Texas Healthcare Transformation and Quality Improvement Program

Quality Improvement Strategy

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Quality Improvement Strategy

Since 1991, 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 in accordance with Texas Government Code Chapter 531 and is responsible for the oversight of all Texas health and human service agencies. It is the goal of HHSC to use its Quality Improvement Strategy to:

- Transition from volume-based purchasing models to a pay-for-performance model
- Improve member satisfaction with care
- Reduce payments for low quality care

It is the intention of HHSC to achieve these goals through the mechanisms described in this Strategy, including:

- Program integrity monitoring through both internal and external processes
- Implementation of financial incentives for high performing managed care organizations and financial disincentives for poor performing managed care organizations
- Developing and implementing targeted initiatives that encourage the adoption by managed care organizations of evidence-based clinical and administrative practices

HHSC's fundamental commitment is to contract for results. HHSC defines a successful result as the generation of defined, measurable, and beneficial outcomes that satisfy the contract requirements and support HHSC's missions and objectives. HHSC's mission is to create a customer-centered, innovative, and adaptable managed care system that provides the highest quality of care to individuals served by the agency while at the same time ensures access to services.

MANAGED CARE PROGRAMS

The Texas Healthcare Transformation and Quality Improvement Program 1115 Waiver, known as the 1115 Transformation Waiver, allows the state to expand Medicaid managed care, including pharmacy and dental services, while preserving federal hospital funding historically received as Upper Payment Level payments.

There are multiple programs included in the 1115 Transformation Waiver:

STAR
Medicaid's State of Texas Access Reform (STAR) program provides primary, acute care, behavioral health care, and pharmacy services for low-income families, children, pregnant women, as well as some former foster care youth. The program operates statewide with services delivered through managed care organizations (MCOs) under contract with HHSC. There are 13 STAR service areas. STAR Medicaid members can select from at least two MCOs in each service area. There are 18 MCOs serving different STAR service areas throughout the state.

STAR+PLUS
The Medicaid STAR+PLUS program provides both acute care services and long-term services and supports (LTSS) by integrating primary care, behavioral health care, pharmacy services, and LTSS for individuals who are age 65 or older or adults who have a disability. LTSS includes services such as attendant care and day activity and health services. In addition, STAR+PLUS members can access unlimited prescriptions and service coordination. Service coordinators are responsible for coordinating acute care and LTSS for STAR+PLUS members.

STAR+PLUS Home and Community-based Services
The STAR+PLUS home and community-based services program provides LTSS to members ages 21 and older, who meet nursing facility level of care, and who need and are receiving home and community-based services as an alternative to nursing facility care. The 1115 Transformation Waiver population includes individuals who could have been eligible under 42 CFR 435.217 had the State continued its Section 1915(c) home and community-based services waiver for individuals who are elderly and individuals with physical disabilities.

On September 1, 2014, the Department of Aging and Disability Services (DADS) Community Based Alternatives (CBA) waiver program was terminated. All remaining individuals receiving CBA services were transitioned into the STAR+PLUS home and community-based services program.

STAR Kids
The STAR Kids program provides acute and LTSS benefits to children and young adults who are 20 and younger with disabilities. LTSS includes private duty nursing and personal care services. STAR Kids implemented statewide on November 1, 2016. There are 13 STAR Kids service areas and 10 MCOs. In addition to existing Medicaid benefits, all STAR Kids members receive:
- A comprehensive, holistic, person-centered assessment of member and family needs and preferences

- An Individual Service Plan (ISP) identifying short and long-term goals, service and support needs, and member preferences
- Integrated care through service coordination tailored to individuals' needs
- Comprehensive transition planning from age 15 to 21

Dental
Effective March 1, 2012, Children's Medicaid Dental Services are provided through a managed care model to children under age 21. Children residing in institutional settings receive dental through a fee-for-service model. Members who receive dental services through a Medicaid managed care dental plan are required to select a dental plan and a main dentist. A main dentist 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.

CHIP
CHIP, which is also a jointly funded state-federal program, provides primary and preventive health care to low-income, uninsured children up to age 19 with household incomes up to 201 percent of the Federal Poverty Level who do not qualify for Medicaid, and to unborn children with household incomes up to 202 percent of the FPL. CHIP covers children in families who have too much income to qualify for Medicaid, but cannot afford to buy private insurance.

HHSC administers CHIP under its CHIP state plan.

Medically Dependent Children Program (MDCP)
MDCP is a 1915(c) home and community-based services waiver program that provides LTSS to individuals under age 21 who meet a nursing facility or hospital level of care. The MDCP waiver provides supports to families and primary caregivers of individuals who wish to move from a nursing facility to the community or to remain in the community. MDCP waiver services are available statewide and as of November 2016 are delivered through STAR Kids and STAR Health MCOs.

HHSC administers MDCP under its 1915(c) MDCP waiver.

STAR Health
STAR Health is a Medicaid managed care program for children in state conservatorship. These children are a high-risk population with greater medical and behavioral health care needs than most children in Medicaid and their changing circumstances make continuity of care an ongoing challenge. STAR Health serves children as soon as they enter state conservatorship and continues to serve them in two transition categories:

- Young adults up to 22 years of age with voluntary foster care placement agreements
- Young adults below 21 years of age who were previously in foster care and continue to receive Medicaid services

HHSC administers the program under a contract with a single statewide MCO.

The 1115 Transformation Waiver does not include any provisions for the Children's Health Insurance Program (CHIP), STAR Health, or MDCP waiver, which are covered under separate agreements. However, these programs are administered through a managed care model; therefore, Texas monitors them in a way similar to the 1115 programs.

BASIS FOR QUALITY IMPROVEMENT STRATEGY

In accordance with Code of Federal Regulations (CFR) Title 42, Chapter IV, Subchapter C, Part §438.340, the State must implement a quality strategy for assessing and improving the quality of healthcare and services provided through managed care. The State must also review and update the quality strategy no less than every three years. The CFR includes requirements outlining the components of a state quality strategy.

The Quality Improvement Strategy encompasses the preceding programs, the HHSC divisions below, as well as advisory committees, and the external quality review organization (EQRO). This section describes each of these groups and their role in the Strategy.

External Quality Review Organization

The 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 managed care organizations 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 and CHIP. In collaboration with the EQRO, HHSC evaluates, assesses, monitors, guides, and directs the Medicaid managed care programs and organizations for the State. 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 three CMS-required functions:

- Validation of performance improvement projects
- Validation of performance measures
- A review to determine managed care organization compliance with certain federal Medicaid managed care regulations

ICHP also conducts focused quality of care studies, performs encounter data validation and certification, assesses member satisfaction, provides assistance with rate setting activities, and completes other reports and data analysis as requested by HHSC. The EQRO develops studies, surveys, or other analytical approaches to assess enrollee's quality and outcomes of care and to identify opportunities for managed care organization improvement. To facilitate these activities, HHSC ensures that ICHP has access to enrollment, health care claims and encounter, and pharmacy data. HHSC also ensures access to immunization registry data. The managed care organizations collaborate with ICHP to ensure medical records are available for focused clinical reviews. In addition to these activities, ICHP collects and analyzes data on potentially preventable events for the Delivery System Reform Incentive Payment (DSRIP) program projects.

HHSC and the Medicaid and CHIP Services Department

The Medicaid and CHIP Services Department develops and oversees the Texas Medicaid and CHIP policies that determine client services and provider reimbursements while complying with

federal program mandates. The Medicaid and CHIP Services Department develops benefit policies that apply to both fee-for-service and managed care through the key program areas described below.

<u>Policy and Program</u>
The Office of Policy
Provides oversight and strategic direction for Policy and Program Development; Policy Development Support; and Specialized Health Services.

Policy Development Support
Provides coordination activities related to the state plan amendments, 1915(c), 1915(b), and 1115 waiver applications, advisory committees and information management. The Long Term Services & Supports Policy Unit within Policy Development Support manages rule and provider policy for Title XIX & Title XX entitlement programs and 1915(c) Medicaid waiver programs. The majority of communication with the Centers for Medicare and Medicaid Services is coordinated through Policy Development Support for contracts and any of the Medicaid waiver and state plan programs.

Policy and Program Development
Serves as the staff responsible for analyzing new Medicaid and CHIP state and federal requirements and leading efforts to implement changes to policy and programs. This requires proactively designing policy and programmatic solutions when issues with existing policies or program requirements are identified and preventing or mitigating future issues, including serving as the subject matter experts to draft new administrative rules, state plan changes, and 1115 waiver amendments. This team also provides program expertise and coordinates with other areas to refine existing or implement new managed care programs, including working with Policy Development Support as subject matter experts as it relates to the 1115 waiver managed care requirements, developing managed care contract requirements. The team manages the policies of the various managed care programs, such as STAR, STAR Kids, STAR+PLUS, STAR Health, CHIP, and Dental.

Medical Benefits
Researches, develops, and implements Medicaid medical and dental benefit policy. The teams serve as a resource on Medicaid benefits for providers, managed care organizations, and external stakeholders and provide policy guidance and interpretation of benefits to staff. Staff manages the medical and dental benefit claims administrator contract requirements.

