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Quarterly Quality Provider Meeting

January 27, 2022

Agenda (1 of 2)

1. Welcome and Introductions
2. Update: HHSC projects
   - Annual Report on Quality Measures and Value-Based Payments
   - Alternative Payment Model Contract Requirements

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Agenda (2 of 2)

3. Update: Texas Medical Association
    - TMA activities from the past year
4. Update: Texas Hospital Association
    - THA activities from the past year
5. Open Discussion
6. Action Items and topics for staff follow-up
7. Adjourn

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Welcome and Introductions

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

Annual Report on Quality Measures and Value-Based Payments

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

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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

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Main Headings

- Managed Care Value-Based Payments Programs
  - Pay-for-Quality Program
  - Alternative Payment Model Requirements for MCOs
  - Hospital Quality-Based Payment Program
  - Medicaid Value-Based Enrollment
- 1115 Healthcare Transformation Waiver
  - Delivery System Reform Incentive Payment (DSRIP) Program
- Directed Payment Programs
  - Nursing Home Quality Incentive Payment Program (QIPP)
  - Uniform Hospital Rate Increase Program (UHRIP)
- Trends in Key Quality Measures
  - Trends in Potentially Preventable Events, 2014-2010
  - Performance Indicator Dashboard; HIV Viral Load Suppression; Relocation to a Community-Based Setting

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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

At-Risk Measures for the Medical P4Q Program (1 of 2)

Measures	STAR+PLUS	STAR	STAR Kids	CHIP
Potentially Preventable Emergency Room Visits (PPVs)	2018 2019 2022 2023	2018 2019 2022 2023	2022 2023	2018 2019 2022 2023
Potentially Preventable Admissions (PPAs)		2022 2023		
Potentially Preventable Readmissions (PPRs)	2022 2023			
Appropriate Treatment for Children with Upper Respiratory Infection (URI)		2018 2019		2018 2019 2022 2023
Prenatal and Postpartum Care (PPC)		2018 2022 2023		
Well Child Visits in the First 30 months of Life (W30), First 15 Months of Life		2018 2019		
Diabetes Control - HbA1c < 8% (CDC)	2018 2019 2022 2023			
Diabetes Screening for Members with Schizophrenia or Bipolar Disorder Who are Using Antipsychotics (SSD)	2018 2019			

At-Risk Measures for the Medical P4Q Program (2 of 2)

Measures	STAR+PLUS	STAR	STAR Kids	CHIP
Cervical Cancer Screening (CCS)	2018 2019 2022 2023			
Child and Adolescent Well-Care Visits (WCV), 12-21 years of age				2018 2019
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (WCC)				2018 2019 2022 2023
Follow-up After Hospitalization for Mental Illness (FUH)	2022 2023		2022 2023	
Childhood Immunization Status (CIS) Combination 10		2022 2023		2022 2023
Follow-up Care for Children Prescribed ADHD Medication (ADD)		2022 2023		
Getting Specialized Services Composite			2022 2023	
Assistance with Care Coordination			2022 2023	

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

Link: HHSC Value-Based Enrollment Incentive Program Report

Value-Based Enrollment (VBE) (2 of 2)

