

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-25-26
Baltimore, Maryland 21244-1850



State Demonstrations Group

December 15, 2020

Stephanie Stephens
State Medicaid Director
Texas Health and Human Services Commission
4900 Lamar Boulevard
MC: H100
P.O. Box 13247
Austin, Texas 78751

Dear Ms. Stephens:

Thank you for your application for a five-year extension of Texas' section 1115 demonstration, entitled "Texas Healthcare Transformation and Quality Improvement Program (THTQIP)" (project number 11-W002786) submitted on November 30, 2020. CMS completed our preliminary review of Texas' extension request, and we have determined that the state's extension request has met the requirements for a complete extension application and is exempt from the requirements for public notice and comment.

If you have additional questions, please contact your CMS project officer, Diona Kristian, at 410-786-1102 or diona.kristian@cms.hhs.gov.

Sincerely,

Angela D. Garner -S

Digitally signed by
Angela D. Garner -S
Date: 2020.12.15
16:31:47 -05'00'

Angela D. Garner
Director
Division of System Reform Demonstrations

cc: Ford Blunt, State Lead, Medicaid and CHIP Operations Group



Centers for Medicare & Medicaid Services

Section 1115 Demonstration FAST TRACK Extension Template for Program Changes



TEXAS
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Proposed Demonstration Changes for the Extension Period

- A. General Description.** Provide an overall description of the changes the state proposes for the extension of the demonstration. Specifically, include information on the expected impact these proposed program changes will have on populations covered by the demonstration and how it furthers the approved objectives and goals of the demonstration.

The Texas Health and Human Services Commission (HHSC) is submitting a "Fast Track" extension application to the Centers for Medicare & Medicaid Services (CMS) for an amendment to the Texas Healthcare Transformation Quality Improvement Program (THTQIP) waiver under section 1115 of the Social Security Act. The extension request is for 5 years, which will allow the 1115 waiver authority to run through 2027.

The requested extension will allow Texas continued flexibility to pursue the goals of the existing 1115 waiver. The extension will also create financial stability for Texas Medicaid providers, as HHSC works to transition the valuable work identified through Delivery System Reform Incentive Payment (DSRIP) innovations. The extension years as requested create a continuous demonstration period over 10 years, ending September 30, 2027. There are no substantial changes requested under this extension application, therefore, no substantive impact on populations covered by the demonstration.

Through this demonstration, the state aims to continue to:

- Expand risk-based managed care to new populations and services;
- Support the development and maintenance of a coordinated care delivery system;
- Improve outcomes while containing cost growth; and
- Transition to quality-based payment systems across managed care and providers.

- B. Expenditure Authorities.** List any proposed modifications, additions to, or removal of currently approved expenditure authorities. Indicate how each new expenditure authority is necessary to implement the proposed changes and also how each proposed change furthers the state's intended goals and objectives for the requested extension period.

There are no proposed modifications to currently approved expenditure authorities.

- c. Waiver Authorities.** List any proposed modifications, additions to, or removal of currently approved waiver authorities. Indicate how each new waiver authority is necessary to implement the proposed changes and also how each proposed change furthers the state's intended goals and objectives for the requested extension period.

There are no proposed changes to currently approved waiver authorities.

- d. Eligibility.** List any proposed changes to the population(s) currently being served under the demonstration.

If the state is proposing to add populations, please refer to the list of Medicaid Eligibility Groups at: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/List-of-Eligibility-Groups.pdf> when describing Medicaid State plan populations, and for an expansion eligibility group, please provide a plain language description of the group(s) that is sufficiently descriptive to explain to the public.

If the state is proposing to remove any demonstration populations, please include in the justification how the state intends to transition affected beneficiaries into other eligible coverage as outlined in the Special Terms and Conditions (STCs).

There are no proposed changes to currently approved eligibility.

- e. Benefits and Cost Sharing.** Describe any proposed changes to the benefits currently provided under the demonstration and any applicable cost sharing requirements. The justification should include any expected impact these changes will have on current and future demonstration enrollment.

There are no proposed changes to benefits and cost sharing.

- f. Delivery System.** Describe any proposed changes to the healthcare delivery system by which benefits will be provided to demonstration enrollees. The justification should include how the state intends a seamless transition for demonstration enrollees and any expected impact on current and future demonstration enrollment.

There are no proposed changes to the healthcare delivery system under the demonstration. Under the CMS approved DSRIP Transition Plan, HHSC is developing proposals for new programs and policies to sustain quality

improvement started under DSRIP and advance value in the Medicaid managed care program.

- G. Budget/Allotment Neutrality.** Describe any proposed changes to state demonstration financing (i.e., sources of state share) and/or any proposed changes to the overall approved budget/allotment neutrality methodology for determining federal expenditure limits (other than routine updates based on best estimate of federal rates of change in expenditures at the time of extension).

There are no proposed changes. The extended demonstration period continues current budget neutrality methodologies as illustrated in the STCs. A summary of our Budget Neutrality workbook is included as an attachment to this template.

- H. Evaluation.** Describe any proposed changes to the overall demonstration evaluation design, research questions or hypotheses being tested, data sources, statistical methods, and/or outcome measures. Justification should include how these changes furthers and does not substantially alter the currently approved goals and objectives for the demonstration.

The current CMS-approved 1115 evaluation design examines the three components of the THTQIP demonstration (DSRIP, UC Pool, MMC expansion), as well as the overall impact of the THTQIP demonstration (as measured by quality-based payment systems and transformation of the health care system for the Medicaid/low-income population in Texas). The current evaluation design includes 5 evaluation questions and 13 hypotheses. Preliminary findings suggest the THTQIP demonstration waiver is on track to meet its intended objectives. Specifically, early evidence suggests DSRIP has incentivized some forms of collaboration and improved health outcomes; MMC shows early signs of improved access and quality of care; more providers are participating in Alternate Payment Models; and, the demonstration generates overall cost savings.

Although preliminary findings from the THTQIP demonstration waiver are promising, the COVID-19 pandemic, which coincides with the final three years of the demonstration, presents a serious challenge to the final evaluation of the THTQIP demonstration waiver. The THTQIP extension would support the rigor of the evaluation in determining if the demonstration achieved its intended objectives by allowing for additional years of data to evaluate the impact of demonstration policies under stable conditions free of the COVID-19 pandemic. Moreover, additional years of the demonstration would allow HHSC to examine the DSRIP transition process and the impact of new benefits or populations recently carved into MMC.

The THTQIP demonstration waiver extension does not alter the overall goals and objectives of the evaluation; therefore, HHSC is not proposing changes to the approved evaluation questions. HHSC is also not proposing changes to hypotheses, data sources, statistical methods, and/or outcome measures for the evaluation of the UC Pool or components related to the overall impact of the THTQIP demonstration. HHSC proposes changes be considered to further the DSRIP and MMC expansion components. A discussion of potential changes and preliminary findings are included in APPENDIX C: Interim Evaluation. HHSC will submit a revision to the CMS-approved evaluation design incorporating these edits following approval of the THTQIP extension. HHSC does not anticipate that proposed adjustments will substantially alter the data sources or analytic methods used in the evaluation. The proposed changes to DSRIP and MMC expansion align with the current goals and objectives for the THTQIP demonstration.

- I. **Other.** Describe proposed changes to any other demonstration program feature that does not fit within the above program categories. Describe how these change(s) furthers the state's intended goals and objectives for the requested extension period.

Major deletions and edits have been foregone to avoid involvement of any complex policy area as noted in the CMCS Informational Bulletin dated July 24, 2015. This application seeks an extension of the current demonstration waiver. Once sections expire, amendments can be prepared to clean up the STCs as needed.

State Contact Person(s)

Please provide the contact information for the state's point of contact for this demonstration extension application.

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**Section 1115
Demonstration
Extension
Section 1115(a)
Fast Track Application
Supporting
Documentation**

Texas Healthcare Transformation and
Quality Improvement Program

Project #11-W-00278/6

Texas Health and Human Services
Commission

November 27, 2020



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Appendix A. Historical Summary

Waiver Approval: 2011 – 2022

Based on direction from the Texas Legislature in 2011, the State sought a section 1115 Demonstration as the vehicle to transform healthcare in Texas by expanding the Medicaid managed care delivery system statewide, while operating funding pools, supported by managed care savings and diverted supplemental payments, to reimburse providers for uncompensated care costs and to provide incentive payments to providers that implement and operate delivery system reforms. The waiver was designed to build on existing Texas health care reforms and to redesign health care delivery in Texas consistent with Centers for Medicare & Medicaid Services (CMS) goals to improve the experience of care, improve population health, and reduce the cost of health care.

CMS initially approved the waiver on December 12, 2011. The Texas Healthcare Transformation and Quality Improvement Program 1115 Waiver, commonly called the 1115 Transformation Waiver, is currently approved through September 30, 2022.

Through the 1115 Transformation Waiver, the State expanded its use of Medicaid managed care to achieve program savings, while also preserving locally funded supplemental payments to hospitals under two new funding pools. Through this Demonstration, the State has aimed to:

- Expand risk-based managed care statewide;
- Support the development and maintenance of a coordinated care delivery system;
- Improve outcomes while containing cost growth; and
- Transition to quality-based payment systems across managed care and hospitals.

Texas has made substantial progress toward achieving these four goals and requests a five-year extension utilizing the fast track template as provided by the CMS to reduce uncertainty for our health care systems during the Public Health Emergency, as determined and renewed by Secretary Azar on October 2, 2020.

Texas Medicaid has met its initial goal of expanding risk-based managed care statewide. Texas Medicaid has a mature 1115 Waiver inclusive of 17 Medicaid Managed Care Organizations (MCOs) and three Dental Maintenance Organizations. The State's managed care contracts require our health and dental plan contractors to meet goals related to quality improvement and alternative payment arrangements or value-based purchasing.

The waiver also includes the Delivery System Incentive Reform Payment (DSRIP) and Uncompensated Care (UC) Programs. Currently, 288 Performing Providers participate in DSRIP, and 529 providers participate in the Uncompensated Care Program. Significant

participation in these programs has led to successful outcomes. As DSRIP transitions, it has also led to significant financial stress on providers. Texas is on target and will continue working with CMS to successfully achieve the DSRIP Transition goals as approved. Uncompensated Care revisions were implemented successfully.

HHSC significantly expanded risk based managed care to additional populations over the last 6 years under the current 1115 waiver. In 2014, HHSC expanded STAR+PLUS to the rural service areas making STAR+PLUS a statewide program and added individuals in an intellectual or developmental disability (IDD) waiver program or in an intermediate care facility to STAR+PLUS for their acute care services. In 2016, HHSC implemented a new managed care program for children with disabilities, STAR Kids. In 2017, HHSC moved individuals in adoption assistance, permanency care assistance, and Medicaid for breast and cervical cancer programs into the managed care model. This work supports a more coordinated care delivery system for these populations as they are able to benefit from service coordination offered by the managed care organization. MCOs are reimbursed through a risk-based capitation rate that helps ensure MCOs contain cost growth while still providing all medically necessary services that improve outcomes for individuals they serve.

HHSC expanded risk based managed care by adding new services to managed care programs under the current 1115 waiver. In 2014, Community First Choice (CFC) services were added under the state plan and became available in the managed care programs offered by the MCOs in all managed care programs. CFC improves outcomes for people receiving the services because often these individuals are on an interest list for a waiver program and these services help them to remain in the community while they wait for their name to come to the top of the interest list. In 2015, HHSC added nursing facility services to the STAR+PLUS program. The addition of nursing facility services supports a more coordinated care delivery system as individuals in nursing facilities are able to benefit from service coordination offered by the managed care organization. Also, having nursing facility services as part of the array offered by the STAR+PLUS MCOs helps to contain cost growth as the MCO has the incentive to help individuals transition to less costly services in the community.

Recently HHSC implemented changes to support a coordinated care delivery system by more quickly moving children to another managed care program when they go from foster care Medicaid to adoption assistance or permanency care assistance Medicaid. Thus eliminating any time in fee-for-service and ensuring a more seamless transition under the current 1115 waiver.

The Texas Medicaid program has been transitioning to a value-based model for some time now. For over 25 years, the state has gradually moved care delivered through Medicaid

away from traditional fee-for-service reimbursement to a managed care system where private health plans are financially responsible for controlling costs and improving quality. The transition to managed care has been supported by system initiatives to improve quality and efficiency in state health care services. Chief among these is the state's 1115 Healthcare Transformation and Quality Improvement Program Waiver, which includes incentive payments to hospitals and other providers for strategies to enhance access to health care, increase the quality and cost-effectiveness of care, and improve the health of patients and families through the Delivery System Reform Incentive Payment (DSRIP) program. DSRIP has been an effective incubator allowing the state to establish consensus priorities for health system improvement and test how flexible payment models can support patient centered care and clinical innovation. Since 2012, DSRIP providers have earned over \$19 billion all funds (federal funds matched with intergovernmental transfer funds).

The DSRIP program structure, beginning in FFY 2018, evolved from a focus on projects and project-level reporting to targeted measure bundles (or measures, depending on performing provider type). Among the allowable menu of measure bundles and measures, State priority measure bundle areas for hospitals and physicians include:

- Chronic care: diabetes and heart disease care, pediatric asthma management
- Primary care and prevention
- Pediatric primary care
- Maternal care
- Integrated behavioral health/primary care
- Chronic non-malignant pain management
- Behavioral health and appropriate utilization

Other significant initiatives for increasing value in state health care include: the MCO Pay for Quality Program (P4Q); Program Improvement Projects (PIPs), which focus on improving quality across the managed care system; Hospital Quality Based Payment Program for Potentially Preventable Readmissions and Complications to incentivize quality and efficiency among hospitals; and Quality Incentive Payment Program (QIPP) to promote patient safety in nursing homes.

Finally, MCO Value-Based Contracting with Providers seeks to facilitate and encourage the development of alternative payment and flexible practice approaches between MCOs and their providers. Under this initiative, HHS created contractual targets for MCOs to connect provider payments to value using APMs, starting in calendar year 2018. The APM percentage targets increase over time. If an MCO fails to meet the APM targets or certain

allowed exceptions for high performing plans, the MCO must submit an action plan, and HHSC may impose graduated contractual remedies, including liquidated damages.

Waiver Extension

HHSC is working to expand Nonemergency Medical Transportation (NEMT) to the array of services provided by Medicaid managed care organizations (MCOs) for their members under the current 1115 waiver. In addition to providing the full array of NEMT services, HB 1576 (86th Regular Legislature) requires MCOs to provide NEMT demand response transportation services for certain trips requested with less than 48-hours' notice and increases opportunities for transportation network companies (TNCs) to provide demand response transportation services. This will expand risk-based managed care by no longer operating NEMT through managed transportation organizations under a state plan transportation broker model to MCOs under the 1115 waiver authority. This effort will improve outcomes and support a coordinated delivery system by making the same MCOs responsible for arranging health care services also responsible for arranging the NEMT some members require to access healthcare services.

HHSC will also be seeking to remove the cost cap for individuals meeting specific medically fragile criteria and removing the current state legislative requirement that the individual be deemed unable to safely be served in an institution under the current 1115 waiver. There will not be additional home and community-based services added to the program. Impacted individuals will continue to have access to services they are currently receiving. While the population impacted by this change is not new to managed care and will not receive new services, the new process for serving this very medically fragile population will improve the coordination of their care and improve health outcomes for them while containing cost growth. It is expected to result in a more cost-effective system, including better coordination of the person's care, a more streamlined system benefiting the person, their family, and their MCO, all of which will lead to improved health outcomes for these particularly vulnerable individuals.

HHSC is also actively working to implement the legislatively mandated STAR+PLUS Pilot Program under the current 1115 waiver. The pilot must be implemented by September 1, 2023 and will operate for at least 24 months. The eligibility criteria for the program will include Medicaid-eligible adults age 21 and over who meet one of the following:

- Individuals with an IDD or cognitive disability, including:
 - ▶ individuals with autism; and
 - ▶ individuals with significant complex behavioral, medical, and physical needs who are receiving home and community-based services through the STAR+PLUS Medicaid managed care program.

- Individuals enrolled in the STAR+PLUS Medicaid managed care program who:
 - are on a Medicaid waiver program interest list;
 - meet criteria for an IDD; or
 - have a traumatic brain injury that occurred after the age of 21.
- Other individuals with disabilities who have similar functional needs without regard to the age of onset or diagnosis.

The STAR+PLUS Pilot Program will operate in one service area selected by HHSC with up to two STAR+PLUS Medicaid managed care plans. The pilot will test the delivery of long-term services and supports (LTSS) for people with intellectual and development disabilities (IDD), traumatic brain injury that occurred after age 21, or people with similar functional needs as a person with IDD.

The STAR+PLUS Pilot Program is expected to further goals and objectives of the demonstration to expand risk based managed care to new populations as it will be offering home and community-based services to individuals with traumatic brain injury that currently could not qualify for a home and community-based waiver program. Additionally, this new program will also create and support a more coordinated care delivery system by having MCOs who currently provide acute care services for people with intellectual and developmental disabilities to also provide the long-term services and supports through a waiver program. This is expected to improve outcomes while containing cost growth.

HHSC would also like to call attention to the Public Health Emergency arising from the impact of COVID-19 which has significantly impacted Texas' health care delivery system. Texas recently released an open survey to all healthcare providers in Texas, which concluded on November 13, 2020. The results indicate a dire emergency of another kind is unfolding: The long-term stability of healthcare infrastructure and Medicaid provider networks is in jeopardy. CMS and Texas must act immediately to ensure that Medicaid clients retain access to care through a stable Medicaid managed care program, and that providers are financially stabilized by assured continuation of the Uncompensated Care pool available under the 1115 waiver and a successful DSRIP transition. According to survey results:

- 76% of providers said they were very concerned or extremely concerned about the financial impacts of COVID-19;
- 42% of providers reported reduced hours of service;
- 20% of providers actively reduced services unrelated to COVID-19;
- 23% of providers closed locations or facilities; and

- 27% of providers reported that COVID-19 demand has exceeded provider capacity.

Overtasked providers are considering dropping out of Texas Medicaid because of the overwhelming financial pressure and reduced service availability and locations. These problems are exacerbated by uncertainty over the future of the state's 1115 waiver. The extension application seeks to mitigate that uncertainty.

The scope of the COVID-19 public health emergency and its impacts on Texas Medicaid beneficiaries and providers continues to unfold, and its ultimate toll remains unknown. The state is acting expeditiously in response to the crisis to preserve and stabilize Medicaid program funding in order to protect the health, safety, and welfare of Medicaid beneficiaries and avoid further suffering for Texas families.

Under a 5-year extension of the current demonstration period through 2027, the State will continue the goals of the current 1115 Transformation Waiver. While the State has made significant progress toward the achievement of these goals, they remain ongoing priorities that will evolve and strengthen over time. Texas Medicaid also continues to advance value by expanding performance measurement and implementing new ways to incentivize quality and cost efficiency. Under the extension, DSRIP will fully transition and Medicaid managed care expenditures will adjust to promote access to care and provide incentives that drive value.

Health Care Delivery System, Eligibility Requirements, Benefit Coverage and Cost Sharing

Texas currently operates four of its Medicaid managed care programs under the demonstration: STAR+PLUS (including STAR+PLUS Home and Community Based Services waiver), STAR, STAR Kids, and its children's dental services managed care program. Under these programs individuals receive the full array of state plan services (including EPSDT), in STAR+PLUS the HCBS waiver service array is offered, and MCOs provide services on a case-by-case and through value added services. MCOs also provide service management or service coordination to ensure individuals have their care coordinated to the level of their need.

The state is not requesting changes to the DSRIP program. DSRIP includes 288 performing providers who serve patients with a focus on Medicaid and Low Income Uninsured. Currently, the DSRIP program funding and authorization will expire October 1, 2021. HHSC has separately requested an extension of the DSRIP program authorization and funding for the final demonstration year of the current waiver in order to minimize the disruption to the healthcare system occurring as a result of COVID-19 and the timing of the planned DSRIP Transition. While the requested extension is pending a response from

CMS, the state continues to develop new proposals under the approved DSRIP Transition Plan and submit required deliverables.

Uncompensated Care (UC) payments are cost-based and help offset the costs of uncompensated care provided by hospitals and other providers. UC costs are federally defined as unreimbursed charity care costs. UC payments are based on each provider's uncompensated care costs as reported to the state on a UC application. The non-federal share is provided by local governmental entities. In order to receive UC payments, providers must participate in one of the twenty Regional Health Partnerships (RHPs).

