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Quarterly Quality Provider Meeting

March 10, 2023

11:00am – 12:30pm

Agenda

1. Welcome and introductions
2. Update: HHSC program updates
   a. Alternative Payment Models (APM) Performance Framework
   b. Non-Medical Drivers of Health (NMDOH) Action Plan
   c. Directed Payment Programs (DPP)
   d. Hospital Quality-Based Payment (HQBP) program
3. Cross-Agency Collaboration (5 Agencies) Project: UTHouston Data Center
4. Texas Medical Association's recent activities
5. Texas Hospital Association's recent activities
6. Open Discussion
7. Action Items and topics for staff follow-up
8. Adjourn

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Alternative Payment Model (APM) Performance Framework

Jimmy Blanton, Director

Office of Value-Based Initiatives

Alternative Payment Model (APM) Framework

HCP LAN Framework

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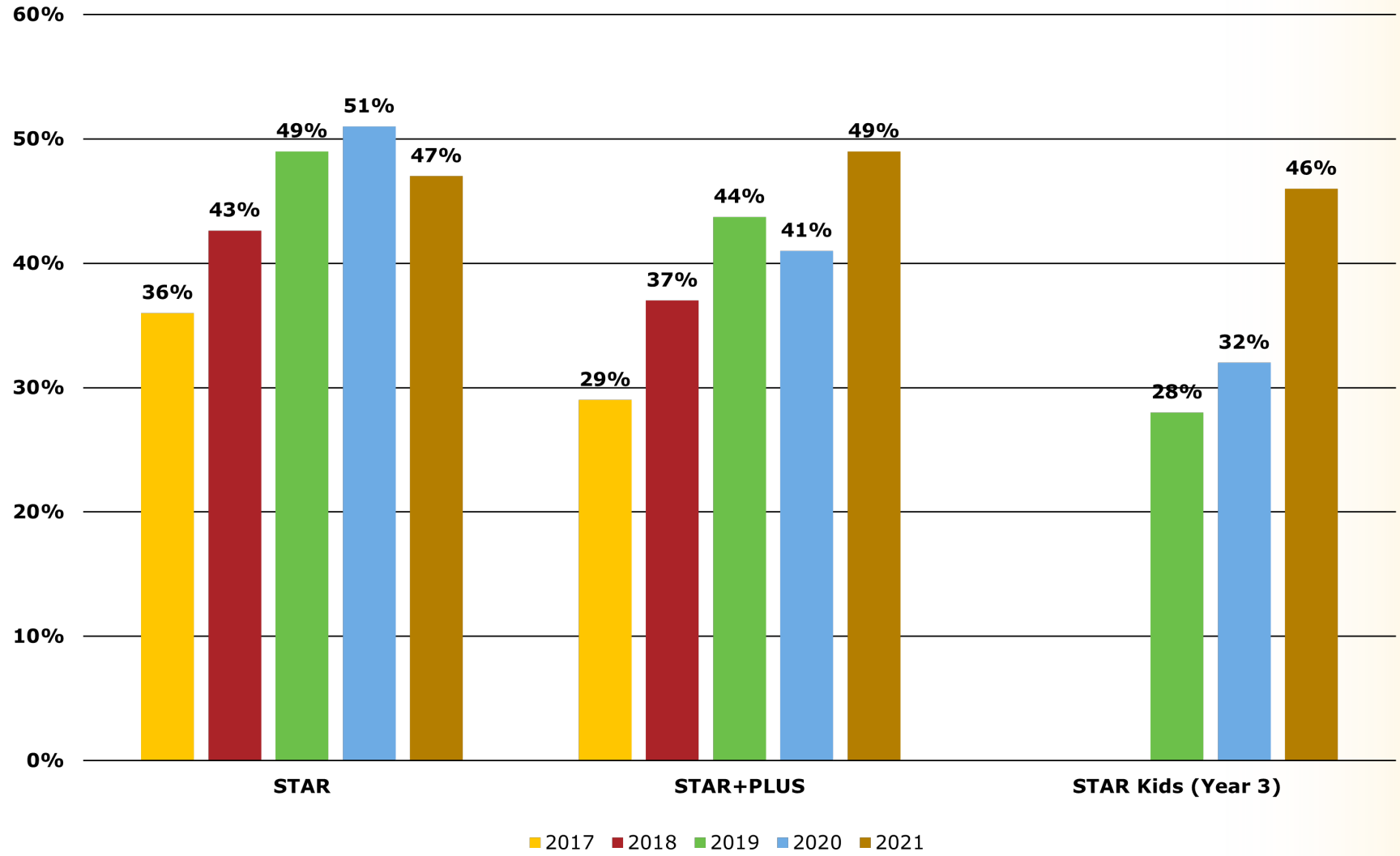
Current APM Targets~

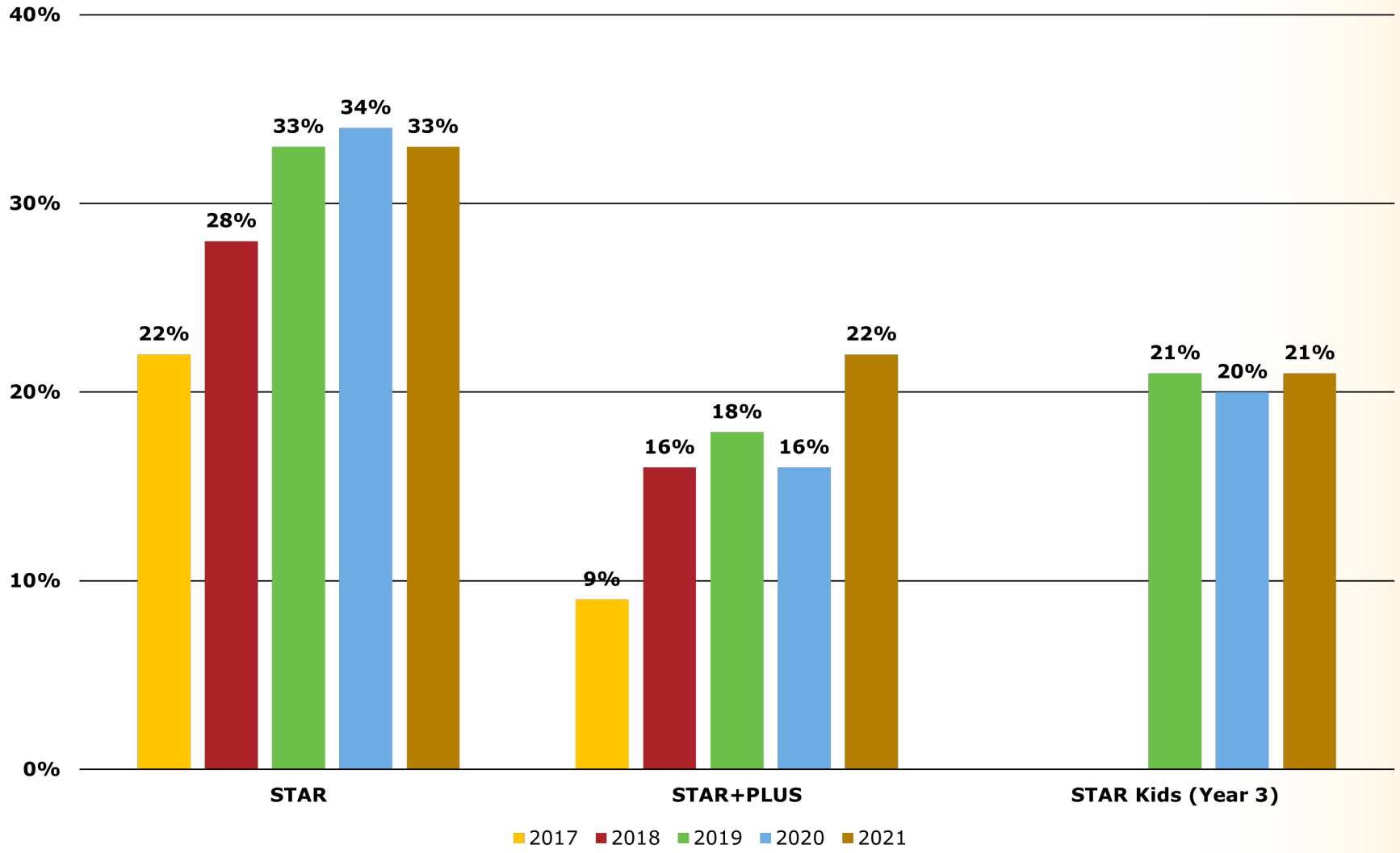
Table 1 - Annual total APM and risk based APM ratios		
HHSC will require that MCOs increase their total APM, and risk based APM ratios according to the following schedule*.		
Period	**Minimum Overall APM Ratio**	**Minimum Risk-Based APM Ratio**
Measurement Year 1	>= 25%	>= 10%
Measurement Year 2	Year 1 Overall APM Ratio +25%	Year 1 Risk-Based APM Ratio +25%
Measurement Year 3	Year 2 Overall APM % + 25%	Year 2 Risk-Based APM % + 25%
Measurement Years 4 and 5	>= 50%	>= 25%
*** A Measurement Year (MY) is a 12-month period from January 1 to December 31. Measurement Year 1 is calculated starting January 1 after the respective MCO enters a new Medicaid or CHI Program.**		

~ Targets started in CY 2018. HHSC extended CY 2021 targets through CY 2022 (UMCM-Ch 8.10 "Alternative Payment Model Data Collection Tool").