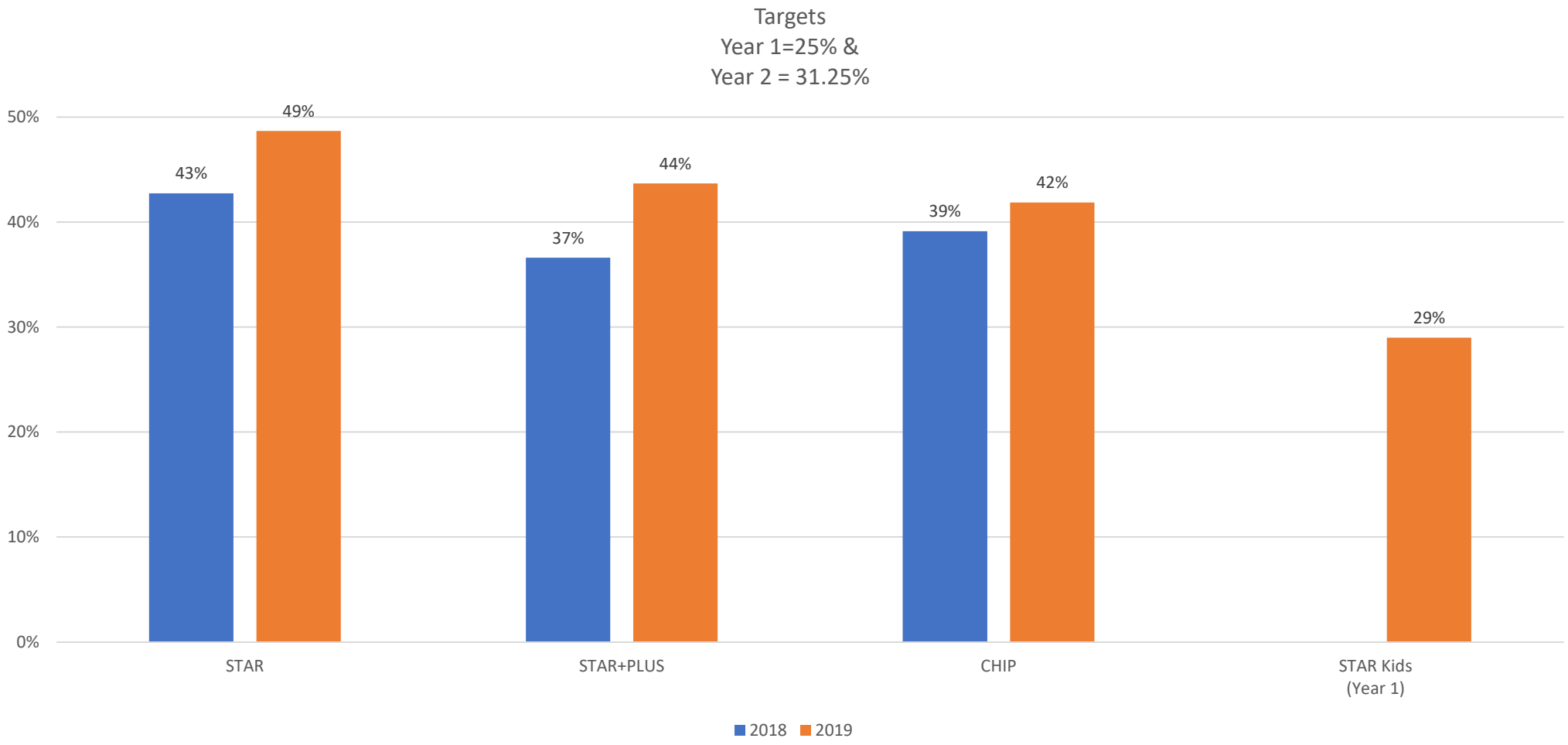
- After implementation, HHSC assessed the effect of the VBE process based on six months of enrollment data for STAR, STAR+PLUS, and STAR Kids.
- For 17 participating MCOs across the programs from December 2020 to May 2021:
  - Five plans gained greater than 2.5 percent in auto-enrollments compared to 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