<u>Quality and Program Improvement</u>
Healthcare Transformation Waiver
Leads the overall 1115 waiver activities. Primarily operates the DSRIP program that provides financial incentives that encourage hospitals and other providers to develop programs or strategies to enhance access to health care, quality of care, cost-effectiveness, and the health of patients and families served. Major activities have included:

- Review and submission of more than 1,300 proposed DSRIP projects from all 20 Regional Healthcare Partnerships to CMS
- Review and submission of outcome measures associated with each project
- Development of policies and protocols, reporting process, tools, and guidelines
- Provision of ongoing and extensive technical assistance for Regional Healthcare Partnership anchoring entities and providers related to areas including project plan corrections, milestone and metrics reporting, and outcome measures
- Ongoing and extensive submission of information to CMS to support waiver implementation
- Review of metric reporting
- Establishing formal waiver evaluation in coordination with HHSC Center for Analytics and Decision Support
- Development of the monitoring for DSRIP projects

Quality Institute and Quality Oversight
Coordinates quality programs to harmonize initiatives across the HHSC system (including reducing potentially preventable events), reduce MCO and provider administrative burden and improve patient outcomes and experience of care. Collaborates with internal and external stakeholders (including: CMS, academic institutions, advisory committees, state programs, MCOs, and hospitals) to support research, analysis and best practices in quality oversight; and to expand the use of value-based payment models.

Quality Assurance
Works with the EQRO, MCOs, and stakeholders to develop and implement quality programs, including medical and dental Pay-for-Quality programs, performance improvement projects, and MCO report cards. Reviews and analyzes data produced by the EQRO. Serves as the primary liaison between HHSC and the EQRO and between the MCOs and the EQRO. Provides oversight of the EQRO contract. Also provides technical assistance to other areas of HHSC and to the various providers, MCOs, and stakeholder groups.

Program Enrollment & Support
Supports managed care client eligibility and enrollment related issues including analyzing managed care, premium payment, and encounter data issues. This area monitors enrollment broker staff by validating vendor deliverables for compliance. This section also places Medicaid members on the Community Living Assistance Support Services (CLASS), Deaf Blind with Multiple Disabilities (DBMD) and Medically Dependent Children Program (MDCP) interest lists. This area also makes level-of-care determinations, supports and processes all transfers, suspension, and termination activities, and manages enrollment for the Home and Community-based Services (HCS), CLASS, and Texas Home Living (TxHmL) waivers, and Community First Choice (CFC) and Intermediate Care Facilities for Individuals with an Intellectual Disability or Related Conditions (ICF/IID) non-waiver programs.

Operations
Operations Management Claims Administrator
Develops, oversees, and performs functions related to information technology operational systems processing, data management, analysis, and reporting. Operations Management works on information technology program development and oversight, encounter data processing, provider enrollment, and provider claims oversight. This section of HHSC provides data that is used for multiple quality purposes, including tracking rates of potentially preventable events and sharing encounter data with the EQRO. Operations Management also manages the vendor responsible for housing the data.

Vendor Drug Program
Provides statewide access to covered outpatient drugs in an efficient and cost-effective manner. This includes drugs dispensed by a pharmacy and those administered in an outpatient setting. Provides quality pharmaceutical care for recipients enrolled in Medicaid (managed care and fee-for-service), CHIP, Children with Special Health Care Needs Services Program, Kidney Health Care program, and the Healthy Texas Women program. Effectively manages the federal and state drug manufacturer rebate programs to maximize rebate revenue.

Medicaid and CHIP Medical Director
Utilization Management and Review
Conducts utilization reviews of both acute care and LTSS. For LTSS, Utilization Management and Review conducts reviews of assessment and service planning in Medicaid managed care, and for acute care Utilization Management and Review conducts reviews of MCO prior authorization practices and utilization review processes.

Health Plan Monitoring and Contract Services
Health Plan Management (HPM)
Manages the day-to-day operational aspects of Medicaid and CHIP managed care programs including STAR, STAR+PLUS, STAR Kids, STAR Health, CHIP, CHIP Dental and Children's Medicaid Dental Services. The area acts as a liaison between the managed care organizations and HHSC. HPM monitors MCO compliance with the managed care contracts and relevant sections of Texas statute and rule.

HPM's major activities include monitoring of service delivery, provider networks including geo-mapping and provider terminations, claims processing, complaints and appeals, call centers, out-of-network utilization, encounter data reconciliation, and marketing as well as other deliverables and administrative requirements.

Monitoring of service delivery includes evaluating and trending provider and member complaints in correlation with information reported by the managed care organizations. This approach consists of the review of two or more interrelated elements in comparison to each other or to a dependency that provides cross-verification of information to identify reporting discrepancies or inaccuracies while examining trends. It also includes monitoring service coordination, call center services, claims adjudication processing, and encounters.

Monitoring provider networks involves analyzing managed care organization provider network data and review of provider termination rates, geo-mapping access for time and distance, primary care provider and main dentist open panel status, provider directory accuracy, appointment availability, and out-of-network utilization.

HPM also assists with the resolution of complex issues; facilitates internal and external stakeholder meetings; obtains and develops policy clarifications; resolves encounter data issues; and clarifies contract requirements. HPM staff reviews managed care organization marketing and member materials, member handbook, provider manual, and provider contract templates for compliance with the Uniform Managed Care Marketing Policy and Procedures, Provider, and Critical Elements Manuals.

Contract Compliance and Performance Management (CCPM)
Performs contract management and contract compliance functions by documenting and tracking performance information from multiple areas of HHSC. CCPM analyzes this performance information, along with mitigating and exacerbating conditions, and contract terms and conditions to impose, communicate, and track contractual remedies.

<u>Medicaid and Social Services Division</u>

The Medicaid and Social Services Division (MSS) oversees eligibility services, community services, and Medicaid and CHIP programs. Multiple areas outside of the Medicaid & CHIP Services Department (MCS) but within MSS contribute to quality related activities.

<u>Actuarial Analysis</u>
Calculates the capitated premium rates paid to the Medicaid and CHIP managed care organizations. HHSC uses an external actuary to certify these rates as meeting the actuarial soundness guidelines established by CMS. Actuarial Analysis is also involved with benefit and rate changes, program expansions, and legislative mandates that affect managed care organizations. Key quality-related activities with which Actuarial Analysis is involved include financial incentive programs, data certification, and implementation of provider-level and managed care organization-level disincentives related to potentially preventable events.

<u>Financial Reporting and Audit Coordination</u>
Monitors managed care organization financial compliance with the Uniform Managed Care Contract (UMCC) and the Uniform Managed Care Manual (UMCM). This group has primary responsibility for monitoring managed care organizations' financial performance, including the financial aspects of subcontracts and affiliate relationships, and recommending strategies to address issues and concerns; reviewing and validating financial deliverables; administering the recovery of excess profits through the experience rebate process; managing the MCO external audit process; developing financial reporting principles; supporting HPM and other HHSC stakeholders regarding financial reporting and related issues; providing ad hoc analysis; providing financial expertise for request for proposal and contract amendments; responding to and implementing recommendations of State and HHSC internal auditors; and performing

financial aspects of MCO readiness reviews. The Financial Reporting and Audit Coordination section collaborates with the Quality Assurance section in calculating the amounts of payments and recoupments based on results of managed care organization financial incentive programs.

Center for Analytics and Decision Support
Provides research and analytic support to HHSC. Broadly, the Center for Analytics and Decision Support staff conduct quantitative analysis of health and human services program data; compiles, analyzes, and reports relevant third-party data (e.g., Census Bureau, Labor Statistics, CDC programs); collects, analyzes, and reports survey data; conducts program evaluation studies; and conducts innovative research studies on various topics of interest to executive management staff.

Data Analytics
Establishes and oversees a data analysis process that is designed to improve contract management; detect data trends; and identify anomalies relating to service utilization, providers, payment methodologies, and compliance with requirements in Medicaid and child health plan program managed care and fee-for-service contracts. The Data Analytics unit is in the Center for Analytics and Decision Support.

Advisory Committees

Multiple quality-focused advisory committees provide HHSC and the Legislature recommendations on quality-related activities.

Value Based Payment and Quality Improvement Advisory Committee

The Value Based Payment and Quality Improvement Advisory Committee provides a forum to promote public-private, multi-stakeholder collaboration in support of quality improvement and value-based payment initiatives for Medicaid, other publicly funded health services, and the wider health care system. The committee advises HHSC on:

- Value-based payment and quality improvement initiatives to promote better care, better outcomes, and lower costs for publicly funded health care services
- Core metrics and a data analytics framework to support value-based purchasing and quality improvement in Medicaid/CHIP
- Incentive and disincentive programs based on value
- The strategic direction for Medicaid/CHIP value-based program

STAR Kids Managed Care Advisory Committee

The STAR Kids Managed Care Advisory Committee advised HHSC on the establishment of the STAR Kids Medicaid managed care program. The committee has statewide representation and is comprised of family members of children with disabilities, providers, advocates, and managed care representatives. The committee meets quarterly to hear updates on STAR Kids implementation activities and provide feedback and technical assistance to the state on the implementation.

Intellectual and Developmental Disabilities System Redesign Committee

The Intellectual and Developmental Disability (IDD) System Redesign Advisory Committee advises HHSC on the implementation of the acute care services and LTSS system redesign for people with intellectual and developmental disabilities.

Policy Council for Children and Families

The Policy Council for Children and Families works to improve the coordination, quality, efficiency, and outcomes of services provided to children with disabilities and their families through the state's health, education, and human services systems. The council includes majority representation from families and acts as a voice of the parent in developing recommendations to ensure children with disabilities and special health and mental health care needs receive high quality long-term services and support, including community-based supports.

