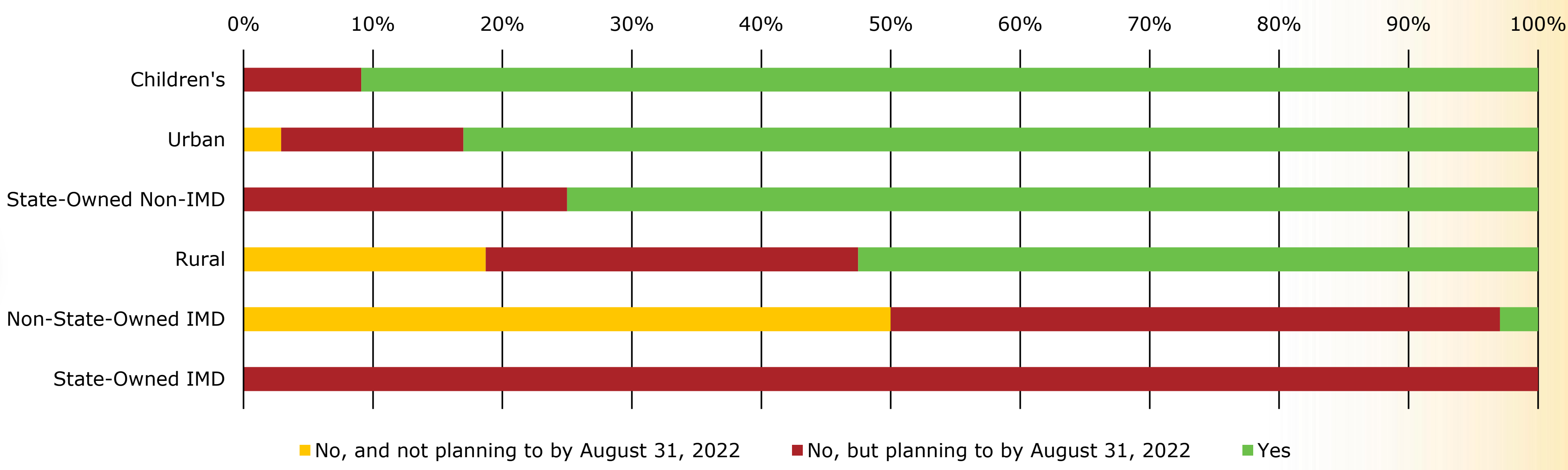
Public HIE Participation among Hospitals in CHIRP, as of August 2021



- Yes
- No, but planning to by August 21, 2022
- No, and not planning to by August 31, 2022

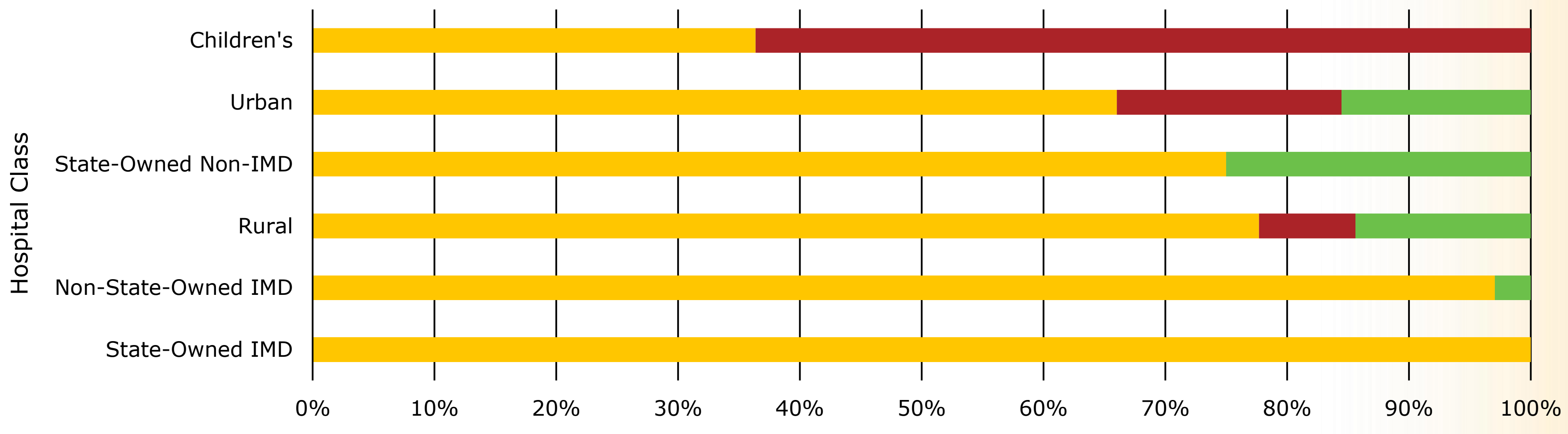
HIE Participation by CHIRP Hospital Class

Children's Hospitals were the most likely to be participating in a public HIE and IMDs were the least likely.