Alternative Payment Model Requirements for MCOs*

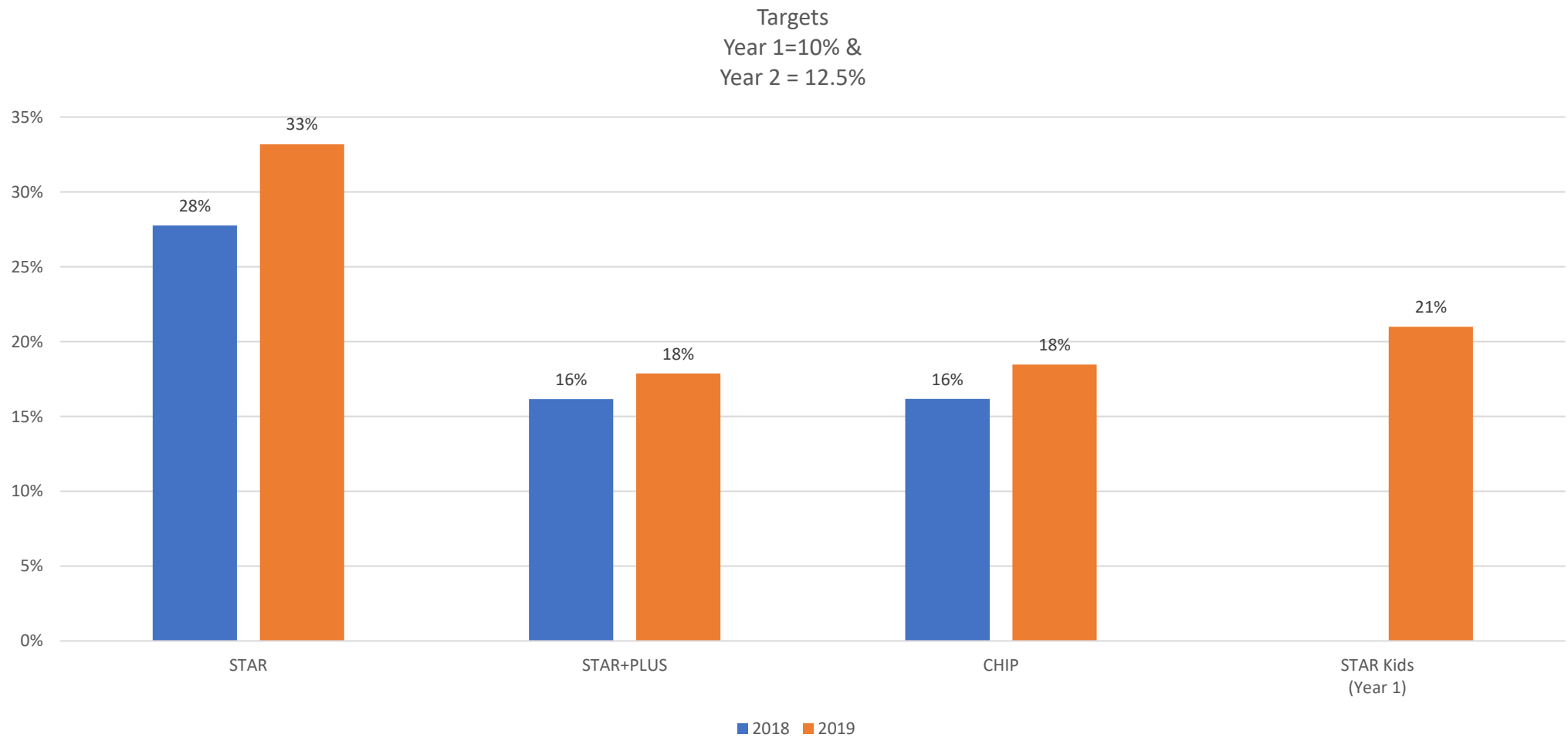
CATEGORY 1: FEE FOR SERVICE – NO LINK TO QUALITY & VALUE	CATEGORY 2: FEE FOR SERVICE – LINK TO QUALITY & VALUE	CATEGORY 3: APMs BUILT ON FEE-FOR-SERVICE ARCHITECTURE	CATEGORY 4: POPULATION- BASED PAYMENT
	CATEGORY 2A: Foundational Payments for Infrastructure & Operations (e.g. care coordination fees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

* Healthcare Payment Learning and Action Network Alternative Payment Model Framework (available at: http://hcp-lan.org/workproducts/apm-framework- onepager.pdf)

Overall APM Achievement by Program CYs 2018 - 2019



Risk-Based APM Achievement by Program CYs 2018 - 2019



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.

