# Texas Managed Care Quality Strategy

As Required by
Title 42 Code of Federal Regulations
Section 438.340

Texas Health and Human Services
September 2024

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# 1. Managed Care Quality Strategy

Since 1991, the Texas Health and Human Services Commission (HHSC) has overseen and coordinated the planning and delivery of health and human service programs in Texas. HHSC was established by Texas Government Code Chapter 531 and is responsible for ensuring the delivery of services in a manner that:

- uses an integrated system to determine client eligibility;
- maximizes the use of federal, state, and local funds; and
- emphasizes coordination, flexibility, and decision-making at the local level

HHSC uses its Managed Care Quality Strategy (quality strategy) following Title 42 Code of Federal Regulations (CFR) §438.340 to assess and improve the quality of health care and services provided through the managed care system, prioritizing the goals and objectives outlined in Table 1.

**Table 1. Managed Care Quality Strategy Goals and Objectives**

| TX Health Care Quality Goals | Objectives |
|---|---|
| 1. **Promote optimal health through prevention and by engaging people, families, communities, and the health care system to optimize health outcomes.** | a. Increase access to and use of preventive and primary care, including through telehealth<br>b. Increase screening for chronic disease, behavioral health conditions, and substance use disorders<br>c. Address non-medical drivers of health<br>d. Increase the rate of preconception, early prenatal, and postpartum care and other preventive health utilization<br>e. Promote a positive experience of care for Medicaid and CHIP members and providers<br>f. Reduce avoidable hospital admissions and emergency department visits |
| 2. **Keep patients free from harm by building a safer health care system.** | a. Reduce avoidable complications or adverse health care events in all care settings<br>b. Reduce the rate of avoidable hospitalization for nursing facility residents<br>c. Reduce severe maternal morbidity<br>d. Reduce unnecessary cesarean sections<br>e. Promote evidence-based best practices, including antibiotic stewardship |

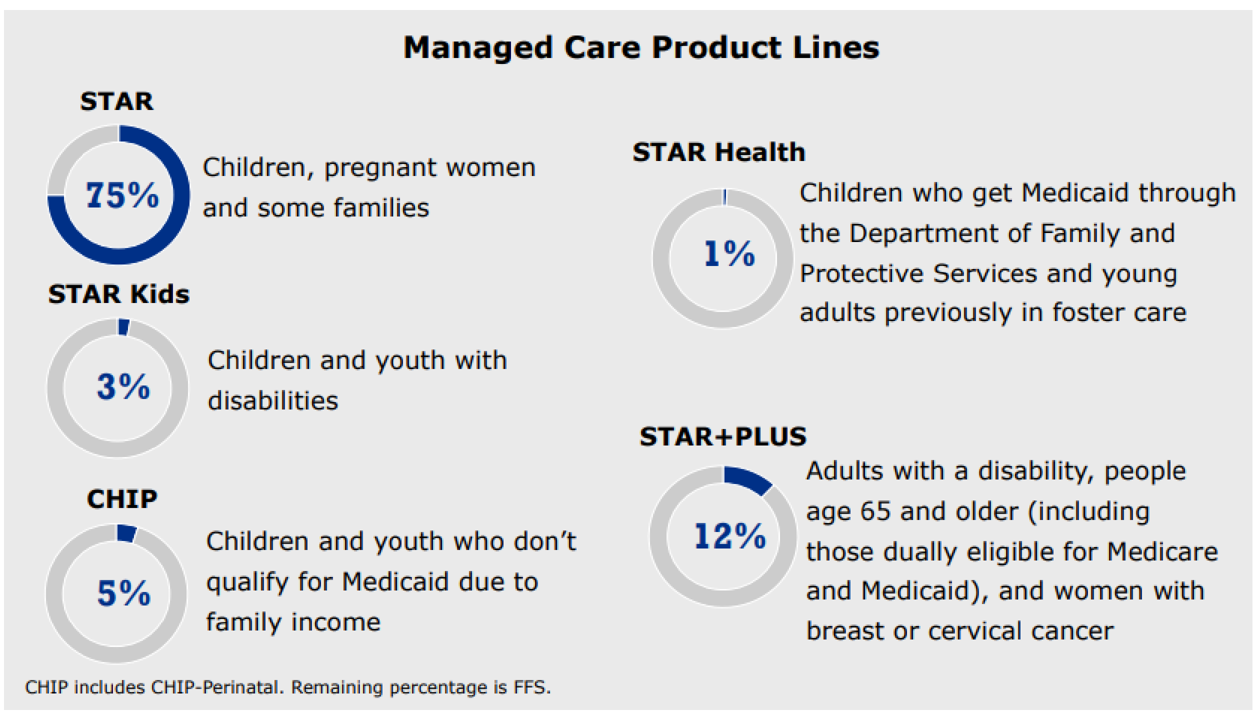
| TX Health Care Quality Goals | Objectives |
|---|---|
| 3. **Promote effective practices for people with chronic, complex, and serious conditions to improve people's quality of life and independence, reduce mortality rates, and better manage the leading drivers of health care costs.** | a. Reduce avoidable hospital readmissions.<br>b. Promote effective medication management<br>c. Increase community and long-term services and supports (LTSS) workforce retention<br>d. Increase the proportion of people with a disability or that are aging that are living in the community rather than an institution<br>e. Improve access to appropriate LTSS<br>f. Improve access to specialty care, including through telehealth<br>g. Improve the treatment and management of chronic physical health condition or serious illness.<br>h. Improve the treatment and management of behavioral health conditions and substance use disorders, prioritizing services in community settings<br>i. Increase use of integrated physical and behavioral health care<br>j. Strengthen person-centered practices and family engagement in care<br>k. Improve the quality of care for residents in nursing facilities (NFs) |
| 4. **Use high quality health information for people, families, communities, and the health care system to make data driven decisions to improve quality health care for all Texans.** | a. Update, integrate, and standardize health information systems and data to improve quality health care and reduce redundancies<br>b. Increase access to electronic health data<br>c. Expand health information exchange (HIE) capacity and participation in the state with particular focus on Medicaid, public health, and behavioral health services<br>d. Improve ability to identify and reduce health disparities by geography, sex, race, ethnicity, and disability<br>e. Increase correct and timely contact information in provider directories<br>f. Optimize care transitions and access to care through timely data exchange |

HHSC policymaking and program activities related to health care value will align with these goals and objectives. See Appendix A for how HHSC's quality initiatives, reports, and external quality review organization (EQRO) activities align with the goals and objectives set forth in Table 1. Transforming Medicaid and the Children's Health Insurance Program (CHIP) into a value-based system will be a long-term endeavor involving many decisions and coordinated actions by HHSC programs and stakeholders. Ongoing efforts will support system-wide change to achieve better care and health for people and populations while managing health care costs.

# 2. Managed Care Programs

Multiple Texas Medicaid and CHIP managed care programs serve different populations as seen in Figure 1.

**Figure 1: Managed Care Programs**




All members in Medicaid managed care are assigned a primary care provider and receive the following services:

- Regular checkups at the doctor and dentist[1]
- Prescription drugs and vaccines
- Hospital care and services
- X-rays and lab tests
- Vision and hearing care
- Access to medical specialists and mental health care
- Treatment of special health care needs and pre-existing conditions

[1] Only Medicaid managed care members under 21 are eligible to receive state plan dental services

- A 24/7 nurse hotline for caregivers and caseworkers
- Medical transportation services

Additional detail on Texas's Medicaid and CHIP programs and services can be found in the Texas Medicaid and CHIP Reference Guide. For a map of managed care organizations (MCOs) by program and service area, see the HHSC website.

# Dental

Most Texas Medicaid members under age 21 receive dental benefits through a managed care model as part of the Children's Medicaid Dental Services (CMDS) program. Members who receive dental services through a Medicaid managed care dental plan are required to select a primary dentist who serves as the client's dental home and is responsible for providing routine care, maintaining the continuity of patient care, and initiating referrals for specialty care. For purposes of this quality strategy, when MCOs are mentioned, the term also includes dental maintenance organizations (DMOs), unless otherwise specified.

# Nonemergency Medical Transportation

Nonemergency medical transportation (NEMT) services provide transportation for a Medicaid beneficiary or their child to and from Medicaid-covered health care and dental services. NEMT was carved into managed care September 1, 2022 and services are for people who have no other way to get to their health care visits, including people enrolled in:

- Medicaid; the
- Children with Special Health Care Needs (CSHCN) program; and the
- Transportation for Indigent Cancer Patients (TICP) program.

NEMT services do not include nonemergency or emergency ambulance services or transportation by stretcher. MCOs coordinate NEMT services for people enrolled in managed care. HHSC coordinates NEMT services for people enrolled in Medicaid FFS, CSHCN, and TICP.

NEMT services include:

- Demand response transportation service: curb-to-curb transportation to and from a covered health care service in an accessible passenger vehicle, bus, van, sedan, or ride-share vehicle

- Mass transit, which provides tickets or tokens for bus, rail, publicly or privately owned transit, and commercial airline transportation to people to use to travel to allowable services
- Individual Transportation Participant services, which provides mileage reimbursement to a designated driver, who can be the person receiving the covered health care service, for trips to and from a covered health care service
- Meals and lodging for eligible overnight stays for people ages birth through 20 years
- Advanced funds for ride and travel-related expenses for people ages birth through 20 years
- Airline fare, when medically necessary, or the most cost-efficient means of travel.

An attendant is covered if required. NEMT services are to be requested as early as possible, at least two business days before a ride is needed. A person may request an NEMT service with less than 48 hours' notice, known as nonmedical transportation, when picked up after being discharged from a hospital; trips to the pharmacy to pick up medication or approved medical supplies; and trips to receive treatment for urgent conditions. If a trip outside the member's service area is needed, a person must request a trip at least five business days before the appointment.

# 3. Foundation of the Managed Care Quality Strategy

To comply with 42 CFR §438.340, the state must implement a quality strategy for assessing and improving the quality of health care and services provided through managed care. The state must review and update the quality strategy no less than every three years. The draft updated quality strategy is made available for public comment, including obtaining input from the Medical Care Advisory Committee and consulting with tribes in accordance with the state's tribal consultation policy.

The quality strategy is monitored for effectiveness both internally by HHSC and externally by the EQRO. Internally, HHSC tracks progress towards achieving objectives through our various initiatives and programs discussed below.

The effectiveness of the quality strategy is evaluated annually as a part of the EQRO's Annual Technical Report available on HHSC's website. Updates to the quality strategy will, as appropriate, take into consideration recommendations made by the EQRO. The updated quality strategy will be submitted to CMS whenever significant changes are made to it. Significant changes include:

- Adding new populations to the managed care programs
- Expanding managed care programs to new parts of the state
- Carving new services into the managed care programs

The quality strategy encompasses the preceding programs and describes the EQRO, the main HHSC departments and advisory committees identified below, and their role in the quality strategy.