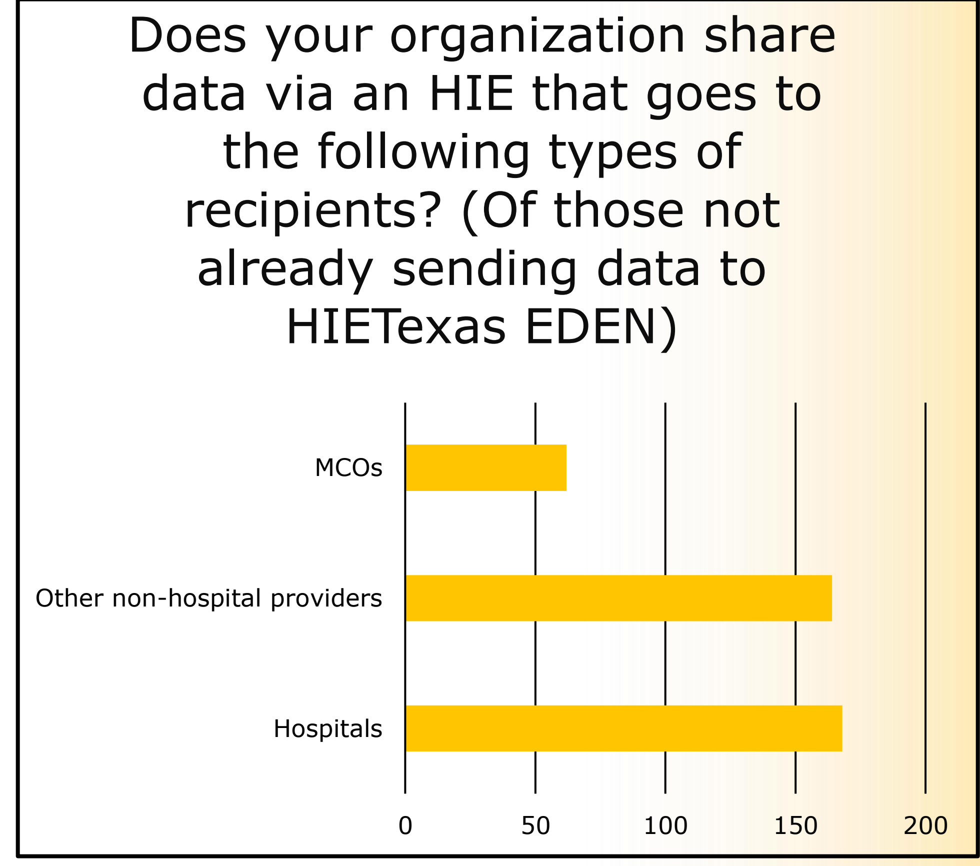
Data Sharing by Hospital Class

IMDs were also the least likely to send data to HIETexas EDEN, and Children's Hospitals were the most likely.



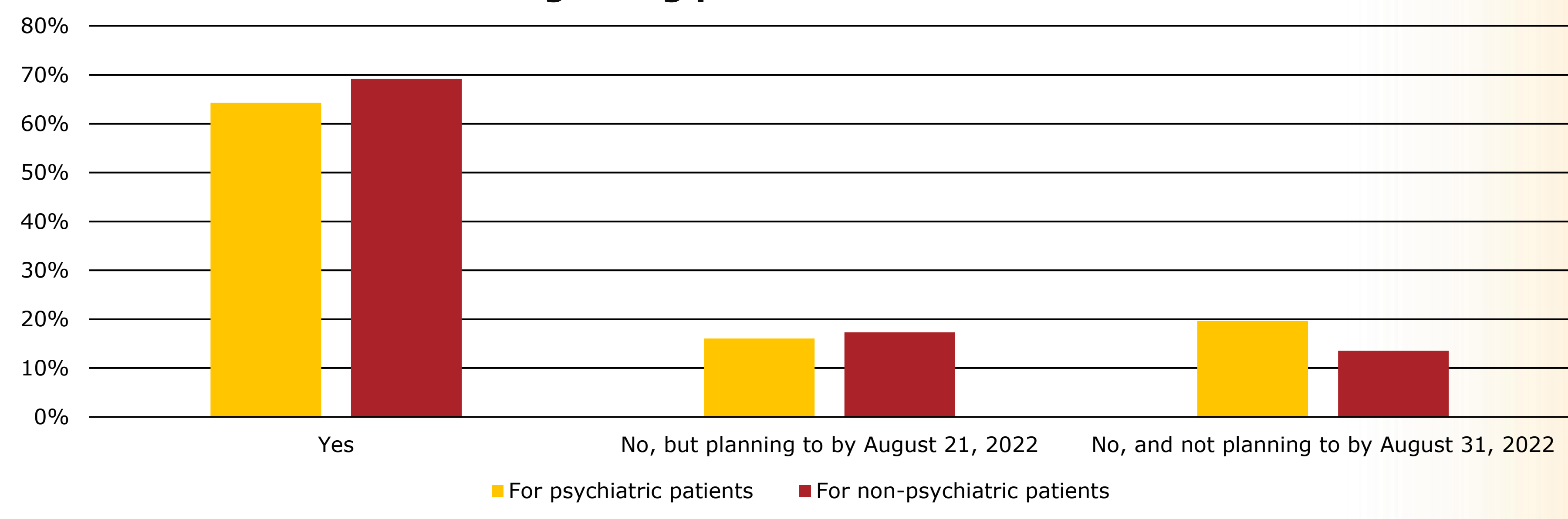
MCO Notification via HIE by Hospitals

Those not sending data to HIETexas EDEN are less likely to send data via an HIE to MCOs than to other providers or hospitals.



MCO notifications via any method

A higher percentage of hospitals reported having written procedures to notify MCOs regarding non-psychiatric patient transitions compared to psychiatric patients.



Additional Resources on Texas DPP Quality:

https://www.hhs.texas.gov/services/health/medicaid-chip/provider-information/medicaid-chip-directed-payment-programs

QIPP Updates

Erin Cibrone, *Manager*
Quality Reporting Unit

What is QIPP?

Statewide directed payment program

42 C.F.R. §438.6(c)

Annual CMS review and approval cycle

Quality Incentive Payment Program

1 TAC §353.1301 to §353.1304

Designed to incentivize NFs to improve quality and innovation in the provision of NF services to Medicaid recipients through the use of metrics that are expected to advance at least one of the goals and objectives of the state's quality strategy.

Quality Metrics in Four Components

1 — One Metric

- Conduct monthly QAPI meetings and report Performance Improvement Project (PIP) focused on MDS measure

2 — Three Metrics

- Staffing: 4+ RN Hours*
- Staffing: 8+ RN Hours*
- PIP focused on workforce issues

3 — Four Metrics

- Pressure ulcers
- Antipsychotic medication
- Mobility worsened
- Urinary tract infections

4 — One metric- changes Quarterly

- Facility has active infection control program that includes pursuing improved outcomes in vaccination rates and antibiotic stewardship

***Federal requirement:**
On-site RN eight hours a day, seven days a week.

HB2658: QIPP Staffing Ratio Improvement Project

Implementation for State Fiscal Year 2024

- House Bill 2658, Sec. 9(b)(2) (87th Regular Legislative Session, 2021) directs HHSC to require improvements to staff-to-patient ratios in nursing facilities participating in the Quality Incentive Payment Program (QIPP) by January 1, 2025.
  - Ratios will be developed with internal and external stakeholders and in accordance with ongoing CMS guidance, state rules, available data, and best practices.