State Medicaid Managed Care Advisory Committee

The State Medicaid Managed Care Advisory Committee provides recommendations and ongoing input to HHSC on the statewide implementation and operation of Medicaid managed care. The committee looks at a range of issues, including program design and benefits, systemic concerns from consumers and providers, efficiency and quality of services delivered by Medicaid managed care organizations, contract requirements for Medicaid managed care, provider network adequacy, and trends in claims processing. The committee also will help HHSC with policies

related to Medicaid managed care and serves as the central source for stakeholder input on the implementation and operation of Medicaid managed care.

Management Information System Requirements

Managed care organizations are required to maintain a Management Information System (MIS) that supports all functions of the MCO's processes and procedures for the flow and use of MCO data. They must have hardware, software, and a network and communications system with the capability and capacity to handle and operate all MIS subsystems for the following operational and administrative areas:

- Enrollment/eligibility
- Provider network
- Encounter/claims processing
- Financial system
- Utilization/quality improvement
- Reporting
- Interfaces
- Third party liability reporting

Intersection of Roles

Each of these areas is responsible for complex unique activities and serves a specific purpose in the overall Texas Medicaid quality system. Their distinct roles interact with each other to fluctuating degrees, largely dictated by specific projects and needs of the agency and stakeholders. The diagram found in Attachment B summarizes the roles and interactions of these units.

EVIDENCE-BASED CARE AND QUALITY MEASUREMENT

The goals and objectives of managed care include improving outcomes and transitioning to quality-based payment systems. The Quality Improvement Strategy is intended to outline the internal and external resources, mechanisms, and initiatives that together will achieve these goals.

Measurement
Texas relies on a combination of established sets of measures and state-developed measures that are validated by the EQRO. This approach allows the State to collect data comparable to nationally recognized benchmarks and ensure validity and reliability in collection and analysis of data that is of particular interest to Texas. Resources used by Texas include:

- 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

Mechanism for identifying race, ethnicity, and primary language of members
The State obtains race, ethnicity, and primary language spoken by a member from the enrollment form completed by that member. Applications are processed through the Texas Integrated Eligibility Redesign System (TIERS) and routed to a third-party enrollment broker. The enrollment broker transmits a file containing the race/ethnicity and primary language of each enrollee to the managed care organizations monthly. Additionally, the EQRO has developed questions to obtain demographic and household information as part of the CAHPS member and caregiver surveys.

Tools for obtaining and disseminating information related to quality
The analysis and dissemination of quality data is primarily conducted using managed care organization-generated data and reports and EQRO data analysis and summary reports. Quality data is disseminated to the public, including policymakers, through the Texas Healthcare Learning Collaborative Portal. Information about MCO performance on quality measures is disseminated to members through MCO report cards, which are included in enrollment packets and on the HHSC website.

Encounter Data Requirements
Managed care organizations are required to submit complete and accurate encounter data for all covered services, including value-added services, at least monthly to a data warehouse for reporting purposes. The data file must include all encounter data and encounter data adjustments processed by the managed care organization no later than the 30th calendar day after the last day of the month in which the claim was adjudicated. The Texas Medicaid claims administrator contractor developed and maintains the data warehouse and is responsible for collecting, editing, and storing managed care organization encounter data.

HHSC contracts with the EQRO to validate and certify the accuracy and completeness of managed care organization encounter data. To validate encounter data, the EQRO requests medical records for a sample of encounters for each managed care organization or dental maintenance organization and compares the information contained in the medical record to the encounter data. The data certification reports support rate-setting activities and provide information relating to the quality, completeness, and accuracy of the managed care organization encounter data. Certification reports include a quality assessment analysis to assure data quality within agreed standards for accuracy, a summary of amounts paid by service type and month of service, and a comparison of paid amounts reported in the encounter data to financial statistical reports provided by the managed care organizations.

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 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 within a time period specified by HHSC.

Long Term Supports and Services (LTSS) Utilization Review
The Utilization Review team is responsible for conducting a thorough investigation of each STAR+PLUS Home and Community-based Services (HCBS) managed care organization's (MCO's) procedures for determining whether an individual or member should be enrolled in the program. Reviews initially included an analysis of the conduct of assessments and MCO service planning activities. Similar reviews of assessments and service planning and service provision for STAR Kids will occur. Ongoing reviews will include any STAR+PLUS HCBS and STAR Kids member service plan reviews and home visits with members to determine if the MCO is following contract requirements for providing the STAR+PLUS HCBS program and STAR Kids program. LTSS utilization review anticipates an informational review of STAR Kids MCOs in state fiscal year 2018. Utilization review also provides significant clinical consultancy for Medicaid managed care members, for those individuals with high-needs or transitioning from services for children to adult programs, and for HPM and other internal HHSC units as well. Some key details and duties of the UR section include:

- Conduct MCO site visits as part of utilization review activities, and provide technical assistance/training on identified issues
- Compile and analyze data collected from desk reviews and home visits to determine if services authorized are meeting the needs of a member, evaluate the conduct of the assessments by the MCO, and to evaluate the quality of the services delivered
- Develop and utilize an ongoing internal quality assurance plan to ensure the outcomes, review tools, and policies and procedures are consistently applied
- Coordinate with internal HHSC divisions to report UR outcomes for purposes of monitoring contracts with MCOs, risk management, informing contract language, operations policy updates, and performance measure development/quality initiatives

- Coordinate services for individuals who are transitioning services from children's programs to adult programs in STAR+PLUS and STAR+PLUS HCBS waiver and provide clinical consultancy regarding services for such transition cases, as well as high needs members
- Participate and collaborate with other units on special projects as requested
- Work closely with the Health Plan Management section on referrals regarding member access to care and health and safety issues/complaints initiated by UR as a result of utilization reviews, until a satisfactory resolution is reached
- Work with the Data Analytics section to obtain sampling and claims data
- Provide clinical consultancy to investigate member complaints and complaints made against an MCO, and provide a report of findings to the appropriate area
- Act as subject matter experts for other units to provide support on the policy and procedures for each MCO's upgrade process
- Use tested review tools, and a database, to collect, analyze, and house review outcomes for annual reporting to the Legislature, and ad hoc reporting
- Analyze, interpret, and implement related legislation, as required

Acute Care Utilization Review

The mission of the Managed Care Acute Care Utilization Review (ACUR) unit is to build a healthier Texas by ensuring Texas Medicaid members have access to medically necessary and quality acute healthcare provided efficiently in a managed care environment.

HHSC formed the ACUR unit in response to SB 8 from the 83rd Texas Legislative Session, 2013. The ACUR unit is in the Utilization Review Section of the Medicaid and CHIP Services Department's Office of the Medical Director. The unit monitors Medicaid managed care organizations (MCOs) to ensure the efficacy of their prior authorization and utilization review processes to reduce authorization of unnecessary and inappropriate services. The ACUR unit will also safeguard against access to care disparities by ensuring that Medicaid MCOs are not underutilizing acute care services by denying necessary and appropriate services.

The authority for ACUR functions is found in Texas Government Code § 531.076(b) and in 42 Code of Federal Regulations (CFR) § 438.66 (b). Some of the key duties of the ACUR Unit include the following:

- Ensure that each MCO's utilization management policies and procedures comply with the requirements of the applicable HHSC managed care contracts, the UMCM, state and federal rules and regulations, and legal agreements
- Ensure that each MCO is adhering to its respective utilization management policies and procedures
- Ensure that each MCO provides all medically necessary, Medicaid-covered services to eligible members
- Identify potential risks of over or underutilization through data analytics
- Monitor the effectiveness and efficiency of the MCO's UR processes and determinations
- Educate/train MCOs on identified areas of concern and adverse findings

MCO Monitoring
Managed care organizations report specific data to HPM each fiscal quarter by program and service area. HPM analyzes the deliverables and creates a summary quarterly reports. These reports capture data on the following elements:

- Enrollment
- Provider network
- Geo-mapping
- Member hotline, behavioral health hotline, and provider hotline performance
- Member appeals and member and provider complaints
- Member and provider complaints received by state agencies
- Claims processing
- Out-of-network utilization
- Encounter data reconciliation

While the MCO is the initial point of contact to address member and provider concerns, HPM assists with issues that have been escalated to HHSC. Inquiries and complaints are referred to HPM from a variety of sources including elected officials, the Office of the Ombudsman, and other state agencies and departments. Provider inquiries and complaints are received directly from providers. HPM also monitors member appeal outcomes to identify potential issues in which it appears 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 disparities, HPM determines if further analysis is necessary and whether complaints are timely adjudicated. HPM may conduct enhanced monitoring, desk reviews, and/or targeted operational on-sites. HPM 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 UMCC:

- Assessment of liquidated damages
- Accelerated and/or escalated monitoring which includes Corrective Action Plans 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 a managed care organization contract
- Appointing temporary managed care organization management under the circumstances described in 42 CFR §438.706
- Initiating or suspending member enrollment
- Withholding or recouping payment to the managed care organization
- Requiring forfeiture of all or part of the managed care organization's performance bond

HPM in coordination with Contract Compliance and Performance Management determines the scope and severity of the material non-compliance and remedy on a case-by-case basis.

Managed care organization-generated data and reports
Quality Assessment and Performance Improvement (QAPI)
Each managed care organization must develop, maintain, and operate a QAPI that meets state and federal requirements. The managed care organization must approach all clinical and nonclinical aspects of quality assessment and performance improvement based on principles of Continuous Quality Improvement/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 Quality Assessment and Performance Improvement 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 managed care organization must adopt at least two evidence-based clinical practice guidelines per program (e.g., STAR, STAR+PLUS). Practice guidelines must be based on valid and reliable clinical evidence, consider the needs of the managed care organization's members, be adopted in consultation with network providers, and be reviewed and updated periodically, as appropriate. The managed care organization must adopt practice guidelines based on members' health needs and opportunities for improvement identified as part of the QAPI.