Payments from this pool are used to defray the actual uncompensated cost of medical services that meet the definition of "medical assistance" contained in section 1905(a) of the Act, that are provided to uninsured individuals as charity care by hospitals, clinics, or by other provider types, including uninsured full or partial discounts, that provide all or a portion of services free of charge to patients who meet the provider's charity care policy and that adhere to the charity care principles of the Healthcare Financial Management Association. Annual UC Pool payments are limited to annual amounts. Expenditures for UC payments must be claimed in accordance with CMS-approved claiming protocols for each provider type and application form. The methodology used by the state to determine UC payments will ensure that payments to hospitals, clinics, and other providers are distributed based on uncompensated cost, without any relationship to source of non-federal share. HHSC will continue the UC pool through the demonstration extension period and is not requesting changes to the UC program. The UC program includes 529 providers which provide charity care to patients who meet their charity care policy.

The extension will not change the array of benefits provided under the current 1115 waiver authority. The extension does not make any changes to eligibility requirements. Extending the waiver will not have a significant impact on enrollment. Under the extension there will continue to be no beneficiary cost sharing.

The state is not requesting changes to the existing health care delivery system, eligibility requirements or benefit coverage through this extension request. Additionally, there will continue to be no cost sharing requirements related to premiums, co-payments, or deductibles as part of this extension request. There are not changes requested to DSRIP nor UC.

Managed Care Overview

Texas currently operates four of its Medicaid managed care programs under the demonstration: STAR+PLUS (including STAR+PLUS Home and Community Based Services waiver), STAR, STAR Kids, and its children's dental services managed care program.

Under these programs individuals receive the full array of state plan services (including EPSDT for those under 21), in STAR+PLUS the HCBS waiver service array is offered, and MCOs provide services on a case-by-case and through value added services. MCOs also provide service management or service coordination to ensure individuals have their care coordinated to the level of their need, this includes coordination with non-capitated services that exist outside of this section 1115 demonstration. Individuals who are members of federally-recognized tribes in Texas are voluntary to enroll in our managed care programs and can opt to remain in fee-for-service Medicaid. There is no cost sharing in any of these programs and that will remain the same through the demonstration extension period.

HHSC plans to continue these managed care programs and services through the demonstration extension period.

Managed Care Eligibility and Enrollment Requirements

STAR+PLUS.

STAR+PLUS provides acute and long-term service and supports to older adults and adults with disabilities, including individuals with breast and cervical cancer. Also, the STAR+PLUS program includes adults 21 and older who reside in an intermediate care facility for individuals with an intellectual or developmental disability (ICF/IID) or receiving 1915(c) waiver services (Home and Community-based Services (HCS), Texas Home Living (TxHmL), Community Living and Support Services (CLASS), or Deaf Blind with Multiple Disabilities (DBMD)) who do not have Medicare Part A and B. These individuals receive their state plan services through STAR+PLUS and receive their 1915(c) services through their respective waivers and waiver providers.

STAR+PLUS HCBS.

STAR+PLUS provides acute and long-term service and supports to older adults and adults with disabilities. The STAR+PLUS HCBS Program provides long-term services and supports to two groups of people, as defined below:

- **STAR+PLUS 217-Like HCBS Group.** This group consists of persons age 21 and older, who meet the nursing facility level of care (LOC), who qualify as members of the 217-Like HCBS Group, and who need and are receiving HCBS as an alternative to nursing facility care. This includes persons who could have been eligible under 42 CFR 435.217 had the state continued its section 1915(c) HCBS waiver for persons who are elderly and/or physically disabled. This group is subject to a numeric enrollment limitation.

- **SSI-Related Eligibles.** Persons age 65 and older, and adults age 21 and older, with physical disabilities that qualify as SSI eligibles and meet the nursing facility LOC as defined by the state.

Individuals can be eligible for HCBS under STAR+PLUS depending upon their medical and / or functional needs, financial eligibility designation as a member of the 217-Like STAR+PLUS HCBS Group or an SSI-related recipient, and the ability of the State to provide them with safe, appropriate, and cost-effective LTC services.

- Medical and / or functional needs are assessed according to level of care (LOC) criteria published by the State in State rules. These LOC criteria will be used in assessing eligibility for STAR+PLUS HCBS benefits through the 217-Like or SSI-related eligibility pathways.
- For an individual to be eligible for HCBS services, the State must have determined that the individual's cost to provide services is equal to or less than 202 percent of the cost of the level of care in a nursing facility.

STAR

STAR is the primary managed care program providing acute care services to low-income families, children, pregnant women, adoption assistance and permanency care assistance, and former foster care children.

STAR Kids

The STAR Kids program provides a continuum of services, including acute care, behavioral health, state plan long-term services and supports, and 1915(c) home and community based waiver services to children with disabilities. The following groups of Medicaid clients from birth through age 20 are mandatory in the STAR Kids program.

1. Children receiving SSI and disability-related (including SSI-related) Medicaid who do not participate in a 1915(c) waiver: these children will receive their state plan acute care services and their state plan long term services and supports (LTSS) through STAR Kids.
2. Children receiving HCBS services through the Medically Dependent Children's Program (MDCP) 1915(c) waiver: these children and young adults will receive the full range of state plan acute care services and state plan LTSS as well as MDCP 1915(c) HCBS waiver services through STAR Kids.
3. Children receiving HCBS through the following 1915(c) waivers -- CLASS, DBMD, HCS, TxHmL, and YES:

- Children enrolled in CLASS, DBMD, HCS and TxHmL receive their 1915(c) LTSS and 1915(k) (Community First Choice) services through their current 1915(c) waiver provider. These clients receive all other state plan LTSS and acute care services through STAR Kids.
 - Children enrolled in the YES waiver receive their 1915(c) LTSS through their current 1915(c) provider. These clients receive all state plan LTSS, including 1915(k) services, as well as all acute care services through STAR Kids.
4. Children receiving SSI and disability-related (including SSI-related) Medicaid who reside in a community-based intermediate care facility for individuals with intellectual disabilities or a nursing facility: clients will continue to receive all long-term services and supports provided by the facility through the current delivery system. All non-facility related services will be provided through STAR Kids.

Children's Dental Program

Children's primary and preventive Medicaid dental services are delivered through a capitated statewide dental services program (the Children's Dental Program) to most children under 21. Contracting dental maintenance organizations (DMOs) maintain networks of Main Dental Home providers, consisting of general dentists and pediatric dentists. The dental home framework under this statewide program is informed by the improved dental outcomes evidenced under the "First Dental Home Initiative" in the State. The Children's Dental Program must conform to all applicable regulations governing prepaid ambulatory health plans (PAHPs), as specified in 42 C.F.R. 438.

The following Medicaid recipients are excluded from the Children's Dental Program, and will continue to receive their Medicaid dental services outside of the Demonstration: Medicaid recipients age 21 and over; all Medicaid recipients, regardless of age, residing in Medicaid-paid facilities such as nursing homes, state supported living centers, or Intermediate Care Facilities for Individuals with an Intellectual Disability or Related Conditions (ICF/ID); and STAR Health Program recipients.

Managed Care Benefits

STAR, STAR+PLUS, and STAR Kids enrollees are provided benefits in the same amount, duration, and scope as in the Medicaid State plan. Members under the age of 21 are also provided all EPDST benefits. In addition, the members of STAR+PLUS HCBS are provided 1915(b)(3)-like services as described below. Individuals in 1915(c) waivers receive all Texas state plan services based on medical necessity and delivered outside of managed care (e.g. dental, ICF/IID pursuant to their respective 1915(c) waivers), with the exception of MDCP which is provided by the STAR Kids MCOs. Services provided through the Children's Dental Program and DMOs are separate from the medical services provided

by the STAR, STAR+PLUS, and STAR Kids MCOs, and are available to persons who are under age 21, with the exception of the groups listed above. DMOs are expected to provide all medically necessary dental services in the same amount, duration and scope as in the Medicaid state plan.

STAR+PLUS HCBS Program

In addition to all state plan benefits, STAR+PLUS HCBS participants, whether in the 217-Like HCBS Group or the SSI-related group, that are provider-directed and, if the participant elects the option, self-directed, receive a number of other 217-Like HCBS Services including: Personal Assistance Services, Respite, Financial Management Services, Support Consultation, Adaptive Aids and Medical Supplies, Adult Foster Care, Assistive Living, Dental Services, Emergency Response Services, Home Delivered Meals, Minor Home Modifications, Nursing, Occupational Therapy, Physical Therapy, Speech, Hearing, and Language Therapy, Transition Assistance Services, Cognitive Rehabilitation Therapy, Supported Employment Services, and Employment Assistance Services.

Appendix B. Budget

In compliance with CMS-approved STCs, the extended demonstration period continues current budget neutrality methodologies as illustrated in the relevant STC tables and charts. No changes have been incorporated as the STCs reflect:

- Without Waiver PMPM methodology with current trends, the UPL is held flat at the current level;
- Uncompensated Care maintained at current size of \$3.87 billion annually; and
- Continued savings phase down policy as developed by CMS.

The budget neutrality 5-year “roll over” is held flat at \$9.47 billion through the continued DY 07-16 demonstration period.

This extension request continues current budget neutrality policies through the end of the extended demonstration period. No deviations from current financial performance are expected as no methodology changes have been requested.

Cost Growth Containment

Through initial managed care initiatives and continued expansions into the managed care delivery system, HHSC and the clients we serve have benefited from both increased coordination and quality of care. Over time, these same benefits and efficiencies have helped flatten the cost curve and maintain stable Medicaid client service cost trends year over year. For the current approved demonstration period over FFY12-22, with waiver Per Member Per Month (PMPM) annual cost growth trends are estimated to average 3.3%, a full 2% lower than without waiver PMPM cost growth for the same period (excluding UPL).

Enrollment

No impact to enrollment is expected as a result of the 1115 transformation waiver extension. There are no 1115 waiver policies that limit or impact Medicaid enrollment. While fiscal year trends during and following the Covid Public Health Emergency period are impacted due to policies and economic recovery, overall member months under the 1115 are expected to experience long term annual caseload growth trends of roughly 1% to 1.5% consistent with historical program growth.

Current enrollment growth during the PHE has been significant, with growth of over 12% since the PHE began. Annual growth of 10% over fiscal year 2021 is expected as the PHE continues and could increase depending on further PHE extensions and unemployment. While recovery is assumed over fiscal years 2022-2023, any number of factors can greatly influence the impact to Medicaid caseloads due to policy and economic conditions.

1115 MEG Total Member Months, DY06-DY21

	DY 06 (FFY 17)	DY 07 (FFY 18)	DY 08 (FFY 19)	DY 09 (FFY 20)	DY 10 (FFY 21)	DY 11 (FFY 22)
Aged and Medicare Related	4,260,091	4,260,293	4,254,228	4,295,619	4,316,342	4,348,666
Blind and Disabled	5,042,514	4,990,061	4,898,834	4,911,242	5,211,975	5,151,745
Adults	3,423,661	3,416,287	3,274,638	3,670,408	4,086,896	3,366,107
Children	31,460,800	31,614,307	30,691,208	32,018,364	35,249,138	32,945,528
	DY 12 (FFY 23)	DY 13 (FFY 24)	DY 14 (FFY 25)	DY 15 (FFY 26)	DY 16 (FFY 27)	
Aged and Medicare Related	4,421,112	4,507,470	4,616,355	4,698,756	4,782,628	
Blind and Disabled	5,114,843	5,130,933	5,220,264	5,304,033	5,389,146	
Adults	3,323,019	3,364,809	3,411,887	3,455,563	3,499,799	
Children	31,807,744	32,053,486	32,494,047	32,939,929	33,391,930	

Based on actual data through July 2020, projected member months thereafter.

Appendix C. Interim Evaluation

The current CMS-approved 1115 evaluation design examines the three components of the THTQIP demonstration (DSRIP, UC Pool, Medicaid Managed Care (MMC) expansion), as well as the overall impact of the THTQIP demonstration (as measured by quality-based payment systems in Texas Medicaid and transformation of the health care system for the Medicaid/low-income population in Texas). The interim evaluation is still on schedule to be submitted to CMS by September 30, 2021. The current evaluation design includes 5 evaluation questions and 13 hypotheses. The THTQIP demonstration waiver extension does not alter the overall goals and objectives of the evaluation; therefore, HHSC is not proposing modifications to the approved evaluation questions. HHSC is also not proposing changes to hypotheses, data sources, statistical methods, and/or outcome measures for the evaluation of the UC Pool or components related to the overall impact of the THTQIP demonstration. HHSC is proposing changes to further the DSRIP and MMC expansion components.

DSRIP funds are scheduled to phase out for the final year of the current THTQIP demonstration which begins October 1, 2021. HHSC may continue to examine DSRIP using a revised hypothesis and measure set focused on the DSRIP transition process occurring under the THTQIP extension.

Hypotheses under the MMC component of the THTQIP extension evaluation will remain the same, but HHSC will revise the study populations and/or measures associated with each hypothesis. The current THTQIP evaluation examines six populations that transitioned into MMC between March 1, 2012 and September 1, 2017. All populations included in the current THTQIP evaluation include at least five years of post-transition data. Further inquiry into these populations will not yield additional insight into whether the expansion of MMC improved health outcomes for clients in these programs.

The MMC component of the THTQIP extension evaluation will focus on recent or forthcoming changes in services or benefits provided to populations served under the THTQIP. Populations included in the MMC evaluation during the THTQIP extension may include individuals impacted by possible THTQIP amendments (e.g., individuals utilizing non-emergency transportation services, children and youth receiving early and periodic screening, diagnostic, and treatment services, individuals with disabilities), and/or additional populations as necessary based on THTQIP interim report findings and statutory changes resulting from legislation related to the THTQIP demonstration. HHSC will review and modify current MMC measures to examine access to care, care coordination, quality, outcomes, and satisfaction, as applicable to the new populations and/or benefits.

HHSC will submit a revision to the CMS-approved evaluation design incorporating these edits following approval of the THTQIP extension. HHSC does not anticipate adjustments will substantially alter the data sources or analytic methods used in the evaluation. The proposed changes to DSRIP and MMC expansion align with the current goals and objectives for the THTQIP demonstration.

The overarching objectives of the THTQIP demonstration waiver are to expand risk-based managed care to new populations and services, support the development and maintenance of a coordinated care delivery system, improve outcomes while containing cost growth, and transition to quality-based payment systems across managed care and providers. The THTQIP demonstration waiver achieves these objectives through three components: the DSRIP pool, the UC pool, and MMC expansion. The focus of the THTQIP evaluation is to determine if the THTQIP demonstration waiver achieved its intended objectives through the three components. The THTQIP evaluation is guided by five evaluation questions, with one question each pertaining to DSRIP, UC, MMC, and two questions pertaining to the demonstration overall. Each evaluation question is addressed through a minimum of one corresponding hypothesis and measure.¹ Altogether, the current THTQIP evaluation design includes 5 evaluation questions, 13 hypotheses, and 48 evaluation measures.

Evaluation Activities To Date

The THTQIP demonstration waiver is in the fourth year of the current renewal period. During the past four years, HHSC developed the CMS-approved evaluation design; procured an external evaluator; provided the external evaluator with data sources outlined in the evaluation plan; provided data-related technical assistance as requested by the external evaluator; participated in quarterly and ad hoc meetings with the external evaluator, and; submitted four revisions to the THTQIP evaluation design. The next scheduled evaluation deliverable is the interim evaluation report, which is on schedule to be submitted to CMS by September 30, 2021.

Preliminary Evaluation Findings

The external evaluator will deliver a draft of the interim report to HHSC for review on May 28, 2021. The external evaluator submitted preliminary findings to HHSC in support of this extension application on December 7, 2020. Key points from the preliminary findings are summarized below. Texas A&M University System's *Preliminary Draft Results*

¹ The current CMS-approved evaluation design plan can be found at <https://hhs.texas.gov/sites/default/files/documents/laws-regulations/policies-rules/1115-docs/tool-guidelines/1115-waiver-evaluation-design-plan.pdf>.

(Supplement A) provides the full summary of preliminary findings provided by the external evaluator. Preliminary findings are still in draft form and are only provided for the purposes of this application.

Evaluation Question 1: Did the DSRIP program incentivize changes to transform the health care system for the MLIU population in Texas?

Preliminary findings suggest the DSRIP program incentivized collaboration in tangible resource sharing and data sharing agreements, but less so in other areas of collaboration, such as joint service delivery. The DSRIP program has also supported improvements in Category C outcome measures such as heart disease management (A2-509) and primary care prevention (C1-502), but additional data is necessary to fully understand the impact of DSRIP on health outcomes.

Evaluation Question 2: Did the Demonstration impact unreimbursed costs associated with the provision of care to the MLIU population for UC providers?

Preliminary findings suggest the rate of UC cost reimbursement decreased over time. Analysis of the overall UC cost growth rate is currently underway.

Evaluation Question 3: Did the expansion of the MMC health care delivery model to additional populations and services improve healthcare (including access to care, care coordination, quality of care, and health outcomes) for MMC clients?

Preliminary findings provide some support for the premise that the expansion of MMC improved access to care and quality of care for renewal study populations, but additional data are necessary to fully understand the impact of the MMC expansion.

Evaluation Question 4: Did the Demonstration impact the development and implementation of quality-based payment systems in Texas Medicaid?

Preliminary findings suggest providers' use of Alternate Payment Models (APMs) increased, but organizations were somewhat ambivalent about the benefits of APMs. Organizations reported financial efficiency as the most common perceived benefit of APMs, and lack of MCO engagement as the most common perceived barrier to APM participation.

Evaluation Question 5: Did the Demonstration transform the health care system for the MLIU population in Texas?

Preliminary findings suggest the THTQIP demonstration waiver has resulted in overall cost savings and this trend is expected to continue.

Planned Evaluation Activities During THTQIP Extension

HHSC will continue to fulfill federal evaluation monitoring and reporting requirements during the THTQIP extension. The THTQIP demonstration waiver extension does not alter the overall goals and objectives of the evaluation; therefore, HHSC is not proposing modifications to the approved evaluation questions. HHSC is also not proposing changes to hypotheses, data sources, statistical methods, and/or outcome measures for the evaluation of the UC Pool (Evaluation Question 2) or components related to the overall impact of the THTQIP demonstration (Evaluation Questions 4 and 5). HHSC is proposing changes to further the DSRIP and MMC expansion components, as detailed below.

HHSC will submit a revision to the CMS-approved evaluation design incorporating these edits following approval of the THTQIP extension. HHSC does not anticipate adjustments will substantially alter the data sources or analytic methods used in the evaluation. The proposed changes to DSRIP and MMC expansion align with the current goals and objectives for the THTQIP demonstration waiver.

Changes to the DSRIP Evaluation Component

The CMS-approved evaluation design includes one evaluation question and four hypotheses related to DSRIP:

Evaluation Question 1: Did the DSRIP program incentivize changes to transform the health care system for the MLIU population in Texas?

- Hypothesis 1.1 DSRIP incentivized changes to the health care system that maintained or increased collaboration among providers.
- Hypothesis 1.2 DSRIP incentivized performing providers to improve continuity, quality, and cost of care for Medicaid clients with diabetes.
- Hypothesis 1.3 DSRIP incentivized performing providers to improve quality-related outcomes, specified as Category C population-based clinical outcome measures.
- Hypothesis 1.4 DSRIP transformed the health care system, resulting in improvements in population health, specified as DSRIP Category D outcomes.

DSRIP funds are scheduled to phase out during the final year of the current THTQIP demonstration waiver, which begins October 1, 2021. The current evaluation question and hypotheses pertaining to DSRIP will no longer be applicable after DSRIP's scheduled completion date. HHSC may continue to examine DSRIP or related transitional programs using a revised hypothesis and measure set focused on the DSRIP transition process and related programming under the THTQIP extension.

Changes to the MMC Evaluation Component

The CMS-approved evaluation design includes one evaluation question and four hypotheses pertaining to MMC:

Evaluation Question 3: Did the expansion of the MMC health care delivery model to additional populations and services improve healthcare (including access to care, care coordination, quality of care, and health outcomes) for MMC clients?

- Hypothesis 3.1 Access to care will improve among clients whose Medicaid benefits shift from FFS to a MMC health care delivery model.
- Hypothesis 3.2 Care coordination will improve among clients whose Medicaid benefits shift from FFS to a MMC health care delivery model.
- Hypothesis 3.3 Quality of care will improve among clients whose Medicaid benefits shift from FFS to a MMC health care delivery model.
- Hypothesis 3.4 Health and health care outcomes will improve among clients whose Medicaid benefits shift from FFS to a MMC health care delivery model.
- Hypothesis 3.5 Client satisfaction will improve among clients whose Medicaid benefits shift from FFS to a MMC health care delivery model.

Hypotheses under the MMC component of the THTQIP extension evaluation will remain the same, but HHSC will revise the study populations and/or measures associated with each hypothesis. The current THTQIP evaluation examines six populations that transitioned into MMC between March 1, 2012 and September 1, 2017. All populations included in the current THTQIP evaluation include at least five years of post-transition data. Further inquiry into these populations will not yield additional insight into whether the expansion of MMC improved health outcomes for clients in these programs.