Dates to Remember

- **State Fiscal Year 2022**
  - Oct. 15, 2022: Final scorecard published
- **State Fiscal Year 2023 (CMS Approval Pending)**
  - Sept. 1, 2022: Program year launches
- **State Fiscal Year 2024**
  - External stakeholder meetings held in August and September 2022
  - Dec. 1, 2022: Post draft Quality Metric Requirements
  - Dec. 15, 2022: Public hearing
  - Feb. 1, 2023: Post final Quality Metric Requirements
  - March 15, 2023: Submit Preprint application to CMS

Thank you

QIPPProjectProposal@hhs.texas.gov
Erin.Cibrone@hhs.Texas.gov

Minimum Performance Standard

Amber Campbell, *Director*

Quality Monitoring Program

Background

83rd Legislature (2013) – SB 7

- STAR+PLUS credentialing requirements and minimum performance standards (MPS) established for partnering nursing facilities (NF).

87th Legislature (2021) – HB 2658

- Requires HHSC to adopt rules to:
  - Monitor NF provider performance on the MPS.
  - Require corrective action from NF providers that do not meet the MPS.
  - Share data with MCOs as appropriate.

Rule

- The draft rule is in the development phase and was posted for public comment.
- The informal public comment period closed 07/13/2022, and no comments were received.
- HHSC will present rule during the November 2022 Medicaid Advisory Committee (MCAC) meeting with public comment opportunity through December 3, 2022.
- Based on current timelines, the rule takes effect on March 7, 2023.

Measures and Benchmarks

CMS Long-Stay Measures	2022-2023 Benchmarks
N028.02 Percent of long-stay residents whose need for help with activities of daily living has increased	30%
N015.03 Percent of high-risk residents with pressure ulcers	17%
N016.03 Percent of residents assessed and appropriately given the seasonal influenza vaccine	77%
N020.02 Percent of residents assessed and appropriately given the pneumococcal vaccine	80%
N035.03 Percent of residents whose ability to move independently worsened	31%

Annual Data and Publishing Process Steps

Action	Timeline
Uniform Managed Care Manual content update drafted.	Annually on September 1
NF MPS benchmarks published on the HHSC website	Annually no later than December
HHSC to notify MCOs and NFs of published NF MPS benchmarks	Annually no later than December
CMS Four-Quarter average minimum data set (MDS) calendar year (CY) data made available on Nursing Home Compare (NHC).	Annually beginning mid-April 2023
HHSC to extract MDS CY data	Start date contingent on above
HHSC internal processing, review and assessment of MDS data	To begin after extraction for a duration of 12 weeks
HHS to publish NF MPS compliance results on HHSC website	Annually on June 1, 2023
HHSC to notify MCOs and NFs of the availability of data	Annually on June 1, 2023

Thank You

Amber.Campbell03@hhs.texas.gov

PPE Analysis

Fiona Gilmore-Khan, DSQI

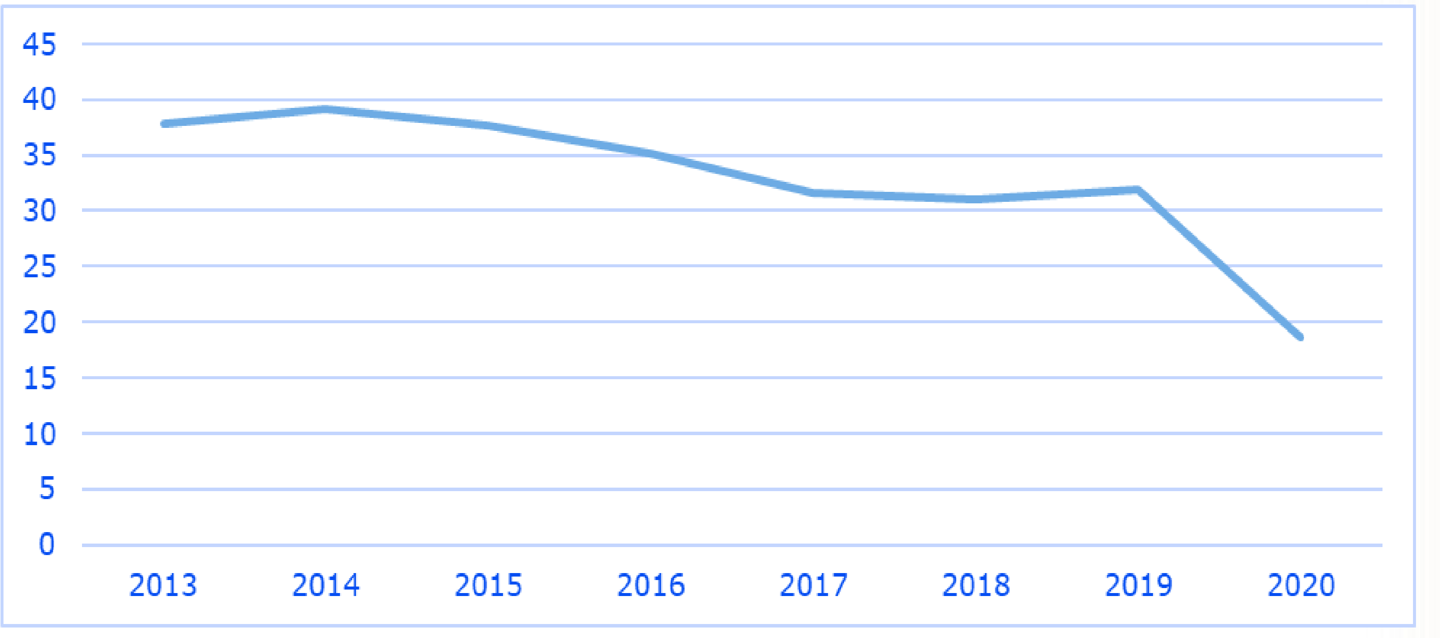
Overview of S.B. 1136

- S.B. 1136, 87th Legislature, Regular Session, 2021, requires HHSC to biannually report on HHSC's efforts to coordinate with hospitals and other providers to:
  - Identify and implement initiatives designed to reduce Medicaid recipients' use of emergency room services as a primary means of receiving health care benefits, and
  - Encourage Medicaid providers to continue implementing effective interventions and best practices that were developed and achieved under the DSRIP program.