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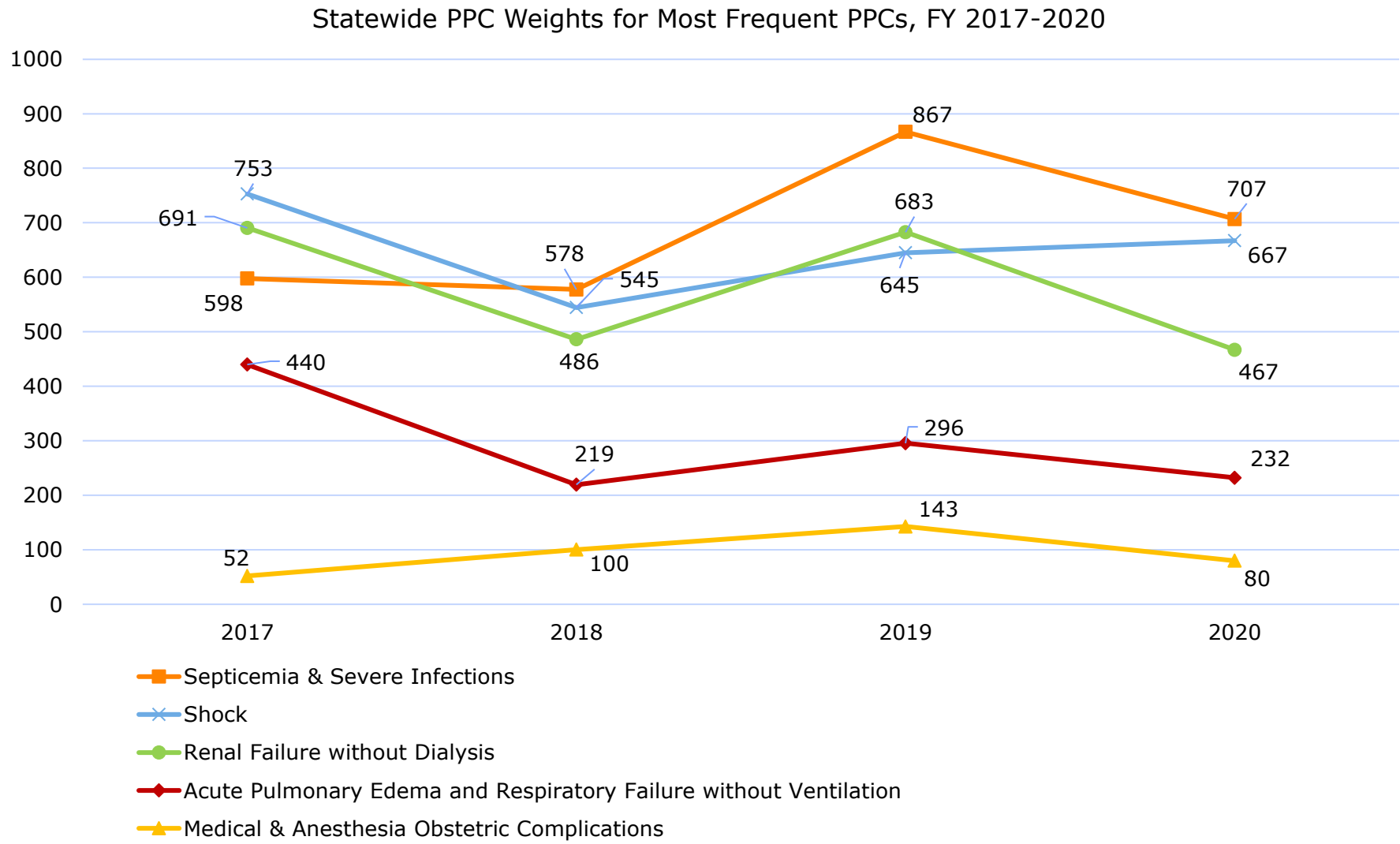