## External Quality Review Organization

The federal Balanced Budget Act of 1997 requires state Medicaid agencies to provide an annual external independent review of quality outcomes, timeliness of services, and access to services provided by Medicaid and CHIP MCOs and prepaid ambulatory health plans. To comply with this requirement and to provide HHSC with data analysis and information to effectively manage its Medicaid managed care programs, HHSC contracts with an EQRO for Medicaid managed care. Using information and analysis provided by the EQRO, HHSC evaluates, assesses, monitors, guides, and directs the Texas Medicaid managed care programs and

organizations. Since 2002, Texas has contracted with the University of Florida's Institute for Child Health Policy (ICHP) to conduct EQRO activities.

ICHP performs the following four CMS-required EQRO protocol functions:

- Validation of performance improvement projects (PIPs)
- Validation of performance measures
- A review to determine MCO compliance with certain federal Medicaid managed care regulations
- Validation of network adequacy

Under the HHSC contract, ICHP also performs many EQRO optional protocols, focused quality of care studies, encounter data validation and certification, member satisfaction assessments, rate setting activities, and other reports and data analysis as requested by HHSC. The EQRO develops studies, surveys, or other analytical approaches to assess quality and outcomes of enrollee's care and to identify opportunities for MCO improvement. To facilitate these activities, HHSC ensures that ICHP has access to enrollment, health care claims and encounter, pharmacy, and immunization registry data. The MCOs collaborate with ICHP to ensure medical records are available for focused clinical reviews. In addition to these activities, ICHP collects and analyzes data on certain evaluation measures, including potentially preventable events (PPEs), for directed payment programs (DPPs) such as Comprehensive Hospital Increase Reimbursement Program (CHIRP), Texas Incentives for Physicians and Professional Services (TIPPS), Rural Access to Primary and Preventive Services Program (RAPPS), Directed Payment Program for Behavioral Health Services (DPP BHS), and the Quality Incentive Payment Program (QIPP) for nursing facilities (NF).

# Texas Health and Human Services Commission

## Medicaid and CHIP Services Department

The Medicaid and CHIP Services (MCS) Department serves as the primary HHSC department performing quality-related activities for the Medicaid and CHIP programs. MCS is led by the State Medicaid Director. MCS develops and oversees the Texas Medicaid and CHIP policies that determine client services while complying with federal program mandates. MCS develops benefit policies that apply to both

fee-for-service and managed care, and manages Medicaid and CHIP state plan and waiver programs.

### Other HHSC Departments

MCS works with other HHSC departments such as Access and Eligibility Services; Actuarial Analysis; Provider Finance; and the Office of Data, Analytics and Performance. Each of these departments informs and assists MCS in quality assessment and improvement activities.

## Advisory Committees

Advisory committees such as the Intellectual and Developmental Disability System Redesign Advisory Committee, Medical Care Advisory Committee, Policy Council for Children and Families, Perinatal Advisory Council, Palliative Care Interdisciplinary Advisory Council, State Medicaid Managed Care Advisory Committee, and Value-Based Payment and Quality Improvement Advisory Committee provide recommendations on quality-related activities.

# 4. Managed Care Quality Measurement

## Quality Measure Sets

A comprehensive list of quality measures Texas uses to assess quality by program and year is available on the Texas Healthcare Learning Collaborative Portal (THLC Portal) (thlcportal.com)

**All measure results on the THLC Portal are validated.**

Texas relies on a combination of established sets of measures, in addition to state-developed measures that are validated by the EQRO in its quality programs. This approach allows HHSC to collect data comparable to nationally recognized benchmarks and ensure validity and reliability in collection and analysis of data that is of interest to Texas. Measure sets used by Texas include:[2]

- National Committee for Quality Assurance Healthcare Effectiveness Data and Information Set (HEDIS®)
- Agency for Healthcare Research and Quality Pediatric Quality Indicators /Prevention Quality Indicators
- 3M Software for Potentially Preventable Events
- Consumer Assessment of Healthcare Providers & Systems (CAHPS®) Surveys
- National Core Indicators Surveys
- CMS Core Sets of Adult and Child Health Care Quality Measures

## Health Disparities

### Demographics

The state obtains race, ethnicity, and information about primary language spoken from the Medicaid application form completed by that applicant. Applications are processed through the Texas Integrated Eligibility Redesign System and routed to a

[2] In addition to EQRO validated measures, Texas also uses the Minimum Data Set to track quality in the QIPP program.

third-party enrollment broker. The enrollment broker transmits a file containing the race, ethnicity and primary language of each enrollee to the MCOs and EQRO monthly. HHSC is continuously working on efforts to increase demographic data quality, including race and ethnicity fill.

# Efforts to Reduce Health Disparities

The EQRO evaluates health disparities in several deliverables incorporating quality measures that include demographic data:

- Annual quality of care administrative and hybrid HEDIS and AHRQ measures data tables disparities
- Annual MCO level reports for potentially preventable hospital admissions (PPAs), potentially preventable hospital readmissions (PPRs), potentially preventable emergency room visits (PPVs), potentially preventable complications (PPCs) and potentially preventable services (PPSs)
- Annual MCO report cards surveys Many of the key quality measures are analyzed by additional demographic categories, including sex, race/ethnicity, and health status.

This information has been applied to implement initiatives to reduce health disparities in existing quality initiatives such as the development of PIPs. Stratified results are used to tailor and target initiatives to specific populations such as populations that disproportionately experience negative health outcomes (e.g., Black pregnant women). Stratifying results by demographic groups has also allowed the EQRO to conduct research to better understand disparate health outcomes in populations.

## Managed Long Term Services and Supports

**Texas' definition of disability in managed care contracts** means a physical or mental impairment that substantially limits one or more of a person's major life activities, such as caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and/or working.

If **additional indicators** below are met the member may be considered a person with a disability and a member with special health care needs.

**Members who meet disability criteria are served by either STAR Kids or STAR+PLUS managed care programs.**

Additional indicators of disability status, which may allow member to receive LTSS such as personal assistance services or day activity and health services include:

- Medicaid eligibility for people under age 65 who qualify for Supplemental Security Income (SSI) based on disability, as determined by the Social Security Administration
- Medicaid eligibility determined by HHSC for the following:
    - People who qualify for an SSI related program (Pickle, Disabled Adult Children, Early Aged or Disabled Widow/Widowers)
    - People who qualify for a Medicaid buy-in program (Medicaid Buy-In and Medicaid Buy-In for Children)
    - People who qualify as medical assistance only based on receipt of waiver services
- Enrollment in the STAR+PLUS or STAR Kids managed care programs
- LTSS needs, or as indicated by participation in a home and community-based services (HCBS) program, claims history, or MCO assessment

MCOs are required to perform a functional assessment to identify a member's LTSS needs. Assessments and person-centered service planning are performed at least annually and upon a change in condition, and on request of the person or their legally authorized representative.

Texas utilizes NCI surveys and quality measures to monitor the MCOs that provide Managed Long Term Services and Supports (MLTSS) and continues to work on incorporating more MLTSS quality measures into the programs.

In 2018, CMS issued specifications for four new HEDIS MLTSS measures:

- LTSS Comprehensive Assessment and Update (LTSS-CAU)
- LTSS Comprehensive Care Plan and Update (LTSS-CPU)
- LTSS Reassessment/Care Plan Update After Inpatient Discharge (LTSS-RAC)
- LTSS Shared Care Plan with Primary Care Practitioner (LTSS-SCP)

HHSC is collaborating with the EQRO to implement these measures for STAR+PLUS. Texas is also leveraging STAR Kids assessment data for performance measurement to evaluate key elements of MLTSS quality among STAR Kids MCOs.

# 5. State Monitoring of MCO Requirements

## MCO Monitoring

MCO Monitoring supports all four Quality Strategy Goals

MCOs report specific data to MCS each fiscal quarter by program and service area. MCS analyzes the deliverables and creates quarterly report summaries. These reports capture performance data on the following elements[3]:

- Enrollment
- Provider network
- Member hotline, behavioral health hotline, and provider hotline performance
- Member appeals and member and provider complaints
- Claims processing
- Out-of-network utilization
- Encounter data reconciliation

While the MCO is the initial point of contact to address member and provider concerns, MCS assists with issues that have been escalated to HHSC. Inquiries and complaints are referred to MCS from a variety of sources including the Office of the Ombudsman, and other state agencies and departments. Provider inquiries and complaints are received directly from providers. MCS also monitors member appeal outcomes to identify potential instances where MCOs may have denied services inappropriately.

Based on findings from monthly and quarterly self-reported performance data or current potential non-compliant information or complaint discrepancies, MCS determines if further analysis or corrective action is necessary. MCS may conduct enhanced monitoring, desk reviews, or targeted operational on-site reviews. MCS

[3] This list is not meant to be all-inclusive, but rather a highlight of data collected.

monitors immaterial and material non-compliance and may recommend one or more of the following remedies for each item of material non-compliance in accordance with the Uniform Managed Care Contract (UMCC):

- Assessment of liquidated damages
- Accelerated or escalated monitoring which includes corrective action plans (CAPs) and more frequent or extensive monitoring by HHSC
- Requiring additional financial or programmatic reports
- Requiring additional or more detailed financial or programmatic audits or other reviews
- Terminating or declining to renew or extend an MCO contract
- Appointing temporary MCO management under the circumstances described in 42 CFR §438.706
- Initiating or suspending member enrollment
- Withholding or recouping payment to the MCO
- Requiring forfeiture of all or part of the MCO’s performance bond

MCS determines the scope and severity of the material non-compliance and the remedy on a case-by-case basis. Article 12, Remedies & Disputes, of the Uniform Terms and Conditions of all MCO contracts contains a list of sanctions HHSC may assess against MCOs for non-compliance with the contract. Sanctions may be assessed for failure to provide medically necessary services or for premiums or charges that exceed those permitted under the Medicaid or CHIP program.

As part of their participation in Value-Based Payment (VBP) arrangements, MCOs must report annually to HHSC the volume of contracts they developed with their providers in prior calendar year, employing alternative payment models (APMs). These reports include a detailed description of the APMs and the expense amounts associated with them. Using the data from these reports, HHSC calculates the annual level of APM target achievement for each MCO by program type. If the MCO's APM report does not meet HHSC contractual requirements, is not submitted by the required deadline, or if an MCO does not demonstrate minimum required progress within the APM Performance Framework[4], the MCO will be required to

[4] You can read more about the APM Performance Framework at https://www.hhs.texas.gov/about/process-improvement/improving-services-texans/medicaid-chip-quality-efficiency-improvement/value-based-care.

submit a CAP to HHSC and may be subject to additional contractual remedies, including liquidated damages.