Potentially Preventable Emergency Department Visit (PPV) Rates

Number of PPVs

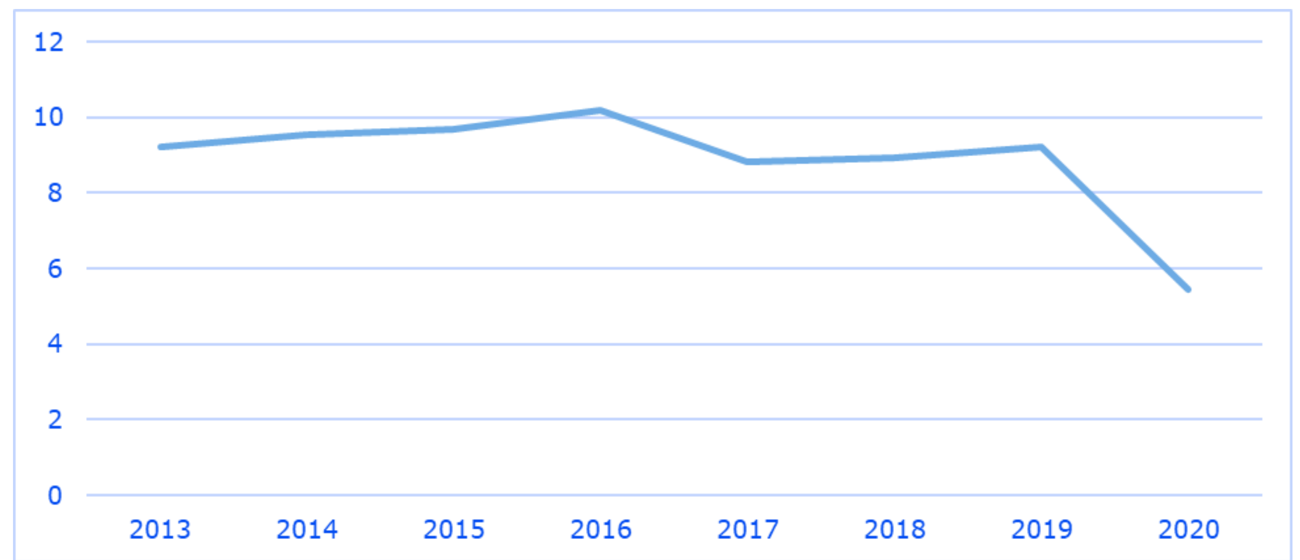
- Decreased significantly from 37.8 in 2013 to 32 in 2019
- Number of PPVs Per 1,000 Member Months, All Programs, 2013-2020



PPV Weight

- PPV weight reflects the estimated intensity of resource costs needed to provide effective treatment for a visit, based on national data
- Did not significantly decrease from 2013 to 2019

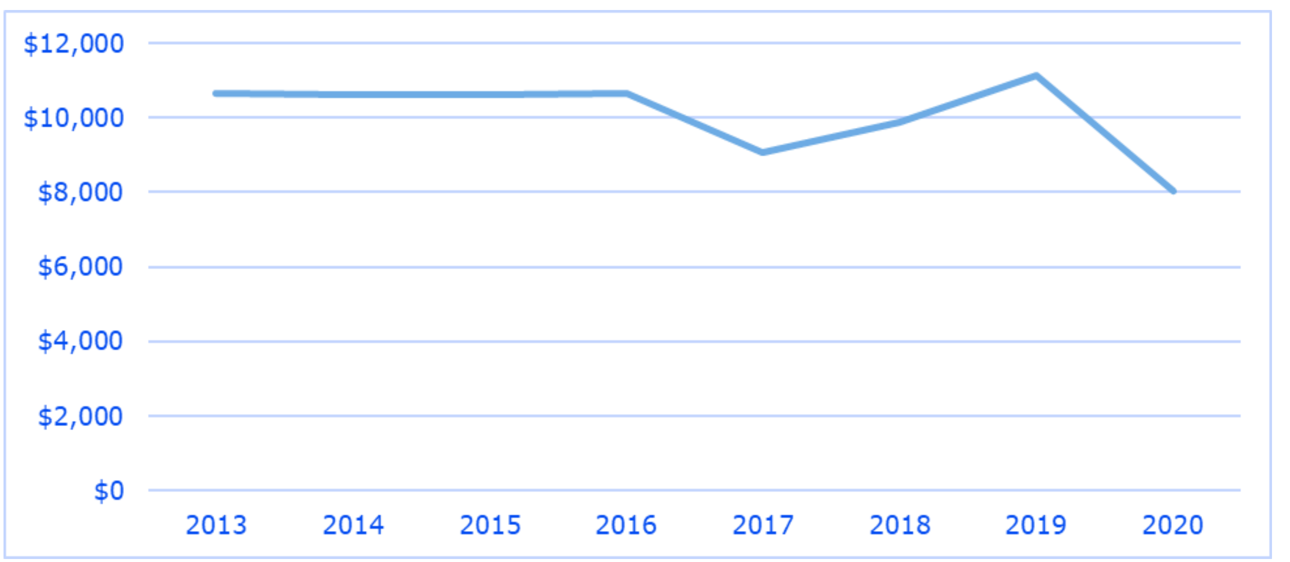
PPV Weight Per 1,000 Member Months, All Programs, 2013-2020



PPV Expenditures

- Increased from $10,665 in 2013 to $11,120 in 2019. Total expenditures associated with PPVs in Medicaid and CHIP increased from approximately $444 million in 2013 to $492 million in 2019

PPV Expenditures Per 1,000 Member Months, All Programs, 2013-2020



Summary

- While the number of PPVs decreased from 2013 to 2019, the resource use or prices of the remaining PPVs increased enough to increase total PPV expenditures
- All three measures declined in 2020, which could represent changes from the COVID-19 PHE.
  - The increase in telehealth availability may have also diverted some inappropriate ED visits, but the reduction in face-to-face urgent care may also have prevented some patients from receiving appropriate recommendations to go to the ED for evaluation