Overall APM Achievement CYs 2017* – 2021 (Preliminary)



Risk-based APM Achievement CYs 2017* – 2021 (Preliminary)



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Distribution of Total Payments, Claims, and Incentives in an APM by Provider Type CY 2021 (Preliminary)

Provider Type	Total Payments	Percentage of Total Payments	Claims Paid	Percentage of Claims Paid	Incentives	Percentage of Incentives
Primary Care + Ob/Gyn + Urgent Care	$3,535,945,966	51.2%	$3,535,945,966	51.0%	$82,290,694	63.3%
Health Home, Nursing Facilities, and Home Care	$2,252,858,413	32.6%	$2,252,858,413	33.2%	$5,250,089	4.0%
Specialist, Behavioral & Mental Health	$121,722,934	1.8%	$121,722,934	1.4%	$28,904,723	22.2%
ACO	$47,363,117	0.7%	$47,363,117	0.6%	$6,588,081	5.1%
Pharmacy and Lab	$628,972,986	9.1%	$628,972,986	9.3%	$212,713	0.2%
Other	$319,608,673	4.6%	$319,608,673	4.6%	$6,719,655	5.2%
Total	$6,906,472,090	100.0%	$6,906,472,090	100.0%	$129,965,955	100.0%

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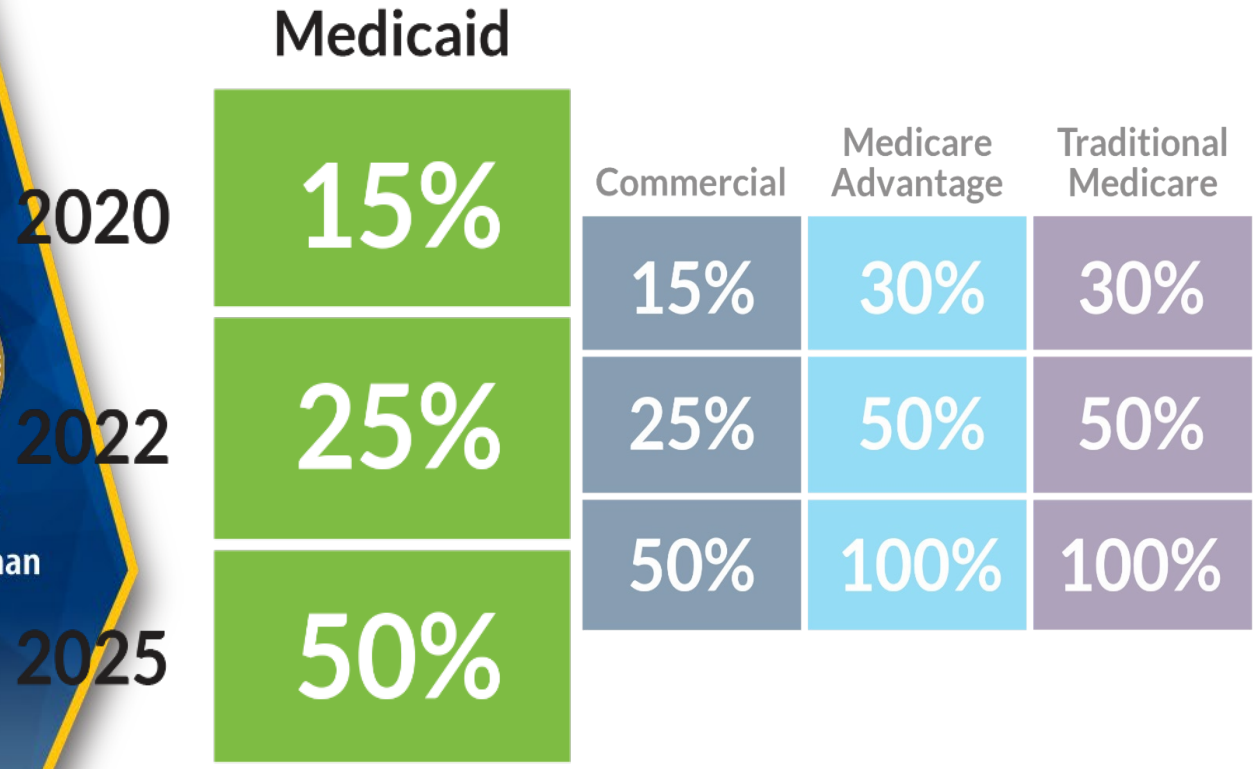
National LAN Goals for APMs with Risk



National Baseline:
Percentage of payments flowing through two-sided risk models (Categories 3B & 4* in the LAN APM Framework)

2018	8.3%

***Category 3B:** APMs with Shared Savings and Downside Risk
Category 4: Population-Based Payments

Overview: Updated APM Framework

- Provides flexibility for MCOs to advance value-based strategies and initiatives, while maintaining alignment with the Health Care Payment Learning & Action Network (LAN)
- Includes APM Frameworks for STAR/CHIP, STAR+PLUS, and STAR Kids programs

MCOs earn points across five APM Domains over four years

1. *Achievement levels*
2. *Quality*
3. *APM Priorities*
4. *APM Pilots/Initiatives*
5. *APM Support*

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APM Domains One & Two

1 APM Achievement Level

- Maintain current APM achievement levels
- Increase accountable (including risk-based) APMs
- Increase incentive dollars paid through APMs

2 Quality

- Based on Rider 20 (2022-23 General Appropriations Act) Benchmarks for MCOs
- Exceptional or high performance on Quality-of-Care while maintaining at least satisfactory performance in all other domains

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APM Domain Three

3 APM Priorities

- Rural, community-based providers
- APMs that address NMDOH
- Primary and behavioral health integration
- Pharmacy (incentive dollars & Medication Therapy Management)
- Home and community-based services

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APM Domain Four

4 APM Pilots/Initiatives

- Maternal care models
- STAR PLUS Pilot Innovative Payment Models
- Community Health Access and Rural Transformation
- CHIC Kids Pilot
- Transitions from pediatric to adult services for individuals with complex medical needs
- Emergency Triage, Treat, and Transport (ET3)
- Other pilot in collaboration with HHSC and providers to test an innovative payment/care model

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APM Domain Five

5 APM Support

- Strategic Plan/Roadmap and annual updates
- Evaluations
- Learning and awareness with providers
- Performance reports to providers
- Data sharing with providers

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Timeline

February 2023	March/April 2023	July 2023	Summer 2024
Present detailed performance framework to MCOs and other stakeholders	Incorporate the performance framework into the UMCM, send to MCOs for formal comment	MCOs report 2022 APM information	Test Year: MCOs report 2023 APM information

February 15
MCO Quarterly Meeting

February 21
Value-Based Payment and Quality Improvement Advisory Committee

+ Other meetings

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Non-Medical Drivers of Health Action Plan

Noelle Gaughen, Director of Quality Evaluation

Joelle Jung, Senior Policy Advisor

Delivery System Quality & Innovation, Medicaid & CHIP Services

What is the NMDOH Action Plan?

- Guiding priorities and strategic goals for Medicaid & CHIP Services (MCS) to coordinate new and ongoing NMDOH activities
- Actions support the work of MCOs and providers, for example:
  - Recommended screenings and follow-up best practices
  - Policy guidance like Quality Improvement costs
  - Aligning incentives or requirements (VBP requirements, P4Q metrics, DPP metrics, etc.)
- Success requires collaboration across HHS and with MCOs, providers, and community-based organizations

Non-Medical Drivers of Health (NMDOH) are the conditions in the places where people live, learn, work, and play that affect a wide range of health risks and outcomes.

Definition adapted from the CDC www.cdc.gov/socialdeterminants/about

Why did MCS make the Action Plan?

1. Advance the goals and objectives of the Texas Managed Care Quality Strategy
2. Potential cost savings from improved population health management and reduced utilization
3. Respond to requests from MCOs and providers for state guidance

Non-Medical Drivers of Health Action Plan

Priorities

- **Food Insecurity**
- **Housing**
- **Transportation**

Goals

A) Build data infrastructure for statewide quality measurement and evaluation

B) Coordinate services and existing pathways throughout the delivery system

C) Develop policies and programs that incentivize MCOs and providers to identify and address health-related social needs while containing costs

D) Foster opportunities for collaboration with key partners

Goal A) Build Medicaid NMDOH data infrastructure for statewide quality measurement and evaluation

1. Recommend a set of food insecurity measures and clinical quality measures for HHS, MCOs, and providers to use for quality programs and evaluation purposes. Include measure specifications, screening questions/tools, target population, demographic stratifications, and other data elements.
2. Identify and implement a strategy for collecting Medicaid member-level food insecurity data. May leverage existing HHS or MCO processes to screen members for food insecurity.
3. Evaluate statewide trends on the impact of addressing food insecurity on clinical quality measures and progress on promoting health equity among beneficiaries

Goal B) Coordinate services and existing pathways throughout the delivery system to address food insecurity, housing, and transportation for Texas Medicaid beneficiaries

1. Identify and facilitate strategic partnerships and a systematic approach for MCOs, providers, and community-based organizations (CBOs) to coordinate their service delivery models and referral systems to address identified food insecurity among Medicaid beneficiaries
2. Identify options to assess and enhance the impact of SNAP benefits and WIC resources to address identified food insecurity among Medicaid beneficiaries
3. Assess and enhance the impact of the 2-1-1 system on the HRSNs of Medicaid beneficiaries

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Goal C) Develop policies and/or programs to incentivize MCOs and providers to identify and address food insecurity, housing, and transportation for Medicaid beneficiaries while demonstrating cost containment

1. Propose and develop policies to reimburse Medicaid providers for completing recommended NMDOH screenings and follow-up actions (e.g., referrals or connections to resources) for Medicaid beneficiaries.
2. Develop and implement MCO incentives or requirements for NMDOH into existing initiatives, such as Performance Improvement Projects, recommended Value-Based Payment models, Pay-for-Quality metrics, Quality Improvement costs, and In-Lieu-of Services
3. Incorporate and standardize recommended NMDOH measures and clinical quality measures from A.1 in MCO and provider incentive programs
4. Explore statutory authorities to test health care delivery models for managed care (e.g., accountable care and population health approaches) and financial models (e.g., social risk-adjusted capitation)

Goal D) Foster opportunities for collaboration with partners internal and external to Health & Human Services

1. Sustain and strengthen an internal workgroup of NMDOH subject matter experts across the HHS agency to share best practices and collaborate
2. Sustain and expand external workgroups or learning collaboratives with key stakeholders (including MCOs, providers, CBOs, other state Medicaid agencies, and CMS) to share best practices and collaborate
3. Strengthen or establish a stakeholder engagement process with Medicaid beneficiaries to solicit feedback and inform NMDOH policy and program development with an understanding of the needs and experiences of the people served by MCS

How can Providers get involved?