The MMC component of the THTQIP extension evaluation will focus on recent or forthcoming changes in services or benefits provided to populations served under the THTQIP demonstration. Populations included in the MMC evaluation during the THTQIP extension may include individuals impacted by possible THTQIP amendments (e.g., individuals utilizing non-emergency transportation services; children and youth receiving early and periodic screening, diagnostic, and treatment services; individuals with disabilities) and/or additional populations as necessary based on THTQIP interim report findings and statutory changes resulting from legislation related to the demonstration. HHSC will review and modify current MMC measures to examine access to care, care coordination, quality, outcomes, and satisfaction, as applicable to the new populations and/or benefits.

Need for THTQIP Extension

Only preliminary evaluation findings are available for the THTQIP demonstration waiver at this time. However, based on preliminary findings HHSC believes the THTQIP demonstration waiver is on track to meet its intended objectives. Specifically, early evidence suggests DSRIP has incentivized some forms of collaboration and improved health outcomes; MMC shows early signs of improved access and quality of care; more providers are participating in APMs, and; the demonstration generates overall cost savings.

Although preliminary findings from the THTQIP demonstration waiver are promising, the COVID-19 pandemic, which coincides with the final three years of the demonstration, presents a serious challenge to the final evaluation of the THTQIP demonstration waiver. The pandemic and ensuing economic recession significantly reordered priorities for clients and providers in the state, impacting enrollment, utilization, and health care delivery across the Medicaid system. HHSC anticipates the COVID-19 pandemic will have a direct or indirect impact on many of the measures used in the THTQIP evaluation. Like most time-series designs, the THTQIP demonstration evaluation is vulnerable to external validity threats; COVID-19 introduces a number of confounding factors that undermine causal inference and impede evaluators' ability to isolate the impact of demonstration policies. At the time of writing, it is unknown how long the most severe effects of the COVID-19 pandemic will last, and it is unlikely that the current evaluation will be able to fully remove or account for the impacts of the pandemic. Additional years of data are necessary to evaluate the impact of demonstration policies under stable conditions free of the COVID-19 pandemic.

The THTQIP extension is also necessary to examine recent or forthcoming changes to the current THTQIP demonstration waiver. Specifically, the THTQIP extension would allow HHSC to examine the DSRIP transition process and the impact of new benefits or populations recently carved into MMC. Collectively, the THTQIP extension would support the rigor of the evaluation in determining if the THTQIP demonstration waiver achieved its intended objectives.

Resources

The current CMS-approved evaluation design plan can be found at <https://hhs.texas.gov/sites/default/files/documents/laws-regulations/policies-rules/1115-docs/tool-guidelines/1115-waiver-evaluation-design-plan.pdf>.

Appendix D. Quality Assurance Monitoring

Texas has a strong focus on quality of care in Medicaid and CHIP that includes initiatives based on state and federal requirements, including protocols published by the Centers for Medicare & Medicaid Services (CMS). HHSC strives to ensure high-value healthcare for Texans through its monitoring and oversight of Medicaid and CHIP managed care organizations (MCOs).

External Quality Review

Federal regulations require external quality review of Medicaid managed care programs to ensure states and their contracted MCOs are compliant with established standards. The external quality review organization (EQRO) performs four CMS required functions as mandated by the Balanced Budget Act of 1997 related to Medicaid managed care quality:

- Validation of MCOs' performance improvement projects,
- Validation of performance measures,
- Determination of MCOs' compliance with certain federal Medicaid managed care regulations, and
- Validation of MCO and dental maintenance organization (DMO) network adequacy.

In addition, states may also contract with the EQRO to validate member-level data; conduct member surveys, provider surveys, or focus studies; and calculate performance measures. The Institute for Child Health Policy (ICHP) has been the EQRO for HHSC since 2002. HHSC's EQRO follows CMS protocols to assess access, utilization, and quality of care for members in Texas' CHIP and Medicaid programs.

The EQRO produces reports to support HHSC's efforts to ensure managed care clients have access to timely and quality care in each of the managed care programs. The results allow comparison of findings across MCOs in each program and are used to develop overarching goals and quality improvement activities for Medicaid and CHIP managed care programs. MCO findings are compared to HHSC standards and national percentiles, where applicable. A link to the annual EQRO Summary of Activities (SOA) Report can be found [here](#).

The EQRO assesses care provided by MCOs participating in STAR, STAR+PLUS (including the STAR+PLUS home and community-based services waiver), STAR Health, CHIP, STAR Kids, and the Medicaid and CHIP dental managed care programs. The EQRO conducts ongoing evaluations of quality of care primarily using MCO administrative data, including claims and encounter data. The EQRO also reviews MCO documents and provider medical records, conducts interviews with MCO administrators, and conducts surveys of Texas Medicaid and CHIP members, caregivers of members, and providers.

Multi-Year Focus

In summer 2016, the Texas Medicaid and CHIP external quality review organization (EQRO) began a multi-year focus study to evaluate the STAR Kids program and develop a set of quality measures for the STAR Kids population. The EQRO produced five reports for the study:

1. STAR Kids Program Focus Study Measures Background Report (February 10, 2017)
2. STAR Kids Program Focus Study Pre-Implementation Descriptive Report (May 26, 2017). <https://hhs.texas.gov/sites/default/files/documents/about-hhs/process-improvement/quality-efficiency-improvement/STAR-Kids-Pre-Implementation-Report-052617.pdf>
3. STAR Kids Post-Implementation Managed Care Organization (MCO) Interview Report (June 18, 2018). <https://hhs.texas.gov/sites/default/files/documents/about-hhs/process-improvement/medicaid-chip-gei/star-kids-post-mco-interview-report-june-2018.pdf>
4. Measures Feasibility Report (April 18, 2019)
5. Summary Report (November 13, 2019)

The final summary report contained a series of recommendations including

- Conducting regular NCI-CFS surveys with STAR Kids caregivers;
- Conducting additional studies with the STAR Kids-Screening and Assessment Instrument (SK-SAI) and Individual Service Plan (ISP);
- Conducting CAHPS surveys to assess member experiences;
- Creating quality of care measures specific to members enrolled in the Medically Dependent Children Program (MDCP); and,
- Conducting focus groups with MDCP caregivers.

These recommendations were incorporated into SB 1207, 86th Legislature, and HHSC has or is in the process of implementing them.

The annual Summary of Activities (SOA) reports to CMS all activities performed by the EQRO during the contract year. The SOA report presents findings by the Texas EQRO on activities for state fiscal year (SFY) 2018, which address quality of care in Texas Medicaid and CHIP. The report's recommendations include the following:

- validate and update provider addresses to improve the return rate on records requested from providers;

- identify members that most benefit from addressing social determinants of health (SDOH) and improve their access to care;
- continue to improve access to behavioral health care; and
- focus on improving key vaccination rates.

In response to these recommendations, MCOs are required to verify the provider address information prior to the EQRO requesting patient records for encounter data validation (EDV). In addition, MCOs and DMOs are subject to corrective action plans (CAPs) for data that does not meet minimum EDV quality standards.

HHSC, in conjunction with the EQRO, recently completed an analysis of state and national SDOH tools. HHSC plans to use this information to identify a recommended tool for Medicaid MCOs. In addition, the Medicaid/CHIP Services Department has formed an internal workgroup to further incorporate SDOH into quality initiatives.

In 2019, MCOs began a statewide, two-year performance improvement project (PIP) focused on members with complex behavioral health conditions. In 2020, PIPs focus on improving integration of behavioral health and physical health care, with the goal of reducing hospitalization.

To improve vaccination rates, HHSC has added immunizations for adolescents (IMA) as a quality measure in the Medical Pay-for-Quality (P4Q) program for STAR, CHIP and STAR Kids.

Quality Measures

A combination of established sets of national measures and state-developed measures validated by the EQRO are used to track and monitor program and health plan performance. Measures include:

- National Committee for Quality Assurance Healthcare Effectiveness Data and Information Set (HEDIS®) - A nationally recognized and validated set of measures used to gauge quality of care provided to members.
- Agency for Healthcare Research and Quality (AHRQ) Pediatric Quality Indicators (PDIs)/ Prevention Quality Indicators (PQIs) - PDIs use hospital discharge data to measure the quality of care provided to children and youth. PQIs use hospital discharge data to measure quality of care for specific conditions known as “ambulatory care sensitive conditions” (ACSCs). ACSCs are conditions for which good outpatient care can potentially prevent the need for hospitalization, or for which early intervention can prevent complications or more severe disease.

- 3M® Potentially Preventable Events (PPEs) - HHSC uses and collects data on Potentially Preventable Admissions (PPAs), Potentially Preventable Readmissions (PPRs), Potentially Preventable Emergency Department Visits (PPVs), Potentially Preventable Complications (PPCs), and Potentially Preventable Ancillary Services (PPSs).
- Consumer Assessment of Healthcare Providers & Systems (CAHPS®) Surveys - CAHPS Health Plan Surveys are nationally recognized and validated tools for collecting standardized information on members' experiences with health plans and services.

Initiatives

HHSC uses quality measures to evaluate health plan performance and develop initiatives to improve the quality of care provided to Medicaid and CHIP members in managed care.

Administrative Interviews

In accordance with 42 CFR 438.358, the EQRO conducts administrative interviews with each plan in Medicaid/CHIP—within a three-year period—to assess MCO/dental maintenance organization compliance with state standards for access to care, structure and operations, and quality assessment and performance improvement (QAPI). The administrative interview process consists of four main deliverables, namely Administrative Interview (AI) tool, AI evaluations, onsite visits, and AI reports.

Core Measure Reporting

CMS has a Children's and an Adult Health Care Quality Core Set of measures which states voluntarily report on for children in Medicaid and CHIP and adults in Medicaid. The EQRO assists HHSC in reporting core measures to CMS each year.²

MCO Report Cards

HHSC provides information on outcome and process measures to Medicaid and CHIP members regarding MCO performance during the enrollment process. To comply with this requirement and the quality rating system required by 42 CFR 438.334, HHSC develops report cards for each program service area to allow members to compare the MCOs on specific quality measures. These report cards are intended to assist potential enrollees in selecting an MCO based on quality metrics. Report cards are posted on the HHSC website and included in the Medicaid enrollment packets. Report cards are updated annually.³

² <https://www.medicaid.gov/medicaid/quality-of-care/quality-of-care-performance-measurement/adult-and-child-health-care-quality-measures/index.html>

³ <https://hhs.texas.gov/services/health/medicaid-chip/programs/managed-care-report-cards>

Figures 1 and Figure 2 show 2020 report cards for STAR adult members in the Bexar Service Area and STAR Kids members in the Harris Service Area.

Figure 1: STAR Adult Report Card, Bexar Service Area

HEALTH PLAN PERFORMANCE Ratings are based on a scale of one to five stars. Fewer stars mean the plan has lower performance (but does not always mean bad performance) than other plans. ★★★★★ Highest Performance in STAR ★★★★ ★★★ ★★ ★ Lowest Performance in STAR				
	Aetna Better Health	Amerigroup	Community First Health Plans	Superior HealthPlan
Overall Health Plan Quality	★★	★	★★★★	★★★★★
Experience with Doctors and the Health Plan	★★	★	★★★★	★★★★★
People get the care they need without problems or long waits	★★★★	No rating [†]	★★★★	★★★★
Doctors listen carefully, explain clearly and spend enough time with people	★★★★	No rating [†]	★★★★	★★★★
People give high ratings to their personal doctor	★★★★	★★★★	★★★★	★★★★
People give high ratings to the health plan	★	★★★★	★★★★	★★★★★
Staying Healthy	★★★★	★★	★★★★★	★★★★★
Women get checkups during pregnancy	★★	★★	★★★★★	★★★★★
New mothers get checkups after giving birth	★★★★★	★★★★	★★★★★	★★★★★
People get regular yearly checkups	★★	★★	★★★★	★★★★★
Women get regular screenings for cervical cancer	★★★★★	★★★★★	★★★★★	★★★★★
Common Chronic Conditions	★★★★★	★★	★★★★	★★★★★
People get care for depression and constant low mood	★★★★★	No rating [†]	★★	★★★★
People get care for diabetes	★★★★	★★★★	★★★★	★★★★★

[†] If a plan shows "No rating": this is not a bad rating. At the time of the study, the plan either (1) was new to the area or (2) had too few members to rate.

Network Adequacy

SB 760, 84th Legislature, Regular Session, 2015 directed HHSC to establish and implement a process for direct monitoring of a 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 Texas Uniform Managed Care Contract 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.

Network adequacy initiatives include the Appointment Availability (AA) Study and the Primary Care Provider (PCP) Referral Study. The AA study is a series of sub-studies completed by the state's EQRO. The AA Study is comprised of four reports in the areas of prenatal, primary care, vision, and behavioral health. MCO performance is assessed by determining provider compliance with contract standards for appointment availability and wait time for an appointment. The PCP Referral Study is conducted annually and examines PCP experiences when referring Medicaid managed care and CHIP beneficiaries for specialty care.

Pay-for-Quality

Senate Bill 7, 83rd Legislature, Regular Session, 2013, focused on the use of quality-based outcome and process measures in quality-based payment systems by measuring PPEs, rewarding use of evidence-based practices, and promoting health care coordination, collaboration, and efficacy. To comply with this legislative direction HHSC implemented redesigned medical and dental Pay-for-Quality (P4Q) programs in January 2018. The P4Q programs create financial incentives and disincentives based on health plan performance on a set of quality measures. Contracted health plans are at-risk.

Another key initiative to improve Medicaid and CHIP quality of care is the medical P4Q program. Under medical P4Q, 3 percent of the MCOs' capitation is at-risk based on their performance on a series of key quality metrics that focus on prevention, chronic disease management, behavioral health, and maternal and infant health. MCOs are evaluated on their own year to year performance and compared to their peers at the state and national level.

Medical P4Q has led to marked improvement in quality. In comparing 2017 to 2018 program rates, all at-risk measures in all programs (i.e., STAR, CHIP and STAR+PLUS) showed improvement except for potentially preventable emergency room visits (PPVs) in STAR and CHIP. For example, rates for counseling for nutrition and physical activity increased by 8 percent in CHIP. In addition, rates for six or more well child visits in the first 15 months increased by 4 percent in STAR. Additional detail regarding each program's results are provided below.

2018 Medical P4Q Results

Overall, MCOs performed well. FirstCare (CHIP, STAR) was the only MCO to have a net recoupment across all programs (\$3.7 million). While Molina had a recoupment for CHIP, gains in STAR more than offset the recoupment resulting in a net distribution overall. The sum of amounts recouped is apportioned to successful MCOs relative to the percentage they were eligible to earn. There are no amounts to be recouped in STAR+PLUS, so no dollars earned. No money is available for the bonus pool in any program.

In the tables that follow, the columns labeled “Potential” are based on each MCO’s performance and reflect the maximum amount they could have earned or lost. The columns labeled “Actual” reflect the actual financial impact to each MCO, based on their performance and amounts available for payments. Attachment 2 presents each MCO’s performance per measure and program, in summary and detail.

CHIP

In CHIP, only Molina and FirstCare are subject to recoupment out of 15 MCOs. Table 1 presents the total amounts earned or lost per MCO and Figure 3 summarizes CHIP MCOs’ performance against benchmarks and performance against self on the at-risk P4Q measures.

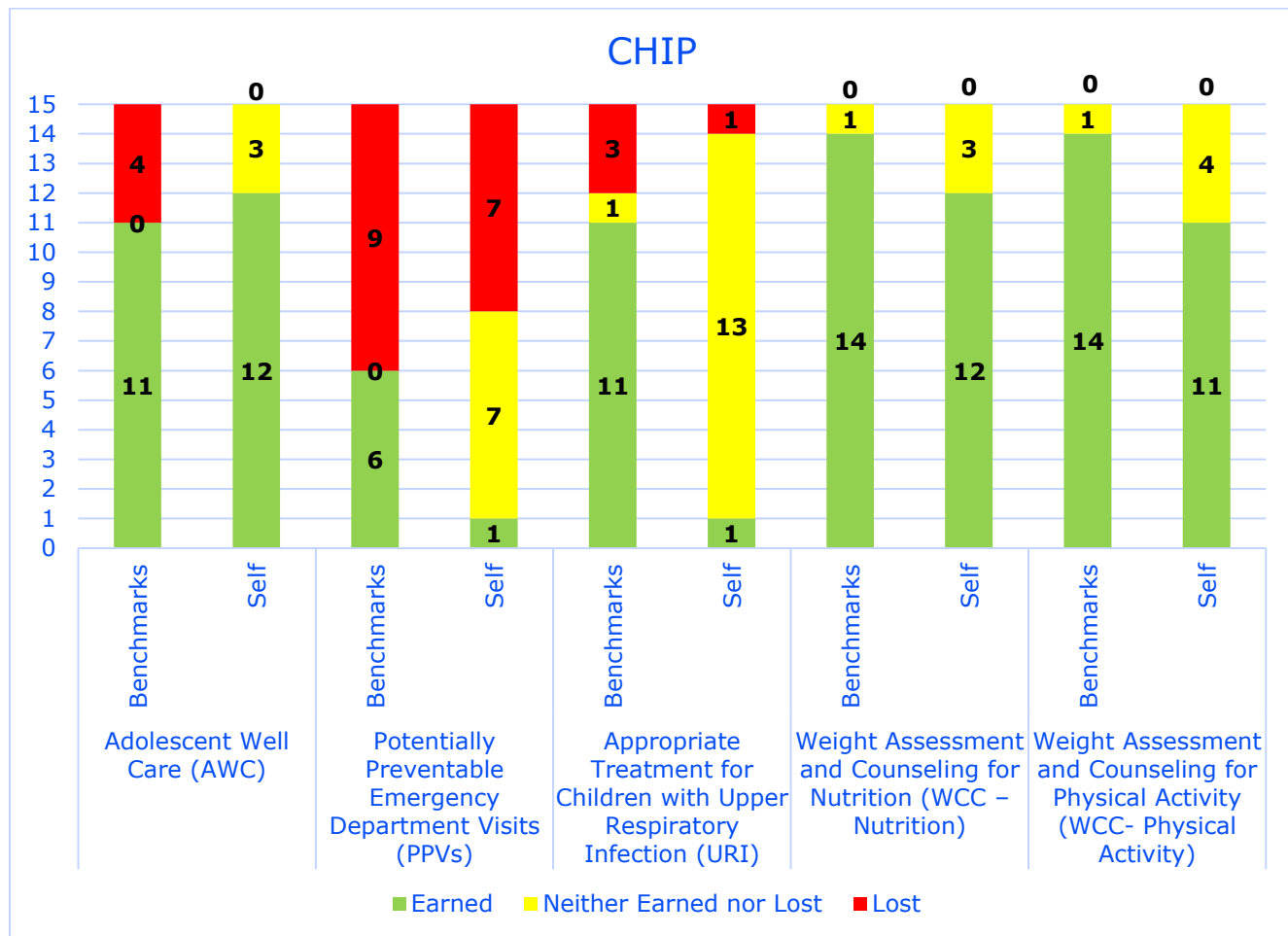
Table 1: CHIP Capitation Earned/Recouped by MCOⁱ

MCO	2018 Capitation	Potential Percent Earned/ Recouped	Potential Dollars Earned/ Recouped	Actual Percent Earned/ Recouped	Actual Dollars Earned/ Recouped
Aetna Better Health	\$12,638,456	0.47	\$59,243	0.005	\$629
Amerigroup	\$98,358,993	1.41	\$1,383,173	0.015	\$14,686
Blue Cross Blue Shield of Texas	\$8,600,747	0.47	\$40,316	0.005	\$428
Community First Health Plans	\$25,499,485	0.28	\$71,717	0.003	\$761
Community Health Choice	\$49,189,346	1.88	\$922,300	0.020	\$9,793
Cook Children's Health Plan	\$35,367,648	1.69	\$596,829	0.018	\$6,337
Dell/Seton Health Plan	\$12,322,433	1.69	\$207,941	0.018	\$2,208
Driscoll Health Plan	\$16,056,881	1.31	\$210,747	0.014	\$2,238
El Paso First Health Plans, Inc	\$12,280,560	0.94	\$115,130	0.010	\$1,222
FirstCare Health Plans	\$7,093,344	-0.28	(\$19,950)	-0.281	(\$19,950)
Molina Healthcare of Texas, Inc.	\$31,833,836	-0.19	(\$59,688)	-0.188	(\$59,688)
Parkland Community Health Plan	\$37,646,219	1.31	\$494,107	0.014	\$5,246
Superior HealthPlan	\$139,907,396	0.47	\$655,816	0.005	\$6,963
Texas Children's Health Plan	\$122,286,440	2.06	\$2,522,158	0.022	\$26,779

MCO	2018 Capitation	Potential Percent Earned/ Recouped	Potential Dollars Earned/ Recouped	Actual Percent Earned/ Recouped	Actual Dollars Earned/ Recouped
UnitedHealthCare Community Plan	\$15,730,603	1.41	\$221,212	0.015	\$2,349
Total			\$7,421,050		\$0

- *Adolescent Well Care (AWC) and Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (WCC)* - CHIP MCOs generally performed well on these preventive care measures, with 11 or more earning money on both performance against self and benchmarks. No MCOs lost capitation for performance on the WCC for Nutrition and Physical Activity. For AWC, four MCOs (Aetna, BCBS, Community First, and Molina) lost capitation for performance against benchmarks.
- *Appropriate Treatment for Children with Upper Respiratory Infection (URI)* - This measure evaluates judicious use of antibiotics. While only one MCO (Cook Children's) improved enough to earn money on performance against self, 11 CHIP MCOs earned money on performance against benchmarks.
- *Potentially Preventable Emergency Department Visits (PPVs)* - CHIP MCOs were most challenged by PPVs. Nine MCOs lost capitation on performance against benchmarks and seven MCOs' performance declined five or more percent for a capitation loss on performance against self.