Performance Improvement Projects (PIPs)
The EQRO recommends topics for PIPs based on managed care organization performance results. HHSC, with input from the managed care organizations, selects goals, which become projects that enable each managed care organization to target specific areas for improvement. These projects are measurable, and reflect areas that present significant opportunities for performance improvement for each managed care organization. When conducting PIPs, managed care organizations are required to follow the ten-step CMS protocol published in the CMS EQRO Protocols.

For the Dual Demonstration, HHSC is utilizing each Medicare-Medicaid Plans' Medicare quality improvement projects (QIP) in place of Medicaid PIPs. Quality Assurance staff review QIPs and information about the projects is included in the EQRO's Summary of Activities Report.

EQRO processes and reports
Managed Care Organization Administrative Interviews
To ensure Medicaid managed care organizations are meeting state and federal requirements related to providing care to Medicaid members, the EQRO conducts managed care organization administrative interviews and on-site visits to assess the following domains:

- Organizational structure
- Children's programs
- 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 managed care organizations complete the administrative interview tool online and are required to provide supporting documentation. For example, when describing disease management programs, the managed care organization 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 managed care organization as necessary. The follow-up questions are administered during in-person site visits and conference calls.

Data Certification Reports
The information contained in these data certification reports is used for actuarial analysis and rate setting, and meets the requirements of Texas Government Code §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 managed care organization financial summary reports, and validity and completeness of provider information (not performed for pharmacy data). Data certification is completed annually.

Encounter Data Validation Report
Encounter data validation ensures the data used for rate setting and calculating quality of care measures is valid. Encounter data validation is an optional EQRO activity per CMS but is highly recommended. Encounter data validation is the strongest approach to ensure that high quality data are available for analysis and reporting. The report summarizes the results of the EQRO's assessment of the accuracy of the information found in the managed care organizations' claims and encounter data compared to corresponding medical records. The EQRO validates all encounter data every two years, alternating medical and dental each year.

Quarterly Topic Reports
These reports provide additional information on issues of importance to HHSC. Historically, Texas HHSC has requested special topic reports to obtain in-depth analyses and information on legislative topics.

Summary of Activities Report
The Summary of Activities Report is the CMS-required annual detailed technical report that summarizes findings on access and quality of care. Texas provides the Summary of Activities report to CMS annually as evidence of EQRO activities. The report includes an annual summary

of all quality of care activities, PIP information, managed care organization structure and processes, and a description of all findings and quality improvement activities.

Quality of Care Reports

CMS requires the EQRO to validate performance measures. This is done through analysis of data used to develop quality of care reports. Additionally, the EQRO calculates the quality of care measures that rely on administrative data (i.e., enrollment, health care claims and encounter data). This provides the state with a comprehensive set of measures calculated using National Committee for Quality Assurance-certified software and audited by a National Committee for Quality Assurance-certified auditor. Data tables are provided by program with a breakdown of MCO and service area level performance. Results are also posted on the Texas Healthcare Learning Collaborative Portal where they are available to the public.

FREW Report

ICHP calculates rates by plan code for 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 managed care organization-submitted reports to determine if the managed care organization-submitted reports are within an eight percent threshold of EQRO calculated rates.

Surveys

ICHP conducts biannual member and caregiver surveys for all managed care programs. ICHP uses questions from the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) surveys, including the Health Plan Survey (Medicaid module), supplemental questions, questions from the Clinician and Group Survey on the patient-centered medical home, and questions from the Cultural Competence item set. ICHP also uses questions they have developed pertaining to member demographic and household characteristics. The Experience of Care and Health Outcomes (ECHO®) Questionnaire for Children - BHO and MCO versions are utilized for measuring and reporting consumer experiences with their health plan (MCO or BHO) and behavioral health care providers.

TEXAS QUALITY INITIATIVES

The primary goal of the 1115 Transformation Waiver is to preserve Upper Payment Level payments by creating two pools of funds into which those payments would be distributed.

Uncompensated Care Pool
Uncompensated Care Pool payments are designed to help offset the costs of uncompensated care provided by the hospital or other providers.

Delivery System Reform Incentive Payment Program (DSRIP)
The DSRIP program is intended to incentivize hospitals and other providers to transform their service delivery practices to improve quality, health status, patient experience, coordination, and cost-effectiveness.

Under the 1115 Transformation Waiver, eligibility to receive Uncompensated Care or DSRIP requires participation in a regional healthcare partnership. Regional Healthcare Partnerships collaborate with participating providers to establish a plan designed to achieve quality outcomes and learn more about local needs through population-based reporting. Performing providers in a Regional Healthcare Partnership can access waiver DSRIP funding by performing improvement projects leading to quality outcomes. Improvement projects and outcome reporting in the Regional Healthcare Partnership plans align with the following four categories:

- Infrastructure development
- Program innovation and redesign
- Quality improvements
- Population-focused improvements

Counties and other entities providing state share determine how their funds are used in the Regional Healthcare Partnership consistent with waiver requirements. Participants developed a regional plan identifying partners, community needs, proposed projects, and funding distribution. These plans provide the basis for:

- Voluntarily improving regional access, quality, cost-effectiveness and collaboration
- Identifying transformation programs, performance metrics, and incentive payments for each participating performing provider consistent with the DSRIP menu of projects
- Eligibility to earn incentive payments

Each partnership must have an anchoring entity, which acts as a primary point of contact for HHSC in the region and is responsible for seeking regional stakeholder engagement and coordinating development of the regional plan.

In order to achieve and sustain success at responding to community needs, providers and communities will need to apply best practices in continuous quality improvement. Most notably, learning collaboratives are essential to the success of high quality health systems that have

achieved the highest level of performance. Participants are strongly encouraged to form learning collaboratives to promote sharing of challenges and testing of new ideas and solutions by providers implementing similar projects in each Regional Healthcare Partnership. These regionally-focused learning collaboratives also can inform the learning collaborative conducted annually during demonstration years three through five to share learning, experiences, and best practices acquired from the DSRIP program across the State.

Regional Healthcare Partnerships can be a natural hub for this type of shared learning by connecting providers who are working together on common challenges in the community, but providers and Regional Healthcare Partnerships are also encouraged to connect with others across Texas to form a "community of communities" that can connect on an ongoing basis to share best practices, breakthrough ideas, challenges and solutions. This will allow regions to learn from each other's challenges and develop shared solutions that can accelerate the spread of breakthrough ideas across Texas.

HHSC, together with ICHP, has developed multiple quality initiatives that are in various stages of implementation.

Appointment Availability Studies
SB 760, 84th Legislature, Regular Session, 2015 directed HHSC to establish and implement a process for direct monitoring of a managed care organization's (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. To fulfill this direction, Section 8.1.3 of the UMCC specifies that Medicaid and CHIP MCOs must assure that all members have access to all covered services on a timely basis, consistent with medically appropriate guidelines and accepted practice parameters.

The state's EQRO conducts the Texas Medicaid Managed Care Provider Appointment Availability Study, which evaluates MCO compliance with UMCC appointment availability standards. Using a secret shopper methodology to examine member experience in scheduling appointments, the Appointment Availability Study is comprised of four reports in the areas of obstetrics and gynecology (OBGYN), primary care (PC or PCP for primary care provider), vision, and behavioral health (BH). The Study was first conducted in 2015 and is being repeated in 2016 and 2018.

Focused analysis and quality improvement efforts with managed care organizations on Beneficiaries with Complex Care Needs and High Costs (BCNs)
HHSC encourages managed care organizations to focus on the unique needs of beneficiaries with complex care needs and high costs. Managed care organizations are required to submit to HHSC their plans for targeting BCNs, including intervention strategies, and resources dedicated to care management of this group, allowing HHSC to better assess managed care organization progress in this area.

Interagency collaboration on strategies to promote improved birth outcomes
Prenatal care, delivery, newborn care and postpartum care represent areas of ongoing quality improvement and cost savings. HHSC recognizes that often this requires close coordination among the HHSC agencies, namely the Department of State Health Services. The Department of State Health Services (DSHS) is Texas' public health agency. HHSC and DSHS have formed interagency workgroups focused on targeted projects of mutual concern in this area.

Financial Incentive Programs
Medical Pay-for-Quality Program (P4Q)
The Medicaid and CHIP Services Department implemented the medical P4Q program in 2014, which replaced the Performance Based At-Risk Capitation and Quality Challenge Award. Medical P4Q provides financial incentives and disincentives to managed care organizations based on performance on a set of quality measures. The quality of care measures used in this initiative are a combination of process and outcome measures which include select potentially preventable events as well as other measures specific to the program's enrolled populations.

The P4Q program includes an at-risk pool that is a percentage of the managed care organization capitation rate. All funds recouped from managed care organizations for poor performance are redistributed to managed care organizations that performed well. No funds are returned to the State. Participation in this program is required for all Texas managed care organizations in STAR, STAR+PLUS, CHIP, and STAR Kids. The medical P4Q program is being redesigned for implementation in 2018, with STAR Kids added in 2019. Processes and procedures for program development are included in attachment D. Measures and methodology will be published in the Uniform Managed Care Manual, Chapter 6.2.14.