PPV Weights by Program (1 of 2)

- The PPV weight in STAR+PLUS was more than twice as high as the overall rate across other programs
- While HHSC does not know the cause of these differences, they could reflect differences between the populations in health-related social needs, behavioral health conditions, tobacco use, age, or in disabilities, leading to more comorbidities

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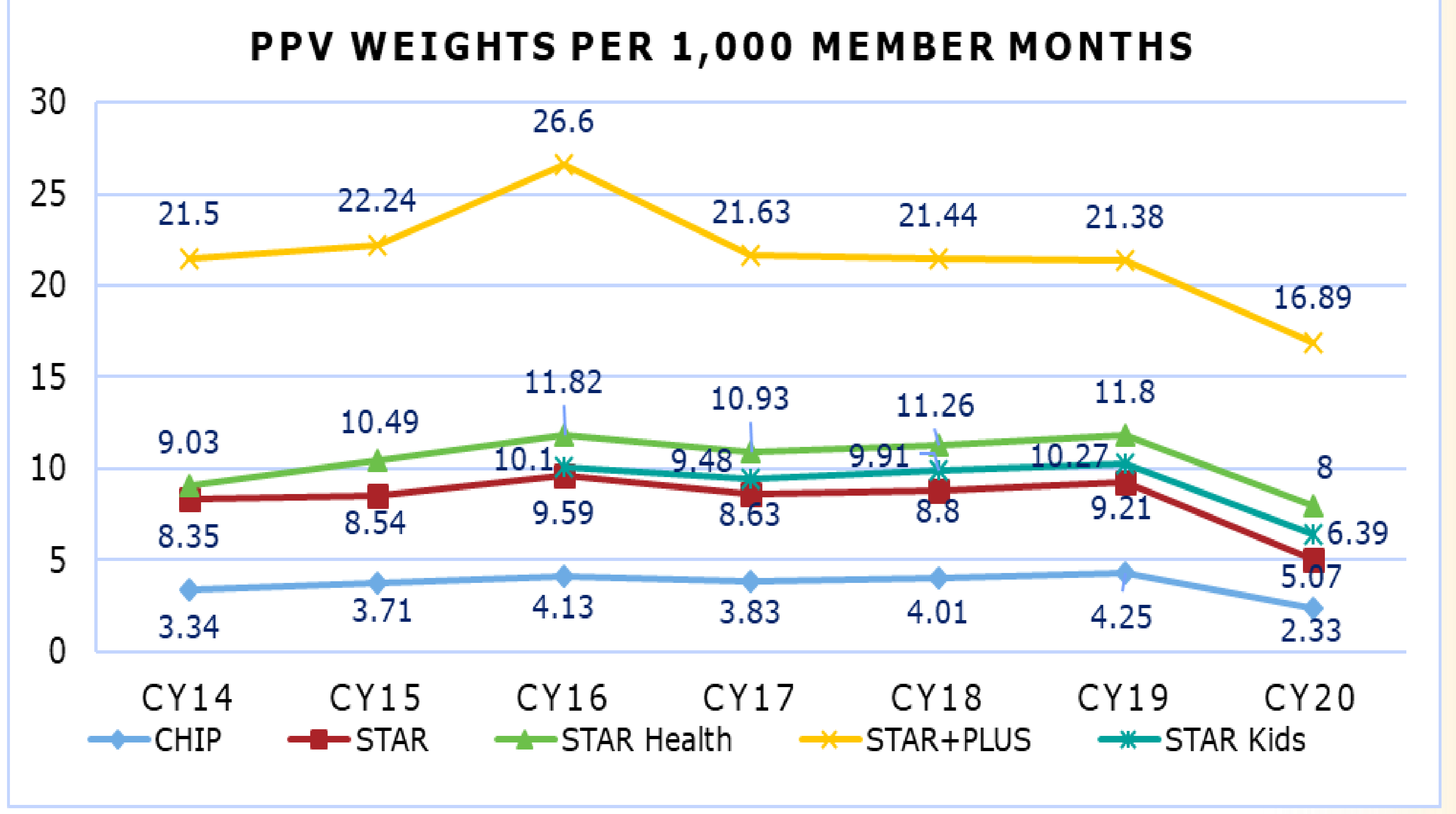
PPV Weights by Program (2 of 2)



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Types of PPVs

Top Medical Reasons for PPVs in Texas Medicaid and CHIP, 2019

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

Factors Contributing to PPVs (1 of 3)

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

Factors Contributing to PPVs (2 of 3)

- Many counties in Texas are designated as Health Professional Shortage Areas for Primary Care, Mental Health, and Dental
- The results of HHSC's monitoring initiatives show MCOs continue to perform well in meeting requirements related to providing access to preventive care, with nearly all MCOs compliant with access standards for PCPs and main dentists.
    - However, specialty provider shortages, particularly in rural areas of the state, continue to present challenges to member access.

Factors Contributing to PPVs (3 of 3)

- According to the EQRO, “lack of weekend and after-hours appointments limits member access to vital services for prenatal, preventive, and behavioral health care.”
- Medicaid member surveys for STAR and STAR+PLUS indicated that 44-57% of members or their caregivers reported appointment delays due to limited availability, and 28-44% reported visiting an ED due to limited appointment availability

PCPs with appointments that offered weekend appointments, by program

SFY	STAR	CHIP	STAR+PLUS	STAR Health	STAR Kids
SFY 2016	37.4%	34.2%	35.2%	-	-
SFY 2018	41.7%	41.4%	33.0%	29.4%	34.1%

Initiatives to Reduce Potentially Preventable ED Utilization in Medicaid

Initiatives focused on ED use

Established Initiatives

- Medical P4Q
- Performance Improvement Projects
- Performance Indicator Dashboards
- Medicaid Value-based Enrollment

Upcoming Initiatives

- Emergency Triage, Treat, and Transport (ET3)
- Medicaid Teleservices Expansion

TEXAS
Health and Human
Services

ET3 Project (1 of 2)