Figure 3: CHIP MCO Performance by Measure



STAR

In STAR, only FirstCare out of 16 MCOs is subject to recoupment. Table 2 shows the actual dollars earned or lost by each MCO. Figure 4 presents MCO performance against benchmarks and against self on STAR P4Q measures.

Table 2: STAR Capitation Earned/Recouped by MCOⁱⁱ

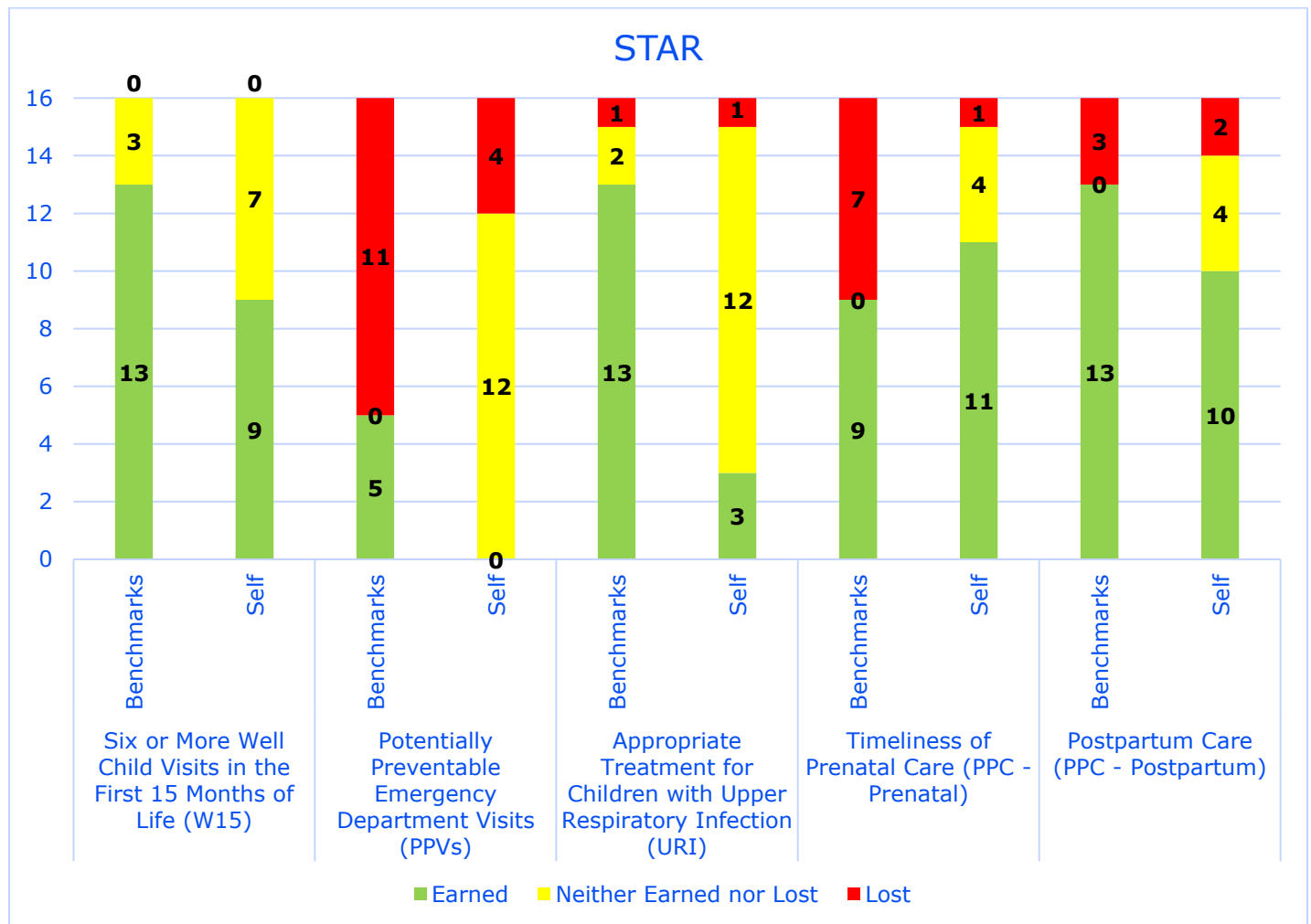
MCO	2018 Capitation	Potential Percent Earned/ Recouped	Potential Dollars Earned/ Recouped	Actual Percent Earned/ Recouped	Actual Dollars Earned/ Recouped
Aetna Better Health	\$208,462,504	1.03	\$2,149,770	0.047	\$97,683
Amerigroup	\$1,440,716,417	1.22	\$17,558,731	0.055	\$797,850
Blue Cross Blue Shield of Texas	\$77,513,430	0.75	\$581,351	0.034	\$26,416
Community First Health Plans	\$284,949,776	0.19	\$534,281	0.009	\$24,277
Community Health Choice	\$825,959,465	1.78	\$14,712,403	0.081	\$668,516
Cook Children's Health Plan	\$275,435,635	0.47	\$1,291,105	0.021	\$58,666
Dell/Seton Health Plan	\$45,050,796	1.41	\$633,527	0.064	\$28,787
Driscoll Health Plan	\$463,063,325	1.88	\$8,682,437	0.085	\$394,520
El Paso First Health Plans, Inc	\$172,171,647	0.84	\$1,452,698	0.038	\$66,009
FirstCare Health Plans	\$245,963,022	-1.50	(\$3,689,445)	-1.500	(\$3,689,445)
Molina Healthcare of Texas, Inc.	\$252,846,368	1.22	\$3,081,565	0.055	\$140,023
Parkland Community Health Plan	\$495,034,885	0.94	\$4,640,952	0.043	\$210,880
RightCare from Scott & White Health Plan	\$127,242,677	0.75	\$954,320	0.034	\$43,363
Superior HealthPlan	\$2,061,684,117	0.66	\$13,529,802	0.030	\$614,779

MCO	2018 Capitation	Potential Percent Earned/ Recouped	Potential Dollars Earned/ Recouped	Actual Percent Earned/ Recouped	Actual Dollars Earned/ Recouped
Texas Children's Health Plan	\$865,191,531	0.84	\$7,300,054	0.038	\$331,706
UnitedHealthCare Community Plan	\$485,064,936	0.84	\$4,092,735	0.038	\$185,969
Total			\$77,506,285		\$0

- *Well Child Visits in the First 15 Months of Life (W15)* - STAR MCOs generally performed well on ensuring infants receive the recommended number of well child visits, with more than half the MCOs earning money and no MCOs subject to recoupment for both performance against self and performance against benchmarks.
- *Prenatal and Postpartum Care (PPC)* - More than half the MCOs earned money for both performance against self and benchmarks on timeliness of prenatal care and postpartum care. Some MCOs lost capitation on these measures for performance against benchmarks, including seven MCOs on prenatal care and three on postpartum care. For performance against self, one MCO lost capitation on prenatal care (Texas Children's) and two MCOs (FirstCare and Scott & White) lost capitation on postpartum care.
- *URI* - MCOs generally performed well on the URI measure, with 13 MCOs earning capitation and only FirstCare losing capitation on performance against self and benchmarks.
- *PPVs* - Similar to CHIP, STAR MCOs were most challenged by PPVs, with 11 MCOs losing capitation on performance against benchmarks and four MCOs losing capitation on performance against self (El Paso, FirstCare⁴, Molina, and United). No MCO achieved the five or more percent improvement required to earn capitation on performance against self.

⁴ This may not reflect FirstCare's true performance due to their encounter data errors.

Figure 4: STAR MCO Performance by Measure



STAR+PLUS

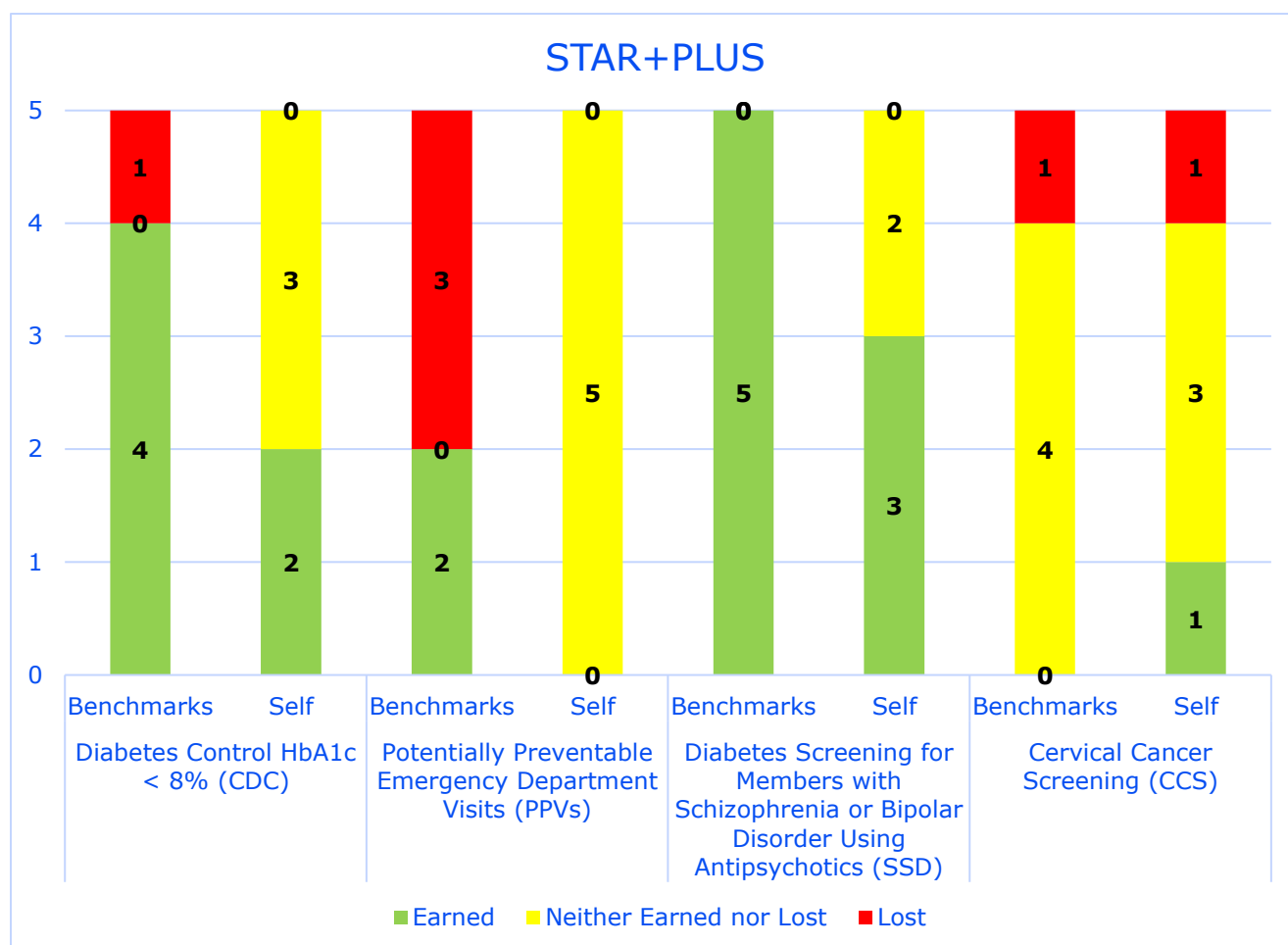
In STAR+PLUS, none of the five MCOs are subject to recoupment and no money is available to redistribute. Table 3 shows the actual dollars earned by each MCO. Figure 5 presents MCO performance against benchmarks and against self on STAR+PLUS P4Q measures. While MCOs may have lost capitation on one or more measures, it was offset by capitation earned on other measures resulting in net overall capitation earned.

Table 3: STAR+PLUS Capitation Earned/Recouped by MCOⁱⁱⁱ

MCO		2018 Capitation	Potential Percent Earned/ Recouped	Potential Dollars Earned/ Recouped	Actual Percent Earned/ Recouped	Actual Dollars Earned/ Recouped
Amerigroup		\$1,296,905,712	0.30	\$3,890,717	0.0	\$0
Cigna-HealthSpring		\$426,826,409	0.30	\$1,280,479	0.0	\$0
Molina Healthcare of Texas, Inc.		\$856,235,158	0.75	\$6,421,764	0.0	\$0
Superior HealthPlan		\$1,493,042,737	0.90	\$13,437,385	0.0	\$0
UnitedHealthCare Community Plan		\$1,287,229,942	0.45	\$5,792,535	0.0	\$0

- *Cervical Cancer Screening (CCS)* - For performance against self, STAR+PLUS MCOs did not lose capitation on any of the measures except CCS, with one MCO's rate (United) declining more than the five percent threshold for recoupment. One MCO also lost capitation for performance against benchmark for this measure.
- *Diabetes Screening for Members Using Antipsychotics (SSD)* - All MCOs earned capitation on performance against benchmarks for the measure SSD. Three MCOs also earned capitation on performance against self for this measure.
- *PPVs* - Similar to STAR and CHIP, STAR+PLUS MCOs were most challenged by PPVs: three MCOs (Amerigroup, Cigna, and Molina) lost capitation on performance against benchmarks and no MCO achieved the five or more percent improvement required to earn capitation on performance against self.
- *Diabetes Control (CDC)* - Only one MCO lost capitation on performance against benchmarks for the CDC measure (Superior). Two MCOs earned capitation on performance against self for this measure (Molina and Superior).

Figure 5: STAR+PLUS Performance by Measure



HHSC's focus on maternal and infant health through P4Q, PIPs and other initiatives have resulted in significant improvement in infant and maternal health outcomes. From 2008 to 2018, there was a 24 percent rate of improvement in children receiving six or more well child visits in the first 15 months of life; a 26 percent rate of improvement for adolescents receiving an annual well child visit; and, a 14 percent rate of improvement in timeliness of prenatal care.

The medical P4Q program serves as a catalyst for MCOs to pursue value-based payment (VBP) arrangements with providers to achieve required P4Q outcomes. The state uses the [Healthcare Payment Learning and Action Network \(HCP LAN\) Alternative Payment Model \(APM\) Framework](http://hcp-lan.org/workproducts/apm-framework-onepager.pdf)⁵ to guide this effort. APMs incentivize high-quality and cost-efficient care by linking healthcare payments to measures of

⁵ LAN Framework available at: <http://hcp-lan.org/workproducts/apm-framework-onepager.pdf>

value. The LAN provides a menu of payment models from which MCOs can choose to develop APM contracts with their providers.

Medicaid Value-Based Enrollment

Pursuant to Texas Government Code §533.00511, HHS is implementing an incentive program that automatically enrolls a greater percentage of Medicaid recipients who have not selected a managed care plan into a plan based on quality of care, efficiency and effectiveness of service provision, and performance. The state's new autoenrollment method uses metrics aligned with the Triple Aim to promote value-based healthcare that achieves better care at lower costs.⁶

Alternative Payment Model (APM) Requirements

The P4Q and value-based enrollment programs serve as catalysts for managed care to pursue value-based payment arrangements with providers to achieve improved outcomes. APMs are payment arrangements in which some portion of an MCO's reimbursement to a provider is linked to measures of quality and outcomes. HHSC uses the Healthcare Payment Learning and Action Network (HCP LAN) Alternative Payment Model (APM) Framework⁷ to help guide this effort. This framework provides a menu of payment models from which MCOs could choose to develop alternative payment contracts with their providers. Moving from one category to the next adds a level of risk to the payment model.

Under this initiative, HHS created contractual targets for MCOs to connect provider payments to value using APMs. The APM percentage targets increase over time. If an MCO fails to meet the APM targets or certain allowed exceptions for high performing plans, the MCO must submit an action plan, and HHSC may impose graduated contractual remedies, including liquidated damages.

The full range of contractual requirements for MCOs to promote VBP include:

- The establishment of MCO APM targets: Overall and risk-based APM contractual targets were established for MCO expenditures on VBP contracts with providers relative to all medical and pharmacy expenses. The targets start at 25 percent of provider payments in any type of APM and 10 percent of provider payments in risk-based APMs for calendar year 2018. These

⁶ The [Triple Aim](#) is a framework developed by the Institute for Healthcare Improvement that describes an approach to optimizing health system performance by improving the patient experience, improving population health, and reducing costs. These dimensions are also reflected in the Centers for Medicare and Medicaid Services' [value-based programs guidance](#).

⁷ LAN Framework available at: <http://hcp-lan.org/workproducts/apm-framework-onepager.pdf>

targets increase over four years up to 50 percent overall and 25 percent risk-based by calendar year 2021.

- Requirements for MCOs to establish and maintain data sharing processes with providers.
- Requirements for MCOs to adequately resource this activity: MCOs and DMOs must dedicate sufficient resources for provider outreach and negotiation, provide assistance with data and/or report interpretation and initiate collaborative activities to support VBP and provider improvement.
- Requirements for MCOs to have a process in place to evaluate APM models: MCOs are required to evaluate the impact of APM models on utilization, quality, cost and return on investment.

HHSC collects reports on their APM initiatives on an annual basis. In general, most of the reported APM initiatives involve primary care providers, but MCOs also have reported APMs with specialists (including obstetricians/ gynecologists), behavioral health providers, hospitals, nursing facilities and long-term services and supports providers.

In 2018, the first target year for HHSC's Medicaid MCO APM targets, MCOs reported that 40 percent of their payments to providers were in an APM, with about 22 percent in a risk-based APM. As a whole, the Texas Medicaid and CHIP programs performed at or above contractually-required thresholds and national goals in 2018.

Performance Improvement Projects

The Balanced Budget Act of 1997 requires all states with Medicaid managed care to ensure MCOs conduct performance improvement projects (PIPs). 42 CFR 438.330 requires projects be designed to achieve, through ongoing measurements and interventions, significant improvement, sustained over time, in clinical care and nonclinical care areas that have a favorable effect on health outcomes and enrollee satisfaction. Health plans conduct PIPs to examine and improve areas of service or care identified by HHSC in consultation with Texas's EQRO as needing improvement. Topics are selected based on health plan performance on quality measures and member surveys. HHSC requires each health plan to conduct two PIPs per program. One PIP per health plan must be a collaborative with another health plan or a Delivery System Reform Incentive Payment project, or a community-based organization.

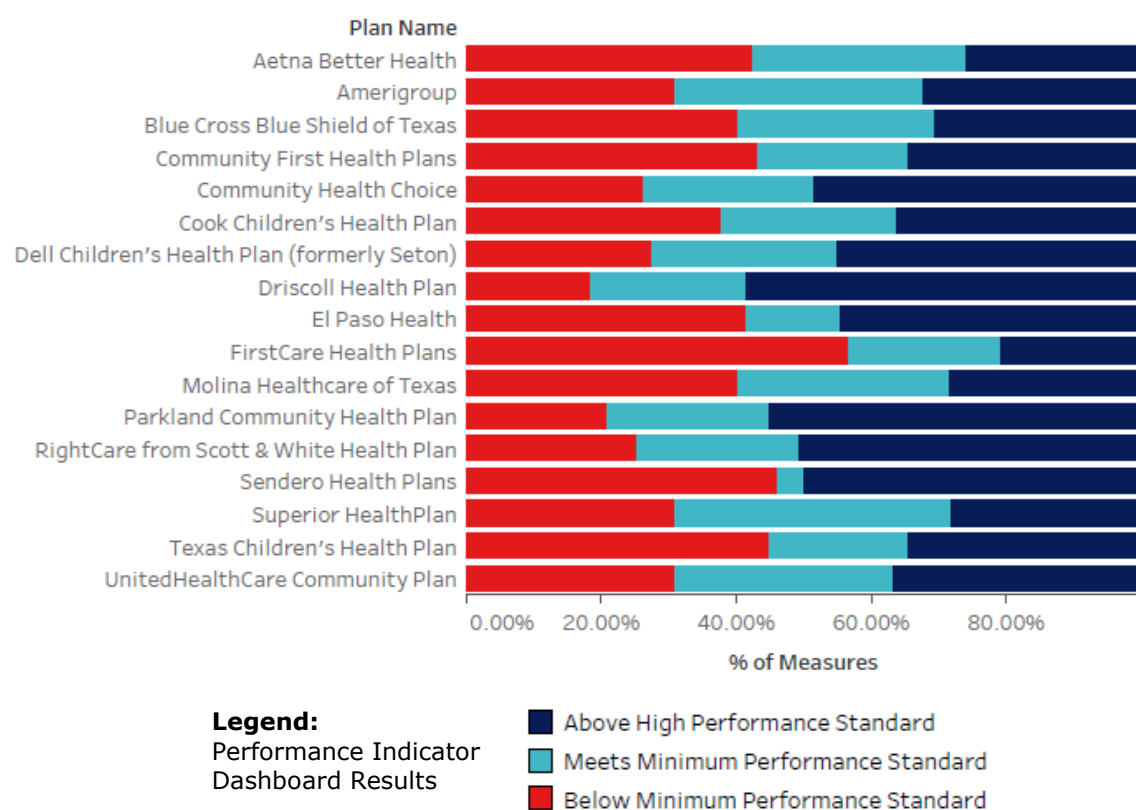
Performance Indicator Dashboards

The Performance Indicator Dashboards include sets of measures per program that identify key aspects of performance to support MCO accountability. HHSC expects Medicaid and CHIP MCOs to meet or surpass the HHSC-defined minimum standard

on more than two-thirds of the measures on the Performance Indicator Dashboard. The minimum standard is the program rate or the national average, whichever is lower, from two years prior to the measurement year.