Dental P4Q
The 2014-2016 Dental P4Q Program include an at-risk pool that is two percent of the dental maintenance organization capitation rate. In the dental P4Q program, points are assigned to each plan based on its performance on each quality measure, with positive points assigned for year-to-year improvements and negative points assigned for most year-to-year declines. The Dental P4Q Program model sets minimum baseline performance levels for the measures so that low-performing dental maintenance organizations are not rewarded for substandard performance. Plans can earn back their full at-risk amount based on rates of year-to-year improvement.

The Dental P4Q Program is being redesigned for 2018.

Hospital Quality Based Payment Program
Even though HHSC Medicaid is almost exclusively managed care, HHSC continues to administer this program for all hospitals in Medicaid/CHIP. This hospital specific program is operationalized in both the MCO and fee-for-service (FFS) systems. All hospitals are measured on their performance for risk adjusted rates of potentially preventable readmissions (PPR) and potentially preventable complications (PPC) across all Medicaid and CHIP programs, as these measures have been determined to be reasonably within the hospital control. Hospitals can experience up to a 4.5 percent reduction to their payments for inpatient stays for high rates of

PPR and/or PPC, and if they are safety net hospitals, could receive bonus payments above their base payments for low risk adjusted rates of PPR and/or PPC above their base payment rates. Measurement and application of disincentives/incentives is on an annual cycle.

Quality Incentive Payment Program (QIPP)
Minimum Payment Amounts Program (MPAP), the Nursing Facility Minimum Payment Program, historically provided enhanced payment rates to participating qualified skilled nursing facilities. Under a new proposed QIPP [1] program, additional payments to nursing facilities will be contingent upon improvements in quality and innovation in the provision of nursing facility services. This includes payment incentives to improve the quality of care for their residents. Facilities will be able to achieve this goal by showing an improvement in their baselines as they relate to each of the four quality measures:

- High-risk residents with pressure ulcers
- Percent of residents who received an antipsychotic medication (long-stay)
- Residents experiencing one or more falls with major injury
- Residents who were physically restrained

Performance Comparisons

Performance Indicator Dashboards
The Performance Indicator Dashboards include a series of measures that identify key aspects of performance to support transparency and managed care organization accountability. The Performance Indicator Dashboards are not an all-inclusive set of performance measures; HHSC measures other aspects of the managed care organization's performance as well. Rather, the Performance Indicator Dashboards assemble performance indicators that assess many of the most important dimensions of managed care organization performance and includes measures that incentivize excellence. The Dashboard is shared on the HHSC website and includes performance targets as a means to gauge performance. Additionally, HHSC includes program level performance data on these measures and shares this information on the HHSC website.

Managed Care Organization Report Cards
Texas Government Code §536.051 requires HHSC to provide information to Medicaid and CHIP members regarding managed care organization performance on outcome and process measures during the enrollment process. To comply with this requirement and other legislatively mandated transparency initiatives, HHSC develops annual managed care organization report cards for each program service area to allow members to easily compare the managed care organizations on specific quality measures. Managed care organization report cards are posted on the HHSC website and included in the Medicaid enrollment packets sent to potential members.

Data sharing and Transparency
Texas Healthcare Learning Collaborative Portal

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[1] QIPP information can be found at: https://hhs.texas.gov/services/health/provider-information/quality-incentive-payment-program-nursing-homes

The Texas Healthcare Learning Collaborative is a secure web portal designed and run by ICHP. The Portal is an online learning collaborative that includes a graphical user interface that allows the public, managed care organizations, HHSC, and ICHP to visualize healthcare metrics. Managed care organizations, HHSC staff, and Texas legislative staff are able to log in to the portal and generate graphical reports of plan and program specific performance.

Through the Texas Healthcare Learning Collaborative Portal, HHSC and ICHP share monthly and quarterly reports with the managed care organizations about potentially preventable events. The reports are interactive and the managed care plans can query the data to create more customized summaries of the quality results. A redesigned portal with enhanced user capabilities is slated to be completed in summer 2017.

Figure 1: Screenshot of the Texas Healthcare Learning Collaborative Portal
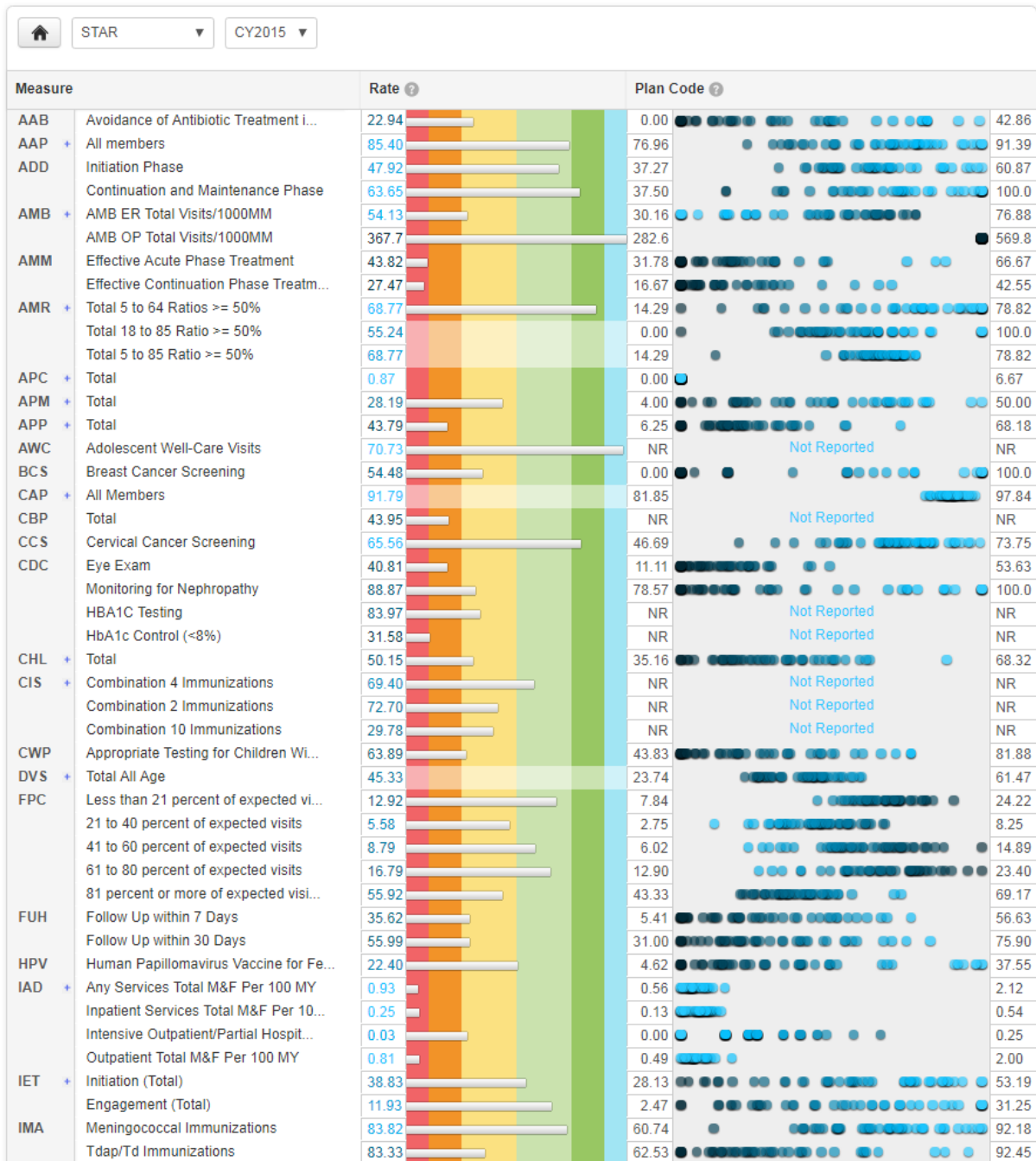
Medicaid Quality Assurance and Improvement Website

HHSC has a dedicated quality website. This website consolidates information related to different quality related initiatives in one place, and promotes better information dissemination. The Medicaid Quality Assurance and Improvement Website serves as a tool for communication and information-sharing about initiatives and other efforts to improve quality and efficiency of Texas Medicaid program with external stakeholders such as health care providers, health plans, and the public, as well as internal HHSC Enterprise divisions. The website also promotes transparency and public reporting related to quality of care and efficiency of services provided to Medicaid beneficiaries, and provides a centralized location for stakeholders to access information such as managed care organization data, presentations, specialized reports, and committee information.

DSRIP Website
The primary purpose of the DSRIP website is to provide targeted technical resources for DSRIP participants. The website is also used to communicate general information regarding the DSRIP program to stakeholders. Examples of communication disseminated through the website include:

- Background and historical information on the waiver
- New and updated policies, procedures, tools, and guidelines for DSRIP anchors and providers
- Provider and Regional Healthcare Partnership (RHP)-specific Excel workbooks providing summary information on reported performance
- Key DSRIP program dates and deadlines

Additionally, the DSRIP website serves as a repository of waiver information related to amendments, program funding, Regional Healthcare Partnership Planning Protocols and plans, and instructional and technical assistance webinars for DSRIP anchors and providers.

Innovation

Texas is engaging in multiple activities to develop new strategies to measure and encourage quality service delivery in Medicaid managed care. Several examples of these activities are outlined here.