1. Voluntarily align with MCS priorities
2. Collaborate with MCS, MCOs, and other stakeholders to accomplish goals
3. Participate in learning collaboratives
4. Identify and share best practices

Potential Next Steps for MCS

Goal A: Data Infrastructure

- Guidance on screening and follow-up best practices
- Consensus sets of screening tools and quality measures for screening and referral

Goal B: Coordinating the Delivery System

- A landscape scan of CBO capacity for partnerships, including rural capacity
- A report that describes partnership models

Goal C: Policies & Programs

- Guidance on existing opportunities to reimburse or financially reward Medicaid providers
- Identify policy barriers to the widespread adoption of NMDOH screening and referral activities

**Actions may be driven by legislative direction*

Goal D: Collaboration

- Leverage the work of existing collaboratives
- Identify new opportunities for collaboration

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Questions about the NMDOH Action Plan?

MCS Delivery System Quality & Innovation

Email: DSQI@HHS.texas.gov

Website: Non-Medical Drivers of Health

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Directed Payment Programs Quality Update

CHIRP, TIPPS, DPP BHS, RAPPS

Noelle Gaughen

Delivery System Quality & Innovation

Texas Medicaid DPPs SFY 2023

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CHIRP
Comprehensive Hospital Increased Reimbursement Program

$5.2 Billion

406 Hospitals

2nd Year

STAR
STAR+PLUS

QIPP
Quality Incentive Payment Program

$1.1 Billion

951 Nursing Facilities

6th Year

STAR+PLUS

TIPPS
Texas Incentive for Physicians and Professional Services

$738 Million

61 Physician Groups

2nd Year

STAR
STAR+PLUS
STAR Kids

DPP BHS
Directed Payment Program for Behavioral Health Services

$253 Million

40 Behavioral Health Centers

2nd Year

STAR
STAR+PLUS
STAR Kids

RAPPS
Rural Access to Primary and Preventive Services

$31 Million

160 Rural Health Clinics

2nd Year

STAR
STAR+PLUS
STAR Kids

Program Changes in SFY2024

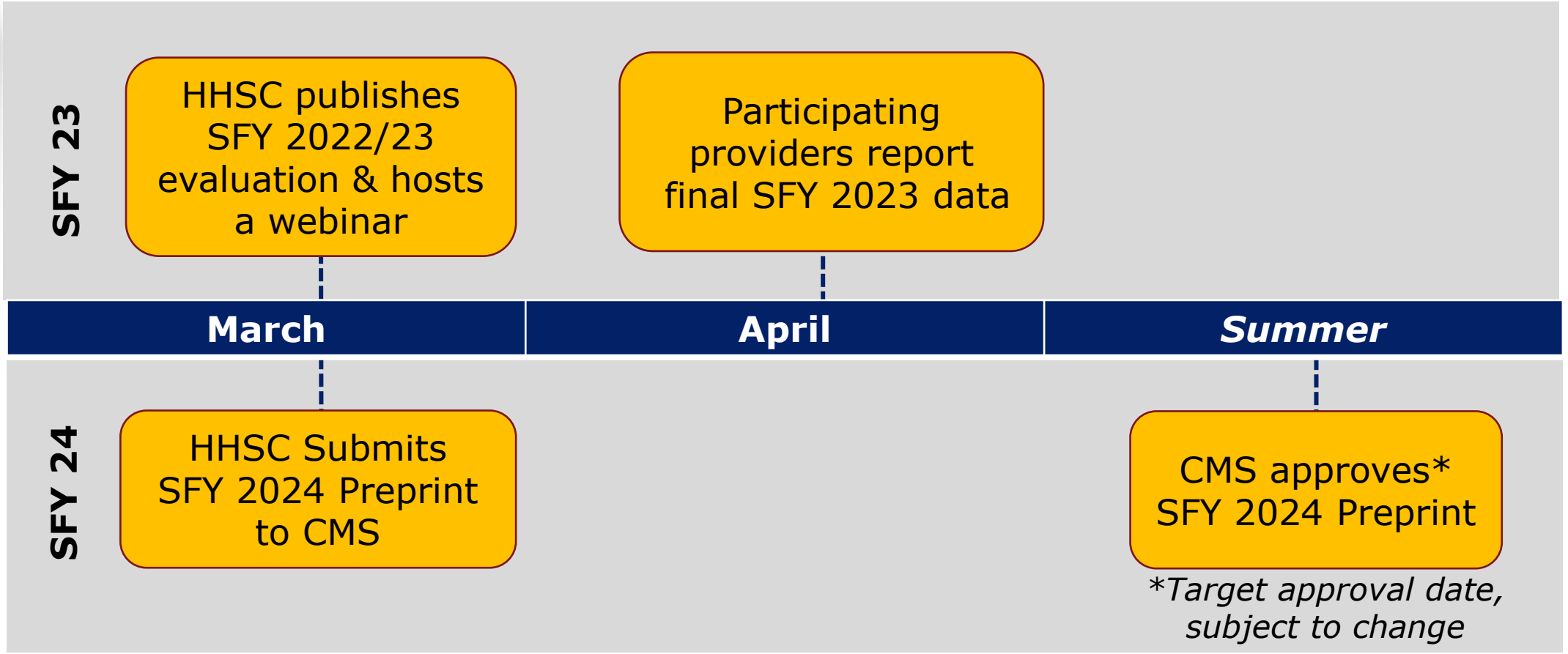
Stakeholder Workgroups

- HHSC worked with stakeholders starting in November 2022 to review progress, prioritize focus areas, and explore potential changes.
- Workgroups included providers and MCOs.

Program Changes

- ✓ Reducing the number of measures reported by providers
- ✓ Increasing the number of measures tracked by the External Quality Review Organization
- ✓ Health Information Exchange and non-medical drivers of health across (NMDOH) reporting across all programs

Next Steps for DPPs



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Questions about DPPs?

Email: DPPQuality@hhs.Texas.gov

Website: DPP Quality Resources

Update: HHSC Projects Hospital Quality-Based Payment Program

Jimmy Blanton, Director
Office of Value-Based Initiatives
Medicaid & CHIP Services

Background

Senate Bill 7, 82nd Legislature and Senate Bill 7, 83rd Legislature, directed HHSC to implement strategies to reduce potentially preventable events (PPEs) by hospitals and managed care organizations.

- Calculated biannually: full and mid-year reporting
- Texas Administrative Code Rules: http://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=5&ti=1&pt=15&ch=354&sch=A&div=35&rl=Y
- HHS PPE webpage: https://hhs.texas.gov/about-hhs/process-improvement/medicaid-chip-quality-efficiency-improvement/potentially-preventable-events

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Definitions

Potentially Preventable Readmission (PPR): A PPR is a readmission (return hospitalization within the specified readmission time interval) that is clinically-related to the initial hospital admission.

Potentially Preventable Complication (PPC): A harmful event or negative outcome, such as an infection or surgical complication, that occurs after a hospital admission and may result from processes of care and treatment rather than from natural progression of the underlying illness and are therefore potentially preventable.

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Hospital Quality-Based Payment Program (HQBP)

HHSC administers the HQBP Program for hospitals in Medicaid and CHIP in the managed care and fee-for-service (FFS) delivery systems.

Hospitals are measured on their performance for risk-adjusted rates of PPRs within 15 days of discharge and PPCs across all Medicaid programs and CHIP.

Hospitals can experience reductions to their payments for inpatient stays:

- Up to 2 percent for high rates of PPRs
- Up to 2.5 percent for PPCs

Measurement, reporting, and application of payment adjustments occur on an annual cycle.

HQBP and the PHE

- During the public health emergency (PHE), hospital admissions dropped significantly.
  - However, by design, an average hospital's actual to expected ratio remains stable (~1)
- The 3M software used to identify PPEs includes clinical logic to exclude hospitalizations and complications related to the PHE.

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Other Recent Program Changes

- SFY 2020 reports were changed to use event based or unweighted rates for PPRs to allow for more accurate risk adjustment.
- SFY 2021 reports excluded neonatal jaundice admissions from PPR consideration.