- The 2022-23 General Appropriations Act, S.B. 1, 87th Legislature, 2021 requires HHSC to implement the Emergency Triage, Treat, and Transport Demonstration Payment Model (ET3) Project in Medicaid to reimburse Medicaid-enrolled emergency medical services providers for:
  - Transporting Medicaid clients to alternative destinations, other than an emergency department, as approved by HHSC
  - Facilitating appropriate treatment in place at the scene
  - Facilitating appropriate treatment via telehealth

ET3 Project (2 of 2)

- HHSC is updating policy to include billing guidance for providers. In alignment with guidelines provided by CMS, Texas Medicaid will reimburse ambulance providers rendering ET3 services using existing procedure codes (already included in the policy).
- Five new modifiers will be added to the policy to allow reimbursement for transport to alternative destinations and for the treatment in place scenarios
- The benefit will be implemented on September 1, 2022

Medicaid Teleservices Expansion (1 of 5)

- During the COVID-19 PHE, HHSC authorized the use of synchronous audio-visual telemedicine and telehealth, and audio-only, platforms to deliver a range of services.
- H.B. 4, 87th Legislative Session, 2021, required HHSC to expand services eligible to be delivered by telemedicine or telehealth in any program, benefit, or service HHSC determines to be cost effective and clinically appropriate.

Medicaid Teleservices Expansion (2 of 5)

- HHSC transitioned many state plan and 1915(c) waiver services delivered in the FFS program from temporary PHE flexibilities to ongoing policy through interim guidance.
  - The interim guidance is in place until the policy is formally effective in the corresponding TMPPM, Texas Administrative Code, and program handbooks.

Medicaid Teleservices Expansion (3 of 5)

- Through interim guidance HHSC authorized providers to submit claims for reimbursement for synchronous audio-visual delivery for several benefits and services including, but not limited to:
  - Behavioral health services and benefits, and in some cases, this included reimbursement for audio-only delivery
  - Healthy Texas Women (HTW) and HTW Plus services and benefits
  - Many professional and specialized therapy services including speech therapy, occupational therapy, and physical therapy services
  - Certain case management services

Medicaid Teleservices Expansion (4 of 5)

- HHSC also authorized telehealth and telemedicine reimbursement for rural health clinics and FQHCs, and reimbursement of patient site fees for telemedicine

Medicaid Teleservices Expansion (5 of 5)

- Teleservices policies require providers to defer to the needs of the person receiving services, allowing the mode of service delivery to be accessible, person- and family-centered, and primarily driven by the person's choice and not provider convenience.
- When implementation of H.B. 4 is complete, HHSC is expecting increased access to care for Medicaid members, especially for members in rural areas, and continued access to services using telecommunications after the PHE ends.

S.B. 1136 Stakeholder Survey

Stakeholder Survey

- In spring 2022 HHSC conducted a survey to collect information from providers that receive UC payments as well as MCOs and other providers regarding initiatives to reduce the use of the ED as a primary means of receiving healthcare and improve access to primary care services.
- The second biannual report will include a detailed discussion of the results of the survey

MCO Responses

- 81% of MCOs indicated observing individuals using the ED services for primary care services
- 91% of MCOs reported implementing initiatives designed to reduce ED visits or improve access to primary care
- About half of interventions included partnerships with other organizations to implement initiatives. MCOs most commonly partnered with PCPs, community health clinics, and HIEs

Questions?

APM Requirements

Jimmy Blanton, *Director*
Quality Institute

Alternative Payment Models

Alternative Payment Models (APMs) are payment approaches that incentivize high-quality and cost-efficient care (i.e., APMs link portions of payments to measure(s) of value).

- APMs:
  - May apply to a specific clinical condition, care episode or population.
  - May involve financial risk and rewards, or simply be rewards-based.
  - Span the full continuum of risk from no shared risk to full risk-sharing.

Texas' managed care APM initiative aligns with the Health Care Payment Learning and Action Network (HCP LAN) Framework