Regional Healthcare Partnership (RHP) Projects
DSRIP pool payments are made to hospitals and other providers that develop programs or strategies to enhance access to health care, and to increase the quality and cost-effectiveness of care provided and the health of the members served. In order to receive DSRIP pool payments, a provider must participate in a RHP that includes governmental entities providing public funds, Medicaid providers, and other stakeholders. Participants must develop a regional plan that identifies community needs and proposed projects to meet those needs, and identifying partners and funding distribution. There are four categories of projects:

- Category I (Infrastructure Development) lays the foundation for the delivery system through investments in people, places, processes and technology
- Category II (Program Innovation & Redesign) tests and replicates innovative care models

- Category III (Quality Improvements) assesses the effectiveness of Category 1 and 2 interventions
- Category IV (Population-based Improvements) requires all regional health partnerships to report on the same measures

Long-Term Services and Supports (LTSS) Performance Measures
The STAR+PLUS home and community-based services program provides assistance with activities of daily living to allow members to remain in the most community-integrated setting available. It includes services available to all STAR+PLUS members as well as those services available only to STAR+PLUS members from the following groups:

- Individuals age 65 and older who meet the nursing facility level of care
- Adults age 21 and older with physical disabilities who meet the nursing facility level of care
- Members eligible for SSI and SSI-related Medicaid who are 21 and older who meet the nursing facility level of care

For an individual to be eligible for home and community-based services, the State must have determined that the cost to provide home and community-based waiver services is equal to or less than 202 percent of the cost of the level of care in a nursing facility.

In the fall of 2013, HHSC convened a workgroup consisting of external stakeholders and EQRO representatives to develop a comprehensive set of performance measures that will provide data that allows the State to evaluate the quality home and community-based services LTSS provided through Medicaid managed care. These include measures that look at days in the community and admissions to nursing facilities. HHSC began collecting data for these performance measures in 2016 and will continue to work with stakeholders on refining the measures.

Value-Based Purchasing (VBP) Requirements
In 2012, HHSC began assessing the payment methodologies that contracted MCOs use to pay providers. This assessment confirmed that while MCOs are paid based on a capitated payment model, they were largely paying providers based on a FFS payment model, unlinked to quality metrics. In 2014, HHSC initiated a contract provision into the managed care contracts that required that MCOs implement VBP models with providers and to submit to HHSC annual reports on their VBP activities.

STAR Kids Focus Study
The EQRO is conducting a study to compare administrative quality measures and member experience before and after the implementation of the STAR Kids managed care program. The EQRO surveyed a cohort of caregivers prior to STAR Kids implementation and will survey the same cohort of caregivers 18 months after implementation to assess demographics, health status, access and timeliness of care, person-centered care, care coordination, and overall satisfaction. Administrative measures for individuals eligible for STAR Kids using claims and encounter data will be used to assess primary and preventive care, care for respiratory conditions, behavioral health care, and potentially preventable events prior to implementation and those results will be compared with post-implementation results on the same set of quality measures.

Reducing Inappropriate Use of Antipsychotic Medications for Nursing Home Residents
Texas has been working to reduce the use of antipsychotic medications in individuals with Alzheimer's disease or other dementia-related conditions residing in nursing facilities. Since 2014, the HHS Quality Monitoring Program has focused heavily on providing education and technical assistance to nursing facility providers to assist them with the reduction of antipsychotic medications in their residents and launched the Texas Reducing Antipsychotics in Nursing homes (T.R.A.I.N) initiative. Several best practices and initiatives have been developed and promoted state-wide – on-line and in person – including: the Music and Memory program, the One a Month Campaign, and many others. HHSC established a multi-disciplinary educational approach to provide educational resources to nursing home leadership, nurses, pharmacists, and prescribers. The rate of antipsychotic drug use has dropped significantly.

FUTURE GOALS AND PROJECTS

Administrative and State-Level Initiatives
HHSC has concrete and specific goals for current and future projects. These include:

- Improving internal HHSC coordination related to quality issues
- Development of a statewide quality strategy
- Emphasizing value based purchasing
- Incorporating long term services and supports for individuals with intellectual and developmental disabilities into managed care
- Improving access by expanding the provider network and enhancing the timeliness of care

At the direction of the Texas Legislature, the state's health agencies have begun restructuring to make the system more efficient, effective and responsive for all Texans. On September 1, 2016, about 4,000 employees and more than 120 programs and functions officially "moved" to HHSC from four other health and human services agencies. The move marks the first of two waves of the state's significant health agency transformation designed to help Texans find and receive services more efficiently. The first phase moved many client services and administrative functions to HHSC, which administers Medicaid, CHIP and other services. The second wave, set for September 1, 2017, will move certain regulatory programs, state hospitals and state supported living centers to HHSC from other agencies. The goals of the transformation are to create a system that:

- Is easier to navigate for people who need information, benefits, or services
- Aligns with the HHSC mission, business, and statutory responsibilities
- Breaks down operational silos to create greater program integration
- Creates clear lines of accountability within the organization
- Develops clearly defined and objective performance metrics for all areas of the organization

One benefit of the restructuring was the consolidation of programs and units from different areas of the HHSC system with responsibility for improving healthcare quality and efficiency into a single section of HHSC's Medicaid and CHIP Services Department, the Quality & Program Improvement section.

1115 Transformation Waiver - New Populations and Services
HHSC is conducting pilot initiatives to evaluate carving additional LTSS into a managed care model. These LTSS services have traditionally been provided by DADS in a FFS model through 1915(c) waivers or ICF-IID facilities for individuals with intellectual or developmental disabilities. The Quality Improvement Strategy will be expanded to include those activities as appropriate through the transition and after final implementation.

Implement an HHSC System Healthcare Quality Plan

HHSC is developing a comprehensive Healthcare Quality Plan to improve the coordination and transparency of state healthcare quality initiatives. The resulting Quality Plan will provide a broad strategy for healthcare quality improvement across all HHSC system agencies. The plan will establish priorities to guide HHSC system policy making and program activities over the next five years.

Minimum MCO Alternative Payment Model Thresholds
To accelerate service delivery transformation from volume-based to value-based models, Texas has proposed MCO contract requirements to establish minimum levels of Medicaid and CHIP MCO payments to providers associated with alternative payment models (APMs). Beginning January 2018, the four-year targets are for 50% of payments to be associated with APMs and 25% linked to APMs in which providers accept some level of risk. Texas is adopting the Health Care Payment Learning and Action Network's *APM Framework* definitions for types of APMs.

Review and Update of Quality Improvement Strategy
The quality strategy will be reviewed and updated every three years at a minimum. The 1115 Waiver also requires the state to revise the strategy whenever significant changes are made. Significant changes include:

- Changes made through the 1115 Transformation Waiver
- 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

Attachment A - CFR and External Quality Review Organization Activities Crosswalk

	CMS Requirement	HHSC Report	Included in Summary of Activities Report?
§438.364(a)(1)	A detailed technical report that describes the manner in which 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.	Summary of Activities Report	N/A
§438.364(a)(2)	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 Member Surveys Quality of Care data tables QAPI Evaluations PIP Evaluations	Yes
§438.364(a)(3)	Recommendations for improving quality of health care services furnished by each MCO or PIHP.	Administrative Interviews Member Surveys Quality of Care data tables QAPI Evaluations PIP Evaluations Summary of Activities Report	Yes

	CMS Requirement	HHSC Report	Included in Summary of Activities Report?
§438.364(a)(4)	Methodologically appropriate, comparative information for all MCOs/PIHPs. This information should align with what the state outlines in its quality strategy as methodologically appropriate.	Member Surveys Quality of Care data tables Administrative Interviews QAPI Evaluations PIP Evaluations	Yes
§438.364(a) (5)	Assessment of the degree to which each MCO or PIHP has addressed effectively the recommendations for quality improvement made by the External Quality Review Organization (EQRO) during the previous year's EQR.	QAPI Evaluations	Yes[2]
Validation of Performance Improvement Projects (PIPs)			
§438.358(b)(1)	Information on the validation of PIPs required by the state to comply with requirements set forth in §438.240(b)(1) and that were underway during the preceding 12 months.	PIP Evaluations Health Plan PIP Reports Summary of Activities Report	Yes
§438.364(a)(1)	Description of the manner in which 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 Health Plan PIP Reports Summary of Activities Report	Yes

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[2] This has not been previously included in the Summary of Activity report, but will be moving forward.

	CMS Requirement	HHSC Report	Included in Summary of Activities Report?
§438.364(a)(1)(i-iv)	The following information related to the validation of PIPs: • Objectives; • 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); • Description of data obtained; and • Conclusions drawn from the data.	PIP Evaluations Health Plan PIP Reports Summary of Activities Report	Yes
	Assessment of the overall validity and reliability of study results and includes any threats to accuracy/confidence in reporting.	PIP Evaluations Health Plan PIP Reports Summary of Activities Report	Yes[3]
§438.358(b)(1)	Validation results for all state-required PIP topics for the current EQR review cycle.	PIP Evaluations Health Plan PIP Reports Summary of Activities Report	Yes[4]
	Description of PIP interventions and outcomes information associated with each state-required PIP topic for the current EQR review cycle.	PIP Evaluations Health Plan PIP Reports	No[5]

Validation of Performance Measures (PMs)

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[3] This has not been previously included in the Summary of Activity report, but will be moving forward.
[4] This has not been previously included in the Summary of Activity report, but will be moving forward.
[5] The Summary of Activity report typically focuses on selected PIP interventions.

	CMS Requirement	HHSC Report	Included in Summary of Activities Report?
§438.358(b)(2)	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 §438.240(b)(2).	Quality of Care data tables Summary of Activities-MCO Profiles	Yes
§438.364(a)(1)	Description of the manner in which 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)(1)(i-iv)	The following information related to the validation of PMs: • Objectives; • 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); • Description of data obtained; and • Conclusions drawn from the data.	Quality of Care data tables	Yes
	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
	EQR assessment of the MCO/PIHP information system as part of the validation process.	Administrative Interviews	Yes[6]

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[6] This has been present in some, but not all, prior Summary of Activity reports. It will be included consistently in these reports moving forward.