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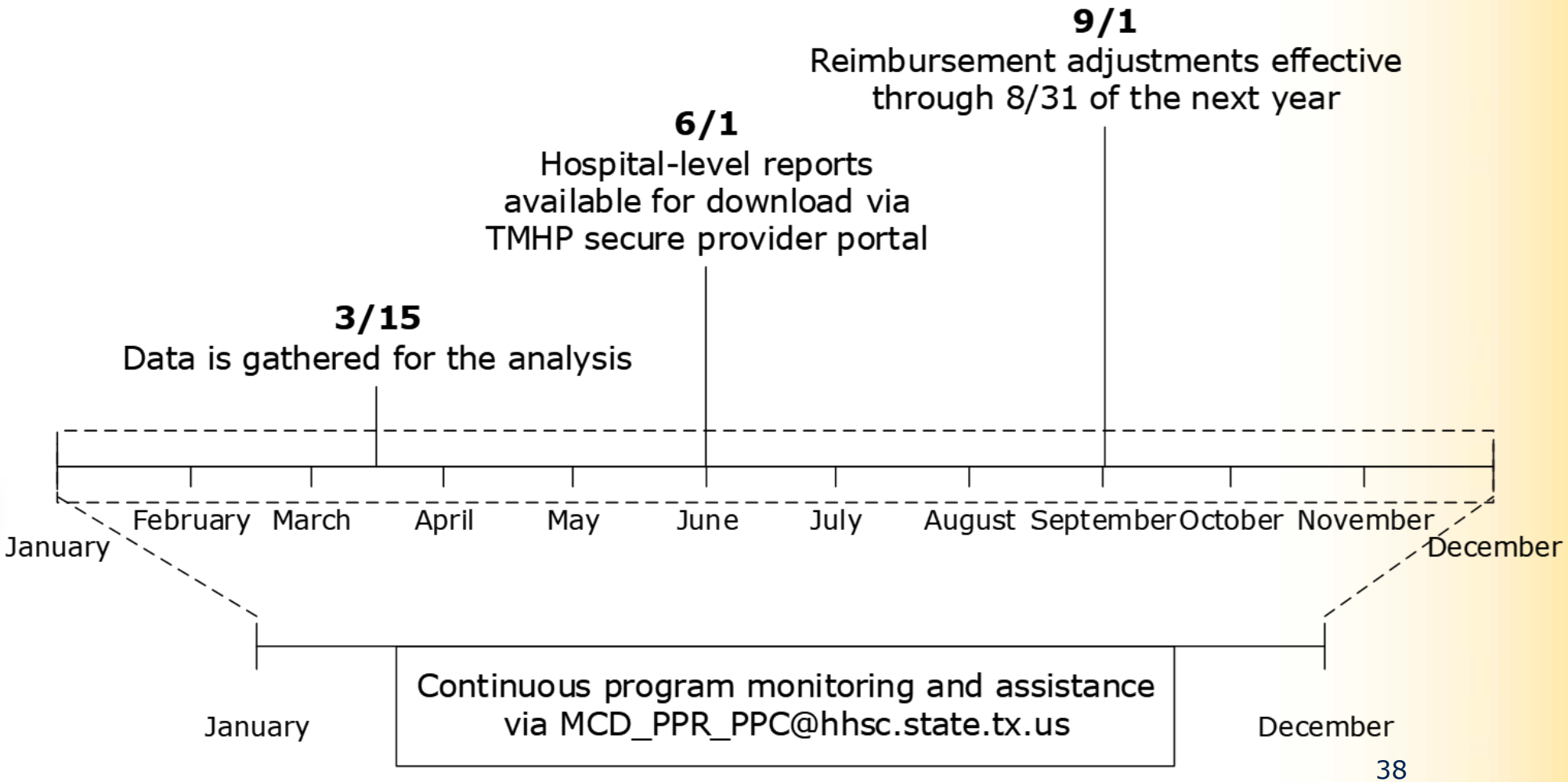
Full Year Report Timeline



Full Year Report Timeline and Adjustments

	Previous	Current	Upcoming
Reporting Period	SFY 2020 (Sept. 1, 2019 to Aug. 31, 2020)	SFY 2021 (Sept. 1, 2020 to Aug. 31, 2021)	SFY 2022 (Sept. 1, 2021 to Aug. 31, 2022)
Adjustment Period	SFY 2022 (Sept. 1, 2021 to Aug. 31, 2022)	SFY 2023 (Sept. 1, 2022 to Aug. 31, 2023)	SFY 2024 (Sept. 1, 2023 to Aug. 31, 2024)

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Reimbursement Adjustments

	Actual-to-Expected Ratio		
	Satisfactory	Unsatisfactory	
	Less than 1.10	1.10 to 1.24	1.25 and Greater
PPCs	No Penalty	LOW Penalty: -2.0%	HIGH Penalty: -2.5%
PPRs	No Penalty	LOW Penalty: -1.0%	HIGH Penalty: -2.0%

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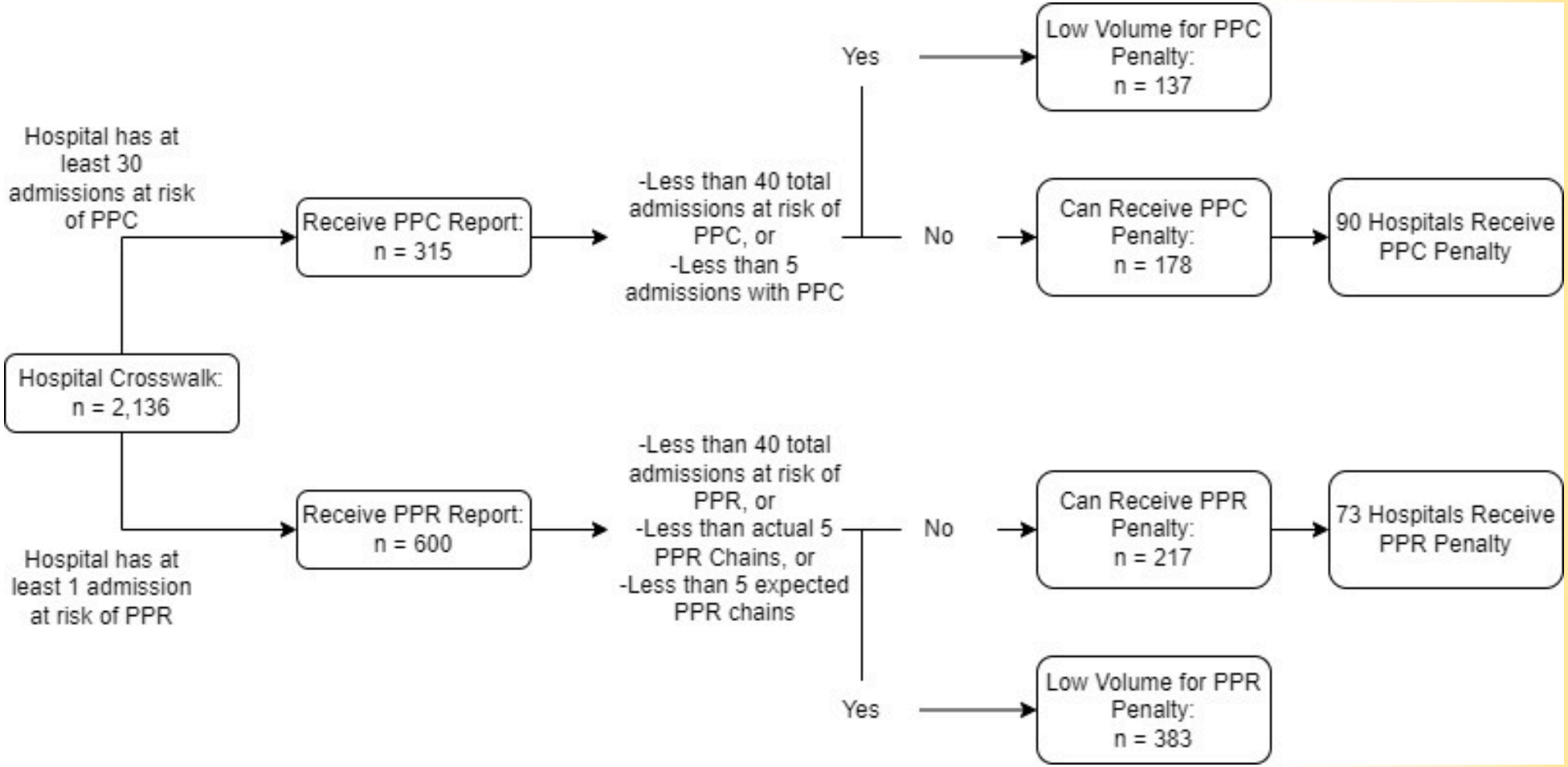
Volume Requirements for PPR/PPC Reports and Penalties



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HQBP Data Elements

Hospital PPR and PPC reports contain metrics to contextualize performance:

- Hospital volume and admissions at risk of PPEs
- PPE performance metrics, including weighted and events-based rates
- Expenditure data associated with PPEs
- PPE category and reason data for the hospital
- Statewide distributions for PPE rates

Summaries of hospital performance are publicly available on the THLC portal one year after hospitals have received their results.

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Accessing HQBP Data

Hospitals can access their confidential PPR and PPC reports on TMHP's secure provider portal at https://www.tmhp.com/.

- Files containing underlying patient level data can also be accessed here.
- For technical assistance with accessing the provider portal or creating an account, contact the TMHP EDI Helpdesk at 888-863-3638, from 7 a.m. to 7 p.m., Central Time. More information can be found at the TMHP website under the "Resources" banner.
- Mid-year reports (available in August of every year) and underlying data are available upon request to the HQBP email box at MCD_PPR_PPC@hhsc.state.tx.us.