## Accreditation

**Requiring plans to have national accreditation ensures plans have been thoroughly vetted through a third party.**

HHSC annually reviews each MCO's national accreditation status, sends a report to CMS, and posts the report on the HHSC website. All MCOs must be accredited by the National Committee for Quality Assurance or URAC. This allows MCOs to choose an accreditation option most appropriate to their organization and the populations they serve. DMOs need to be URAC-accredited, as it is the only entity offering dental plan accreditation. MCOs must submit their most recent accreditation report with scoring as part of their annual summary report on their Quality Assessment and Performance Improvement (QAPI) program. The EQRO uses the scores from the accreditation reports to address certain items in their administrative interview review.

# Network Adequacy Standards and Monitoring

Network Adequacy Standards and Monitoring supports all four Quality Strategy Goals

Texas Government Code, § 533.0061 and 42 CFR §§ 438.68 and 438.206 require HHSC to set minimum provider access standards for the provider network of an MCO. These standards help to ensure a member's access to care—from getting an appointment with a doctor to time and distance standards for providers in a MCO network. HHSC sets these standards, including those required by 42 CFR § 438.236

and in the UMCC Section 8.1.3 Access to Care, associated subsections and attachments, which are incorporated by reference into the quality strategy.

Texas Government Section 533.0061 requires HHSC to biennially submit and make available to the public a report containing information and statistics about recipient access to providers through the provider networks of MCOs and MCO compliance with contractual obligations related to provider access standards established under this section. In addition, the state and its EQRO comply with the mandatory EQRO network adequacy protocol by conducting the appointment availability studies discussed below and, beginning in 2024, by the EQRO validating the state's network adequacy monitoring activities.

## Appointment Availability Studies

| Appointment Availability Studies ensures HHSC can accurately measure member's access to care |
|---|

Texas Government Code 533.005 requires HHSC to establish and implement a process for direct monitoring of an MCO's provider network, including the length of time a recipient must wait between scheduling an appointment with a provider and receiving treatment from the provider. As stated in UMCC Section 8.1.3, HHSC requires Medicaid and CHIP MCOs to ensure that all members have access to all covered services on a timely basis, consistent with medically appropriate guidelines and accepted standards of practice.

The state's EQRO conducts the Appointment Availability Study, which evaluates MCO compliance with UMCC appointment availability standards. Using a "mystery shopper" methodology to examine member experience in scheduling appointments, the Appointment Availability Study is comprised of four reports: behavioral health, prenatal, primary care, and vision. The study has been conducted annually since 2015. Results of the studies are summarized and available as part of the EQRO's Annual Technical Report available on the HHSC webpage

# Utilization Review

LTSS Utilization Review ensures MCOs are following contractual requirements for LTSS services.

Texas Medicaid employs robust utilization review to ensure appropriate, consistent delivery of acute care and LTSS. The Medicaid LTSS utilization review team is responsible for conducting annual reviews of the STAR+PLUS HCBS program and the Medically Dependent Children Program. Annual reviews include member service plan reviews and home visits (in person or by telephone) with members or legally authorized representatives to determine if the MCO is compliant with contract requirements. The MCS Utilization Review Team also provides clinical consultancy on Medicaid managed care members cases, including members with high-needs or members transitioning from pediatric to adult programs.

The Acute Care Utilization Review team monitors Medicaid MCOs to ensure the efficacy of their prior authorization and utilization review processes. The focus is on ensuring the reduction of authorization of unnecessary and inappropriate services. In addition, the review team safeguards against access to care disparities by ensuring that MCOs are providing necessary and appropriate acute care services. The team also ensures Texas Medicaid managed care members have access to medically necessary and quality acute care services provided efficiently.

# EQRO Activities

## Annual Technical Report

Annual Technical Report serves as the evaluation of the Quality Strategy

Texas provides the Annual Technical Report to CMS annually as substantiation of EQRO activities, including validation of performance measures.

The Annual Technical Report is the CMS-required detailed technical report that summarizes findings on access and quality of care and all EQRO activities. The report includes a summary of all quality-of-care activities, PIP information, MCO and DMO structure and processes, recommendations for MCOs, and a description of all findings and quality improvement activities. Additionally, the report includes recommendations for the state, which are subsequently incorporated to the extent possible in the relevant programs. The annual report serves as a report on the implementation and effectiveness of the quality strategy in accordance with 42 CFR §438.202(e). The report is posted on the External Quality Review page of HHSC's website after submission to CMS.

# Encounter Data Requirements

**Ensuring encounter data is complete and accurate serves as the basis for rate setting and for data used in quality performance measures for all quality initiatives.**

MCOs are required to submit complete and accurate encounter data for all covered services, including value-added services, at least monthly to a data warehouse. The Texas Medicaid claims administrator contractor developed and maintains the data warehouse and is responsible for collecting, editing, and storing MCO encounter data. Encounter data must follow the format and data elements as described in the Health Insurance Portability and Accountability Act-compliant 837 Companion Guides and Encounter Submission Guidelines. HHSC specifies the method of transmission, the submission schedule, and any other requirements in the Uniform Managed Care Manual (UMCM). Original records must be made available for inspection by HHSC for validation purposes. Encounter data that does not meet quality standards must be corrected and returned to HHSC within a specified time period. HHSC contracts with the EQRO to validate and certify the accuracy and completeness of MCO encounter data.

## Encounter Data Validation Certification Reports

The information contained in the data certification reports is used for actuarial analysis and capitation rate setting and meets the requirements of Texas Government Code, Section 533.0131, Use of Encounter Data in Determining Premium Payment Rates. Analyses include volume analysis based on service

category, data validity and completeness; consistency analysis between encounter data and MCO financial summary reports; and validity and completeness of provider information. The EQRO produces Data certification reports annually.

### Encounter Data Validation Record Review Report

Encounter data validation by record review ensures the data used for rate setting and calculating quality of care measures is valid. The report summarizes the results of the EQRO's assessment of the accuracy of the information found in the MCOs' encounter data compared to corresponding medical records. The EQRO validates all encounter data every two years, alternating between Medicaid records and CHIP and dental records.

## Administrative Interviews

On a rolling three-year schedule, the EQRO conducts a complete review of all policies and procedures to ensure MCOs are in compliance with federal regulations.

To ensure Medicaid MCOs are meeting state and federal requirements related to providing care to Medicaid members, the EQRO conducts MCO administrative interviews and on-site visits to assess the following domains:

- Organizational structure
- Care coordination and disease management programs
- Utilization and referral management
- Provider network and contractual relationships
- Provider reimbursement and incentives
- Member enrollment and enrollee rights and grievance procedures
- Data acquisition and health information management

The MCOs complete the administrative interview tool online and are required to provide supporting documentation. For example, when describing disease

management programs, the MCO must also provide copies of all evidenced- based guidelines used in providing care to members. The EQRO analyzes all responses and documents and generates follow-up questions for each MCO as necessary. The follow-up questions are addressed during site visits with representatives from HHSC, the EQRO, and the MCO. HHSC assesses CAPs for MCOs that fail to address follow-up questions and provide relevant policies and documentation.

## Evaluation of Quality Assessment and Performance Improvement

Quality Assessment and Performance Improvement (QAPIs) support all four Quality Strategy Goals

Annual review of MCOs' quality initiatives to ensure projects are targeting areas that need improvement and that data is being collected and used to inform effective interventions.

Each MCO must develop, maintain, and operate a QAPI plan that meets state and federal requirements. The MCO must approach all clinical and nonclinical aspects of quality assessment and performance improvement based on established principles of continuous quality improvement and total quality management and must:

- Evaluate performance using objective quality indicators
- Foster data-driven decision-making
- Recognize that opportunities for improvement are unlimited
- Solicit member and provider input on performance and QAPI activities
- Support continuous ongoing measurement of clinical and non-clinical effectiveness and member satisfaction
- Support programmatic improvements of clinical and non-clinical processes based on findings from ongoing measurements
- Support re-measurement of effectiveness and member satisfaction, and continued development and implementation of improvement interventions as appropriate

The MCO must adopt at least two evidence-based clinical practice guidelines per managed care program (e.g., STAR, STAR+PLUS) as outlined in the UMCM Chapter 5.7.1. Practice guidelines must be based on valid and reliable clinical evidence, consider the needs of the MCO's members, be adopted in consultation with network providers, and be reviewed and updated periodically. The MCO must adopt practice guidelines based on members' health needs and opportunities for improvement identified as part of the QAPI. Annually, MCOs report on the progress of their QAPI plans. The EQRO evaluates these annual reports to ensure compliance.

## Performance Improvement Projects

PIPs are designed to achieve, through ongoing measurements and interventions, significant improvement over time with a favorable effect on health outcomes and member satisfaction.

PIP topics are based on health plan performance on quality measures, and state and federal priorities.

The EQRO recommends topics for PIPs based on MCO performance results on key quality measures and goals set forth in Table 1. HHSC, with input from the MCOs, selects goals, which become projects that enable each MCO to target specific areas for improvement. These projects are measurable and reflect areas that present significant opportunities for performance improvement for each MCO. When conducting PIPs, MCOs are required to follow CMS protocols. PIP topics and interventions are posted on the PIP webpage of the HHSC website. Details of completed PIPs are included in the EQRO's Annual Technical Report and Companion webpage on HHSC's website.

# Quality Measurement

Quality measures serve as the foundation for assessing and improving member experiences and outcomes.

## Quality of Care Reports

The EQRO validates and calculates quality of care measures, providing the state with a comprehensive set of measures that serve as the basis for assessing and improving the quality of care that Texas Medicaid and CHIP members receive. Results are posted publicly on the Texas Healthcare Learning Collaborative (THLC) portal.

## PPE Reports

Potentially Preventable Emergency Department Visits (PPVs), Potentially Preventable Hospital Readmissions (PPRs), Potentially Preventable Hospital Admissions (PPAs), and Potentially Preventable Complications (PPCs) for Medicaid and CHIP are publicly reported on the THLC Portal, along with Hospital Level and All-Payer PPRs and PPCs. The EQRO reports PPEs monthly to each MCO.

## Surveys

Asking members about their experience helps HHSC evaluate if member needs are being met.

Texas' EQRO conducts biennial member and caregiver surveys for all managed care programs. The EQRO uses questions from the CAHPS® surveys, including the Health Plan Survey (Medicaid module), as well as supplemental questions. The EQRO also conducts National Core Indicators (NCI) surveys for children and adults.