	CMS Requirement	HHSC Report	Included in Summary of Activities Report?
	Outcomes information associated with each PM for the current EQR review cycle.	Quality of Care data tables Summary of Activities Report-MCO profiles	Yes
§438.358(b)(3)	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 §438.204(g).	Administrative Interviews Quality of Care data tables Member Surveys QAPI Evaluations	Yes[7]
§438.364(a)(1)	Description of the manner in which 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 Quality of Care data tables Member Surveys QAPI Evaluations	Yes[8]
§438.364(a)(1)(i-iv)	The following information related to the compliance review: • Objectives;	Administrative Interviews	Yes[9]

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[7] The Summary of Activity report typically includes a summary of selected results from the Administrative Interview reports.

[8] A summary of methodologies has been present in some, but not all, prior Summary of Activity reports. It will be included consistently in reports moving forward.

[9] A summary of methodologies has been present in some, but not all prior Summary of Activity reports. It will be included consistently in reports moving forward.

	CMS Requirement	HHSC Report	Included in Summary of Activities Report?
	• 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); • Description of data obtained; and • Conclusions drawn from the data.	Quality of Care data tables Member Surveys QAPI Evaluations	
§438.358(b)(3)	Compliance assessment results for each MCO/PIHP from within the past three years.	Administrative Interviews Quality of Care data tables Member Surveys QAPI Evaluations	Yes[10]
§438.364(a)(1)(i-iv)	If appropriate, the following information related to encounter data validation: • Objectives; • Methods of data collection and analysis; • Description of data obtained; and • Conclusions drawn from the data.	Summary of Activities Report - Addendum Encounter Data Validation	Yes
§438.364(a)(1)(i-iv)	If appropriate, the following information related to the administration or validation of consumer or provider surveys of quality of care:	STAR Adult and Caregiver Member Survey data tables	Yes

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[10] Three-year trends have been shown in prior Summary of Activity reports, but typically only at the program level, and not the managed care organization level.
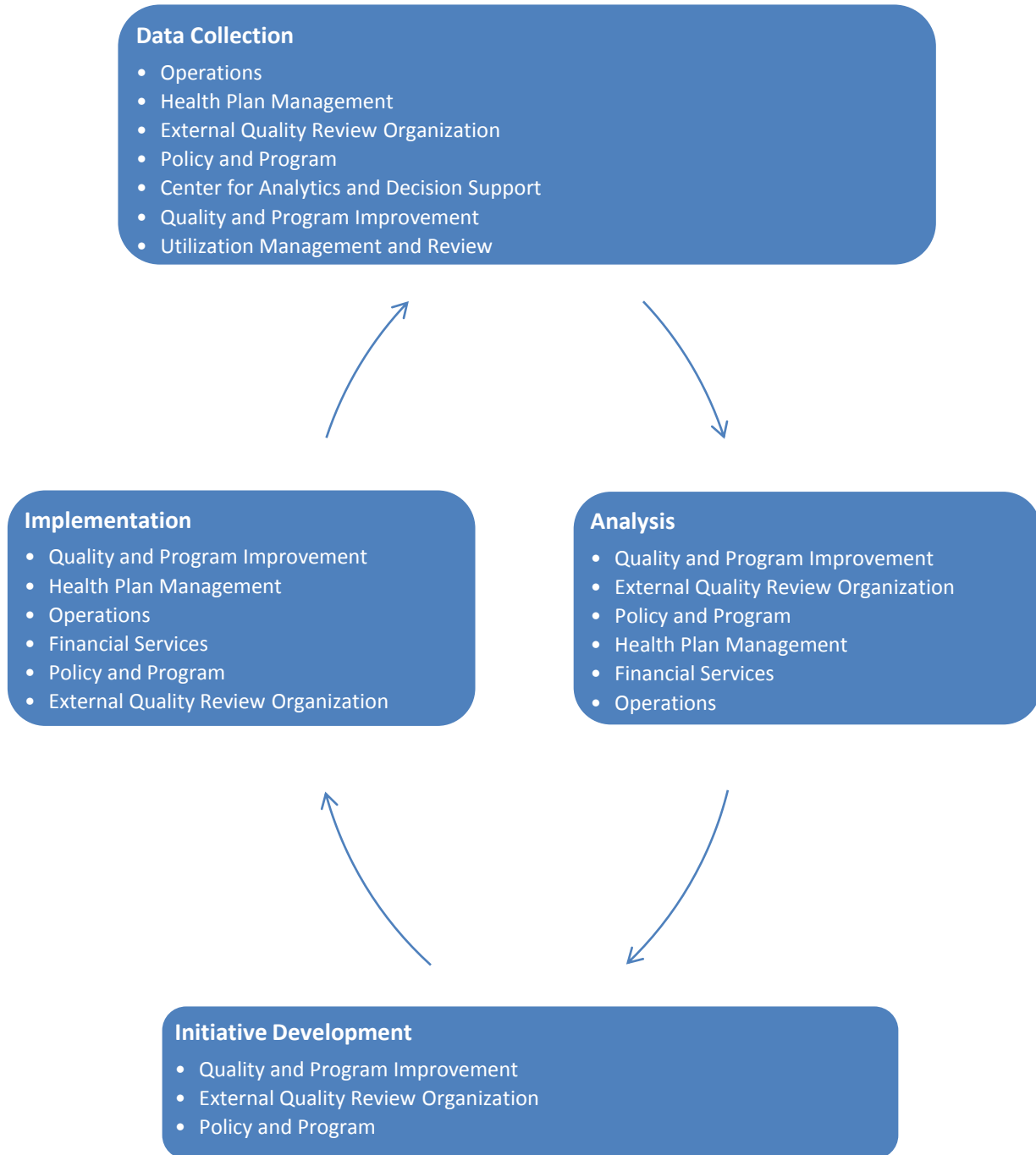
	CMS Requirement	HHSC Report	Included in Summary of Activities Report?
	• Objectives; • Methods of data collection and analysis; • Description of data obtained; and • Conclusions drawn from the data.	STAR+PLUS Adult Member Survey data tables CHIP Caregiver Survey data tables STAR Health Caregiver Survey data tables	
§438.364(a)(1)(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: • Objectives; • Methods of data collection and analysis; • Description of data obtained; and • Conclusions drawn from the data.	Quality of Care data tables	Yes
§438.364(a)(1)(i-iv)	The following information related to the conducting of PIPs: • Objectives; • Methods of data collection and analysis; • Description of data obtained; and • Conclusions drawn from the data.	PIP Evaluations	Yes
§438.364(a)(1)(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:	Ad Hoc Focus Studies Ad Hoc Quarterly Topic Reports	Yes

CMS Requirement	HHSC Report	Included in Summary of Activities Report?

- Objectives;
- Methods of data collection and analysis;
- Description of data obtained; and
- Conclusions drawn from the data.

Attachment B - Interaction of Roles

Data Collection
- Operations
- Health Plan Management
- External Quality Review Organization
- Policy and Program
- Center for Analytics and Decision Support
- Quality and Program Improvement
- Utilization Management and Review

Implementation
- Quality and Program Improvement
- Health Plan Management
- Operations
- Financial Services
- Policy and Program
- External Quality Review Organization

Analysis
- Quality and Program Improvement
- External Quality Review Organization
- Policy and Program
- Health Plan Management
- Financial Services
- Operations

Initiative Development
- Quality and Program Improvement
- External Quality Review Organization
- Policy and Program

Attachment C - CFR and Relevant Managed Care Organization Contract Requirements

42 CFR	Element	Uniform Managed Care Contract Terms and Conditions	STAR Kids Contract Terms and Conditions
§ 438.200	Scope		
§ 438.202	State responsibilities		
§ 438.204	Elements of State quality strategies		
Access Standards			
§ 438.206	Availability of services	8.1.2 Covered Services; 8.1.3 Access to Care; 8.1.4 Provider Network; 8.1.5.8 Cultural Competency Plan; 8.1.12 Services for People with Special Health Care Needs; 8.1.13 Service Management for Certain Populations; 8.1.15 Behavioral Health (BH) Network and Services; 8.1.21 Pharmacy Services; 8.1.24 Immunizations; 8.1.25 Dental Coverage; 8.1.26 Health Home Services; 8.2.1 Continuity of Care and Out-of-Network Services; 8.2.2 Provisions Related to Covered Services for Medicaid Members	8.1.2 Covered Services; 8.1.3 Access to Care; 8.1.4 Provider Network; 8.1.4.10.2 Health Home; 8.1.5.8 Cultural Competency Plan; 8.1.13 Services for Members with Special Health Care Needs; 8.1.16 Behavioral Health (BH) Services and Network; 8.1.17 Pharmacy Services; 8.1.24.13 Immunizations; 8.1.23 Continuity of Care and Out-of-Network Providers; 8.1.24 Provisions Related to Covered Services for Members; 8.1.36 Covered Community-Based Services; 8.1.41 Substance Abuse Benefit; 8.1.45 Facility-Based Care; 8.1.46 Telemedicine, Telehealth, and Telemonitoring Access; 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