Beginning with the measurement year 2018, an MCO whose per program performance is below the minimum standard on more than 33 percent of the measures on the dashboard is subject to remedies under the contract, such as placement on a corrective action plan (CAP). For more information, please see Chapter 10.1.14 of the Uniform Managed Care Manual.⁸ Calendar year 2018 Performance Indicator Dashboard results for STAR, STAR+PLUS and CHIP are presented in Figures 6, 7 and 8, below, and added detail for these and other programs is available on the THLC portal.

Figure 6. STAR Performance Indicator Dashboard Results by MCO, CY 2018



⁸ <https://hhs.texas.gov/sites/default/files/documents/laws-regulations/handbooks/umcm/10-1-14.pdf>

Figure 7. STAR+PLUS Performance Indicator Dashboard Results by MCO, CY 2018

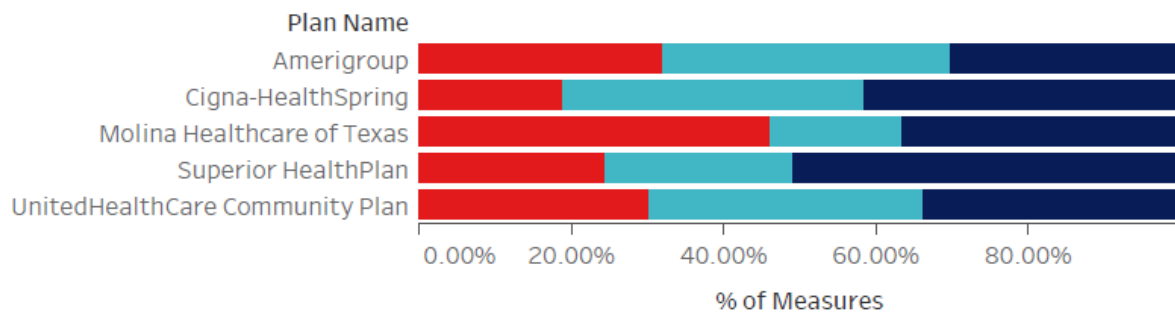
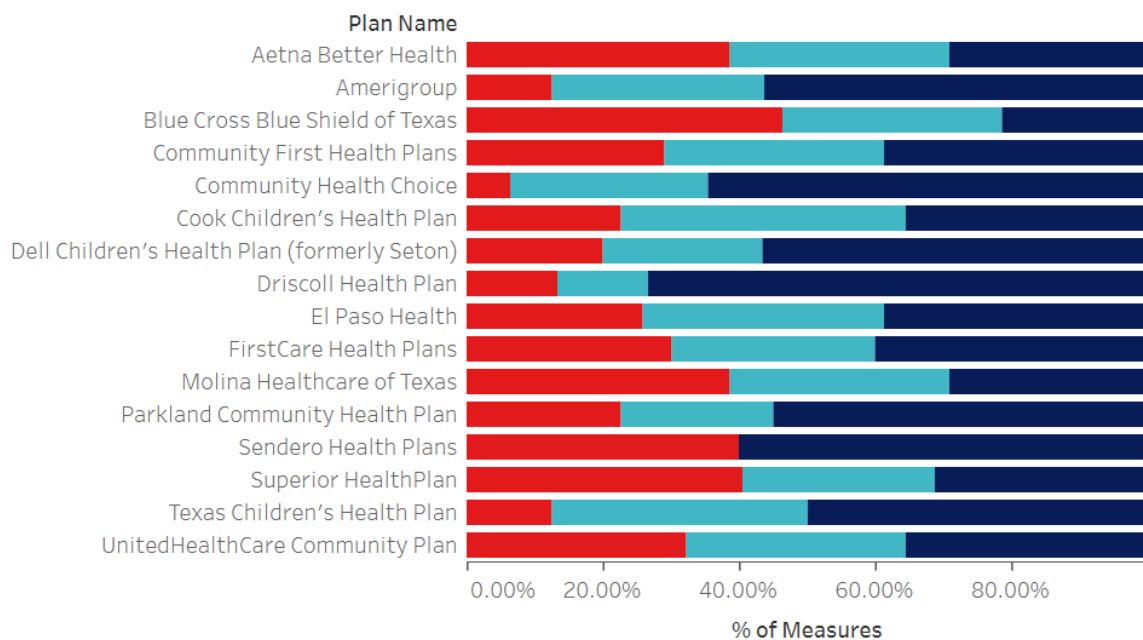


Figure 8. CHIP Performance Indicator Dashboard Results by MCO, CY 2018



The Performance Indicator Dashboard measure sets are comprised of HEDIS and CAHPS survey measures and vary per program. The Dashboard for CHIP includes over 40 measures and sub-measures, STAR has over 60, and STAR+PLUS has over 50. For example, Figure 9, below, presents the performance for one STAR+PLUS MCO (Cigna HealthSpring) on each measure and sub-measure.

Figure 9. Example: STAR+PLUS MCO Performance, Cigna HealthSpring, CY 2018

2018 Performance Summary: HealthSpring
STAR+PLUS Program



■ Above High Performance Standard (41.51%)
■ Meets Minimum Performance Standard (39.62%)
■ Below Minimum Performance Standard (18.87%)

Performance	Measure Description	Minimum Standard	High Standard	Plan Rate	Numerator	Denominator
Above High Performance Standard	■ CDC - HbA1c Control (<8%)	46.00	50.00	50.36	207	411
	■ PQI - Diabetes Short-term Complications Admission Rate (PQI 1)	37.00	34.00	28.24	67	237240
	■ PQI - Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (PQI 5)	166.00	157.00	134.58	206	153074
	■ PQI - Congestive Heart Failure (CHF) Admission Rate (PQI 8)	127.00	120.00	117.60	279	237240
	■ PQI - Bacterial Pneumonia Admission Rate (PQI 11)	50.00	47.00	46.79	111	237240
	■ PQI - Urinary Tract Infection Admission Rate (PQI 12)	40.00	37.00	29.51	70	237240
	■ PQI - Uncontrolled Diabetes Admission Rate (PQI 14)	20.00	18.00	14.75	35	237240
	■ PQI - Asthma in Younger Adults Admission Rate (PQI 15)	15.00	14.00	3.56	3	84166
	■ PQI - Rate of Lower-extremity Amputation among Patients with Diabetes (PQI 16)	15.00	14.00	13.49	32	237240
	■ PCE - Systemic Corticosteroids	68.00	72.00	73.50	513	698
	■ SPC - Total Adherence	56.00	61.00	63.48	372	586
	■ SPD - Received Statin Therapy	62.00	63.00	66.27	1377	2078
	■ PPE - Potentially Preventable Readmissions (PPR)	1.00	0.90	0.85	1024.84	1206.39
	■ SVY-Adult - % Good Access to Urgent Care	62.00	65.00	65.95		
	■ SVY-Adult - % Good Access to Specialist Appointment	54.00	55.00	60.96		
	■ SVY-Adult - % Good Access to Routine Care	56.00	61.00	61.91		
	■ SVY-Adult - % Good Access to Special Therapies	33.00	35.00	52.06		
	■ SVY-Adult - % Good Access to Behavioral Health Treatment or Counseling	52.00	54.00	56.85		
	■ SVY-Smoke - % Advised to Quit Smoking	39.00	48.00	49.41		
	■ PQI - Chronic PQI Composite Rate (PQI 92)	345.00	327.00	312.76	742	237240
	■ HVL - All Ages	67.00	70.00	71.10	155	218
	■ CDS - Non-HCBS Program Primary Home Care	2.50	2.60	4.31	28	650
Meets Minimum Performance Standard	■ AAB - Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	24.00	29.00	26.10	113	433
	■ ABA - Adult BMI Assessment	80.00	86.00	85.40	351	411
	■ AMM - Effective Acute Phase Treatment	47.00	52.00	50.54	375	742
	■ AMM - Effective Continuation Phase Treatment	33.00	36.00	33.42	248	742
	■ CCS - Cervical Cancer Screening	42.00	62.00	44.77	184	411
	■ CDC - Eye Exam	46.00	55.00	51.50	2059	3998
	■ MMA - Total Age 5 to 64 75% Covered	33.00	50.00	47.23	128	271
	■ PQI - Hypertension Admission Rate (PQI 7)	13.00	12.00	12.22	29	237240
	■ PCE - Bronchodilators	83.00	86.00	83.95	586	698
	■ SAA - 80% Coverage	57.00	61.00	60.02	764	1273
	■ SMD - Diabetes Monitoring for People with Diabetes and Schizophrenia	70.00	73.00	70.84	277	391
	■ SSD - Diabetes Screening	80.00	83.00	82.03	1520	1853
	■ SPC - Total Statin Therapy	73.00	76.00	75.42	586	777
	■ SPD - Statin Adherence	53.00	60.00	59.40	818	1377
	■ PPE - Potentially Preventable Admissions (PPA)	1.00	0.95	0.96	1820.55	1900.82
	■ PPE - Potentially Preventable Emergency Department Visits (PPV)	1.00	0.90	1.00	4743.48	4729.45
	■ SVY-Adult - % Good Access to Service Coordination	52.00	54.00	52.74		
	■ SVY-Adult - % Rating Personal Doctor a "9" or "10"	66.00	69.00	67.79		
	■ SVY-Adult - % Rating Their Health Plan a "9" or "10"	57.00	61.00	60.09		
	■ PQI - Diabetes PQI Composite Rate (PQI 93)	96.00	91.00	94.84	225	237240
	■ SVY-Adult - How Well Doctors Communicate Composite	75.00	79.00	78.58		
Below Minimum Performance Standard	■ CDC - Monitoring for Nephropathy	90.00	92.00	89.92	3595	3998
	■ CDC - HbA1c Testing	87.00	87.00	86.37	355	411
	■ CHL - Total	44.00	57.00	39.77	70	176
	■ PPC - Timeliness of Prenatal Care	63.00	84.00	55.05	60	109
	■ PPC - Postpartum Care	40.00	64.00	33.03	36	109
	■ AMR - Total 5 to 64 Ratios >= 50%	57.00	62.00	52.71	214	406
	■ PQI - Diabetes Long-term Complications Admission Rate (PQI 3)	44.00	42.00	45.95	109	237240
	■ SMC - Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia	78.00	82.00	69.77	30	43
	■ PPE - Potentially Preventable Complications (PPC)	1.00	0.90	1.04	145.16	139.13
	■ CDS - HCBS Personal Attendant Services	6.40	6.70	3.25	1400	43057

Appendix E. Public Notice

Request to Waive: 42 CFR § 431.416(g)

The state's health care system is experiencing significant pressure and uncertainty as Texas continues to respond to the Public Health Emergency. Therefore, this application seeks to utilize the authority under § 431.416(g) (including waiver of public notice procedures), and Texas requests that CMS grant approval of this fast track extension as soon as possible. Approval of this *fast track* extension will sustain the achievements of the demonstration and support the needs of beneficiaries and Texans.

Texas Medicaid has sought to be timely in this application request as our providers across Texas continue to face challenges daily. Federal approval of this "fast track" extension of five years will stabilize our Medicaid delivery system during this Public Health Emergency. Texas Medicaid remains committed to achieving the goals set forward and agreed to with the Centers for Medicare and Medicaid Services under our current Special Terms and Conditions (STCs).

Post-award Public Input Process Required by 42 CFR §431.420(c)

HHSC hosted a public forum via webinar on June 22, 2020 to provide the public with updates on the Texas Healthcare Transformation and Quality Improvement Program (THTQIP) 1115 waiver. The last public in person forum was held on June 24, 2019. The date, time, and location of the public forums were published on HHSC's website 30 days in advance of the meetings.

During the June 2020 public forum the public was provided with an update on the following Transformation waiver topics: Health Information Technology (IT) Strategic Plan, Delivery System Reform Incentive Payment program (DSRIP), Uncompensated Care, and Nursing Home Quality Incentive Payment Program. Links to the 1115 DY8 annual report and COVID-19 resource pages was also provided to the public. Public comment was also received and documented at this meeting. Comments received related to identifying external entities involved in the Health IT strategies, the process for creating new Medicaid benefits or programs, DSRIP operations and extension of DSRIP program, Value Based Purchasing, Uncompensated Care pool payments, and the potential to request an extension in light of COVID-19 as some other states are also doing. Requests for the PowerPoint presentation were received from some stakeholders and the slide deck was provided to those individuals electronically. During the forum, HHSC responded to comments and clarifying questions received.

Summary of Public Notice

In accordance with federal public notice requirements for an 1115 extension, Texas will hold 2 public meetings: a public hearing on December 7, 2020 and a meeting of the HHSC Executive Council on December 8, 2020. Given the current concerns regarding in-person meetings during the public health emergency, both meetings will be held virtually. The public will be able to provide public comment in both meetings and submit written comments by December 27, 2020. Comments will be summarized and included below. Additionally, Texas allowed for a 30 day public comment period and notice of the extension was published in the Texas Register on November 27, 2020. Texas invited the federally-recognized tribes in Texas to a call to discuss the extension and provided them with written notice on November 27, 2020. The application packet was posted November 27, 2020, on the Texas Health and Human Services Commission website at <https://hhs.texas.gov/laws-regulations/policies-rules/waivers/waiver-renewal>. The documents were made accessible and requests for copies were sent to TX_Medicaid_Waivers@hhsc.state.tx.us.

ⁱ Percentages have been rounded to fit this table.

ⁱⁱ Percentages have been rounded to fit this table.

ⁱⁱⁱ Percentages have been rounded to fit this table.

Attachment M Historical Demonstration Information

The Texas Legislature, through the 2012-2013 General Appropriations Act and Senate Bill 7, instructed the Texas Health and Human Services Commission (HHSC) to expand its use of prepaid Medicaid managed care to achieve program savings, while also preserving locally funded supplemental payments to hospitals. The State of Texas submitted a section 1115 Demonstration proposal to CMS in July 2011 to expand risk-based managed care statewide consistent with the existing STAR section 1915(b) and STAR+PLUS section 1915(b)/(c) waiver programs, and thereby replace existing Primary Care Case Management (PCCM) or fee-for service (FFS) delivery systems. The state sought a section 1115 Demonstration as the vehicle to both expand the managed care delivery system, and to operate a funding pool, supported by managed care savings and diverted supplemental payments, to reimburse providers for uncompensated care costs and to provide incentive payments to participating hospitals that implement and operate delivery system reforms.

STAR and STAR+PLUS Programs

STAR is the primary managed care program providing acute care services to low-income families, children, and pregnant women. STAR+PLUS provides acute and long-term service and supports to older adults and adults with disabilities.

The STAR and STAR+PLUS managed care programs cover most beneficiaries statewide through three geographic expansions. The first expansion occurred on September 1, 2011, under existing section 1915(b) and section 1915(c) authorities; the second expansion occurred in March 2012, under section 1115 authority; and a third expansion of STAR+PLUS occurred on September 1, 2014 under section 1115 authority as a result of an amendment to the demonstration.

Effective March 1, 2012, the STAR program expanded statewide to include the three Medicaid rural service areas (MRSAs). Following this expansion, Medicaid eligible adults who were not enrolled in Medicare, met the level of care for Home and Community Based Services (HCBS), and resided in the MRSA, had to enroll in a STAR managed care organization (MCO); children meeting these criteria could voluntarily enroll in STAR. STAR MCOs in the MRSA provided acute care services, and will coordinate acute and long-term care services with section 1915(c) waivers, such as the Community Based Alternatives Program and the Community Living Assistance and Support Services Program, that exist outside of this section 1115 demonstration.

Effective September 1, 2014, STAR+PLUS expanded to the MRSA and Medicaid eligible adults over age 21 meeting STAR+PLUS eligibility criteria and residing in the MRSA were required to enroll in STAR+PLUS. Clients under 21 who meet the criteria may be able to voluntarily enroll in STAR+PLUS effective September 1, 2014, and until the implementation of STAR Kids on November 1, 2016.

STAR and STAR+PLUS beneficiaries receive enhanced behavioral health services consistent with the requirements of the Mental Health Parity Act. As of March 2012, STAR+PLUS beneficiaries began receiving inpatient services through the contracted managed care organizations (MCOs). STAR+PLUS MCOs also provide Medicaid wrap services for outpatient drugs and biological products to dual eligible beneficiaries for whom the State has financial payment obligations. Additionally, Medicaid beneficiaries under the age of 21 received the full array of primary and preventive dental services required under the State plan, through contracting pre-paid dental plans.

Effective March 6, 2014, cognitive rehabilitation therapy services (CRT) will be provided through the STAR+PLUS HCBS program.

Effective September 1, 2014, the following additional benefits are provided:

- acute care services for beneficiaries receiving services through an intermediate care
- facility for individuals with intellectual disabilities or a related condition (ICF/IID), or an ICF/IID waiver are provided through STAR+PLUS; employment assistance and supported employment are provided through the STAR+PLUS home and community-based services (HCBS) program;
- mental health rehabilitation services will be provided via managed care; and
- mental health targeted case management for members who have chronic mental illness
- are provided via managed care.
- Effective March 1, 2015, nursing facility services are a covered benefit under
- STAR+PLUS managed care for adults over the age of 21,

Note: The NorthSTAR waiver in the Dallas service delivery area did not change as a result of the September 1, 2014 and the March 1, 2015 STAR+PLUS expansions.

Beginning January 1, 2014, children ages 6 - 18 with family incomes between 100 - 133 percent of the federal poverty level were transferred from the state's separate Children's Health Insurance Program (CHIP) to Medicaid in accordance with section 1902(a)(10)(A)(i)(VII) of the Act. Under the demonstration these targeted low-income children (M-CHIP) are required to enroll in managed care. For the purposes of eligibility and benefits, these children are considered a mandatory Medicaid

group for poverty-level related children and title XIX eligibility and benefit requirements apply. The state may claim enhanced match from the state's title XXI allotment for these M-CHIP children in accordance with title XXI funding requirements and regulations. All references to CHIP and title XXI in this document apply to these M-CHIP children only. Other requirements of title XXI (for separate CHIP programs) are not applicable to this demonstration.

STAR Kids Program

Effective November 1, 2016, the following four groups of Medicaid clients from birth through age 20 will become mandatory populations through a new program under the 1115 waiver - the STAR Kids Medicaid managed care program.

1. Clients receiving SSI and disability-related (including SSI-related) Medicaid who do not participate in a 1915(c) waiver: these children will receive their state plan acute care services and their state plan long term services and supports (LTSS) through STAR Kids.
2. Clients receiving HCBS services through the MDCP 1915(c) waiver: these children and young adults will receive the full range of state plan acute care services and state plan LTSS as well as MDCP 1915(c) HCBS waiver services through STAR Kids. The MDCP waiver will continue but will be operated by HHSC effective November 1, 2016. This is to ensure that options for MDCP services provided under the 1915(c) authority remain available to individuals in STAR Health, which services children and young adults in the conservatorship of the Department of Family and Protective Services.
3. Clients receiving HCBS through the following 1915(c) waivers -- CLASS, DBMD, HCS, TxHmL, and YES:
 - a. Clients enrolled in CLASS, DBMD, HCS and TxHmL receive their 1915(c) LTSS and 1915(k) (Community First Choice) services through their current waiver provider, which are contracted with DADS. These clients receive all other state plan LTSS and acute care services through STAR Kids.
 - b. Clients enrolled in the YES waiver receive their 1915(c) LTSS through their current HCBS delivery system, which is operated by DSHS. These clients receive all state plan LTSS, including 1915(k) services, as well as all acute care services through STAR Kids.
4. Clients receiving SSI and disability-related (including SSI-related) Medicaid who reside in a community-based intermediate care facility for individuals with intellectual disabilities or a nursing facility: clients will continue to receive all long-term services and supports provided by the facility through the current delivery system. All non-facility related services will be paid through STAR Kids.