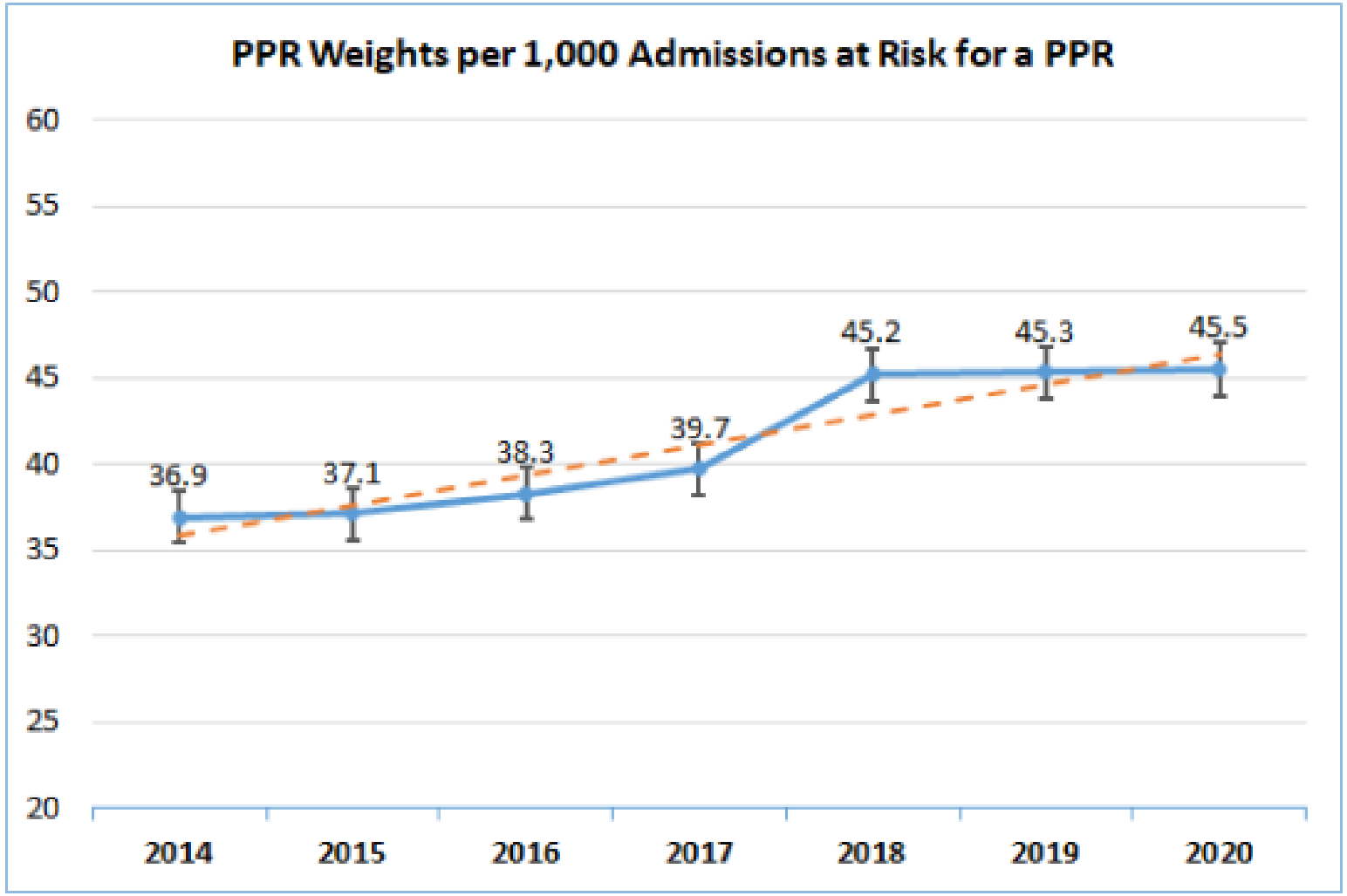