## Frew Report

Frew reporting ensures HHSC is monitoring whether children and youth under 21 receive timely checkups.

As a result of the 1993 class action lawsuit *Frew v. Hawkins,* ICHP calculates rates by plan code for Early and Periodic Screening, Diagnosis, and Treatment, known in Texas as Texas Health Steps, checkups given to new and existing members based on the Medicaid Managed Care Texas Health Steps Medical Checkups Utilization Report instructions. The results are compiled and compared with MCO-submitted reports to determine if the MCO- submitted reports are within an 8 percent threshold of EQRO calculated rates.

# 6. Texas Quality Initiatives

HHSC has implemented multiple quality initiatives and tools to help HHSC and the MCOs improve quality of care. These tools and initiatives stem from state legislation, quality report findings, state agency initiatives, and EQRO recommendations. Where applicable, HHSC leverages the EQRO contract through its optional protocols to support these initiatives and tools.

## Continuity of Care and Transition of Care

Ensuring MCOs provide continuity of care for members during transitions supports all four Quality Strategy Goals

The state requires MCOs to ensure newly enrolled members' care is not disrupted or interrupted. Section 8.2.1 of the UMCC outlines requirements for continuity of care and requirements for out-of-network providers.

When a member transitions from being in FFS to being enrolled with an MCO, the MCO receives information regarding member needs, their current medical necessity determination, existing authorized care, and an individual service plan. The MCO must make every effort to conduct an initial intake screening within 90 days of member enrollment. Existing medical necessity determinations must be honored until the MCO can complete a new assessment. Similarly, any existing prior authorizations must be honored for up to 90 days, until the current authorization expires, or until the MCO evaluates the member and makes a determination for a new authorization.

# Texas Healthcare Learning Collaborative Portal

Data sharing and transparency supports all four Quality Strategy Goals

The THLC portal is a secure web portal that includes a graphical user interface for the public, MCOs, HHSC, and the EQRO to visualize Texas Medicaid and CHIP performance on health care metrics. The THLC portal provides reports on MCO and DMO performance across a variety of measures including HEDIS, CAHPS®, and PPEs. The reports are interactive and the MCOs can query the data to create customized summaries of the data.

**Figure 3: Screenshot of the THLC Portal**

Texas Healthcare Learning Collaborative

HOME MEASURES PPE DASHBOARDS RESOURCES HELP

All Search all...

| Steward | Measure Code | Description | Rate | Demo-graphics | Plan Rank | SA Rank | SA x Plan | National Percentile | 2019 | 2020 |
|---|---|---|---|---|---|---|---|---|---|---|
| NCQA | AAB | All Ages | 64.17 | | | | | | | |
| | AAP | All members | 70.50 | | | | | | | |
| | ADD | Initiation Phase | 39.09 | | | | | | | |
| | | Continuation and Maintenance Phase | 53.58 | | | | | | | |
| | AMB | Emergency Department Visits All Ages Services/1000MM | 41.01 | | | | | | | |
| | | Outpatient Visits All Ages Services/1000MM | 289.25 | | | | | | | |
| | AMM | Effective Acute Phase Treatment | 50.33 | | | | | | | |
| | | Effective Continuation Phase Treatment | 30.46 | | | | | | | |
| | AMR | Total 5 to 64 Ratios > 0.50 | 70.25 | | | | | | | |
| | APM | Blood Glucose All Ages | 51.90 | | | | | | | |
| | | Cholesterol All Ages | 35.06 | | | | | | | |
| | | Glucose and Chol Combined - All Ages | 33.65 | | | | | | | |
| | APP | Use of First-Line Psychosocial Care for Children and Adolescent.. | 42.65 | | | | | | | |
| | BCS | Non-Medicare Total | 45.27 | | | | | | | |
| | CBP | Controlling High Blood Pressure - Total | 49.00 | | | | | | | |
| | CCS | Cervical Cancer Screening - Total | 60.95 | | | | | | | |
| | CDC | Non-Medicare Eye Exam | 38.19 | | | | | | | |
| | | Non-Medicare HbA1c Poor Control (>9) | 59.51 | | | | | | | |
| | | Non-Medicare HbA1c Test | 75.84 | | | | | | | |
| | | Non-Medicare HbA1c Adequate Control (<8) | 32.96 | | | | | | | |
| | CHL | Chlamydia Screening in Women - Total | 49.99 | | | | | | | |
| | CIS | Combination 3 Immunizations | 62.94 | | | | | | | |
| | | Combination 7 Immunizations | 55.45 | | | | | | | |

# Financial Incentive Programs

## Medical Pay-for-Quality Program

Medical P4Q creates financial incentives for MCOs to improve performance on quality measures that support all four Quality Strategy Goals

Texas Medicaid implemented the Medical Pay-for-Quality (P4Q) program in 2018 to provide financial incentives and disincentives to MCOs based on performance on quality measures. The quality measures used in this initiative are a combination of process and outcome measures which include select PPEs and other measures specific to the program's enrolled populations. Biennially, HHSC selects Medical P4Q program measures to focus on prevention, chronic disease management including behavioral health, and maternal and infant health. HHSC staff consider legislative requirements, HHSC goals (Table 1), the number of members affected, the severity of the problem, the need for improvement, and the feasibility of the measures as criteria for measure selection. P4Q incorporates nationally recognized and established measures to the degree possible. HHSC included MCOs, provider organizations, and advisory committees in the development of the redesigned P4Q program and the selection of measures from 2016 to 2018.

The P4Q program places a percentage of the MCOs' capitation at-risk. HHSC recoups all funds from MCOs for failure to perform at or above levels required under the program and redistributes the funds to MCOs that performed at or above levels required by the program. Funds are not returned to the state. HHSC requires all STAR, STAR+PLUS, STAR Kids, and CHIP MCOs to participate. Participation for CHIP is on hold for the 2024-2025 cycle and will be re-evaluated for continued inclusion in the 2026-2027 cycle.

In 2019, three CHIP MCOs, two STAR MCOs, and two STAR+PLUS MCOs were subject to recoupment. HHSC recouped and redistributed a total of $16,904,744 across all programs. HHSC posts detailed results on the THLC portal. For 2020 and 2021, HHSC suspended the P4Q program due to the public health emergency. HHSC publishes measures, methodology, and performance targets in the UMCM, Chapter 6.2.14.

# Dental P4Q Program

In the Dental P4Q Program, 1.5 percent of each DMO's capitation payment is at-risk of recoupment. HHSC publishes measures and methodology in the UMCM, Chapter 6.2.15. DMOs may be subject to recoupment or distribution based on their performance on selected dental measures. HHSC considers measures for inclusion based on HHSC quality goals in (Table 1), number of members affected, past performance, and stakeholder input. Priorities include oral evaluations and primary prevention against dental caries.

While DMOs performed well overall in measurement year 2018, HHSC recouped more than it distributed. Beginning with measurement year 2021, HHSC implemented a bonus pool to allow MCOs to earn additional distributions when funds remain after the at-risk measure recoupments and distributions are complete.

# Medicaid Managed Care Aligning Technology by Linking Interoperable Systems (ATLIS) for Client Health Outcomes Program

Under 42 CFR § 438.6(b)(2), HHSC is implementing a new managed care incentive arrangement named Aligning Technology by Linking Interoperable Systems (ATLIS) to improve HIE and clinical data sharing. Despite other efforts to advance HIE participation, barriers to connectivity persist. The inconsistency in connectivity across the state of Texas inhibits efficient data sharing that would provide actionable data to improve the quality of care delivered to people enrolled in Medicaid and advance alternative payment models. Under ATLIS, each MCO will initially assess its network providers for participation in the state's Emergency Department Event Notification system for submitting admit, discharge, and transfer data. HHSC will require MCOs to report on the number of network providers sharing Consolidated Clinical Document Architecture data via an HIE, a national network, or directly with the MCO. After an initial year assessing the current status of provider and MCO connectivity, the program will evolve to provide incentive payments to MCOs for increasing connectivity within the MCOs network and for improvement on process and outcome measures impacted by timely and actionable data exchange between and among MCOs and MCOs' network providers.

## Hospital Quality-Based Payment Program

HHSC continues to administer the Hospital Quality Based Payment Program for all hospitals participating in Texas Medicaid and CHIP. This hospital-specific program is operationalized in the managed care and FFS systems. HHSC measures the performance of all hospitals for risk adjusted rates of PPRs and PPCs across all Medicaid and CHIP programs.

Measurement and application of disincentives and incentives are done annually. For example, Medicaid and CHIP hospitals with higher-than-average rates of PPR, PPC, or both in FY 2019 experienced payment reductions ranging from 1 percent to 4.5 percent in FY 2021. HHSC paid a lower rate to 144 of 621 Texas hospitals.

HHSC monitors hospital performance on PPCs and PPRs on an ongoing basis to track whether the hospital quality program and other initiatives may be helping to lower rates for these PPEs. Results are available online on the THLC Portal and as part of HHSC's *Annual Report on Quality Measures and Value-Based Payments*.

Reducing PPRs requires concerted action by both hospitals and MCOs. HHSC evaluates PPR rates achieved by hospitals (readmission within 15 days) and by MCOs (readmission within 30 days). In 2018, HHSC conducted an evaluation of Medicaid managed care in Texas and identified the increasing PPR trend as an opportunity to integrate actuarial efficiency factors into the MCO rate setting process. In FY 2020, HHSC reduced Medicaid and CHIP capitation rates with the expectation that MCOs will successfully reduce PPR rates by at least 10 percent.

## Directed Payment Programs

DPPs are designed to help Medicaid managed care programs achieve delivery system and payment reform and performance improvement. DPPs are authorized under 42 CFR 438.6(c) and allow a state to direct Medicaid MCOs to make certain payments to health care providers through an adjustment to the monthly base capitation rates.

Texas Medicaid currently administers five DPPs. Each DPP is limited to specific classes of providers and Medicaid managed care programs. Providers must apply to participate in a DPP and meet certain program requirements to earn payments in each DPP.

HHSC evaluates DPPs annually to show that the payment arrangement is advancing the goals of the Texas Managed Care Quality Strategy.

## Directed Payment Program for Behavioral Health Services

DPP BHS is a DPP for Community Mental Health Centers and Local Behavioral Health Authorities that provide behavioral health services to Texans enrolled in STAR, STAR+PLUS, and STAR Kids Medicaid managed care programs. HHSC implemented DPP BHS in FY 2022 to improve access to behavioral health services, care coordination, and care transitions. DPP BHS also promotes the provision of services aligned with the Certified Community Behavioral Health Clinic model of care.