Individuals in all four categories will receive a continuum of services, including acute care, behavioral health, and state plan long-term services and supports. STAR Kids managed care organizations will provide service coordination for all members, including coordination with non-capitated HCBS services that exist outside of this section 1115 demonstration. Indian children and young adults who are members of federally-recognized tribes and have SSI or disability-related (including SSI-related) Medicaid or who are served through one of the 1915(c) waivers, will be able to voluntarily enroll in STAR Kids or opt to remain in traditional fee-for service Medicaid.

Effective January 1, 2017, the NorthSTAR program (currently operated in Dallas, Ellis, Collin, Hunt, Navarro, Rockwall and Kaufman counties) will discontinue. All Medicaid behavioral health services previously provided to Medicaid-eligible individuals by NorthSTAR will be provided through the 1115 Medicaid STAR, STAR+PLUS and STAR Kids MCOs.^{1,2}

Savings generated by the expansion of managed care and diverted supplemental payments will enable the state to maintain budget neutrality, while establishing two funding pools supported by Federal matching funds, to provide payments for uncompensated care costs and delivery system reforms undertaken by participating hospitals and providers. These payments are intended to help providers prepare for new coverage demands in 2014 scheduled to take place under current Federal law. The state proposes that the percentage of funding for uncompensated care will decrease as the coverage reforms of the Patient Protection and Affordable Care Act are implemented, and the percentage of funding for delivery system improvement will correspondingly increase.

Texas plans to work with private and public hospitals to create Regional Healthcare Partnerships (RHPs) that are anchored financially by public hospitals and/or local government entities, that will collaborate with participating providers to identify performance areas for improvement that may align with the following four broad categories: (1) infrastructure development, (2) program innovation and redesign, (3) quality improvements, and (4) population focused improvements. The non-Federal share of funding pool expenditures will be largely financed by state and local intergovernmental transfers (IGTs). Texas will continue to work with CMS in engaging provider stakeholders and developing a sustainable framework for the

¹ For members enrolled in STAR Kids, these services will be available through MCOs beginning November 1, 2016.

² As with all other service areas, Mental Health Targeted Case Management and Mental Health Rehabilitative services will be paid through FFS for individuals who receive Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOOMMI) funded services or PASSAR services. All wrap-around services and crossover claims will be paid via FFS for dually eligible individuals not enrolled in the duals demonstration.

RHPs. It is anticipated, if all deliverables identified in this demonstration's STCs are satisfied, incentive payments for planning will begin in the second half of the first Demonstration Year (DY).

Through this demonstration, the state aims to:

- Expand risk-based managed care statewide;
- Support the development and maintenance of a coordinated care delivery system;
- Improve outcomes while containing cost growth;
- Protect and leverage financing to improve and prepare the health care infrastructure to serve a newly insured population; and
- Transition to quality-based payment systems across managed care and hospitals.

In May of 2016, CMS granted the demonstration a 15 month temporary extension to allow additional time for DSRIP projects to demonstrate their results. The extension also allows Texas to study its Medicaid payment and financing policies and providers' uncompensated care burdens, and prepare for the next stage in delivery system reform.

Effective September 1, 2017, the following populations are mandatory for managed care. Those who meet the STAR Kids eligibility criteria are mandatory to enroll in STAR Kids, and the remainder are mandatory to enroll in STAR.

- Clients enrolled in the Department for Family and Protective Services (DFPS)
- Adoption Assistance program.
- Clients enrolled in the DFPS Permanency Care Assistance program.

Effective September 1, 2017, women participating in the Medicaid for Breast and Cervical Cancer will transition to STAR+PLUS Medicaid managed care.

<The following paragraphs were added>

Delivery System Reform Incentive Payment Program (DSRIP) evolved from project-level reporting to provider-level outcome reporting to measure the continued transformation of the Texas healthcare system from DY1-6 to DY7-10. DSRIP providers report on required categories at the provider system level, rather than the project level. Regional Healthcare Partnerships (RHP) updated their RHP Plans during Q1, which HHSC reviewed and approved. This included providers updating their outcome measures and activities for reporting during DY9-10.

Providers continued to report performance achievement of DY7 Category C measures in Q1. DSRIP continues to provide technical assistance to correct reported baselines and performance.

Program Description, Goals, and Objectives to be Implemented or Extended Under the Demonstration Project

The state is not requesting changes to the existing goals and objectives of the demonstration through this extension request. The state has made strong strides toward achieving the goals and objectives over the demonstration years; however, the state continues to work to expand risk-based managed care to new populations and services; support the development and maintenance of a coordinated care delivery system; improve outcomes while containing cost growth; and transition to quality-based payment systems across managed care providers. Progress towards the demonstration goals and objectives have been impacted by several factors, such as the public health emergency and managed care procurements, such that more time is needed to fully and successfully achieve them as anticipated.

The Texas Medicaid program has been transitioning to a value-based model for some time now. For over 25 years, the state has gradually moved care delivered through Medicaid away from traditional fee-for-service reimbursement to a managed care system where private health plans are financially responsible for controlling costs and improving quality. The transition to managed care has been supported by system initiatives to improve quality and efficiency in state health care services. Chief among these is the state's 1115 Healthcare Transformation and Quality Improvement Program Waiver, which includes incentive payments to hospitals and other providers for strategies to enhance access to health care, increase the quality and cost-effectiveness of care, and improve the health of patients and families through the Delivery System Reform Incentive Payment (DSRIP) program. DSRIP has been an effective incubator allowing the state to establish consensus priorities for health system improvement and test how flexible payment models can support patient centered care and clinical innovation. Since 2012, DSRIP providers have earned over \$19 billion all funds (federal funds matched with intergovernmental transfer funds).

The DSRIP program structure, beginning in FFY 2018, evolved from a focus on projects and project-level reporting to targeted measure bundles (or measures, depending on performing provider type). Among the allowable menu of measure bundles and measures, State priority measure bundle areas for hospitals and physicians include:

Chronic care: diabetes and heart disease care, pediatric asthma management

Primary care and prevention

Pediatric primary care

Maternal care

Integrated behavioral health/primary care

Chronic non-malignant pain management

Behavioral health and appropriate utilization

Other significant initiatives for increasing value in state health care include: the MCO Pay for Quality Program (P4Q); Program Improvement Projects (PIPs), which focus on improving quality across the managed care system; Hospital Quality Based Payment Program for Potentially Preventable Readmissions and Complications to incentivize quality and efficiency among hospitals; and Quality Incentive Payment Program (QIPP) to promote patient safety in nursing homes.

Finally, MCO Value-Based Contracting with Providers seeks to facilitate and encourage the development of alternative payment and flexible practice approaches between MCOs and their providers. Under this initiative, HHS created contractual targets for MCOs to connect provider payments to value using APMs, starting in calendar year 2018. The APM percentage targets increase over time. If an MCO fails to meet the APM targets or certain allowed exceptions for high performing plans, the MCO must submit an action plan, and HHSC may impose graduated contractual remedies, including liquidated damages.

DSRIP Transition Plan Update

As required, HHSC submitted its Transition Plan to CMS by October 1, 2019, and submitted revisions to CMS on February 20, 2020. To help Texas sustain DSRIP successes HHSC is undertaking comprehensive analyses of populations served by DSRIP and interventions associated with improvements in health outcomes within focus areas of the Transition Plan. The Transition Plan was approved on September 2, 2020.

Waiver Extension

The state continues work to further the goals and objectives of the current demonstration in the following ways:

HHSC is working to expand Nonemergency Medical Transportation (NEMT) to the array of services provided by Medicaid managed care organizations (MCOs) for their members under the current 1115 waiver. In addition to providing the full array of NEMT services, HB 1576 (86th Regular Legislature) requires MCOs to provide NEMT demand response transportation services for certain trips requested with less than 48-hours' notice and increases opportunities for transportation network companies (TNCs) to provide demand response transportation services. This will expand risk-based managed care by no longer operating NEMT through managed transportation

organizations under a state plan transportation broker model to MCOs under the 1115 waiver authority. This effort will improve outcomes and support a coordinated delivery system by making the same MCOs responsible for arranging health care services also responsible for arranging the NEMT some members require to access healthcare services.

HHSC will also be seeking to remove the cost cap for individuals meeting specific medically fragile criteria and removing the current state legislative requirement that the individual be deemed unable to safely be served in an institution under the current 1115 waiver. There will not be additional home and community-based services added to the program. Impacted individuals will continue to have access to services they are currently receiving. While the population impacted by this change is not new to managed care and will not receive new services, the new process for serving this very medically fragile population will improve the coordination of their care and improve health outcomes for them while containing cost growth. It is expected to result in a more cost-effective system, including better coordination of the person's care, a more streamlined system benefiting the person, their family, and their MCO, all of which will lead to improved health outcomes for these particularly vulnerable individuals.

HHSC is also actively working to implement the legislatively mandated STAR+PLUS Pilot Program under the current 1115 waiver. The pilot must be implemented by September 1, 2023 and will operate for at least 24 months. The eligibility criteria for the program will include Medicaid-eligible adults age 21 and over who meet one of the following:

Individuals with an IDD or cognitive disability, including:

individuals with autism; and

individuals with significant complex behavioral, medical, and physical needs who are receiving home and community-based services through the STAR+PLUS Medicaid managed care program.

Individuals enrolled in the STAR+PLUS Medicaid managed care program who:

are on a Medicaid waiver program interest list;

meet criteria for an IDD; or

have a traumatic brain injury that occurred after the age of 21.

Other individuals with disabilities who have similar functional needs without regard to the age of onset or diagnosis.

The STAR+PLUS Pilot Program will operate in one service area selected by HHSC with up to two STAR+PLUS Medicaid managed care plans. The pilot will test the delivery of long-term services and supports (LTSS) for people with intellectual and development disabilities (IDD), traumatic brain injury that occurred after age 21, or people with similar functional needs as a person with IDD.

The STAR+PLUS Pilot Program is expected to further goals and objectives of the demonstration to expand risk based managed care to new populations as it will be offering home and community-based services to individuals with traumatic brain injury that currently could not qualify for a home and community-based waiver program. Additionally, this new program will also create and support a more coordinated care delivery system by having MCOs who currently provide acute care services for people with intellectual and developmental disabilities to also provide the long-term services and supports through a waiver program. This is expected to improve outcomes while containing cost growth.

HHSC would also like to call attention to the Public Health Emergency arising from the impact of COVID-19 which has significantly impacted Texas' health care delivery system. Texas recently released an open survey to all healthcare providers in Texas, which concluded on November 13, 2020. The results indicate a dire emergency of another kind is unfolding: The long-term stability of healthcare infrastructure and Medicaid provider networks is in jeopardy. CMS and Texas must act immediately to ensure that Medicaid clients retain access to care through a stable Medicaid managed care program, and that providers are financially stabilized by assured continuation of the Uncompensated Care pool available under the 1115 waiver and a successful DSRIP transition. According to survey results:

- 76% of providers said they were very concerned or extremely concerned about the financial impacts of COVID-19;
- 42% of providers reported reduced hours of service;
- 20% of providers actively reduced services unrelated to COVID-19;
- 23% of providers closed locations or facilities; and
- 27% of providers reported that COVID-19 demand has exceeded provider capacity.

Overtasked providers are considering dropping out of Texas Medicaid because of the overwhelming financial pressure and reduced service availability and locations. These problems are exacerbated by uncertainty over the future of the state's 1115 waiver. The extension application seeks to mitigate that uncertainty.

The scope of the COVID-19 public health emergency and its impacts on Texas Medicaid beneficiaries and providers continues to unfold, and its ultimate toll remains unknown. The state is acting expeditiously in response to the crisis to

preserve and stabilize Medicaid program funding in order to protect the health, safety, and welfare of Medicaid beneficiaries and avoid further suffering for Texas families.

Proposed Health Care Delivery System, Eligibility Requirements, Benefit Coverage and Cost Sharing

Texas currently operates 4 of its Medicaid managed care programs under the demonstration: STAR+PLUS (including STAR+PLUS Home and Community Based Services waiver), STAR, STAR Kids, and its children's dental services managed care program. Under these programs individuals receive the full array of state plan services (including EPSDT), in STAR+PLUS the HCBS waiver service array is offered, and MCOs provide services on a case-by-case and through value added services. MCOs also provide service management or service coordination to ensure individuals have their care coordinated to the level of their need.

The state is not requesting changes to the DSRIP program. DSRIP includes 288 performing providers who serve patients with a focus on Medicaid and Low Income Uninsured. Currently, the DSRIP program funding and authorization will expire October 1, 2021. HHSC has separately requested an extension of the DSRIP program authorization and funding for the final demonstration year of the current waiver in order to minimize the disruption to the healthcare system occurring as a result of COVID-19 and the timing of the planned DSRIP Transition. While the requested extension is pending a response from CMS, the state continues to develop new proposals under the approved DSRIP Transition Plan and submit required deliverables.

The UC program includes 529 providers which provide charity care to patients who meet their charity care policy.

The extension will not change the array of benefits provided under the current 1115 waiver authority. The extension does not make any changes to eligibility requirements. Extending the waiver will not have a significant impact on enrollment. Under the extension there will continue to be no beneficiary cost sharing.

The state is not requesting changes to the existing health care delivery system, eligibility requirements or benefit coverage through this extension request. Additionally, there will continue to be no cost sharing requirements related to premiums, co-payments, or deductibles as part of this extension request. There are not changes requested to DSRIP nor UC.

Enrollment

No impact to enrollment is expected as a result of the 1115 transformation waiver extension. There are no 1115 waiver policies that limit or impact Medicaid enrollment. While fiscal year trends during and following the Covid Public Health Emergency period are impacted due to policies and economic recovery, overall member months under the 1115 are expected to experience long term annual caseload growth trends of roughly 1% to 1.5% consistent with historical program growth.

Current enrollment growth during the PHE has been significant, with growth of over 12% since the PHE began. Annual growth of 10% over fiscal year 2021 is expected as the PHE continues and could increase depending on further PHE extensions and unemployment. While recovery is assumed over fiscal years 2022-2023, any number of factors can greatly influence the impact to Medicaid caseloads due to policy and economic conditions.

Evaluation

The overarching objectives of the THTQIP demonstration waiver are to expand risk-based managed care to new populations and services, support the development and maintenance of a coordinated care delivery system, improve outcomes while containing cost growth, and transition to quality-based payment systems across managed care and providers. The THTQIP demonstration waiver achieves these objectives through three components: the DSRIP pool, the UC pool, and MMC expansion. The focus of the THTQIP evaluation is to determine if the THTQIP demonstration waiver achieved its intended objectives through the three components. The THTQIP evaluation is guided by five evaluation questions, with one question each pertaining to DSRIP, UC, MMC, and two questions pertaining to the demonstration overall. Each evaluation question is addressed through a minimum of one corresponding hypothesis and measure.² Altogether, the current THTQIP evaluation design includes 5 evaluation questions, 13 hypotheses, and 48 evaluation measures.

Evaluation Activities

The THTQIP demonstration waiver is in the fourth year of the current renewal period. During the past four years, HHSC developed the CMS-approved evaluation design; procured an external evaluator; provided the external evaluator with data

² The current CMS-approved evaluation design plan can be found at <https://hhs.texas.gov/sites/default/files/documents/laws-regulations/policies-rules/1115-docs/tool-guidelines/1115-waiver-evaluation-design-plan.pdf>.

sources outlined in the evaluation plan; provided data-related technical assistance as requested by the external evaluator; participated in quarterly and ad hoc meetings with the external evaluator, and; submitted four revisions to the THTQIP evaluation design. The next scheduled evaluation deliverable is the interim evaluation report, which is on schedule to be submitted to CMS by September 30, 2021.

Preliminary Evaluation Findings

The external evaluator will deliver a draft of the interim report to HHSC for review on May 28, 2021. The external evaluator submitted preliminary findings to HHSC in support of this extension application on December 7, 2020. Key points from the preliminary findings are summarized below. Texas A&M University System's *Preliminary Draft Results* (Supplement A) provides the full summary of preliminary findings provided by the external evaluator. Preliminary findings are still in draft form and are only provided for the purposes of this application.

Evaluation Question 1: Did the DSRIP program incentivize changes to transform the health care system for the MLIU population in Texas?

Preliminary findings suggest the DSRIP program incentivized collaboration in tangible resource sharing and data sharing agreements, but less so in other areas of collaboration, such as joint service delivery. The DSRIP program has also supported improvements in Category C outcome measures such as heart disease management (A2-509) and primary care prevention (C1-502), but additional data is necessary to fully understand the impact of DSRIP on health outcomes.

Evaluation Question 2: Did the Demonstration impact unreimbursed costs associated with the provision of care to the MLIU population for UC providers?

Preliminary findings suggest the rate of UC cost reimbursement decreased over time. Analysis of the overall UC cost growth rate is currently underway.

Evaluation Question 3: Did the expansion of the MMC health care delivery model to additional populations and services improve healthcare (including access to care, care coordination, quality of care, and health outcomes) for MMC clients?

Preliminary findings provide some support for the premise that the expansion of MMC improved access to care and quality of care for renewal study populations, but additional data are necessary to fully understand the impact of the MMC expansion.

Evaluation Question 4: Did the Demonstration impact the development and implementation of quality-based payment systems in Texas Medicaid?

Preliminary findings suggest providers' use of Alternate Payment Models (APMs) increased, but organizations were somewhat ambivalent about the benefits of APMs. Organizations reported financial efficiency as the most common perceived benefit of APMs, and lack of MCO engagement as the most common perceived barrier to APM participation.

Evaluation Question 5: Did the Demonstration transform the health care system for the MLIU population in Texas?

Preliminary findings suggest the THTQIP demonstration waiver has resulted in overall cost savings and this trend is expected to continue.

Planned Evaluation Activities During THTQIP Extension

HHSC will continue to cooperate with federal evaluation monitoring and reporting requirements during the THTQIP extension. The THTQIP demonstration waiver extension does not alter the overall goals and objectives of the evaluation; therefore, HHSC is not proposing modifications to the approved evaluation questions. HHSC is also not proposing changes to hypotheses, data sources, statistical methods, and/or outcome measures for the evaluation of the UC Pool (Evaluation Question 2) or components related to the overall impact of the THTQIP demonstration (Evaluation Questions 4 and 5). HHSC is proposing changes to further the DSRIP and MMC expansion components, as detailed below.

HHSC will submit a revision to the CMS-approved evaluation design incorporating these edits following approval of the THTQIP extension. HHSC does not anticipate adjustments will substantially alter the data sources or analytic methods used in the evaluation. The proposed changes to DSRIP and MMC expansion align with the current goals and objectives for the THTQIP demonstration waiver.

Changes to the DSRIP Evaluation Component

The CMS-approved evaluation design includes one evaluation question and four hypotheses related to DSRIP:

Evaluation Question 1: Did the DSRIP program incentivize changes to transform the health care system for the MLIU population in Texas?

Hypothesis 1.1 DSRIP incentivized changes to the health care system that maintained or increased collaboration among providers.

Hypothesis 1.2 DSRIP incentivized performing providers to improve continuity, quality, and cost of care for Medicaid clients with diabetes.

Hypothesis 1.3 DSRIP incentivized performing providers to improve quality-related outcomes, specified as Category C population-based clinical outcome measures.

Hypothesis 1.4 DSRIP transformed the health care system, resulting in improvements in population health, specified as DSRIP Category D outcomes.

DSRIP funds are scheduled to phase out during the final year of the current THTQIP demonstration waiver, which begins October 1, 2021. The current evaluation question and hypotheses pertaining to DSRIP will no longer be applicable after DSRIP's scheduled completion date. HHSC may continue to examine DSRIP or related transitional programs using a revised hypothesis and measure set focused on the DSRIP transition process and related programming under the THTQIP extension.

Changes to the MMC Evaluation Component

The CMS-approved evaluation design includes one evaluation question and four hypotheses pertaining to MMC:

Evaluation Question 3: Did the expansion of the MMC health care delivery model to additional populations and services improve healthcare (including access to care, care coordination, quality of care, and health outcomes) for MMC clients?

Hypothesis 3.1 Access to care will improve among clients whose Medicaid benefits shift from FFS to a MMC health care delivery model.

Hypothesis 3.2 Care coordination will improve among clients whose Medicaid benefits shift from FFS to a MMC health care delivery model.

Hypothesis 3.3 Quality of care will improve among clients whose Medicaid benefits shift from FFS to a MMC health care delivery model.