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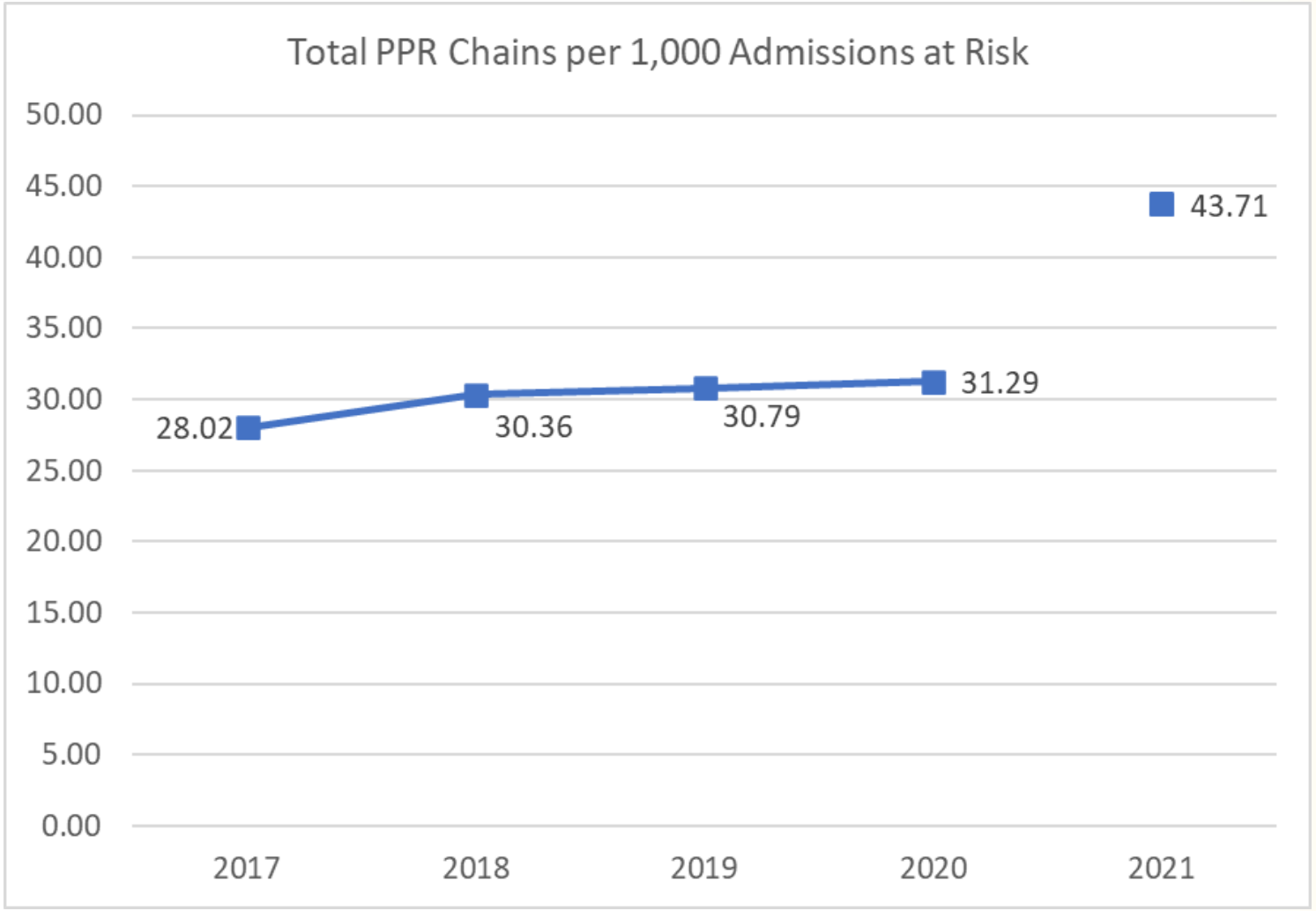
Changes in Hospital PPR Performance for 2017-2021



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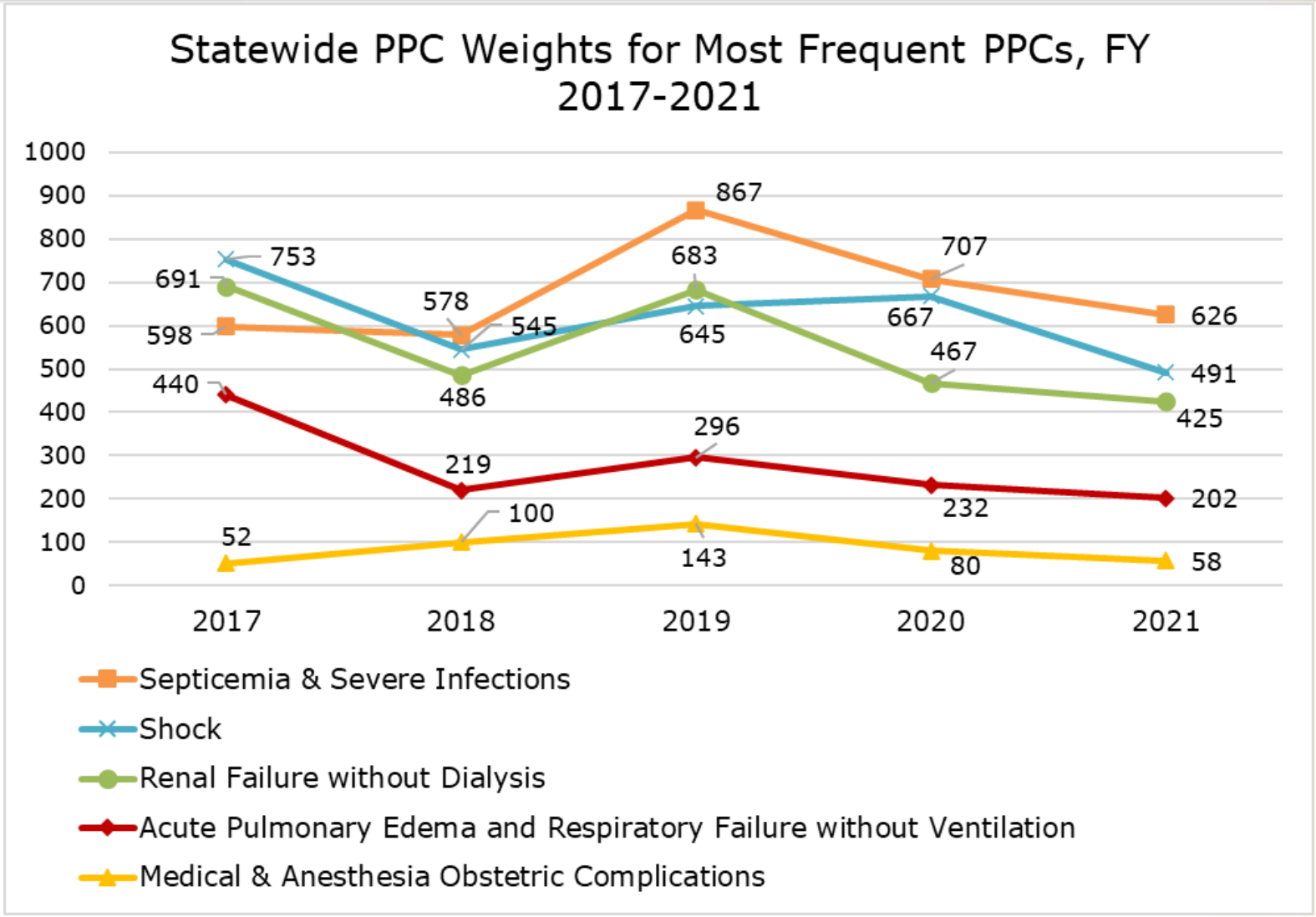
Changes in Hospital PPC Performance for 2017-2021



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Hospitals with Payment Adjustments: 2019 and 2021

PPR Penalties: Hospital Counts	Penalty Amount		
Year	-1.0%	-2.0%	**Total in Penalty**
2019*	41	41	82
2020	45	35	80
2021	41	32	73

*2019 used weighted PPR results

PPR Penalties: Hospital Counts	Penalty Amount		
Year	-2.0%	-2.5%	**Total in Penalty**
2019	15	63	78
2020	20	64	84
2021	21	69	90

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Cross-Agency Coordination on Healthcare Strategies and Measures