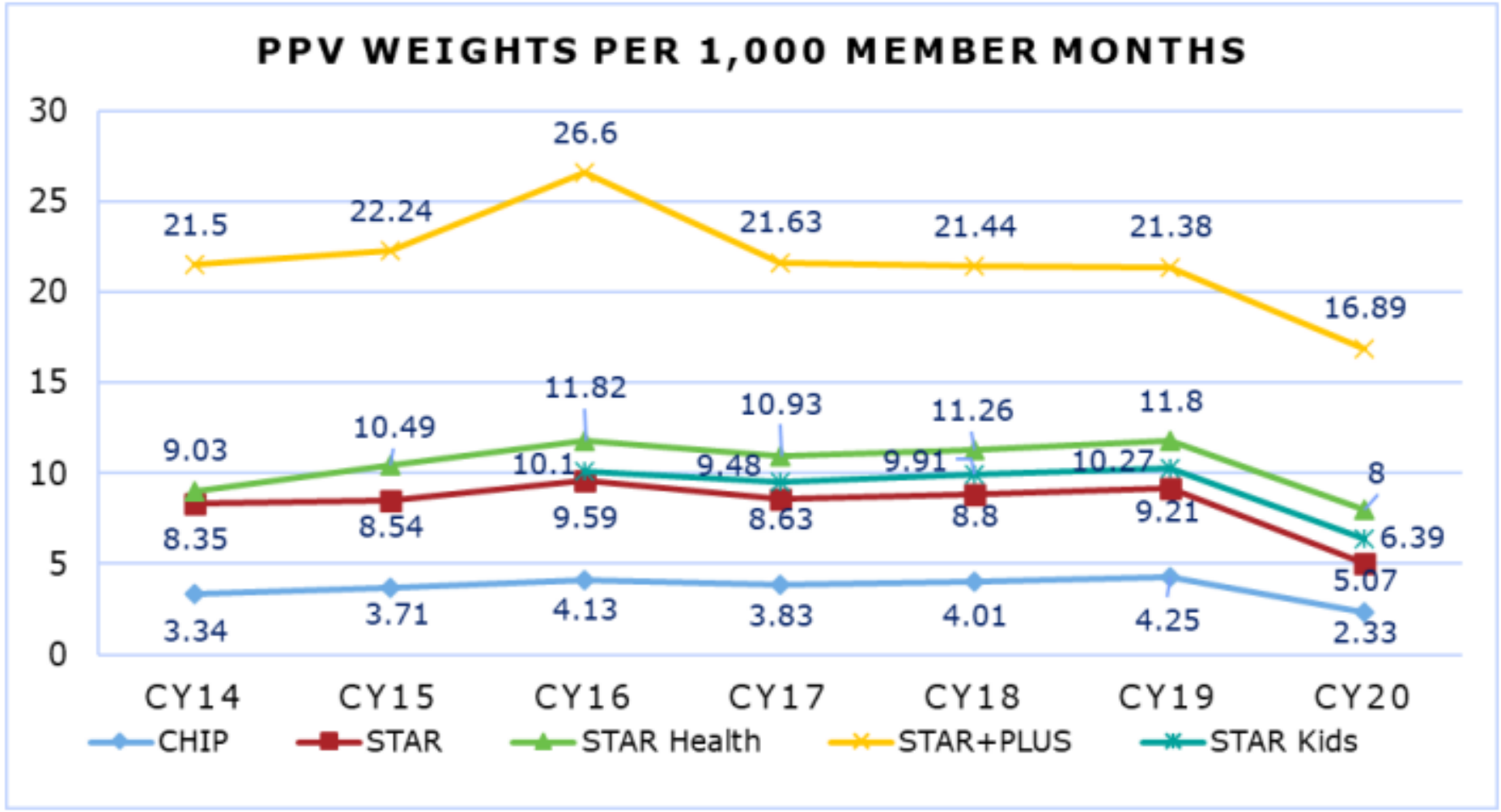
Changes in Hospital PPC Performance for 2017-2020