Hypothesis 3.4 Health and health care outcomes will improve among clients whose Medicaid benefits shift from FFS to a MMC health care delivery model.

Hypothesis 3.5 Client satisfaction will improve among clients whose Medicaid benefits shift from FFS to a MMC health care delivery model.

Hypotheses under the MMC component of the THTQIP extension evaluation will remain the same, but HHSC will revise the study populations and/or measures associated with each hypothesis. The current THTQIP evaluation examines six populations that transitioned into MMC between March 1, 2012 and September 1, 2017. All populations included in the current THTQIP evaluation include at least five years of post-transition data. Further inquiry into these populations will not yield

additional insight into whether the expansion of MMC improved health outcomes for clients in these programs.

The MMC component of the THTQIP extension evaluation will focus on recent or forthcoming changes in services or benefits provided to populations served under the THTQIP demonstration. Populations included in the MMC evaluation during the THTQIP extension may include individuals impacted by possible THTQIP amendments (e.g., individuals utilizing non-emergency transportation services; children and youth receiving early and periodic screening, diagnostic, and treatment services; individuals with disabilities) and/or additional populations as necessary based on THTQIP interim report findings and statutory changes resulting from legislation related to the demonstration. HHSC will review and modify current MMC measures to examine access to care, care coordination, quality, outcomes, and satisfaction, as applicable to the new populations and/or benefits.

Need for THTQIP Extension

Only preliminary evaluation findings are available for the THTQIP demonstration waiver at this time. However, based on preliminary findings HHSC believes the THTQIP demonstration waiver is on track to meet its intended objectives. Specifically, early evidence suggests DSRIP has incentivized some forms of collaboration and improved health outcomes; MMC shows early signs of improved access and quality of care; more providers are participating in APMs, and; the demonstration generates overall cost savings.

Although preliminary findings from the THTQIP demonstration waiver are promising, the COVID-19 pandemic, which coincides with the final three years of the demonstration, presents a serious challenge to the final evaluation of the THTQIP demonstration waiver. The pandemic and ensuing economic recession significantly reordered priorities for clients and providers in the state, impacting enrollment, utilization, and health care delivery across the Medicaid system. HHSC anticipates the COVID-19 pandemic will have a direct or indirect impact on many of the measures used in the THTQIP evaluation. Like most time-series designs, the THTQIP demonstration evaluation is vulnerable to external validity threats; COVID-19 introduces a number of confounding factors that undermine causal inference and impede evaluators' ability to isolate the impact of demonstration policies. At the time of writing, it is unknown how long the most severe effects of the COVID-19 pandemic will last, and it is unlikely that the current evaluation will be able to fully remove or account for the impacts of the pandemic. Additional years of data are necessary to evaluate the impact of demonstration policies under stable conditions free of the COVID-19 pandemic.

The THTQIP extension is also necessary to examine recent or forthcoming changes to the current THTQIP demonstration waiver. Specifically, the THTQIP extension would allow HHSC to examine the DSRIP transition process and the impact of new benefits or populations recently carved into MMC. Collectively, the THTQIP extension would support the rigor of the evaluation in determining if the THTQIP demonstration waiver achieved its intended objectives.

External Quality Review Organization (EQRO) reports, Managed Care Organization (MCO) and State Quality Assurance Monitoring

Texas has a strong focus on quality of care in Medicaid and CHIP that includes initiatives based on state and federal requirements, including protocols published by the Centers for Medicare & Medicaid Services (CMS). HHSC strives to ensure high-value healthcare for Texans through its monitoring and oversight of Medicaid and CHIP managed care organizations (MCOs).

External Quality Review

Federal regulations require external quality review of Medicaid managed care programs to ensure states and their contracted MCOs are compliant with established standards. The external quality review organization (EQRO) performs four CMS required functions as mandated by the Balanced Budget Act of 1997 related to Medicaid managed care quality:

Validation of MCOs' performance improvement projects,

Validation of performance measures,

Determination of MCOs' compliance with certain federal Medicaid managed care regulations, and

Validation of MCO and dental maintenance organization (DMO) network adequacy.

In addition, states may also contract with the EQRO to validate member-level data; conduct member surveys, provider surveys, or focus studies; and calculate performance measures. The Institute for Child Health Policy (ICHP) has been the EQRO for HHSC since 2002. HHSC's EQRO follows CMS protocols to assess access, utilization, and quality of care for members in Texas' CHIP and Medicaid programs.

The EQRO produces reports to support HHSC's efforts to ensure managed care clients have access to timely and quality care in each of the managed care programs. The results allow comparison of findings across MCOs in each program and are used to develop overarching goals and quality improvement activities for Medicaid and CHIP managed care programs. MCO findings are compared to HHSC

standards and national percentiles, where applicable. A link to the annual EQRO Summary of Activities (SOA) Report can be found [here](#).

The EQRO assesses care provided by MCOs participating in STAR, STAR+PLUS (including the STAR+PLUS home and community-based services waiver), STAR Health, CHIP, STAR Kids, and the Medicaid and CHIP dental managed care programs. The EQRO conducts ongoing evaluations of quality of care primarily using MCO administrative data, including claims and encounter data. The EQRO also reviews MCO documents and provider medical records, conducts interviews with MCO administrators, and conducts surveys of Texas Medicaid and CHIP members, caregivers of members, and providers.

Multi-Year Focus

In summer 2016, the Texas Medicaid and CHIP external quality review organization (EQRO) began a multi-year focus study to evaluate the STAR Kids program and develop a set of quality measures for the STAR Kids population. The EQRO produced five reports for the study:

- STAR Kids Program Focus Study Measures Background Report (February 10, 2017)
- STAR Kids Program Focus Study Pre-Implementation Descriptive Report (May 26, 2017). <https://hhs.texas.gov/sites/default/files/documents/about-hhs/process-improvement/quality-efficiency-improvement/STAR-Kids-Pre-Implementation-Report-052617.pdf>
- STAR Kids Post-Implementation Managed Care Organization (MCO) Interview Report (June 18, 2018). <https://hhs.texas.gov/sites/default/files/documents/about-hhs/process-improvement/medicaid-chip-qei/star-kids-post-mco-interview-report-june-2018.pdf>
- Measures Feasibility Report (April 18, 2019)
- Summary Report (November 13, 2019)

The final summary report contained a series of recommendations including

- Conducting regular NCI-CFS surveys with STAR Kids caregivers;
- Conducting additional studies with the STAR Kids-Screening and Assessment Instrument (SK-SAI) and Individual Service Plan (ISP);
- Conducting CAHPS surveys to assess member experiences;
- Creating quality of care measures specific to members enrolled in the Medically Dependent Children Program (MDCP); and,
- Conducting focus groups with MDCP caregivers.

These recommendations were incorporated into SB 1207, 86th Legislature, and HHSC has or is in the process of implementing them.

The annual Summary of Activities (SOA) reports to CMS all activities performed by the EQRO during the contract year. The SOA report presents findings by the Texas EQRO on activities for state fiscal year (SFY) 2018, which address quality of care in Texas Medicaid and CHIP. The report's recommendations include the following:

- validate and update provider addresses to improve the return rate on records requested from providers;
- identify members that most benefit from addressing social determinants of health (SDOH) and improve their access to care;
- continue to improve access to behavioral health care; and
- focus on improving key vaccination rates.

In response to these recommendations, MCOs are required to verify the provider address information prior to the EQRO requesting patient records for encounter data validation (EDV). In addition, MCOs and DMOs are subject to corrective action plans (CAPs) for data that does not meet minimum EDV quality standards.

HHSC, in conjunction with the EQRO, recently completed an analysis of state and national SDOH tools. HHSC plans to use this information to identify a recommended tool for Medicaid MCOs. In addition, the Medicaid/CHIP Services Department has formed an internal workgroup to further incorporate SDOH into quality initiatives.

In 2019, MCOs began a statewide, two-year performance improvement project (PIP) focused on members with complex behavioral health conditions. In 2020, PIPs focus on improving integration of behavioral health and physical health care, with the goal of reducing hospitalization.

To improve vaccination rates, HHSC has added immunizations for adolescents (IMA) as a quality measure in the Medical Pay-for-Quality (P4Q) program for STAR, CHIP and STAR Kids.

Quality Measures

A combination of established sets of national measures and state-developed measures validated by the EQRO are used to track and monitor program and health plan performance. Measures include:

- National Committee for Quality Assurance Healthcare Effectiveness Data and Information Set (HEDIS®) - A nationally recognized and validated set of measures used to gauge quality of care provided to members.
- Agency for Healthcare Research and Quality (AHRQ) Pediatric Quality Indicators (PDIs)/ Prevention Quality Indicators (PQIs) - PDIs use hospital discharge data to measure the quality of care provided to children and youth. PQIs use hospital discharge data to measure quality of care for specific conditions known as "ambulatory care sensitive conditions" (ACSCs). ACSCs

are conditions for which good outpatient care can potentially prevent the need for hospitalization, or for which early intervention can prevent complications or more severe disease.

- 3M® Potentially Preventable Events (PPEs) - HHSC uses and collects data on Potentially Preventable Admissions (PPAs), Potentially Preventable Readmissions (PPRs), Potentially Preventable Emergency Department Visits (PPVs), Potentially Preventable Complications (PPCs), and Potentially Preventable Ancillary Services (PPSs).
- Consumer Assessment of Healthcare Providers & Systems (CAHPS®) Surveys - CAHPS Health Plan Surveys are nationally recognized and validated tools for collecting standardized information on members' experiences with health plans and services.

Initiatives

HHSC uses quality measures to evaluate health plan performance and develop initiatives to improve the quality of care provided to Medicaid and CHIP members in managed care.

Administrative Interviews

In accordance with 42 CFR 438.358, the EQRO conducts administrative interviews with each plan in Medicaid/CHIP—within a three-year period—to assess MCO/dental maintenance organization compliance with state standards for access to care, structure and operations, and quality assessment and performance improvement (QAPI). The administrative interview process consists of four main deliverables, namely Administrative Interview (AI) tool, AI evaluations, onsite visits, and AI reports.

Core Measure Reporting

CMS has a Children's and an Adult Health Care Quality Core Set of measures which states voluntarily report on for children in Medicaid and CHIP and adults in Medicaid. The EQRO assists HHSC in reporting core measures to CMS each year.³

MCO Report Cards

HHSC provides information on outcome and process measures to Medicaid and CHIP members regarding MCO performance during the enrollment process. To comply with this requirement and the quality rating system required by 42 CFR 438.334, HHSC develops report cards for each program service area to allow members to compare the MCOs on specific quality measures. These report cards

³ <https://www.medicaid.gov/medicaid/quality-of-care/quality-of-care-performance-measurement/adult-and-child-health-care-quality-measures/index.html>

are intended to assist potential enrollees in selecting an MCO based on quality metrics. Report cards are posted on the HHSC website and included in the Medicaid enrollment packets. Report cards are updated annually.⁴

Network Adequacy

SB 760, 84th Legislature, Regular Session, 2015 directed HHSC to establish and implement a process for direct monitoring of a 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 Texas Uniform Managed Care Contract 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.

Network adequacy initiatives include the Appointment Availability (AA) Study and the Primary Care Provider (PCP) Referral Study. The AA study is a series of sub-studies completed by the state's EQRO. The AA Study is comprised of four reports in the areas of prenatal, primary care, vision, and behavioral health. MCO performance is assessed by determining provider compliance with contract standards for appointment availability and wait time for an appointment. The PCP Referral Study is conducted annually and examines PCP experiences when referring Medicaid managed care and CHIP beneficiaries for specialty care.

Pay-for-Quality

Senate Bill 7, 83rd Legislature, Regular Session, 2013, focused on the use of quality-based outcome and process measures in quality-based payment systems by measuring PPEs, rewarding use of evidence-based practices, and promoting health care coordination, collaboration, and efficacy. To comply with this legislative direction HHSC implemented redesigned medical and dental Pay-for-Quality (P4Q) programs in January 2018. The P4Q programs create financial incentives and disincentives based on health plan performance on a set of quality measures. Contracted health plans are at-risk.

Another key initiative to improve Medicaid and CHIP quality of care is the medical P4Q program. Under medical P4Q, 3 percent of the MCOs' capitation is at-risk based on their performance on a series of key quality metrics that focus on prevention, chronic disease management, behavioral health, and maternal and infant health. MCOs are evaluated on their own year to year performance and compared to their peers at the state and national level.

⁴ <https://hhs.texas.gov/services/health/medicaid-chip/programs/managed-care-report-cards>

Medical P4Q has led to marked improvement in quality. In comparing 2017 to 2018 program rates, all at-risk measures in all programs (i.e., STAR, CHIP and STAR+PLUS) showed improvement except for potentially preventable emergency room visits (PPVs) in STAR and CHIP. For example, rates for counseling for nutrition and physical activity increased by 8 percent in CHIP. In addition, rates for six or more well child visits in the first 15 months increased by 4 percent in STAR.

HHSC's focus on maternal and infant health through P4Q, PIPs and other initiatives have resulted in significant improvement in infant and maternal health outcomes. From 2008 to 2018, there was a 24 percent rate of improvement in children receiving six or more well child visits in the first 15 months of life; a 26 percent rate of improvement for adolescents receiving an annual well child visit; and, a 14 percent rate of improvement in timeliness of prenatal care.

The medical P4Q program serves as a catalyst for MCOs to pursue value-based payment (VBP) arrangements with providers to achieve required P4Q outcomes. The state uses the [Healthcare Payment Learning and Action Network \(HCP LAN\) Alternative Payment Model \(APM\) Framework](#)⁵ to guide this effort. APMs incentivize high-quality and cost-efficient care by linking healthcare payments to measures of value. The LAN provides a menu of payment models from which MCOs can choose to develop APM contracts with their providers.

Medicaid Value-Based Enrollment

Pursuant to Texas Government Code §533.00511, HHS is implementing an incentive program that automatically enrolls a greater percentage of Medicaid recipients who have not selected a managed care plan into a plan based on quality of care, efficiency and effectiveness of service provision, and performance. The state's new autoenrollment method uses metrics aligned with the Triple Aim to promote value-based healthcare that achieves better care at lower costs.⁶

Alternative Payment Model (APM) Requirements

The P4Q and value-based enrollment programs serve as catalysts for managed care to pursue value-based payment arrangements with providers to achieve improved

⁵ LAN Framework available at: <http://hcp-lan.org/workproducts/apm-framework-onepager.pdf>

⁶ The [Triple Aim](#) is a framework developed by the Institute for Healthcare Improvement that describes an approach to optimizing health system performance by improving the patient experience, improving population health, and reducing costs. These dimensions are also reflected in the Centers for Medicare and Medicaid Services' [value-based programs guidance](#).

outcomes. APMs are payment arrangements in which some portion of an MCO's reimbursement to a provider is linked to measures of quality and outcomes. HHSC uses the [Healthcare Payment Learning and Action Network \(HCP LAN\) Alternative Payment Model \(APM\) Framework](#)⁷ to help guide this effort. This framework provides a menu of payment models from which MCOs could choose to develop alternative payment contracts with their providers. Moving from one category to the next adds a level of risk to the payment model.

Under this initiative, HHS created contractual targets for MCOs to connect provider payments to value using APMs. The APM percentage targets increase over time. If an MCO fails to meet the APM targets or certain allowed exceptions for high performing plans, the MCO must submit an action plan, and HHSC may impose graduated contractual remedies, including liquidated damages.

The full range of contractual requirements for MCOs to promote VBP include:

- The establishment of MCO APM targets: Overall and risk-based APM contractual targets were established for MCO expenditures on VBP contracts with providers relative to all medical and pharmacy expenses. The targets start at 25 percent of provider payments in any type of APM and 10 percent of provider payments in risk-based APMs for calendar year 2018. These targets increase over four years up to 50 percent overall and 25 percent risk-based by calendar year 2021.
- Requirements for MCOs to establish and maintain data sharing processes with providers.
- Requirements for MCOs to adequately resource this activity: MCOs and DMOs must dedicate sufficient resources for provider outreach and negotiation, provide assistance with data and/or report interpretation and initiate collaborative activities to support VBP and provider improvement.
- Requirements for MCOs to have a process in place to evaluate APM models: MCOs are required to evaluate the impact of APM models on utilization, quality, cost and return on investment.

HHSC collects reports on their APM initiatives on an annual basis. In general, most of the reported APM initiatives involve primary care providers, but MCOs also have reported APMs with specialists (including obstetricians/ gynecologists), behavioral health providers, hospitals, nursing facilities and long-term services and supports providers.

⁷ LAN Framework available at: <http://hcp-lan.org/workproducts/apm-framework-onepager.pdf>

In 2018, the first target year for HHSC's Medicaid MCO APM targets, MCOs reported that 40 percent of their payments to providers were in an APM, with about 22 percent in a risk-based APM. As a whole, the Texas Medicaid and CHIP programs performed at or above contractually-required thresholds and national goals in 2018.

Performance Improvement Projects

The Balanced Budget Act of 1997 requires all states with Medicaid managed care to ensure MCOs conduct performance improvement projects (PIPs). 42 CFR 438.330 requires projects be designed to achieve, through ongoing measurements and interventions, significant improvement, sustained over time, in clinical care and nonclinical care areas that have a favorable effect on health outcomes and enrollee satisfaction. Health plans conduct PIPs to examine and improve areas of service or care identified by HHSC in consultation with Texas's EQRO as needing improvement. Topics are selected based on health plan performance on quality measures and member surveys. HHSC requires each health plan to conduct two PIPs per program. One PIP per health plan must be a collaborative with another health plan or a Delivery System Reform Incentive Payment project, or a community-based organization.

Performance Indicator Dashboards

The Performance Indicator Dashboards include a series of measures that identify key aspects of performance to support MCO accountability. Dashboard measures include high and minimum performance standards by program. MCO program level performance on each measure is compared to the standards and MCOs falling below minimum performance standards on one-third or more of the dashboard measures are subject to corrective action plans.

Quality Assessment and Performance Improvement Programs

42 CFR 438.330 requires Medicaid MCOs to operate QAPI programs. These programs evaluate performance using objective quality standards, foster data-driven decision-making, and support programmatic improvements. MCOs report on their QAPI programs each year and these reports are evaluated by Texas's EQRO.

Hospital Quality-Based Payment Program

HHSC administers a Hospital Quality-Based Payment Program for all hospitals in Medicaid and CHIP in both the managed care and FFS delivery systems. Hospitals are measured on their performance for risk-adjusted rates of potentially preventable hospital readmissions within 15 days of discharge (PPR) and potentially preventable inpatient hospital complications (PPC) across all Medicaid and CHIP programs, as these measures have been determined to be reasonably within hospitals' ability to improve. Under the program, hospitals can experience reductions to their payments for inpatient stays: up to 2 percent for high rates of

PPRs and 2.5 percent for PPCs. Measurement, reporting, and application of payment adjustments occur on an annual cycle.

Texas Healthcare Learning Collaborative Portal

The Texas Healthcare Learning Collaborative (THLC) portal is a secure web portal developed for use by HHSC and their Medicaid contractors to track performance data on key quality of care measures, including potentially preventable events (PPEs), Healthcare Effectiveness Data and Information Set (HEDIS) data, and other quality of care information. The data is interactive and can be queried to create more customized summaries of the quality results. Most of the data is available to the public with some additional information available to HHSC and MCO staff with a login.

Resources

HHSC quality webpage:

- ▶ <https://hhs.texas.gov/about-hhs/process-improvement/medicaid-and-chip-quality-and-efficiency-improvement>

Texas Healthcare Learning Collaborative Portal:

- ▶ <https://thlcportal.com>

Post-award Public Input Process Required by 42 CFR §431.420(c)

HHSC hosted a public forum via webinar on June 22, 2020 to provide the public with updates on the Texas Healthcare Transformation and Quality Improvement Program (THTQIP) 1115 waiver. The last public in person forum was held on June 24, 2019. The date, time, and location of the public forums were published on HHSC's website 30 days in advance of the meeting.

During the June 2020 public forum the public was provided with an update on the following Transformation waiver topics: Health Information Technology (IT) Strategic Plan, Delivery System Reform Incentive Payment program (DSRIP), Uncompensated Care, and Nursing Home Quality Incentive Payment Program. Links to the 1115 DY8 annual report and COVID-19 resource pages was also provided to the public. Public comment was also received and documented at this meeting. Comments received related to identifying external entities involved in the Health IT strategies, the process for creating new Medicaid benefits or programs, DSRIP operations and extension of DSRIP program, Value Based Purchasing, Uncompensated Care pool payments, and the potential to request an extension in light of COVID-19 as some other states are also doing. Requests for the powerpoint

presentation were received from some stakeholders and the slide deck was provided to those individuals electronically. During the forum, HHSC responded to comments and clarifying questions received.