## Rural Access to Primary and Preventive Care Services Program

RAPPS is a DPP for Rural Health Clinics that provide primary care and long term care services to Texans enrolled in STAR, STAR+PLUS, and STAR Kids Medicaid managed care programs. HHSC implemented RAPPS in FY 2022 to incentivize the provision of primary and preventive services in rural areas of the state. RAPPS also focuses on management of chronic conditions.

## Texas Incentives for Physicians and Professional Services

TIPPS is a DPP for health-related institutions physician groups, indirect medical education physician groups, and certain other MCO network physician groups that provide health care services to Texans enrolled in the STAR, STAR+PLUS and STAR Kids Medicaid programs. HHSC implemented TIPPS in FY 2022 which provides increased Medicaid payments to eligible physician groups to improve primary care, chronic care, maternal health, behavioral health, and NMDOH.

## Comprehensive Hospital Increase Reimbursement Program

**CHIRP increases payments to hospitals to support the reduction of adverse health care events.**

CHIRP is a DPP for children's hospitals, rural hospitals, mental health hospitals, state-owned hospitals, and urban hospitals that provide health care services to Texans enrolled in STAR and STAR+PLUS Medicaid managed care programs. It originated as the Uniform Hospital Rate Increase Program, which HHSC

implemented FY 2018 as part of the Delivery System Reform Incentive Payment Transition Plan.

CHIRP is a statewide program that provides for increased Medicaid payments to hospitals for inpatient and outpatient services provided to people enrolled in Medicaid. CHIRP's purpose is to advance goals and objectives in the state's Medicaid managed care quality strategy by incentivizing improved quality and access for hospitals that serve people enrolled in Medicaid.

### Quality Incentive Payment Program for Nursing Facilities

QIPP for NFs is a DPP for NFs owned by non-state governmental entities and certain NFs that serve a high volume of Medicaid enrollees. NFs that provide health care services to Texans enrolled in the STAR+PLUS Medicaid managed care program are eligible to participate in QIPP. HHSC designed QIPP to incentivize NFs participating in Medicaid to improve quality and innovation in NF services. NFs earn payments by meeting performance requirements in four components: Hospital Partner Minimum Data Set (MDS) Measures, Workforce Development, Texas Priority MDS Measures, and Resident Focus MDS Measures. HHSC first implemented QIPP on September 1, 2017.

Evaluation results to date indicate that QIPP has achieved significant performance gains in residents' health and safety. NFs participating in QIPP continue to show better quality outcomes as compared to those that don't participate in QIPP.

# Performance Comparisons

## MCO Report Cards

**MCO Report Cards rely on key quality metrics to provide newly enrolled Medicaid and CHIP members and their caregivers information to support selection of a MCO in their service area.**

Texas Government Code, Section 536.051 requires HHSC to provide information to Medicaid and CHIP members regarding MCO performance on outcome and process measures during the enrollment process. To comply with this requirement and other legislatively mandated transparency initiatives, HHSC develops annual MCO

report cards for each program service area to allow members to easily compare MCOs on specific quality measures before enrolling in an MCO plan. For example, MCO report cards are based on quality measures and cover areas of care such as "Babies get regular checkups"; Doctors listen carefully, explain clearly and spend enough time with people"; and "People get care for diabetes." MMSC posts MCO report cards on the HHSC website and includes them in Medicaid enrollment packets.

## Value-Based Enrollment

Texas Government Code Section 533.00511 directs HHSC to create an incentive program that automatically enrolls a greater percentage of Medicaid recipients who have not selected an MCO into an MCO based on quality of care, efficiency, and effectiveness of service provision. Accordingly, HHSC developed a value-based enrollment methodology that incorporates results from key cost, quality, and member satisfaction metrics. MCOs with better performance receive a higher share of default enrollments.

## Performance Indicator Dashboards

Performance Indicator Dashboards assess MCO performance on a set of measures that support all four Quality Strategy Goals

The Performance Indicator Dashboards are a set of measures with associated minimum and high performance standards. HHSC evaluates MCOs on their performance relative to the measure standards to support transparency and MCO accountability. HHSC shares the Performance Indicator Dashboard results on the THLC portal and HHSC implements contract remedies for MCOs not meeting minimum standards on 33.33% or more of the measures.

# 7. Innovation

Texas continues to develop new strategies to support the goals of the quality strategy.

## Non-Medical Drivers of Health Action Plan

The NMDOH Action Plan supports all four Quality Strategy Goals

NMDOH are "the conditions in the place where people live, learn, work, and play that affect a wide range of health risks and outcomes."[5] The NMDOH Action Plan sets out the priorities and goals that will guide Texas MCS as new and ongoing NMDOH activities are coordinated and continue to progress. In the action plan, the priority NMDOH are food, housing, and transportation. The four goals are to:

- Build data infrastructure for statewide quality measurement and evaluation;
- Coordinate services and existing pathways throughout the delivery system;
- Develop policies and programs that encourage MCOs and providers to identify and address health-related social needs while containing costs; and
- Foster opportunities for collaboration with key partners

In spring 2023, HHSC posted the action plan to the HHSC website and HHSC staff began presenting the action plan to stakeholders, including MCOs, providers, and community-based organizations.

The action plan supports the continuation of best practices associated with improvements in the health outcomes of Medicaid recipients as identified during the Delivery System Reform Incentive Payment program.

Texas Government Code Section 531.024183 requires HHSC to adopt standardized screening questions for MCOs and Thriving Texas Families organizations to screen

[5] These are also known as social determinants of health and drivers of health. The definition is from the CDC. *Social Determinants of Health at CDC.* Available at: https://www.cdc.gov/about/sdoh/index.html

for and aggregate data regarding nonmedical health-related needs of pregnant women and share the data with HHSC. Additionally, Section 531.024183 requires STAR MCOs to use the NMDOH screening questions to determine if the client is eligible for service coordination benefits or should be referred for program services.

# Alternative Payment Model Performance Framework

MCO APM PF priorities promote all four Quality Strategy Goals

The APM Performance Framework (APM-PF) promotes a wide range of options for MCOs to advance their APM initiatives, aligned with HHSC priorities and provider engagement. The APM-PF:

- Encourages MCOs to continue increasing the adoption of APMs, particularly APMs connected to accountable models of care;
- Gives MCOs credit for partnering with HHSC on specific APM opportunities; and
- Encourages MCOs to address a full set of activities important for successful APMs.

APM-PF provides flexibility for MCOs to advance VBP initiatives while maintaining alignment with the Health Care Payment Learning & Action Network (HCP-LAN) Framework. The APM-PF measures MCO performance using a point system for five APM Domains: (1) Achievement levels; (2) Quality; (3) APM Priorities; (4) APM Pilots and Initiatives and (5) APM Support.

The APM Priorities focus on non-metro and community-based providers, APMs that address NMDOH, Pharmacy (incentive dollars & Medication Therapy Management), HCBS, and adoption of integrated models of care including Primary and Behavioral Health integration.

MCOs will also gain points within APM-PF for implementing HHSC recommended initiatives, including Maternal Care Models, STAR PLUS Pilot Innovative Payment Models, the Comprehensive Health Homes for Integrative Care Kids Pilot program, transitions from pediatric to adult services for children with complex medical needs,

Emergency Triage, Treat, and Transport, and the Behavioral Health Evidenced Based Practice (EBP) Pilot. The APM-PF encourages MCOs to implement pilot in collaboration with HHSC and providers to test innovative payment and care models.

## Reducing Inappropriate Use of Antipsychotic Medications for Nursing Facility Residents

In 2014, Texas became part of the CMS National Partnership to Improve Dementia in Nursing Homes. Texas has worked to reduce the inappropriate use of antipsychotic medications to treat behaviors of people with Alzheimer's disease or other dementia-related conditions in people residing in NF. HHSC's Quality Monitoring Program has provided education and technical assistance to NFs and launched the Texas Reducing Antipsychotics in Nursing homes (T.R.A.I.N) initiative. The focus of T.R.A.I.N. was to implement non-pharmacological approaches first and continuously throughout the care of people with dementia. Several initiatives promoted state-wide, both online and in person, have helped Texas nursing homes reduce unnecessary antipsychotic use:

- Virtual Dementia Tours
- Alzheimer's disease and dementia care seminars
- Music and Memory™
- Reminiscence activities
- The "One a Month" campaign
- T.R.A.I.N
- Texas OASIS: Dementia Care Training
- Person-centered Thinking
- Hand Feeding technique training
- Quality Monitoring Program educational academy trainings

This multi-disciplinary approach to provide educational resources to NF leadership, nurses, pharmacists, and prescribers helped Texas to drastically reduced the inappropriate use of antipsychotic medication in NFs (66.% reduction and 3rd place nationally—4th Quarter, 2022).

# 8. Conclusion

In conclusion, the quality strategy serves as a comprehensive framework for enhancing health care quality and improving outcomes across Texas. Through collaborative efforts and strategic initiatives, HHSC has identified key goals and objectives for improving care. By focusing on increasing access and use of routine and timely preventive and primary care among the other objectives laid out in Table 1, HHSC aims to promote optimal health, keep patients safe from harm, promote effective practices for people with chronic conditions, and make data driven decisions to improve quality health care for all Texans.

Moving forward, HHSC will emphasize the quality strategy in all stakeholder engagement on quality initiatives. By leveraging resources, sharing best practices, and fostering partnerships, HHSC will drive positive change and create a health care system that delivers high-quality, patient-centered care to all Texans.