Alternative Payment Model (APM) Framework

HCP LAN Framework

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

Texas Medicaid APM Targets*

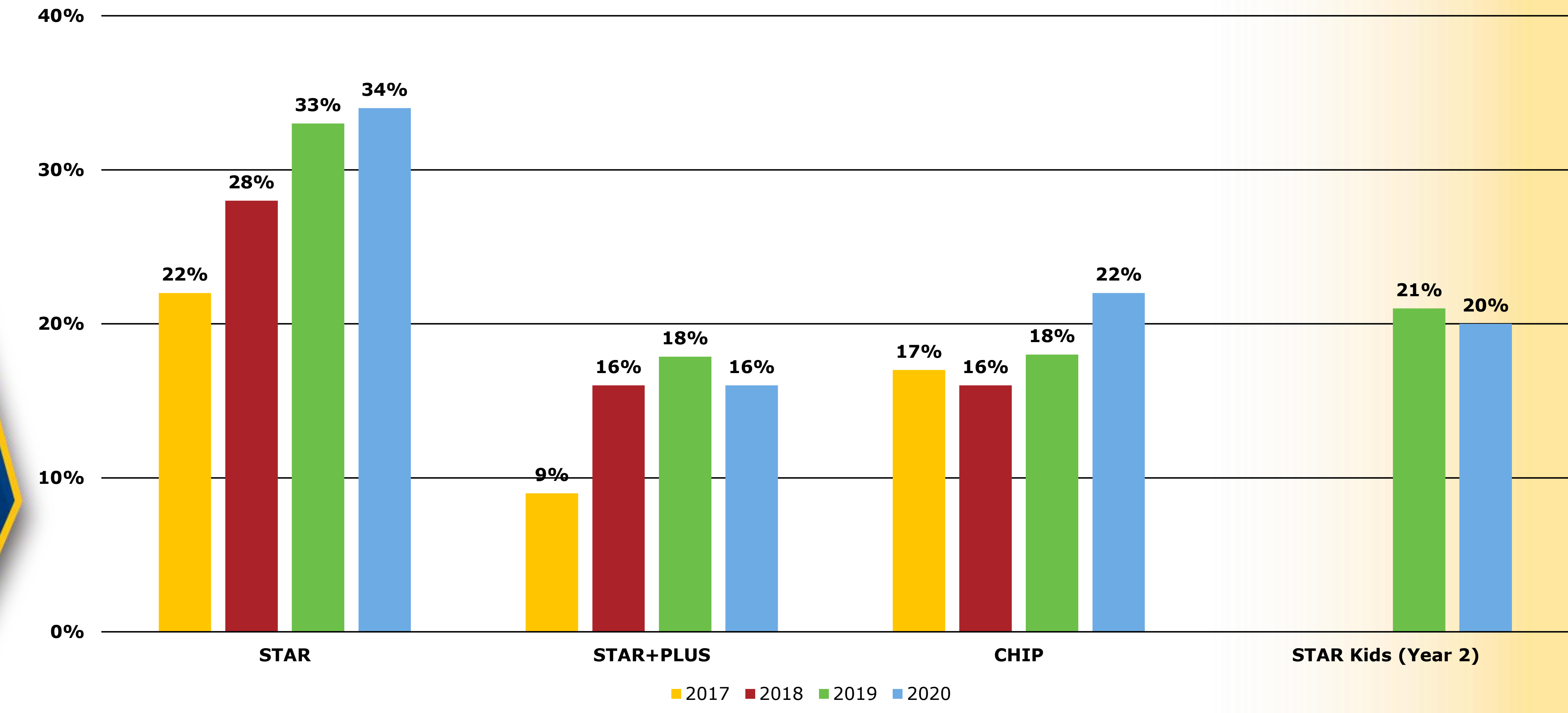
Table 1 - The annual MCO targets established by HHSC by Calendar Year		
HHSC will require that MCOs increase their total APM and risk based APM ratios according to the following schedule*		
Period	**Minimum Overall APM Ratio**	**Minimum Risk-Based APM Ratio**
Calendar Year 1	>= 25%	>= 10%
Calendar Year 2	Year 1 Overall APM Ratio +25%	Year 1 Risk-Based APM Ratio +25%
Calendar Year 3	Year 2 Overall APM % + 25%	Year 2 Risk-Based APM % + 25%
Calendar Year 4	>= 50%	>= 25%
* 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. CY 2021 is Year 4, in most cases. HHSC has extended these requirements to Year 5, keeping the same targets as Year 4.

Overall APM Achievement CYs 2017* – 2020

Program	2017	2018	2019	2020
STAR	36%	43%	49%	51%
STAR+PLUS	29%	37%	44%	41%
CHIP	38%	39%	42%	48%
STAR Kids (Year 2)			28%	32%

Risk-based APM Achievement CYs 2017* – 2020



* 2017 Experimental Year; 2018 – 2020 Target Years.

Percentage of APM Targets Achieved (2020)

- **Calculated based on the following:**
  - Denominator – Number of combinations of MCO and Program
  - Numerator – Number of MCOs reaching the contractual target

- **Program operational goals, by 2022:**
  - Medicaid overall: 90%
  - Medicaid risk-based: 90%
  - CHIP overall: 80%
  - CHIP risk-based: 66%
- **Program results, 2020:**
  - Medicaid overall: 71%
  - Medicaid risk-based: 77%
  - CHIP overall: 53%
  - CHIP risk-based: 60%

Distribution of APMs by HCP LAN Type CY 2020

Cat.	APM Type	Frequency	Percent
2A	Foundational Payments for Infrastructure & Operations (e.g. care coordination fees and payments for HIT investments)	37	8.5%
2B	Pay for Reporting (e.g. bonuses for reporting data or penalties for not reporting data)	24	5.5%
2C	Pay for Performance (e.g. bonuses for quality performance)	195	44.7%
3A	APMs with Shared Savings e.g. shared savings with upside risk only)	51	11.7%
3B	APMs with Shared Savings and Downside Risk (e.g. episode-based payments for procedures and comprehensive payments with upside and downside risk)	98	22.5%
4A+4B	Condition-Specific Population-Based Payment and Comprehensive Population-Based Payment	24	5.5%
4N	Capitated Payments NOT Linked to Quality	7	1.6%
Total		436	100%

Distribution of Total Payments, Claims and Incentives by Provider Type CY 2020

Provider Type	Total Payments	Percentage of Total Payments	Claims Paid	Percentage of Claims Paid	Incentives	Percentage of Incentives
Primary Care + Ob/Gyn + Urgent Care	$2,927,979,822	50.1%	$2,847,570,308	49.6%	$80,409,513	79.2%
Health Home, Nursing Facilities, and Home Care	$1,671,789,034	28.6%	$1,668,955,130	29.1%	$2,833,904	2.8%
Specialist, Behavioral & Mental Health	$138,512,200	2.4%	$127,266,099	2.2%	$11,246,101	11.1%
ACO	$521,999,387	8.9%	$515,108,547	9.0%	$6,890,840	6.8%
Pharmacy and Lab	$521,682,034	8.9%	$521,568,087	9.1%	$113,947	0.1%
Case Management	$56,545,235	1.0%	$56,497,235	1.0%	$48,000	0.05%
Total	**$5,838,507,712**	**100%**	**$5,736,965,406**	**100%**	**$101,542,306**	**100%**

National Goals and Initiatives (1 of 2)

HCPLAN Goal

- "Accelerate the percentage of US health care payments tied to quality and value in each market segment through the adoption of two-sided risk alternative payment models". Medicaid: 25% by 2022 and 50% by 2025.

CMMI Strategy

- First of five objectives is to drive accountable care: "…beneficiaries will be in a care relationship with accountability for quality and total cost of care by 2030; all Medicare fee-for-service and the vast majority of Medicaid."

National Goals and Initiatives (2 of 2)

States with active APM initiatives

- General: At least 13 States and the District of Columbia are using the LAN APM Framework to set requirements for value-based payment; WA, OR, AZ, IA, MI, KY, VA, NC, SC, MD, DE, NH, LA, & TX;
- Specific - State Transformation Collaborative (STC) LAN strategic initiative: Arkansas, California, Colorado and North Carolina;
- Other states: NY (non-LAN APMs in their DSRIP).