The 5 Agencies Project Update

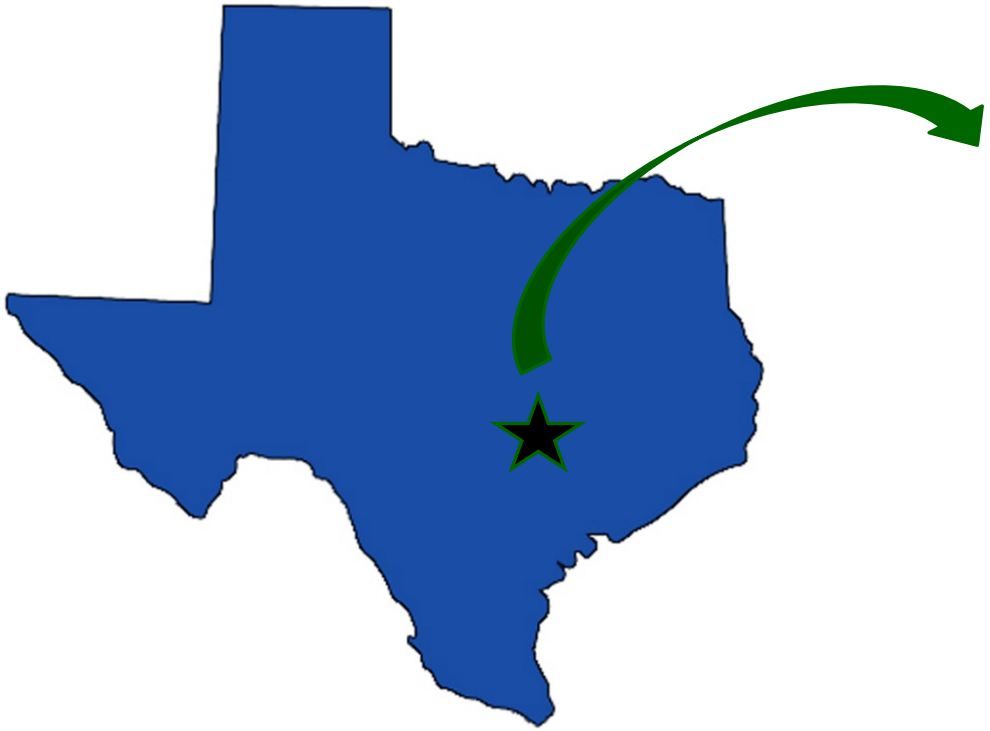
PRESENTATION TO HEALTH AND HUMAN SERVICES COMMISSION

QUARTERLY QUALITY PROVIDER MEETING

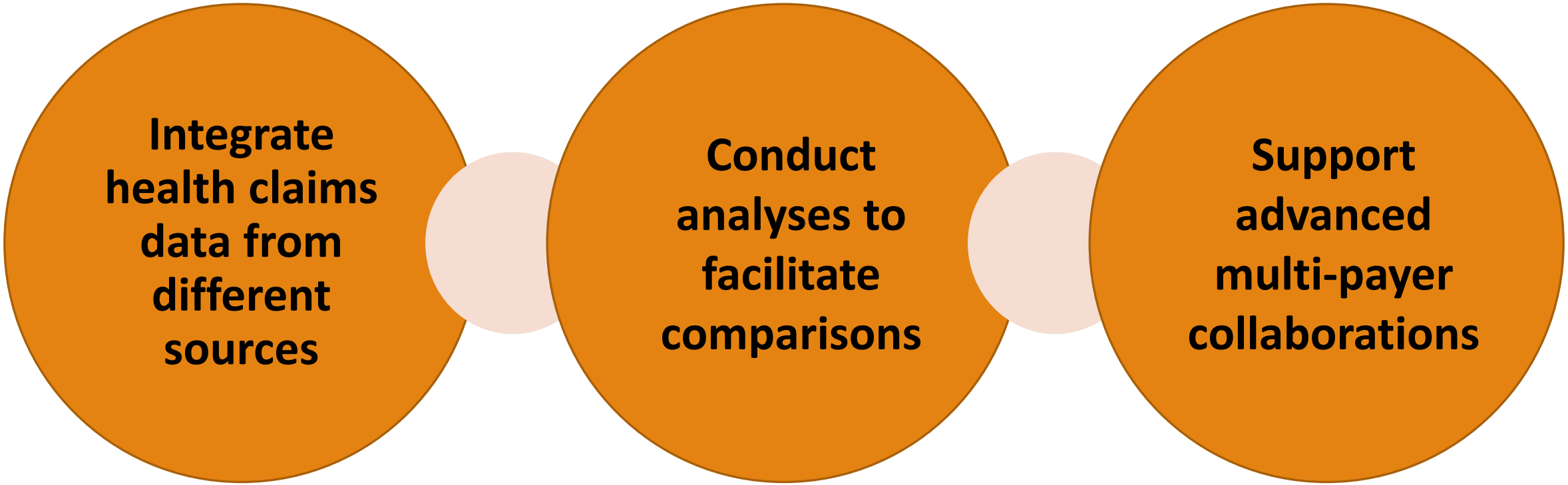
MARCH 10, 2023

Cross-Agency Collaboration

The Texas Legislature requested information from the analysis of data from 5 key state agencies to assess ways to reduce costs and improve the quality of health care provided to Texans.



Project Objectives



Medicaid Portal:
Examples of Dashboards & Data

UTHealth Houston School of Public Health
Center for Health Care Data

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Fiscal Year: 2020

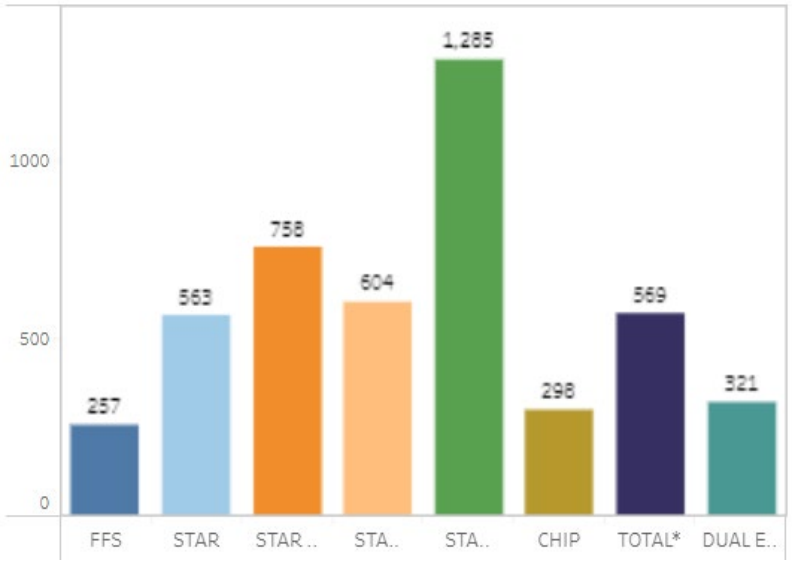
Medicaid Program
- FFS
- STAR
- STAR HEALTH
- STAR KIDS
- STAR PLUS
- CHIP
- TOTAL (excluding DUAL)
- DUAL ELIGIBLE

Utilization

Admission/Visit Type
- Acute Inpatient Admissions
- Emergency Visits with No Inpatient Admissions
- Outpatient Visits
- Professional Visits
- Readmissions Within 30 Days

Select Utilization Metric
- Rate
- Count of Admission/Visits

Emergency Visits with No Inpatient Admissions: Rate Per 1000 MY

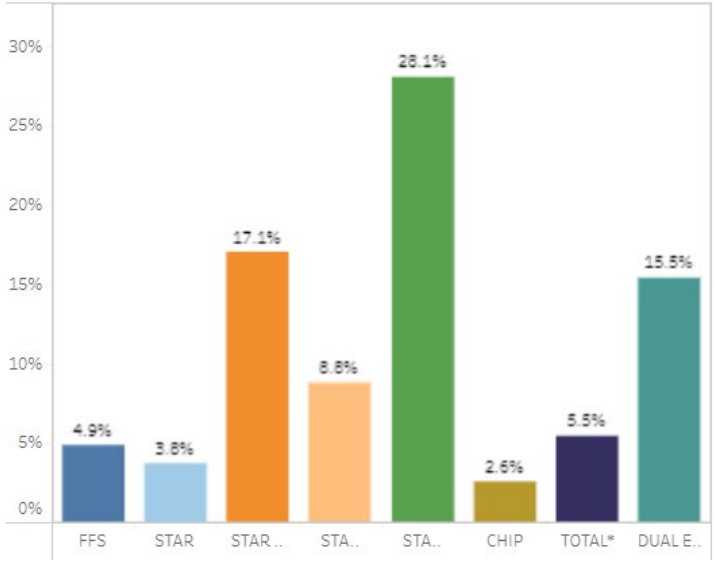


Condition

Condition: Major Depression

- Cancer
- Chronic Kidney Disease
- Chronic Pain
- Congestive Heart Failure
- Diabetes
- HIV and AIDS
- Hypertension
- Low Back Pain
- Major Depression
- Serious Mental Illnesses

Prevalence Rate for Major Depression



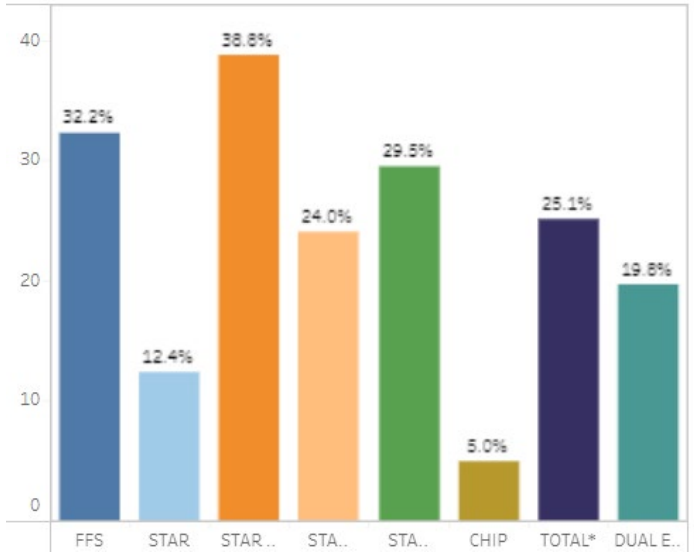
Condition Utilization

Condition: Diabetes

- Cancer
- Chronic Kidney Disease
- Chronic Pain
- Congestive Heart Failure
- Diabetes
- HIV and AIDS
- Hypertension
- Low Back Pain
- Major Depression
- Serious Mental Illnesses

Admit Type
- Acute Inpatient Admits
- Emergency Visits
- Readmits Within 30 Days

Percent of Initial Admissions for Diabetes



UTHealth Houston
School of Public Health
Center for Health Care Data

Medicaid Portal: Sample Trend Data
Utilization Cost by Admission/Visit Type

Select Fiscal Year
2018-2020

Admission/Visit Type
- (•) Acute Inpatient Admissions
- ( ) Emergency Visits with No Inpatient Admissions
- ( ) Outpatient Visits
- ( ) Professional Visits

Select Utilization Cost Metric
- ( ) Total Allowed Amount
- (•) Average Allowed Amount Per Visit

Medicaid Program
- FFS
- STAR
- STAR HEALTH
- STAR KIDS
- STAR PLUS
- CHIP
- TOTAL (excluding DUAL)
- DUAL ELIGIBLE