Changes in hospital PPR performance for 2014-2020



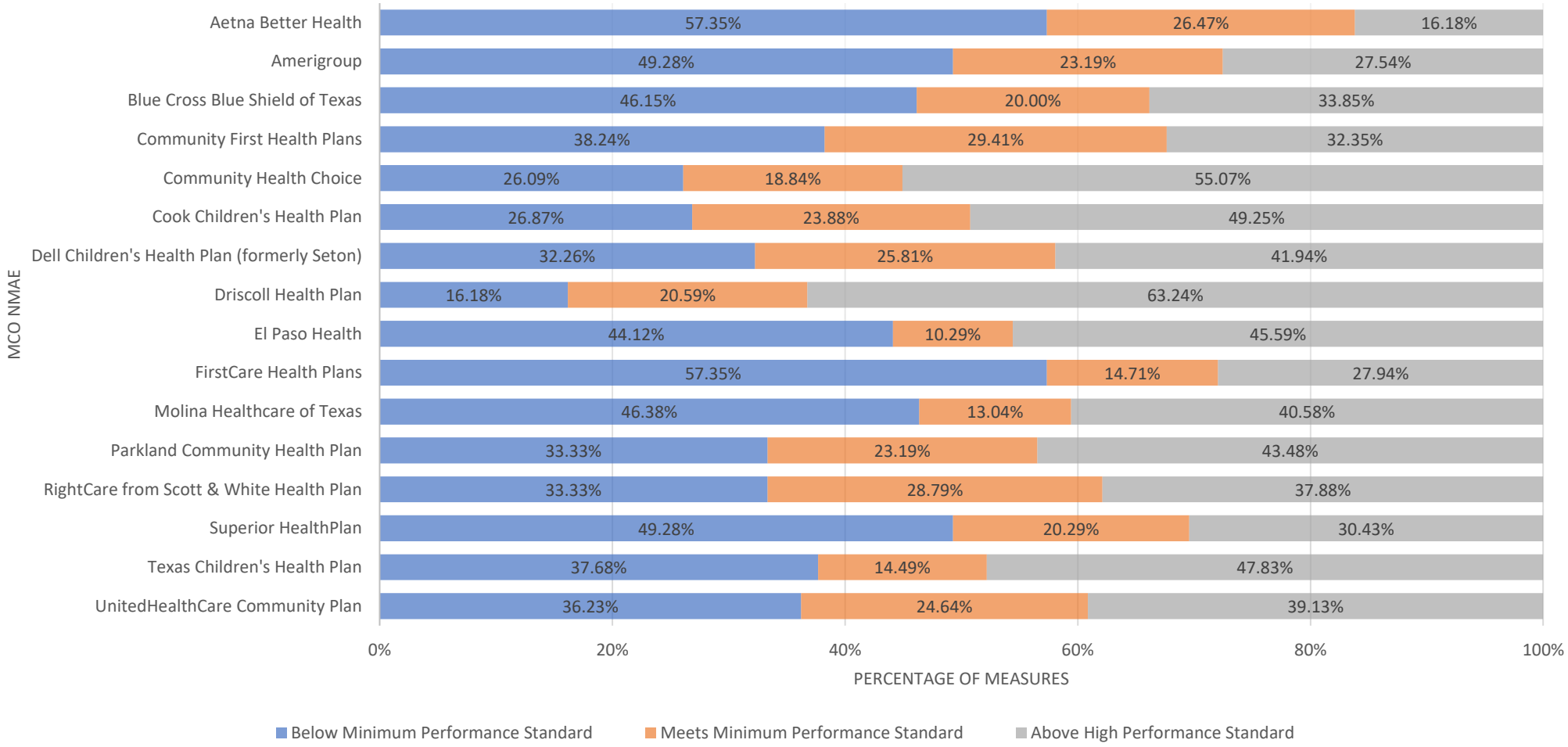
Seven Year Trends of PPV Weights per 1,000 Member Months- All Programs, 2014-2020



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



Resources

Annual Report on Quality Measures and Value-Based Payments

- https://www.hhs.texas.gov/sites/default/files/documents/annual-report-on-quality-measures-and-vbp-dec-2021.pdf

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Alternative Payment Model Contract Requirements

Revisions to contract and manual requirements

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*		
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. HHSC will extend CY 2021 target through CY 2022.

Other Current Requirements (1 of 2)

Current APM Contract Requirements:

- Submit to HHSC its inventories of APMs with Providers by July 1st of each year using the data collection tool in UMCM Chapter 8.10.
- Implement processes to share data and performance reports with Providers on a regular basis.
- Dedicate resources to evaluate the impact of APMs on utilization, quality and cost, as well as return on investment.

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Other Current Requirements (2 of 2)

Contract Language: Alternative Payment Models with Providers

- Uniform Managed Care Contract (UMCC) – 8.1.7.8.2 (STAR, STAR+PLUS and CHIP).
- STAR Health Managed Care Contract - 8.1.7.9.2.
- STAR Kids Managed Care Contract – 8.1.7.9.2.

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VBPQIAC Recommendation

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

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Timeline for Submitting Contract & Manual Changes

MCO/DMO Contract Amendment Process:

- **Concept Phase: submitted concept** Oct. 30, 2021: **Complete**
- Initiation Phase: Change Request Form (CRF) for Managed Care contract changes: Nov – Dec 21
- Submit CRF to MCCO – Jan 1, 2022
- Refinement Phase: Feb – Jun 22
- Finalization Phase: Jun – Jul 22
- Routing & Execution: Jul – Aug 22

MCO/DMO Manual Amendment Process:

- Opportunity exists to update current APM tool for **01/01/2023.**

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Update: Texas Medical Association

TMA activities from the past year

Update: Texas Hospital Association

THA activities from the past year

Open Discussion

Jimmy Blanton
Director, Office of Value-Based Initiatives
HHSC

Action Items and Topics for Follow-up

Erica Dawley

Research Specialist, Office of Value-Based Initiatives

HHSC

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Thank You

Jimmy Blanton

Director, Office of Value-Based Initiatives

Jimmy.Blanton@hhs.texas.gov