# Appendix A. Crosswalk of Quality Objectives and Measures in HHSC Initiatives

**1.a) Increase access to and use of preventive and primary care, including through telehealth**

| Measure | HHSC Initiatives |
|---|---|
| % Getting Care Quickly | MCO Report Cards, Value-based Enrollment, CHIRP |
| % Getting Needed Care | MCO Report Cards, Value-based Enrollment, CHIRP |
| % Good Access to Routine Care | Performance Indicator Dashboard |
| Adult Immunization Status - Influenza (AIS) | Performance Indicator Dashboard, TIPPS, RAPPS |
| Adult Immunization Status - Tdap (AIS) | Performance Indicator Dashboard |
| Adult Immunization Status - Zoster (AIS) | Performance Indicator Dashboard |
| Adults' Access to Preventive/Ambulatory Health Services (AAP) | Performance Indicator Dashboard, MCO Report Cards, Value-based Enrollment |
| BMI Percentile Documentation (WCC) | Performance Indicator Dashboard |
| Child and Adolescent Well-Care Visits (WCV) | Performance Indicator Dashboard, P4Q, MCO Report Cards, Value-based Enrollment |
| Childhood Immunization Status - Combination 10 (CIS) | Performance Indicator Dashboard, P4Q, MCO Report Cards, Value-based Enrollment, TIPPS |
| Counseling for Nutrition (WCC) | Performance Indicator Dashboard, P4Q |
| Counseling for Physical Activity (WCC) | Performance Indicator Dashboard |
| Developmental Screening in the First Three Years of Life (DEV) | Performance Indicator Dashboard |
| IMM-2 Influenza Immunization (The Joint Commission) | CHIRP |
| Immunizations for Adolescents - Combination 2 Immunizations (IMA) | Performance Indicator Dashboard, P4Q, MCO Report Cards, Value-based Enrollment, TIPPS |
| Well-Child Visits in the First 30 Months of Life | Performance Indicator Dashboard, MCO Report Cards, Value-based Enrollment |
| Oral Evaluation, Dental Services | Dental P4Q |
| Topical Fluoride for Children | Dental P4Q |
| Care continuity, Dental Services | Dental P4Q |
| Sealant on At Least One Permanent Molar | Dental P4Q |
| Sealant on All Four Permanent First Molars | Dental P4Q |

| Measure | HHSC Initiatives |
|---|---|
| Sealant on At Least One Permanent Second Molar | Dental P4Q |
| Sealant on All Four Permanent Second Molars | Dental P4Q |

**1.b) Increase screening for chronic disease, behavioral health conditions, and substance use disorders**

| Measure | HHSC Initiatives |
|---|---|
| Breast Cancer Screening (BCS-E) | Performance Indicator Dashboard, P4Q, MCO Report Cards, Value-based Enrollment |
| Cervical Cancer Screening (CCS) | Performance Indicator Dashboard, P4Q, MCO Report Cards, Value-based Enrollment |
| Chlamydia Screening in Women (CHL) | Performance Indicator Dashboard, P4Q |
| Colorectal Cancer Screening (COL-E) | Performance Indicator Dashboard |
| Depression Screening and Follow-up Best Practices | RAPPS |
| Lead Screening in Children (LSC) | Performance Indicator Dashboard |
| Screening for Depression and Follow-Up Plan (CMS) | CHIRP, TIPPS |
| Tobacco Use: Screening & Cessation Intervention (NCQA) | CHIRP, TIPPS |
| Unhealthy Alcohol Use: Screening & Brief Counseling | DPP BHS |

**1.c) Address non-medical drivers of health**

| Measure | HHSC Initiatives |
|---|---|
| Food Insecurity Screening and Follow-Up Plan | CHIRP, TIPPS |
| Non-Medical Drivers of Health Screening and Follow-up Plan Best Practices | CHIRP, RAPPS, DPP BHS |
| Social Need Screening and Intervention (SNS-E*) | Performance Indicator Dashboard |

**1.d) Increase the rate of preconception, early prenatal, and postpartum care and other preventive health utilization**

| Measure | HHSC Initiatives |
|---|---|
| Low Birth Weight Rate (LBW) | Performance Indicator Dashboard, P4Q |

| Measure | HHSC Initiatives |
|---|---|
| Postpartum Care (PPC) | Performance Indicator Dashboard, P4Q, MCO Report Cards, Value-based Enrollment |
| Prenatal Depression Screening and Follow-up (HHSC) | TIPPS |
| Prenatal Immunization Status - Combo (PRS-E*) | Performance Indicator Dashboard |
| Timeliness of Prenatal Care (PPC) | Performance Indicator Dashboard, P4Q, MCO Report Cards, Value-based Enrollment |

### 1.e) Promote a positive experience of care for Medicaid and CHIP members and providers

| Measure | HHSC Initiatives |
|---|---|
| % How Well Doctors Communicate | Performance Indicator Dashboard, MCO Report Cards, Value-based Enrollment |
| % Rate Health Plan 9 or 10 | MCO Report Cards, Value-based Enrollment |
| % Rate Personal Doctor 9 or 10 | MCO Report Cards, Value-based Enrollment |
| Member and Provider Complaints about Health Plan | MCO Report Cards, Value-based Enrollment |
| Personal Doctor Who Knows Child (SVY-Child) | Performance Indicator Dashboard, P4Q |
| Ambulatory Care: Emergency Department (ED) Visits (AMB-CH) | TIPPS, RAPPS, DPP BHS |
| Overall PDI Composite Rate (PDI 90) | Performance Indicator Dashboard |
| Overall PQI Composite Rate (PQI 90) | Performance Indicator Dashboard |
| Potentially Preventable Admissions (PPA) | Performance Indicator Dashboard, P4Q, TIPPS, RAPPS, DPP BHS |
| Potentially Preventable Emergency Department Visits (PPV) | Performance Indicator Dashboard, P4Q, TIPPS, RAPPS, DPP BHS |

### 1.f) Reduce avoidable hospital admissions and emergency department visits

| Measure | HHSC Initiatives |
|---|---|
| Ambulatory Care: Emergency Department (ED) Visits (AMB-CH) | TIPPS, RAPPS, DPP BHS |
| Overall PDI Composite Rate (PDI 90) | Performance Indicator Dashboard |
| Overall PQI Composite Rate (PQI 90) | Performance Indicator Dashboard |
| Potentially Preventable Admissions (PPA) | Performance Indicator Dashboard, P4Q, TIPPS, RAPPS, DPP BHS |
| Potentially Preventable Emergency Department Visits (PPV) | Performance Indicator Dashboard, P4Q, TIPPS, RAPPS, DPP BHS |

| Measure | HHSC Initiatives |
|---|---|
| Ambulatory Care Sensitive ED Visits for Dental Caries in Children | Dental P4Q |

**2.a) Reduce avoidable complications or adverse health care events in all care settings**

| Measure | HHSC Initiatives |
|---|---|
| Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure | CHIRP |
| Central Line Associated Bloodstream Infection (CLABSI) Outcome Measure | CHIRP |
| Medication Reconciliation: Number of Unintentional Medication Discrepancies per Medication per Patient | CHIRP |
| Pediatric CAUTI | CHIRP |
| Pediatric CLABSI | CHIRP |
| Postoperative Sepsis Rate | CHIRP |
| Potentially Preventable Complications (PPC) | Performance Indicator Dashboard, CHIRP |
| % of nursing facility residents experiencing one or more falls with major injury | QIPP |
| % of nursing facility residents who have/had a catheter inserted and left in their bladder | QIPP |
| % of nursing facility residents with pressure ulcers | QIPP |

**2.b) Reduce the rate of avoidable hospitalization for NF residents**

| Measure | HHSC Initiatives |
|---|---|
| Number of hospitalizations per 1,000 Long-Stay Nursing Home Resident Days | QIPP |

**2.c) Reduce severe maternal morbidity**

| Measure | HHSC Initiatives |
|---|---|
| AIM Collaborative Participation | CHIRP |
| PPC 59 Medical and Anesthesia Obstetric Complications | CHIRP |
| Pregnancy-Associated Outcomes - SMM for all deliveries excluding cases identified only by transfusion (OAP) | Performance Indicator Dashboard, P4Q |

| Measure | HHSC Initiatives |
|---|---|
| Severe Maternal Morbidity (AIM) | CHIRP |

### 2.d) Reduce unnecessary cesarean sections

| Measure | HHSC Initiatives |
|---|---|
| Cesarean Sections in uncomplicated Deliveries (CES) | Performance Indicator Dashboard |
| PC-02 Cesarean Birth | CHIRP |

### 2.e) Promote evidence-based best practices, including antibiotic stewardship

| Measure | HHSC Initiatives |
|---|---|
| Appropriate Testing With Pharyngitis (CWP) | Performance Indicator Dashboard |
| Appropriate Treatment with Upper Respiratory Infection (URI) | Performance Indicator Dashboard, P4Q |
| Antibiotic Utilization for Respiratory Conditions (AXR*) | Performance Indicator Dashboard |
| Avoidance of Antibiotic Treatment with Acute Bronchitis (AAB) | Performance Indicator Dashboard |

### 3.a) Reduce avoidable hospital readmissions

| Measure | HHSC Initiatives |
|---|---|
| Follow-up After Hospitalization for Mental Health (FUH) | Performance Indicator Dashboard, P4Q, MCO Report Cards, Value-based Enrollment, CHIRP, DPP BHS |
| Pediatric All-Condition Readmissions | CHIRP |
| Plan All-Cause Readmissions - Total (PCR) | Performance Indicator Dashboard, CHIRP |
| Potentially Preventable Readmissions (PPR) | Performance Indicator Dashboard, P4Q, CHIRP |

### 3.b) Promote effective medication management

| Measure | HHSC Initiative |
|---|---|
| % Getting Prescription Medicine | MCO Report Cards, Value-based Enrollment |
| Adherence to Antipsychotic Medications for Individuals with Schizophrenia- 80% Coverage (SAA) | Performance Indicator Dashboard, P4Q |
| Antidepressant Medication Management (AMM) | Performance Indicator Dashboard, MCO Report Cards, Value-based Enrollment, TIPPS, RAPPS, DPP BHS |

| Measure | HHSC Initiative |
|---|---|
| Asthma Medication Ratio > 50% (all ages) (AMR) | Performance Indicator Dashboard, MCO Report Cards, Value-based Enrollment |
| Measure | HHSC Initiatives |
| Follow-up Care for Children Prescribed ADHD Medication | Performance Indicator Dashboard, MCO Report Cards, Value-based Enrollment |
| Pharmacotherapy Management for COPD Exacerbation | Performance Indicator Dashboard, MCO Report Cards, Value-based Enrollment |

**3.c) Increase community/LTSS workforce retention**

New measures and initiatives under development

**3.d) Increase the proportion of individuals with a disability and/or that are aging living in the community**

New measures and initiatives under development

**3.e) Improve access to appropriate long-term services and supports**

New measures and initiatives under development

**3.f) Improve access to specialty care, including through telehealth**

| Measure | HHSC Initiatives |
|---|---|
| % Getting Specialized Services | MCO Report Cards, Value-based Enrollment |
| Access to Specialized Services | Performance Indicator Dashboard, P4Q |

**3.g) Improve the treatment and management of chronic physical health condition or serious illness**

| Measure | HHSC Initiatives |
|---|---|
| Comprehensive Diabetes Care: HbA1c testing | MCO Report Cards, Value-based Enrollment |
| Controlling High Blood Pressure (CBP) | Performance Indicator Dashboard, TIPPS, RAPPS |
| Follow-up after ED Visit for People with High-Risk Multiple Chronic Conditions | CHIRP |
| Glycemic Status Assessment for Patients With Diabetes - Glycemic Status <8% (GSD) | Performance Indicator Dashboard, P4Q |
| Glycemic Status Assessment for Patients With Diabetes - Glycemic Status >9% (GSD) | Performance Indicator Dashboard, TIPPS |
| Kidney Health Evaluation for Patients With Diabetes (KED) | Performance Indicator Dashboard, MCO Report Cards, Value-based Enrollment |

| Measure | HHSC Initiatives |
|---|---|
| Statin Therapy for Patients with Cardiovascular Disease | Performance Indicator Dashboard |
| Cardiac Rehabilitation (CRE) | Performance Indicator Dashboard |
| Eye Exam for Patients with Diabetes (EED) | Performance Indicator Dashboard |