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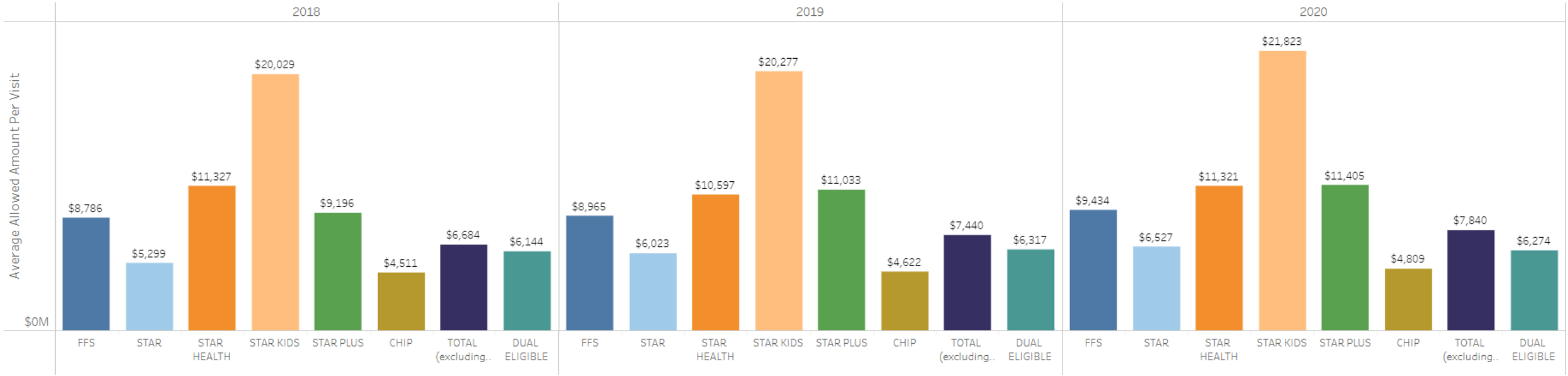
Acute Inpatient Admissions: Average Allowed Amount Per Visit



UTHealth Houston
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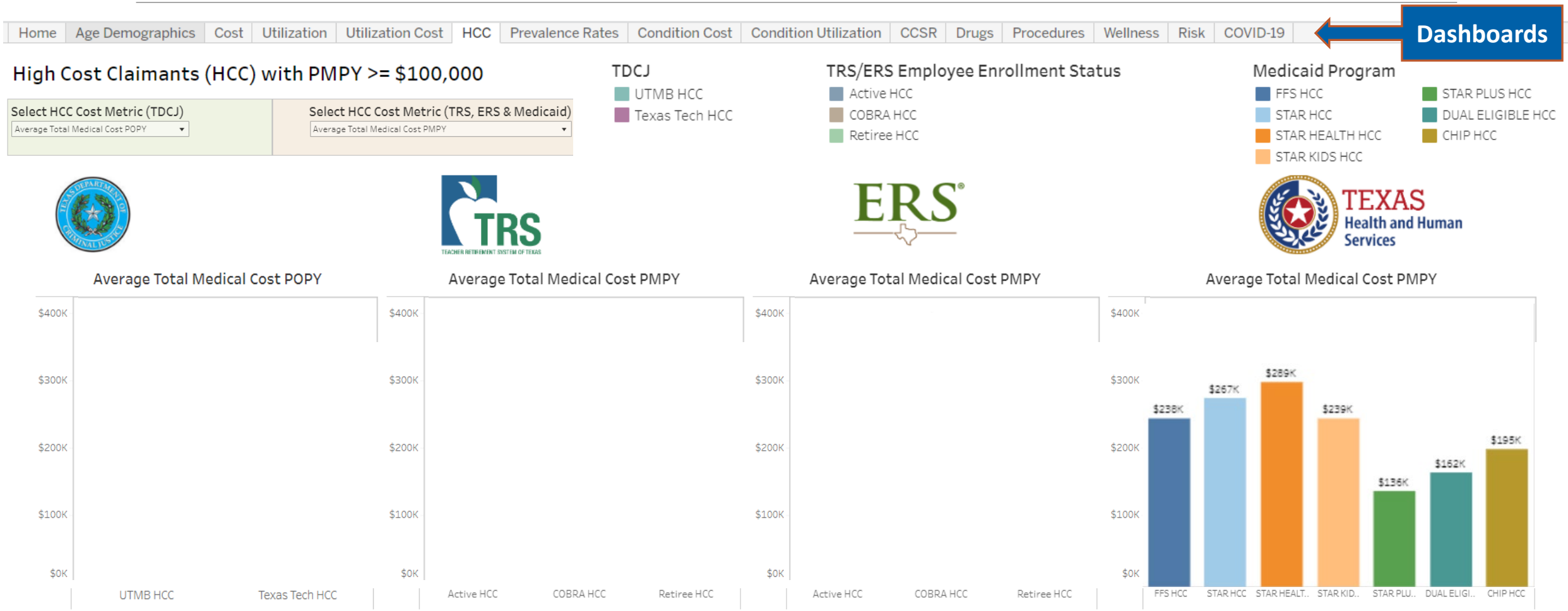
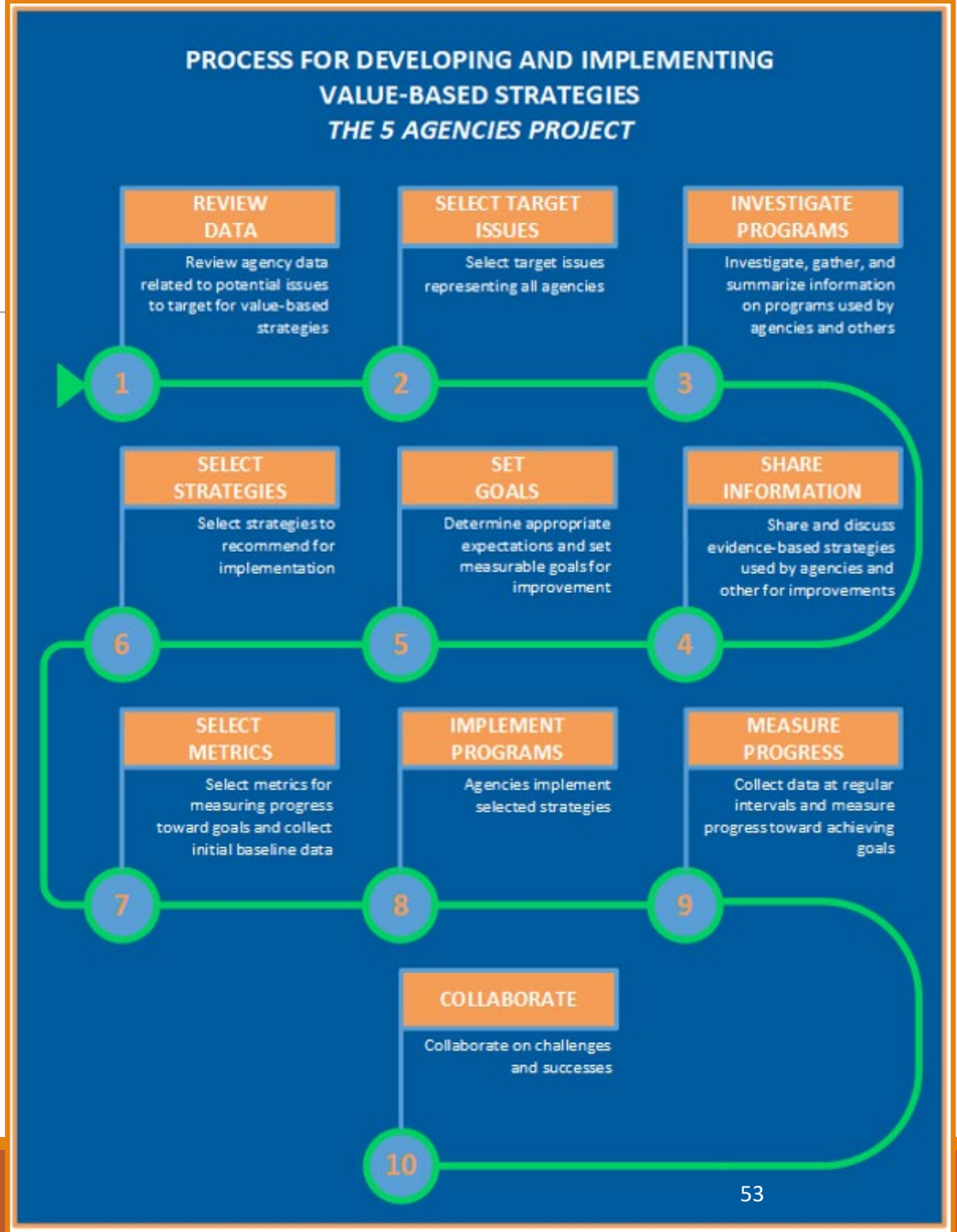
Center for Health Care Data

Comparison Site:
Dashboards & Example of Format (HCC data)