Focus of National Initiatives (1 of 2)

LAN – STCs National Goals

- Shift 60% of payments to an APM for participating providers;
- Reduce avoidable hospitalizations in a state;
- Achieve measurable improvement in select health outcomes based on state-specific goals and needs.

Focus of National Initiatives (2 of 2)

LAN’s "Accountable care"

- Aligns care teams to help realize the best achievable health outcomes for all through comprehensive, high-value, affordable, longitudinal, person-centered care;
- Commitment Curve: APM adoption, health equity, stakeholder alignment;
- Action Collaborative: professionals, leaders, innovators, to collaborate and support LAN initiatives and national policy programs by aligning core recommendations for the implementation of accountable care and amplifying the voices of the LAN.

TEXAS
Health and Human Services

APMs: The Future in Texas Medicaid (1 of 3)

- Updated contract language is pending, with the following objectives:
  - Maintain HHSC's commitment to promoting increasing levels of value-based payment between MCOs and providers
  - Provide more flexibility for HHSC to recognize MCO activities beyond numerical APM targets, such as:
    - Advancing strategic APM priorities (e.g., rural areas, non-medical drivers of health);
    - Directly participating in state defined APM opportunities;
    - Supporting providers to succeed in APMs;
    - Disseminating evidence and information on best practices.

APMs: The Future in Texas Medicaid (2 of 3)

- Updated contract language MCO comments:
  - Requests for later deadline for MCO APM reports
  - Concern over language encouraging some standardization within a region
  - Clarification on expectations for APM evaluations
  - MCOs need opportunity to review UMCM revisions
- Other APM issues under review:
  - How to count directed payments
  - How to define "care relationship with accountability for quality and total cost of care"

APMs: The Future in Texas Medicaid (3 of 3)

- Next steps:
  - Finalize contract (UMCC) update;
  - Complete review of MCO Plans of Action, submitted by MCOs in May;
  - Complete analysis of 2021 APM data, submitted by MCOs on July 1;
  - Implement a more flexible/comprehensive APM Framework through the UMCM.

Thank you

Advisory Committee Recommendations

Jimmy Blanton, *Director*
Quality Institute

Quality and Program Improvement Advisory Committees

Policy Council for Children and Families (PCCF)	Palliative Care Interdisciplinary Advisory Council (PCIAC)	Value-Based Payment & Quality Improvement Advisory Committee (VBPQIAC)
• To improve the coordination, quality, efficiency, and outcomes of services provided to children with disabilities and their families through the state's health, education, and human services systems.	• To consult and advise HHSC on matters related to the statewide palliative care information and education program.	• To provide a forum to promote public-private, multi-stakeholder collaboration in support of quality improvement and value-based payment initiatives for Medicaid, other publicly funded health services, and the wider health care system.

PCCF: Proposed Recommendations (1 of 2)

- Remove requirement for autism spectrum disorder reconfirmation after beginning treatment
- Increase availability of applied behavior analysis (ABA) providers
- Strengthen community attendant and in-home nursing workforce
- Increase funding for waiver programs that serve the families of children with disabilities

PCCF:
Proposed Recommendations (2 of 2)

- Promote collaboration between schools and the private sector to align speech, occupational, and physical therapy, as well as ABA goals
- Review Medicaid and Fee-for-Service/Managed Care newborn hearing screening policy and practices
- Improve health care transitions from pediatric to adult care, hospital to home, and handoffs between provider specialties
- Increase access to childcare for children with disabilities

PCIAC: Proposed Recommendations

Recommendations will address:

- Supportive palliative care (SPC) standards for home health agencies
- Adoption of a Texas Medicaid advance care planning benefit
- Child Life Specialists as essential members of the SPC Team
- Provider continuing education opportunities
- Establishment of an SPC Awareness Day
- Pediatric supportive palliative care

TEXAS
Health and Human Services

VBPQIAC: Proposed Recommendations (1 of 3)

- Develop a metrics system by which home health agency performance and quality of service can be tracked, including expectations for attendants
- Establish definition for an Accountable Pharmacy Organization (APO)
- Develop structure for MCOs to reimburse pharmacists for services within a pharmacist's scope of practice
- Address some non-medical drivers of health through in lieu of services (ILOS)
- Incentivize/facilitate MCOs to partner with community-based organizations

VBPQIAC: Proposed Recommendations (2 of 3)

- Adopt a more comprehensive contractual alternative payment model (APM) framework to assess MCO achievement
- Encourage MCOs to increase the number of beneficiaries in a care relationship with accountability for quality and total cost of care
- Prioritize development of use cases to leverage electronic health information to support Medicaid quality improvement

VBPQIAC: Proposed Recommendations (3 of 3)

- Increase sharing of secure data with Medicaid providers to support participation in APMs
- Review the CMBHS system to assess opportunities and benefits of sharing data with Medicaid Mental Health Targeted Case Management and Rehabilitative Service providers and MCOs
- Develop a modernized system at the county level that would permit rapid access to data related to suicide for researchers and the public, while protecting individual privacy

Upcoming Meetings

PCCF

- Meeting date: September 13, 2022; 9:00 am
- Last day to register for public comment: September 9th at 5:00pm
- PolicyCouncilforChildrenandFamilies@hhs.Texas.gov

PCIAC

- Meeting date: August 24, 2022; 9:00am
- Last day to register for public comment: August 22nd at 5:00pm
- Palliative_Care@hhsc.state.tx.us

VBPQIAC

- Meeting date: July 26, 2022; 9:00 am
- Last day to register for public comment: July 22nd at 5:00pm
- HHSC_VBPQIAC@hhs.Texas.gov

TEXAS
Health and Human Services

Thank You

Update on Report Cards and MCO Accreditation

Denbigh Shelton, *Manager*

Quality Assurance

Upcoming Q&PI Meetings

Quality Forum

- Meeting date: August 3, 2022
- Topic: Social Determinants Of Health
- Register: We will send out the link later this week

Quality in Long Term Care Conference

- Meeting dates: August 11-12, 2022
- Renaissance Austin Hotel
- Register: Here

Open Discussion & Close

Thank you

Emily Sentilles, ***Deputy Associate Commissioner***

Sylvia Addison, ***Special Assistant***

Quality & Program Improvement

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