**3.h) Improve the treatment and management of behavioral health conditions and substance use disorders, prioritizing services in community settings**

| Measure | HHSC Initiatives |
|---|---|
| Concurrent Use of Opioids and Benzodiazepines (COB) | Performance Indicator Dashboard |
| Risk of Continued Opioid Use - >=15 Days Coverage (COU) | Performance Indicator Dashboard |
| Safe Use of Opioids – Concurrent Prescribing (CMS) | CHIRP |
| Measure | HHSC Initiative |
| Use of Opioids at High Dosage (HDO) | Performance Indicator Dashboard |
| Use of Opioids from Multiple Providers | Performance Indicator Dashboard |
| Depression Remission at Six Months | DPP BHS |
| Depression Response at Twelve Months | TIPPS |
| Follow-Up After Hospitalizations for Mental Illness (FUM) | Performance Indicator Dashboard, P4Q, DPP BHS, CHIRP, RAPPS, TIPPS |
| Pharmacotherapy for Opioid Use Disorder (POD) | Performance Indicator Dashboard |
| Adult Major Depressive Disorder (MDD): Suicide Risk Assessment | DPP BHS |
| Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment | DPP BHS |
| Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (all ages) (APP) | Performance Indicator Dashboard, P4Q |
| Engagement and Initiation of Substance Use Disorder Treatment | Performance Indicator Dashboard, MCO Report Cards, Value-based Enrollment, TIPPS, RAPPS, DPP BHS |
| Follow-Up After Emergency Department Visit for Substance Use (FUA) | Performance Indicator Dashboard |
| Follow-Up After High-Intensity Care for Substance Use Disorder (FUI) | Performance Indicator Dashboard |

### 3.i) Increase use of integrated physical and behavioral health care

| Measure | HHSC Initiative |
|---|---|
| Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (SMC) | Performance Indicator Dashboard |
| Certified Community Behavioral Health Clinic (CCBHC) Certification Status | DPP BHS |
| Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD) | Performance Indicator Dashboard |
| Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotics (SSD) | Performance Indicator Dashboard, P4Q |
| Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-E) | Performance Indicator Dashboard, P4Q, MCO Report Cards, Value-based Enrollment |
| Provide integrated physical and behavioral health care services to children and adults with serious mental illness | DPP BHS |

### 3.j) Strengthen person-centered practices and family engagement in care

| Measure | HHSC Initiative |
|---|---|
| Trauma Informed Care Training | CHIRP |
| % Receiving Help Coordinating Child's Care | Performance Indicator Dashboard |
| Care Goals Met: Member had one or more expressed care goals met since last assessment (SAI2) | Performance Indicator Dashboard |
| Doctors Discuss Eventual Transition to Adult Care for Adolescents (SVY-Child) | Performance Indicator Dashboard, P4Q |
| Family Centered Care: % Getting Needed Information | MCO Report Cards, Value-based Enrollment |
| National Survey of Children’s Health K5Q20_R, part of Indicator 4.12e Effective care coordination | MCO Report Cards, Value-based Enrollment |
| National Survey of Children’s Health TREATADULT, part of Indicator 4.15 Transition to adult health care | MCO Report Cards, Value-based Enrollment |
| Person-centered Assessment: The percentage of records that had fields populated in at least two of four person-centered assessment items (6c, 6d, 6e, 6f) (SAI1) | Performance Indicator Dashboard |
| Service Coordinator Contact: Member's family was contacted at least once by an MCO service coordinator by time of reassessment (SAI3) | Performance Indicator Dashboard |

| Measure | HHSC Initiative |
| --- | --- |
| Tailored ISP: Member had ISP tailored to specific needs by time of reassessment (SAI4) | Performance Indicator Dashboard |

**3.k) Improve the quality of care for residents in NF**

| Measure | HHSC Initiatives |
| --- | --- |
| Number of Outpatient Emergency Department Visits per 1,000 Long-Stay Resident Days | QIPP |
| % of nursing facility residents who received an antipsychotic medication | QIPP |
| % of nursing facility residents who used antianxiety or hypnotic medication | QIPP |
| % of nursing facility residents who have depressive symptoms | QIPP |
| % of nursing facility residents who lose too much weight | QIPP |
| % of nursing facility residents whose ability to walk independently has worsened | QIPP |
| % of nursing facility residents with a urinary tract infection | QIPP |
| % of nursing facility residents with new or worsened bowel or bladder incontinence | QIPP |
| Reported Certified Nursing Assistants (CNA) HPRD | QIPP |
| Reported Licensed Nursing HPRD | QIPP |
| Reported Total Nursing Staff HPRD | QIPP |

**4.a) Update, integrate, and standardize health information systems and data to improve quality health care and reduce redundancies**

New measures and initiatives under development

**4.b) Increase access to electronic health data**

| Measure | HHSC Initiatives |
| --- | --- |
| Does your MCO currently receive or exchange clinical or C-CDA data through a connection with any Texas regional HIEs? | ATLIS |
| Does your MCO currently receive or exchange clinical or C-CDA data through a connection with a national or private HIE? | ATLIS |

**4.c) Expand health information exchange (HIE) capacity and participation in the state with particular focus on Medicaid, public health, and behavioral health services**

| Measure | HHSC Initiatives |
|---|---|
| Health Information Exchange (HIE) Participation | CHIRP, TIPPS, RAPPS, DPP BHS |
| Written transition procedures that include formal MCO relationship or EDEN notification/ ADT Feed | CHIRP |

**4.d) Improve ability to identify and reduce health disparities by geography, sex, race, ethnicity, and disability**

New measures and initiatives under development

**4.e) Increase correct and timely contact information in provider directories**

| Measure | HHSC Initiatives |
|---|---|
| Excluded Providers | Appointment Availability |

**4.f) Optimize care transitions and access to care through timely data exchange**

| Measure | HHSC Initiatives |
|---|---|
| Total number of ADTS received by the MCO from any source | ATLIS |

# Appendix B. CFR and EQRO Activities Crosswalk

This chart illustrates how the EQRO meets CFR Requirements and which activities are included in the Annual Technical Report.

| CFR Citation | CFR Requirement | HHSC Report | Included in the Annual Technical Report? |
|---|---|---|---|
| **§438.364(a)(1)** | A detailed technical report that describes the way the data from all activities conducted in accordance with §438.358 were aggregated and analyzed, and conclusions were drawn as to the quality, timeliness, and access to the care furnished by the MCO or PIHP. | Annual Technical Report | N/A |
| **§438.364(a)(3)** | Assessment of each MCOs' and PIHPs' strengths and weaknesses with respect to quality, timeliness, and access to health care services furnished to Medicaid beneficiaries. | Administrative Interviews<br>Member Surveys<br>Quality of Care data tables<br>QAPI Evaluations<br>PIP Evaluations | Yes |
| **§438.364(a)(4)** | Recommendations for improving quality of health care services furnished by each MCO or PIHP. | Administrative Interviews<br>Member Surveys<br>Quality of Care data tables<br>QAPI Evaluations<br>PIP Evaluations<br>Annual Technical Report | Yes |
| **§438.364(a)(5)** | Methodologically appropriate, comparative information for all | Member Surveys | Yes |

| CFR Citation | CFR Requirement | HHSC Report | Included in the Annual Technical Report? |
|---|---|---|---|
| | MCOs/PIHPs.<br>This information should align with what the state outlines in its quality strategy as methodologically appropriate. | Quality of Care data tables<br>Administrative Interviews<br>QAPI Evaluations<br>PIP Evaluations | |
| **§438.364(a)(6)** | Assessment of the degree to which each MCO or PIHP has effectively addressed the recommendations for quality improvement made by the EQRO during the previous year's EQR. | QAPI Evaluations | Yes |
| **§438.358(b)(1)(i)** | Information on the validation of PIPs required by the state to comply with requirements set forth in §438.330(b)(1) and that were underway during the preceding 12 months. | PIP Evaluations<br>Health Plan PIP Reports<br>Annual Technical Report | Yes |
| **§438.364(a)(1)** | Description of the way the data from the validation of PIPs were aggregated and analyzed, and conclusions were drawn as to the quality, timeliness, and access to the care furnished by the MCO or PIHP. | PIP Evaluations<br>Health Plan PIP Reports<br>Annual Technical Report | Yes |
| **§438.364(a)(2)(i-iv)** | The following information related to the validation of PIPs:<br>Objectives<br>Methods of data collection and analysis (Note: this should include a description of the validation process/methodology, e.g., was the CMS PIP validation protocol used, or a method consistent with the CMS protocol);<br>Description of data obtained; and<br>Conclusions drawn from the data. | PIP Evaluations<br>Health Plan PIP Reports<br>Annual Technical Report | Yes |
| **§438.364(a)(2)(i-iv)** | Assessment of the overall validity and reliability of study results and includes any threats to accuracy/confidence in reporting. | PIP Evaluations<br>Health Plan PIP Reports | Yes |

| CFR Citation | CFR Requirement | HHSC Report | Included in the Annual Technical Report? |
|---|---|---|---|
| | | Annual Technical Report | |
| **§438.358(b)(1)(i)** | Validation results for all state-required PIP topics for the current EQR review cycle. | PIP Evaluations<br>Health Plan PIP Reports<br>Annual Technical Report | Yes |
| **§438.358(b)(1)(i)** | Description of PIP interventions and outcomes information associated with each state- required PIP topic for the current EQR review cycle. | PIP Evaluations<br>Health Plan PIP Reports | Yes |
| **§438.358(b)(1)(ii)** | Information on the validation of MCO or PIHP PMs reported (as required by the state) or MCO or PIHP PMs calculated by the state during the preceding 12 months to comply with requirements set forth in §438.330(b)(2). | Quality of Care data tables<br>Annual Technical Report | Yes |
| **§438.364(a)(1)** | Description of the way the data from the validation of PMs were aggregated and analyzed, and conclusions were drawn as to the quality, timeliness, and access to the care furnished by the MCO or PIHP. | Quality of Care data tables | Yes |
| **§438.364(a)(2)(i-iv)** | The following information related to the validation of the PIPs<br>Objectives;<br>Methods of data collection and analysis (Note: this should include a description of the validation process/methodology, e.g., was the CMS PM validation protocol used, or a method consistent with the CMS protocol);<br>Description of data obtained; and<br>Conclusions drawn from the data. | Quality of Care data tables | Yes |