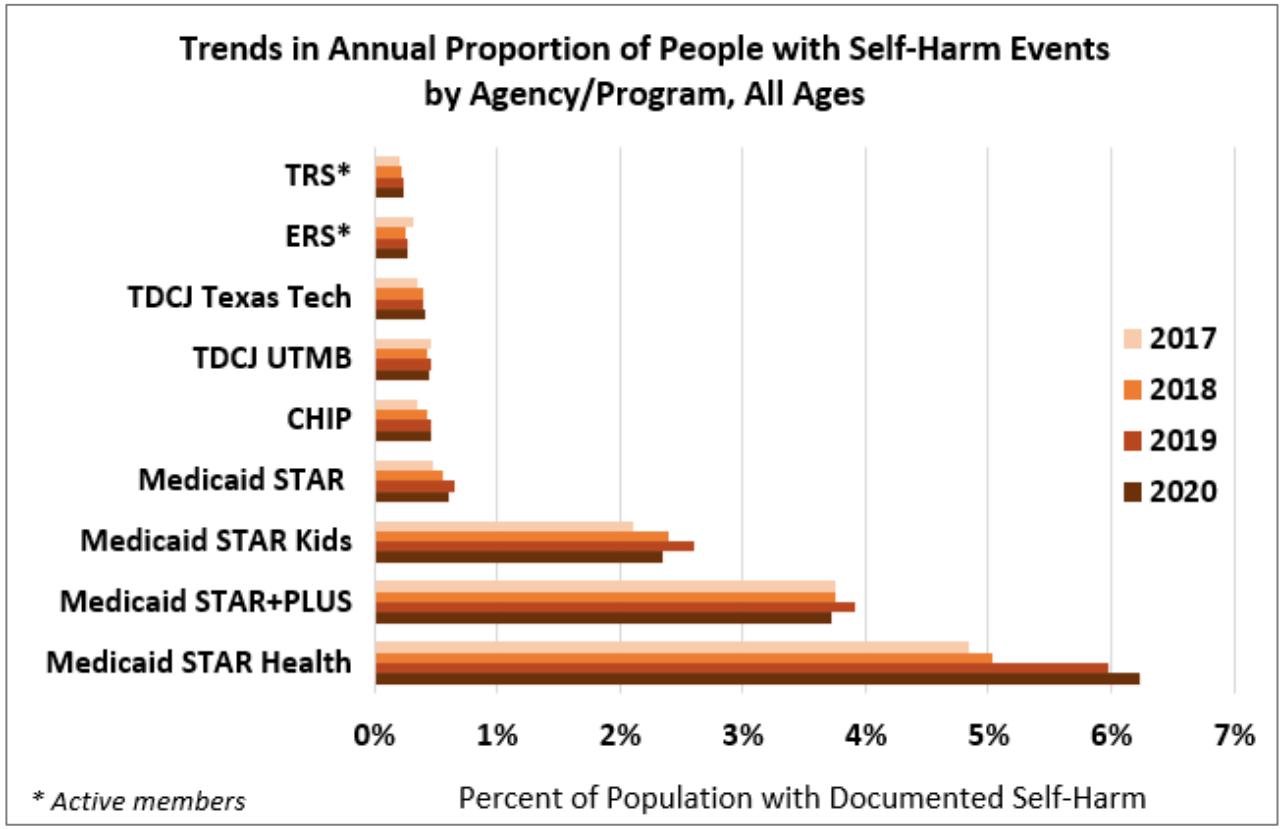
Value-Based Payment Strategies Initiative

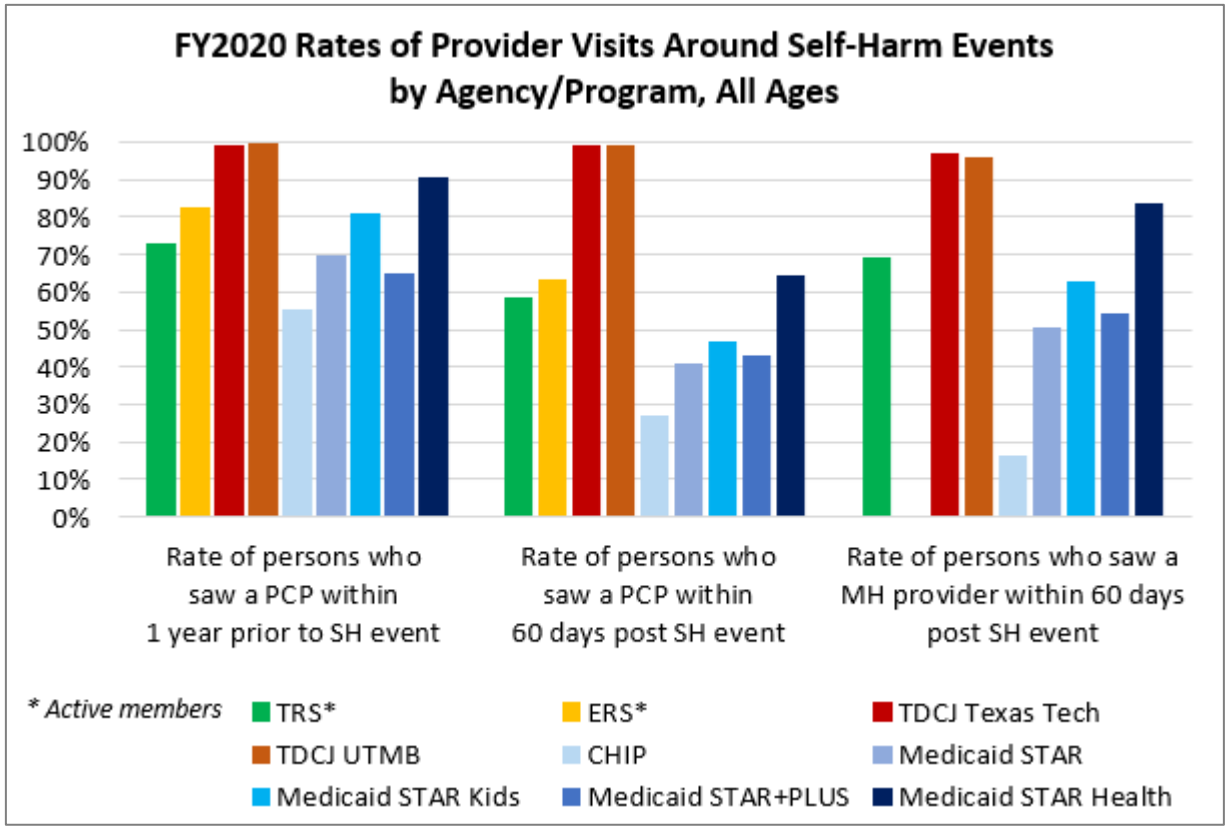
- Developed 10-step process for implementing strategies
- Created specialized sub-workgroups



What the Data Reveal

INCIDENCE TRENDS, Self-Harm by Agency/Program, All Ages





Data as of 8/31/2020

Recommendations & Initiatives Increase Use of Value-based Care

Reduce Self-Harm Events

- Increase primary care visits to add opportunities for early identification of mental health issues
- Support the development of pathways to integrate behavioral health care with primary care

Initiative

- Increase provider enrollment and usage of Child Psychiatry Access Network (CPAN)
  - Educate PCPs and community members about mental health and provide them with mental health resources
    - Develop, conduct, and disseminate webinars
    - Distribute materials via email, websites, and other communications

Medicaid Portal: Maternity Dashboard

Delivery Tab: Rate of Cesarean Deliveries for Low-Risk Pregnancies by SMFM*

UTHealth Houston School of Public Health
Center for Health Care Data

Pregnancy | Delivery | Live Births | Newborns

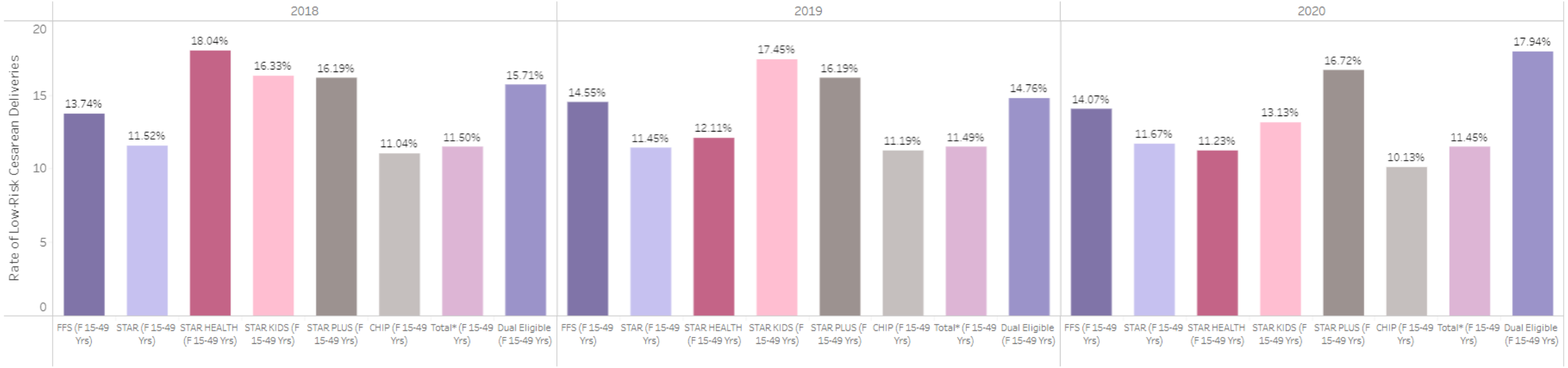
Select Fiscal Year
2018-2020

Select Delivery Metric
- Count of Live Singleton Babies
- Rate of All Cesarean Deliveries
- Rate of Low-Risk Cesarean Deliveries

Medicaid Program
- FFS (F 15-49 Yrs)
- STAR (F 15-49 Yrs)
- STAR HEALTH (F 15-49 Yrs)
- STAR KIDS (F 15-49 Yrs)
- STAR PLUS (F 15-49 Yrs)
- CHIP (F 15-49 Yrs)
- Total* (F 15-49 Yrs)
- Dual Eligible (F 15-49 Yrs)

TEXAS Health and Human Services

Rate of Low-Risk Cesarean Deliveries by SMFM



** The metric used to measure cesarean deliveries for low-risk pregnancies was developed by The Society for Maternal-Fetal Medicine (SMFM)*

Recommendations
Increase Use of Value-based Care

Improve Maternal Health Outcomes

- Support the DSHS TexasAIM Initiative safety bundles
  - Encourage engagement of physicians
  - Support for disseminating information about the program to providers and community
- Evaluate potential opportunities for improvement in rates of cesarean deliveries for low-risk pregnancies across the state

Recommendations

Capitalize on opportunities for collaboration and partnerships

Partner with, and advance, state initiatives

- Foster collaboration and dialogue
- Promote alignment of initiatives with similar goals
- Learn from each other and increase the efficiency of meeting shared goals

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Our team envisions an informed, healthy Texas fueled by insight and collaboration

Thank You

Please feel free to reach out to us with any questions:

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Texas Medical Association

TMA recent activities

Texas Hospital Association

THA recent activities

Open Discussion

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Action Items and Topics for Follow-up

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Thank You

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