§ 438.208	Coordination and continuity of care	8.2.1 Continuity of Care and Out-of-Network Providers; 8.2.7.2.3 Care Coordination; 8.3.2 Service Coordination	8.1.23 Continuity of Care and Out-of-Network Providers; 8.1.38 Service Coordination; 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; 8.1.2 Covered Services;
Structure & Operation Standards			
§ 438.214	Provider selection	8.1.4 Provider Network; 8.1.22 Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs); 8.2.3 Medicaid Significant Traditional Providers	8.1.4 Provider Network; 8.1.23 Continuity of Care and Out-of-Network Providers; 8.1.25 Medicaid Significant Traditional Providers; 8.1.26 Payments to Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs); 8.1.40 Community-Based Service Providers
§ 438.218	Enrollee information	8.1.5 Member Services	8.1.5 Member Services
§ 438.224	Confidentiality	8.1.18.4 Health Insurance Portability and Accountability Act (HIPAA) Compliance	11.0 Disclosure and Confidentiality of Information; 8.1.38.12 Centralized Medical Record and Confidentiality
§ 438.226	Enrollment and disenrollment	5.0 Member Eligibility & Enrollment	5.0 Member Eligibility & Enrollment
§ 438.228	Grievance systems	8.1.5.9 Member Complaint and Appeal Process; 8.2.4 Provider Complaints and Appeals; 8.2.6 Medicaid Member Complaint and Appeal System	8.1.27 Provider Complaints and Appeals; 8.1.29 Member Complaint and Appeal System; 8.1.5.9 Member Complaint and Appeal Process
§ 438.230	Subcontractual relationships and delegation	4.08 Subcontractors; 4.09 HHSC's Ability to Contract with Subcontractors;	4.05 Responsibility for MCO personnel and Subcontractors;

		8.1.20 General Reporting Requirements	4.08 Subcontractors and Agreements with Third Parties; 4.09 HHSC's Ability to Contract with Subcontractors
Measurement & Improvement Standards			
§ 438.236	Practice guidelines	8.1.7.6 Clinical Practice Guidelines; 8.1.8 Utilization Management; 8.1.9 Early Childhood Intervention (ECI): 8.1.10 Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) – Specific Requirements; 8.1.12 Services for People with Special Health Care Needs; 8.1.14 Disease Management	8.1.7.6 Clinical Practice Guidelines; 8.1.9 Utilization Management; 8.1.10 Early Childhood Intervention (ECI): 8.1.11 Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) – Specific Requirements; 8.1.13 Services for Members with Special Health Care Needs; 8.1.14 Disease Management
§ 438.240	Quality assessment and performance improvement program	8.1.1.1 Performance Evaluation; 8.1.7 Quality Assessment and Performance Improvement	8.1.1.1 Performance Evaluation; 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

Attachment D - P4Q Process and Procedures

P4Q model development process

1. Develop a conceptual framework and logic model for P4Q
   a. Obtain vision from the Executive Commissioner
   b. Poll the plans and provider associations about what program elements are important to them
   c. Conduct literature review
   d. Conduct environmental scan
   e. Conceptual framework will include at a minimum:
      i. List of legislative mandates and constraints;
      ii. Types of measures to be used;
      iii. General explanation of how achievement will be assessed (e.g. incremental improvement, ranking, comparison with national benchmarks, etc.);
      iv. General explanation of how goals and/or minimum thresholds will be set including how health plans will be measured (e.g. pass/fail, partial credit awarded for movement towards the goal);
      v. General explanation of how dollars will be recouped and/or distributed.
2. Obtain leadership approval of the conceptual framework and measure selection
   a. Approval will be obtained from Deputy Director of Quality and Program Improvement, Associate Commissioner for Medicaid and CHIP, Deputy Executive Commissioner for Medical and Social Services and the Executive Commissioner via memo
3. Staff develop a model or model options that adhere to the conceptual framework
   a. Model development will include:
      i. Running simulations to determine feasibility
      ii. Assessing impact of measure variability on P4Q results
      iii. Setting all goals, minimum thresholds, dollar amounts/percentages for recoupment/distribution, and any hold harmless zone or other special provisions.
      iv. If feasible staff will also develop a blank Excel workbook for P4Q result calculations to be distributed to plans.
   b. Staff obtain input/feedback from internal stakeholders, including the Medical Director, Director of Data Analytics, other internal quality staff, and ICHP
   c. Make any adjustments needed based on feedback
4. Staff obtain leadership approval of the model and measures
   a. Approval will be obtained from Deputy Director of Quality and Program Improvement, Associate Commissioner for Medicaid and CHIP, Deputy

> Executive Commissioner for Medical and Social Services and the Executive Commissioner via memo

5. Staff meet with plans in person and/or via webinar to share the model for feedback, including simulated results and calculations
   a. Formal review and approval of minutes by the plans
   b. Staff make any adjustments needed based on feedback
6. If adjustments are substantial, get leadership approval. If adjustments are not substantial, move forward with developing technical specifications and excel spreadsheet with calculations.
   a. Thoroughly review the technical specifications and validate the calculations (using internal staff and ICHP)
7. Share with plans and get sign off from each acknowledging they have received the information and had an opportunity to express any concerns
   a. Make any adjustments needed based on feedback
8. Post technical specifications and measures to the UMCM
   a. Allow 30 days for health plan comment
   b. Respond to health plan comments and make any additional adjustments needed
   c. Post final to the UMCM

<u>Policies for P4Q measure selection/retirement/changes</u>

- Staff will receive Executive Commissioner approval of selected measures via memo
- Plans will have received at least two years of results from HHSC before the measure is implemented in P4Q
- HHSC will run simulated P4Q results using the most recently available data for that measure to determine the feasibility of use
  - HHSC will share simulated results with the health plans
- Measures for each year of P4Q will be added to Chapter 6.2.11 of the UMCM prior to the start of the measurement year
  - Plans have the opportunity to comment before UMCM changes are finalized
  - Should measures change, Chapter 6.2.11 will be modified accordingly with opportunity for comment via the usual UMCM process
- When measures are selected, Quality Assurance will document why measures were chosen.

Criteria for measure selection

- Legislative requirements
- HHSC priorities

- o This will be determined via input from leadership, stakeholders, and HHSC workgroups and will consider factors such as the legislative environment, federal direction, and alignment with the state quality strategy
- Prevalence/the number of members affected
  - o Each health plan will have to have a sufficient denominator in order for a measure to be utilized
- Severity of the problem
- Areas where improvement is needed
  - o Quality Assurance will use past performance and national benchmarks where available to assess the need for improvement.
- HHSC will use nationally recognized and established measures to the degree possible
- Feasibility
  - o Quality Assurance and ICHP have or can obtain access to data and other resources needed
  - o The ability of plans to assess their progress

Criteria for measure retirement

Measures will be reviewed annually
- Change in legislative requirements
- Change in HHSC priorities
- Low denominators
- Plans consistently demonstrate high performance, with little variation among health plans
  - o HHSC would continue to track the measure and monitor performance as appropriate
- Changes in standards of care, science or health care delivery
- Retirement/change of measure specifications by NCQA or other national organizations.

Criteria and process for changes to measure specifications

- HHSC will follow specifications for standardized measure (e.g. HEDIS, DQA)
  - o When measure specifications change, HHSC will follow the new specifications
  - o HHSC may deviate from the specifications if mandated by the legislature or HHSC executive leadership
- For PPEs, the EQRO will follow 3M specifications and work with 3M as needed to ensure calculations align with 3M guidance
  - o HHSC may continue to use prior versions of the software if deemed necessary to most accurately measure health plan performance
  - o HHSC may deviate from the specifications if legislatively directed to do so

- For measures that are state-developed (e.g. current dental measures), HHSC will publish new measure specifications when there are changes. Changes will be considered based on the following criteria:
  - Changes in clinical best practices
  - Enhance the accuracy of the measure

Process for making changes to the methodology

- Quality Assurance will evaluate potential changes to the methodology using the following criteria:
  - Is the change in line with the P4Q conceptual framework?
  - Does the change promote quality improvement?
  - Is the change necessary for the model to work?
  - Does the change enhance fairness?
  - Does the change increase transparency?
- If staff agree that the change is worth considering, they will brief leadership on the proposed change including pros and cons
- If the change is significant, staff will run simulations
- Staff will not change the P4Q methodology after the measurement year has started unless necessary and approved by leadership.

Communicating program updates to stakeholders

- As P4Q program changes are developed, Quality Assurance will provide opportunities for input from stakeholders
- Quality Assurance will communicate to health plans changes to the framework, measures, methodology, and processes, using the Quality distribution list, as early as feasible
- These communications will also be posted and retained in the Texas Healthcare Learning Collaborative Portal in the P4Q folder
- If there are significant changes to the methodology or measures, the UMCM will be updated accordingly and health plans will have the opportunity for input via the usual UMCM process
- HHSC will use regular quality call with the plans to communicate P4Q updates, receive feedback, and answer questions

Calculation and validation of results

- Going forward, Quality Assurance will calculate the P4Q results and recoupments/distributions to the degree possible using measure results provided by the EQRO.
- If the EQRO is utilized to run any part of the P4Q results, Quality assurance will review the EQRO's SAS code related to P4Q calculations.
- Quality Assurance will conduct a risk assessment to identify which elements of the P4Q measure calculations will be validated with the following considerations:
  - Quality Assurance will review the EQRO's process for calculating PPEs.
  - Quality Assurance will not validate the calculation of HEDIS measures for P4Q due to the resources this would require and due to the fact the results are already validated by an NCQA-certified auditor.
- Quality Assurance will utilize HHSC staff and the EQRO to validate P4Q results.