| CFR Citation | CFR Requirement | HHSC Report | Included in the Annual Technical Report? |
|---|---|---|---|
| **§438.364(a)(2)(i-iv)** | Documentation of which PMs the state required the EQRO to validate for the current EQR review cycle (Note: this may be a subset of reported PMs or all reported PMs). | Quality of Care data tables | Yes |
| **§438.364(a)(2)(i-iv)** | EQR assessment of the MCO/PIHP information system as part of the validation process. | Administrative Interviews | Yes |
| **§438.364(a)(2)(i-iv)** | Outcomes information associated with each PM for the current EQR review cycle. | Quality of Care data tables<br>Summary of Activities Report-MCO profiles | Yes |
| **§438.358(b)(1)(iii)** | Information on a review, conducted within the previous 3-year period, to determine the MCO's or PIHP's compliance with standards established by the state to comply with the requirements of §438.330. | Administrative Interviews<br>Quality of Care data tables<br>Member Surveys<br>QAPI Evaluations | Yes |
| **§438.364(a)(1)** | Description of the way the data from the compliance review were aggregated and analyzed, and conclusions were drawn as to the quality, timeliness, and access to the care furnished by the MCO or PIHP. | Administrative Interviews<br>Quality of Care data tables<br>Member Surveys<br>QAPI Evaluations | Yes |
| **§438.364(a)(2)(i-iv)** | The following information related to the compliance review:<br>Objectives;<br>Methods of data collection and analysis (Note: this should include a description of the validation process/methodology, e.g., was the CMS PM validation protocol used, or a method consistent with the CMS protocol); | Administrative Interviews<br>Quality of Care data tables<br>Member Surveys<br>QAPI Evaluations | Yes |

| CFR Citation | CFR Requirement | HHSC Report | Included in the Annual Technical Report? |
|---|---|---|---|
| | Description of data obtained; and<br>Conclusions drawn from the data. | | |
| **§438.358(b)(1)(iii)** | Compliance assessment results for each MCO/PIHP from within the past three years. | Administrative Interviews<br>Quality of Care data tables<br>Member Surveys<br>QAPI Evaluations | Yes[6] |
| **§438.364(a)(2)(i-iv)** | If appropriate, the following information related to encounter data validation:<br>Objectives;<br>Methods of data collection and analysis;<br>Description of data obtained; and<br>Conclusions drawn from the data. | Annual Technical Report– Addendum<br>Encounter Data Validation | Yes |
| **§438.364(a)(2)(i-iv)** | If appropriate, the following information related to the administration or validation of consumer or provider surveys of quality of care:<br>Objectives;<br>Methods of data collection and analysis;<br>Description of data obtained; and<br>Conclusions drawn from the data. | STAR Adult and Caregiver Member Survey data tables<br>STAR+PLUS Adult Member Survey data tables<br>CHIP Caregiver Survey data tables<br>STAR Health Caregiver Survey data tables | Yes |

[6] Three-year trends have been shown in prior Annual Technical Reports, but typically only at the program level, and not the MCO level.

| CFR Citation | CFR Requirement | HHSC Report | Included in the Annual Technical Report? |
|---|---|---|---|
| **§438.364(a)(2)(i-iv)** | If state contracts with the EQRO to calculate PMs in addition to those reported by an MCO or PIHP and validated by an EQRO (as described in §438.358(c)(3)), the technical report must include the following related to that EQR activity:<br>Objectives;<br>Methods of data collection and analysis;<br>Description of data obtained; and<br>Conclusions drawn from the data. | Quality of Care data tables | Yes |
| **§438.364(a)(2)(i-iv)** | The following information related to the conducting of PIPs:<br>Objectives;<br>Methods of data collection and analysis;<br>Description of data obtained; and<br>Conclusions drawn from the data. | PIP Evaluations | Yes |
| **§438.364(a)(2)(i-iv)** | If appropriate, the following information related to studies on quality that focus on a particular aspect of clinical or nonclinical services at a point in time:<br>Objectives;<br>Methods of data collection and analysis;<br>Description of data obtained; and<br>Conclusions drawn from the data. | Ad Hoc Focus Studies<br>Ad Hoc Quarterly Topic Reports | Yes |

# Appendix C. CFR and Relevant MCO Contract Requirements

These charts illustrate how HHSC fulfills CFR requirements in its managed care contracts. While HHSC has multiple managed care contracts covering different programs, this table portrays the Uniform Managed Care Contract (UMCM) and the STAR Kids Contract terms and conditions as examples to demonstrate how CFR requirements are fulfilled. The UMCM sections below in the tables can be accessed online at https://www.hhs.texas.gov/sites/default/files/documents/services/health/medicaid-chip/programs/contracts/uniform-managed-care-contract.pdf.

## Access Standards

| 42 CFR Section | Element | UMCC Terms and Conditions | STAR Kids Contract Terms and Conditions |
|---|---|---|---|
| **§ 438.206** | Availability of services | 8.1.2 Covered Services;<br>8.1.3 Access to Care;<br>8.1.4 Provider Network;<br>8.1.5.8 Cultural Competency Plan;<br>8.1.12 Services for People with Special Health Care Needs;<br>8.1.13 Service Management for Certain Populations;<br>8.1.15 Behavioral Health (BH) Network and Services;<br>8.1.21 Pharmacy Services;<br>8.1.24 Immunizations;<br>8.1.25 Dental Coverage;<br>8.1.26 Health Home Services;<br>8.2.1 Continuity of Care and Out-of-Network Services;<br><br>8.2.2 Provisions Related to Covered Services for Medicaid Members | 8.1.2 Covered Services;<br>8.1.3 Access to Care;<br>8.1.4 Provider Network;<br>8.1.4.10.2 Health Home;<br>8.1.5.8 Cultural Competency Plan;<br>8.1.13 Services for Members with Special Health Care Needs;<br>8.1.16 Behavioral Health (BH) Services and Network;<br>8.1.17 Pharmacy Services;<br>8.1.24.13 Immunizations;<br>8.1.23 Continuity of Care and Out-of-Network Providers;<br>8.1.24 Provisions Related to Covered Services for Members;<br>8.1.36 Covered Community-Based Services;<br>8.1.41 Substance Abuse Benefit;<br>8.1.45 Facility-Based Care;<br>8.1.46 Telemedicine, Telehealth, and Telemonitoring Access;<br>8.3.2 MDCP STAR Kids Covered Services<br>8.1.36 Covered Community-Based Services;<br>8.1.41 Substance Abuse Benefit;<br>8.1.45 Facility-Based Care;<br>8.1.46 Telemedicine, Telehealth, and Telemonitoring Access;<br>8.3.2 MDCP STAR Kids Covered Services |
| **§ 438.207** | Assurances of adequate capacity and services | 8.1.3 Access to Care | 8.1.3 Access to Care |

| 42 CFR Section | Element | UMCC Terms and Conditions | STAR Kids Contract Terms and Conditions |
|---|---|---|---|
| **§ 438.208** | Coordination and continuity of care/Transition of care[7] | 8.2.1 Continuity of Care and Out-of-Network Providers;<br>8.2.7.2.3 Care Coordination;<br>8.3.2 Service Coordination | 8.1.23 Continuity of Care and Out-of-Network Providers;<br>8.1.38 Service Coordination;<br>8.3.3 Additional Service Coordination Requirements for MDCP STAR Kids Members |
| **§ 438.210** | Coverage and authorization of services | 8.1.2 Covered Services | 8.1.18 Financial Requirements for Covered Services;<br>8.1.2 Covered Services; |

[7] CMS sent feedback from 2017 Quality Strategy submission, received by HHSC in an email on 08/26/2020. CMS indicated they expected transition of care to be included with coordination and continuity of care.

**Structure and Operation Standards**

| 42 CFR Section | Element | UMCC Terms and Conditions | STAR Kids Contract Terms and Conditions |
|---|---|---|---|
| **§ 438.214** | Provider selection | 8.1.4 Provider Network;<br>8.1.22 Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs);<br><br>8.2.3 Medicaid Significant Traditional Providers | 8.1.4 Provider Network;<br>8.1.23 Continuity of Care and Out-of-Network Providers;<br>8.1.25 Medicaid Significant Traditional Providers;<br>8.1.26 Payments to Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs);<br>8.1.40 Community-Based Service Providers |
| **§ 438.224** | Confidentiality | 8.1.18.4 Health Insurance Portability and Accountability Act (HIPAA) Compliance | 11.0 Disclosure and Confidentiality of Information;<br>8.1.38.12 Centralized Medical Record and Confidentiality |
| **§ 438.228** | Grievance and appeal systems | 8.1.5.9 Member Complaint and Appeal Process;<br>8.2.4 Provider Complaints and Appeals;<br>8.2.6 Medicaid Member Complaint and Appeal System | 8.1.27 Provider Complaints and Appeals;<br>8.1.29 Member Complaint and Appeal System;<br>8.1.5.9 Member Complaint and Appeal Process |
| **§ 438.230** | Sub contractual relationships and delegation | 4.08 Subcontractors;<br>4.09 HHSC's Ability to Contract with Subcontractors;<br>8.1.20 General Reporting Requirements | 4.05 Responsibility for MCO personnel and Subcontractors;<br>4.08 Subcontractors and Agreements with Third Parties;<br>4.09 HHSC's Ability to Contract with Subcontractors |

**Measurement and Improvement Standards**

| 42 CFR Section | Element | UMCC Terms and Conditions | STAR Kids Contract Terms and Conditions |
|---|---|---|---|
| **§ 438.236** | Practice guidelines | 8.1.7.6 Clinical Practice Guidelines;<br>8.1.8 Utilization Management;<br>8.1.9 Early Childhood Intervention (ECI):<br>8.1.10 Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) – Specific Requirements;<br>8.1.12 Services for People with Special Health Care Needs;<br><br>8.1.14 Disease Management | 8.1.7.6 Clinical Practice Guidelines;<br>8.1.9 Utilization Management;<br>8.1.10 Early Childhood Intervention (ECI):<br>8.1.11 Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) – Specific Requirements;<br>8.1.13 Services for Members with Special Health Care Needs;<br><br>8.1.14 Disease Management |
| **§ 438.330** | Quality assessment and performance improvement program | 8.1.1.1 Performance Evaluation;<br><br>8.1.7 Quality Assessment and Performance Improvement | 8.1.1.1 Performance Evaluation;<br><br>8.1.7 Quality Assessment and Performance Improvement |
| **§ 438.242** | Health information systems | 8.1.18 Management Information System Requirements | 8.1.20 Management Information System Requirements |