SUPPLEMENT A

HEALTHCARE TRANSFORMATION AND QUALITY IMPROVEMENT RENEWAL EVALUATION

1115 Medicaid Waiver Demonstration Renewal in Texas DY6-DY11

Preliminary Draft Results

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DECEMBER 7, 2020

SCHOOL OF PUBLIC HEALTH

TEXAS A&M UNIVERSITY SYSTEM

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A. DSRIP

Evaluation Question 1: Did the DSRIP program incentivize changes to transform the health care system for the MLIU population in Texas?

COLLABORATION AMONG PROVIDERS

Hypothesis 1.1 DSRIP incentivized changes to the health care system that maintained or increased collaboration among providers.

Participating DSRIP providers were asked, via an electronic survey, about their collaborative ties to other DSRIP providers in their region. The principle types of ties between providers shared here are:

- Joint service delivery
- Tangible resource sharing
- Data sharing agreements

Across each of these dimensions, for these draft results, the networks in each region have been evaluated by the average number of ties each organization had, the density of ties within each region, and the centralization of ties within a region.

These questions were most recently asked of providers in 2020. They were also asked during the evaluation of the first waiver. Despite being in the midst of a pandemic, 2020 participation rates were high in most regions.

RHP	# of Providers	Participated	Rate	RHP	# of Providers	Participated	Rate
1	20	17	85.0%	11	15	11	73.3%
2	15	12	80.0%	12	36	26	72.2%
3	25	19	76.0%	13	13	10	76.9%
4	17	13	76.5%	14	10	8	80.0%
5	10	9	90.0%	15	8	8	100.0%
6	23	16	69.6%	16	7	7	100.0%
7	7	7	100.0%	17	12	9	75.0%
8	13	7	53.8%	18	6	6	100.0%
9	23	13	56.5%	19	12	10	83.3%
10	24	15	62.5%	20	4	3	75.0%
				Total	300	226	75.3%

Tentative Results:

Average number of ties

The first measure of interest is the average number of ties each provider had within its region. Each of the 20 regions within Texas has a different number of providers participating in the DSRIP program, a number that has generally decreased over time.

					JOINT SERVICE DELIVERY AVERAGE TIES PER ORG.					
	# OF PROVIDERS FOR EACH TIME PERIOD				Average_ties-T0	Average_ties-T1	Average_ties-T2	Average_ties-T3	Network Average - Overall Change	
					(Pre-Waiver)	-2013	-2015	-2020	T0 to T3	
	T0 (Pre-Waiver)	T1 -2013	T2 -2015	T3 -2020					Point Change*	% Change**
RHP 1	37	38	40	20	5.0	7.7	6.5	6.6	1.6	33%
RHP 2	17	17	17	15	5.4	5.6	2.9	4.7	-0.7	-13%
RHP 3	30	30	33	25	5.4	5.9	7.1	3.8	-1.6	-30%
RHP 4	25	25	25	17	4.7	6.2	4.9	3.5	-1.2	-26%
RHP 5	8	8	8	10	3.0	4.8	3.0	2.2	-0.8	-27%
RHP 6	27	27	27	23	3.7	4.2	11.0	4.6	0.9	24%
RHP 7	16	16	17	7	3.6	3.8	5.3	2.3	-1.3	-37%
RHP 8	16	16	18	13	4.4	4.3	5.1	2.3	-2.1	-47%
RHP 9	25	25	25	23	6.2	6.7	6.3	3.3	-2.9	-47%
RHP 10	30	30	33	24	6.7	6.8	5.6	2.8	-3.9	-58%
RHP 11	19	19	19	15	7.7	8.9	3.4	2.5	-5.2	-67%
RHP 12	37	37	39	36	10.1	10.0	7.3	5.9	-4.2	-42%
RHP 13	21	21	21	13	4.9	8.6	5.6	2.3	-2.6	-53%
RHP 14	12	12	13	10	5.3	6.0	6.0	2.6	-2.7	-51%
RHP 15	8	8	8	8	4.0	6.3	4.3	5.0	1.0	25%
RHP 16	9	9	10	7	4.9	6.7	5.2	3.1	-1.8	-37%
RHP 17	19	19	20	12	5.9	5.9	6.2	2.8	-3.1	-53%
RHP 18	10	10	10	6	3.4	4.8	3.2	1.7	-1.7	-50%
RHP 19	13	13	15	12	5.1	6.5	4.7	1.3	-3.8	-74%
RHP 20	8	8	8	4	4.0	4.0	4.0	2.0	-2.0	-50%
Mean across RHPs	-	-	-	-	5.2	6.2	5.4	3.3	-1.9	-37%

It is important to note that the number of participating providers decreased from the beginning of the waiver (T0) to 2020 (T3). Thus, there are often fewer providers to potentially share ties with in most of the regions. The average change in joint service delivery ties per organization within regions was -37%.

					TANGIBLE RESOURCE SHARING AVERAGE TIES PER ORG.					
	# OF PROVIDERS FOR EACH TIME PERIOD				Average_ties-T0	Average_ties-T1	Average_ties-T2	Average_ties-T3	Network Average-Overall Change	
					(Pre-Waiver)	-2013	-2015	-2020	T0 to T3	
									Point Change*	% Change**
	T0 (Pre-Waiver)	T1 -2013	T2 -2015	T3 -2020						
RHP 1	37	38	40	20	3.4	4.6	3.1	2.7	-0.7	-19%
RHP 2	17	17	17	15	2.1	2.9	1.4	1.6	-0.5	-24%
RHP 3	30	30	33	25	1.5	1.5	1.9	2.6	1.1	77%
RHP 4	25	25	25	17	1.4	2.1	2.6	0.7	-0.7	-51%
RHP 5	8	8	8	10	1.3	1.8	1.3	1.8	0.6	44%
RHP 6	27	27	27	23	3.4	5.0	3.7	1.6	-1.8	-53%
RHP 7	16	16	17	7	1.5	2.1	2.9	2.3	0.8	53%
RHP 8	16	16	18	13	1.3	1.5	2.7	2.2	1.0	76%
RHP 9	25	25	25	23	2.3	2.3	3.2	2.3	0.0	-1%
RHP 10	30	30	33	24	1.7	2.0	2.7	2.2	0.5	27%
RHP 11	19	19	19	15	1.2	1.4	1.6	2.4	1.2	107%
RHP 12	37	37	39	36	2.6	3.2	3.5	3.3	0.7	25%
RHP 13	21	21	21	13	1.4	3.2	1.9	1.1	-0.3	-23%
RHP 14	12	12	13	10	2.0	1.8	1.2	3.2	1.2	60%
RHP 15	8	8	8	8	2.8	4.3	1.3	3.3	0.6	20%
RHP 16	9	9	10	7	1.1	4.4	3.4	1.1	0.0	-1%
RHP 17	19	19	20	12	3.8	3.5	3.2	2.2	-1.6	-42%
RHP 18	10	10	10	6	1.6	1.6	2.6	1.0	-0.6	-38%
RHP 19	13	13	15	12	1.1	2.3	1.6	0.8	-0.3	-26%
RHP 20	8	8	8	4	1.3	1.8	0.3	2.0	0.8	60%
Mean across RHPs	-	-	-	-	1.9	2.7	2.3	2.0	0.1	5%

Again, it is important to note that the number of participating providers decreased from the beginning of the waiver (T0) to 2020 (T3). Thus, there are often fewer providers to potentially share ties with in most of the regions. Despite this, the average change in tangible resource sharing ties per organization within regions was +5%.

					FORMAL DATA SHARING AVERAGE TIES PER ORG.					
	# OF PROVIDERS FOR EACH TIME PERIOD				Average_ties-T0	Average_ties-T1	Average_ties-T2	Average_ties-T3	Network Average - Overall Change	
					(Pre-Waiver)	-2013	-2015	-2020	T0 to T3	
	T0	T1	T2	T3						
	Pre-Waiver	-2013	-2015	-2020					Point Change*	% Change**
RHP 1	37	38	40	20	1.0	1.5	2.0	3.6	2.6	270%
RHP 2	17	17	17	15	0.9	1.2	1.8	2.8	1.9	198%
RHP 3	30	30	33	25	2.6	3.5	2.5	1.4	-1.2	-46%
RHP 4	25	25	25	17	0.9	2.1	1.5	1.2	0.3	36%
RHP 5	8	8	8	10	1.3	2.0	1.5	2.0	0.8	60%
RHP 6	27	27	27	23	1.6	2.4	3.9	2.1	0.5	29%
RHP 7	16	16	17	7	1.1	1.8	2.1	1.4	0.3	24%
RHP 8	16	16	18	13	1.4	1.5	2.2	0.8	-0.6	-42%
RHP 9	25	25	25	23	2.1	2.5	3.7	2.3	0.2	11%
RHP 10	30	30	33	24	2.8	2.5	2.0	2.4	-0.4	-14%
RHP 11	19	19	19	15	0.8	1.1	0.9	0.8	0.0	-5%
RHP 12	37	37	39	36	1.2	2.1	2.0	1.9	0.7	53%
RHP 13	21	21	21	13	2.2	3.0	2.1	0.8	-1.4	-63%
RHP 14	12	12	13	10	1.3	1.3	1.2	1.6	0.3	20%
RHP 15	8	8	8	8	1.8	4.5	3.0	2.8	1.1	60%
RHP 16	9	9	10	7	0.7	2.0	1.0	1.4	0.7	110%
RHP 17	19	19	20	12	2.3	2.5	2.7	1.7	-0.6	-27%
RHP 18	10	10	10	6	1.4	2.0	1.8	0.3	-1.1	-79%
RHP 19	13	13	15	12	0.2	2.0	0.7	0.5	0.3	225%
RHP 20	8	8	8	4	1.0	0.8	3.5	2.5	1.5	150%
Mean across RHPs	-	-	-	-	1.4	2.1	2.1	1.7	0.3	20%

Again, it is important to note that the number of participating providers decreased from the beginning of the waiver (T0) to 2020 (T3). Thus, there are often fewer providers to potentially share ties with in most of the regions. Despite this, the average change in data sharing agreement ties per organization within regions was +20%.

Network density

A better measure of trends in joint service delivery, tangible resource sharing, and data sharing agreements between DSRIP providers in a region is *network density*, which controls for any changes in the number of providers in each region over time. Network density is the number of existing ties between any of the organizations in a region divided by the total number of possible ties in that region. These results are shared below.

	JOINT SERVICE DELIVERY NETWORK DENSITY					
	Network Density -T0	Network Density-T1	Network Density-T2	Network Density-T3	Network Density - Overall Change	
	(Pre-Waiver)	-2013	-2015	-2020	T0 to T3	
					Point Change*	% Change**
RHP 1	14%	21%	17%	35%	21%	153%
RHP 2	34%	35%	18%	33%	-1%	-2%
RHP 3	19%	20%	22%	16%	-3%	-14%
RHP 4	20%	26%	20%	22%	2%	12%
RHP 5	43%	68%	43%	24%	-19%	-44%
RHP 6	14%	16%	42%	21%	7%	47%
RHP 7	24%	25%	33%	38%	14%	57%
RHP 8	29%	28%	30%	21%	-8%	-28%
RHP 9	26%	28%	26%	15%	-11%	-42%
RHP 10	23%	23%	17%	12%	-11%	-48%
RHP 11	43%	50%	19%	18%	-25%	-58%
RHP 12	28%	28%	19%	17%	-11%	-39%
RHP 13	24%	43%	28%	19%	-5%	-22%
RHP 14	48%	55%	50%	29%	-19%	-40%
RHP 15	57%	89%	61%	71%	14%	24%
RHP 16	61%	83%	58%	52%	-9%	-15%
RHP 17	33%	33%	33%	26%	-7%	-21%
RHP 18	38%	53%	36%	33%	-5%	-13%
RHP 19	42%	54%	33%	12%	-30%	-72%
RHP 20	57%	57%	57%	67%	10%	17%
Mean across RHPs	34%	42%	33%	29%	-5%	-14%

From the baseline, the average density of joint service delivery ties between DSRIP providers within a region changed by -5 percentage points, a 14% decrease.

TANGIBLE RESOURCE SHARING NETWORK DENSITY						
	Network Density -T0	Network Density-T	Network Density-T2	Network Density-T3	Network Density - Overall Change	
	(Pre-Waiver)	-2013	-2015	-2020	T0 to T3	
					Point Change*	% Change**
RHP 1	9%	13%	8%	14%	5%	50%
RHP 2	13%	18%	9%	11%	-2%	-17%
RHP 3	5%	5%	6%	11%	6%	118%
RHP 4	6%	9%	11%	4%	-2%	-33%
RHP 5	18%	25%	18%	20%	2%	12%
RHP 6	13%	19%	14%	7%	-6%	-47%
RHP 7	10%	14%	18%	38%	28%	280%
RHP 8	8%	10%	16%	20%	12%	140%
RHP 9	10%	10%	13%	10%	0%	3%
RHP 10	6%	7%	8%	9%	3%	51%
RHP 11	6%	8%	9%	17%	11%	164%
RHP 12	7%	9%	9%	9%	2%	22%
RHP 13	7%	16%	10%	9%	2%	26%
RHP 14	18%	17%	10%	36%	18%	98%
RHP 15	39%	61%	18%	46%	7%	17%
RHP 16	14%	56%	38%	19%	5%	37%
RHP 17	21%	19%	17%	20%	-1%	-5%
RHP 18	18%	18%	29%	20%	2%	13%
RHP 19	9%	19%	11%	8%	-1%	-11%
RHP 20	18%	25%	4%	67%	49%	275%
Mean across RHPs	13%	19%	14%	20%	7%	54%

From the baseline, the average density of tangible resource sharing ties between DSRIP providers within a region changed by +7 percentage points, a 54% increase.

	DATA SHARING AGREEMENT NETWORK DENSITY					
	Network Density -T0	Network Density-T1	Network Density-T2	Network Density-T3	Network Density - Overall Change	
	(Pre-Waiver)	-2013	-2015	-2020	T0 to T3	
					Point Change*	% Change**
RHP 1	3%	4%	5%	19%	16%	603%
RHP 2	6%	7%	11%	20%	14%	240%
RHP 3	9%	12%	8%	6%	-3%	-33%
RHP 4	4%	9%	6%	7%	3%	91%
RHP 5	18%	29%	21%	22%	4%	23%
RHP 6	6%	9%	15%	9%	3%	44%
RHP 7	8%	12%	13%	24%	17%	220%
RHP 8	9%	10%	13%	8%	-1%	-13%
RHP 9	9%	10%	15%	10%	1%	15%
RHP 10	10%	9%	6%	11%	1%	14%
RHP 11	5%	6%	5%	6%	1%	28%
RHP 12	3%	6%	5%	6%	3%	74%
RHP 13	11%	15%	10%	6%	-5%	-45%
RHP 14	12%	12%	10%	18%	6%	49%
RHP 15	25%	64%	43%	39%	14%	56%
RHP 16	8%	25%	11%	24%	16%	188%
RHP 17	13%	14%	14%	15%	2%	17%
RHP 18	16%	22%	20%	7%	-9%	-55%
RHP 19	1%	17%	5%	5%	4%	290%
RHP 20	14%	11%	50%	83%	69%	481%
Mean across RHPs	9%	15%	14%	17%	8%	83%

From the baseline, the average density of data sharing agreement ties between DSRIP providers within a region changed by +8 percentage points, an 83% increase.

Centralization

Another network measure that was evaluated was the extent to which ties, in any of the dimensions (joint service delivery, tangible resource sharing, or data sharing agreements), were centralized around any particular provider. If a provider has a tie to everyone else in the region, but no other provider shares ties with a location other than the central provider, the degree of centralization would be 100%.

JOINT SERVICE DELIVERY NETWORK CENTRALIZATION					Network Average - Overall Change T0 to T3	
	T ₀ (Pre-Waiver)	T ₁ -2013	T ₂ -2015	T ₃ -2020	Point Change*	% Change**
RHP 1	53%	58%	45%	61%	8%	15%
RHP 2	25%	73%	36%	36%	11%	42%
RHP 3	35%	52%	36%	32%	-3%	-10%
RHP 4	24%	22%	32%	25%	1%	5%
RHP 5	38%	43%	19%	39%	1%	2%
RHP 6	26%	36%	50%	57%	31%	118%
RHP 7	26%	32%	33%	63%	37%	145%
RHP 8	50%	51%	39%	51%	1%	1%
RHP 9	35%	38%	35%	38%	3%	8%
RHP 10	53%	52%	75%	44%	-9%	-17%
RHP 11	52%	56%	35%	29%	-23%	-44%
RHP 12	70%	68%	30%	36%	-34%	-49%
RHP 13	45%	63%	57%	56%	11%	24%
RHP 14	40%	44%	49%	61%	21%	53%
RHP 15	38%	14%	52%	38%	0%	0%
RHP 16	34%	21%	39%	43%	9%	27%
RHP 17	44%	32%	34%	35%	-9%	-21%
RHP 18	22%	31%	39%	70%	48%	215%
RHP 19	68%	55%	60%	40%	-28%	-41%
RHP 20	19%	38%	38%	67%	48%	252%
Mean across RHPs	40%	44%	42%	46%	6%	15%

Joint service delivery ties became more centralized over time with a 6 percentage point increase from the beginning of the DSRIP program, a 15% increase.

TANGIBLE RESOURCE SHARING NETWORK CENTRALIZATION					Network Average - Overall Change T0 to T3	
	T ₀ (Pre-Waiver)	T ₁ -2013	T ₂ -2015	T ₃ -2020	Point Change*	% Change**
RHP 1	43%	35%	21%	25%	-18%	-42%
RHP 2	28%	36%	40%	28%	1%	2%
RHP 3	28%	17%	24%	34%	6%	22%
RHP 4	21%	22%	43%	16%	-5%	-23%
RHP 5	33%	43%	33%	17%	-16%	-49%
RHP 6	23%	83%	30%	32%	9%	38%
RHP 7	34%	45%	36%	63%	29%	84%
RHP 8	13%	27%	42%	53%	40%	298%
RHP 9	35%	30%	22%	24%	-11%	-31%
RHP 10	19%	26%	54%	37%	18%	90%
RHP 11	30%	16%	34%	21%	-9%	-30%
RHP 12	22%	17%	32%	23%	1%	7%
RHP 13	36%	65%	39%	19%	-17%	-48%
RHP 14	55%	56%	37%	81%	26%	49%
RHP 15	62%	52%	33%	52%	-10%	-16%
RHP 16	30%	57%	50%	20%	-10%	-34%
RHP 17	32%	28%	46%	31%	-1%	-4%
RHP 18	33%	19%	19%	30%	-3%	-10%
RHP 19	19%	95%	77%	24%	5%	27%
RHP 20	33%	24%	14%	67%	34%	101%
Mean across RHPs	32%	40%	36%	35%	3%	11%

Tangible resource sharing ties became more centralized over time with a 3 percentage point increase from the beginning of the DSRIP program, an 11% increase.

DATA SHARING AGREEMENTS NETWORK CENTRALIZATION					Network Average -	
	T ₀ Pre-Waive	T ₁ -2013	T ₂ -2015	T ₃ -2020	Overall Change T ₀ to T ₃	
					Point Change*	% Change**
RHP 1	29%	39%	22%	73%	44%	148%
RHP 2	22%	34%	37%	92%	70%	325%
RHP 3	38%	46%	32%	48%	10%	25%
RHP 4	14%	18%	16%	20%	6%	42%
RHP 5	33%	38%	29%	42%	9%	26%
RHP 6	31%	32%	38%	59%	28%	93%
RHP 7	22%	25%	28%	37%	15%	69%
RHP 8	28%	19%	51%	24%	-4%	-13%
RHP 9	22%	20%	15%	19%	-3%	-15%
RHP 10	23%	20%	63%	45%	22%	96%
RHP 11	20%	18%	38%	26%	6%	33%
RHP 12	20%	15%	25%	36%	16%	81%
RHP 13	27%	72%	60%	42%	15%	58%
RHP 14	40%	40%	37%	33%	-7%	-18%
RHP 15	24%	29%	38%	43%	19%	81%
RHP 16	21%	96%	42%	37%	16%	73%
RHP 17	29%	22%	25%	25%	-4%	-14%
RHP 18	36%	28%	31%	20%	-16%	-45%
RHP 19	8%	98%	36%	27%	19%	224%
RHP 20	38%	24%	48%	33%	-5%	-13%
Mean across RHPs	26%	37%	35%	39%	13%	49%

Data sharing agreement ties became more centralized over time with a 13 percentage point increase from the beginning of the DSRIP program, a 49% increase.

Tentative Observations:

- The network density data (and, to some extent, the data on the average number of ties) points towards increased collaboration between DSRIP providers in a region in terms of tangible resource sharing and data sharing agreement over time, and decreased collaboration in terms of joint service delivery.
- The average level of centralization of ties within regions increased across each of the three dimensions of joint service delivery, tangible resource sharing, and data sharing agreements.
- Reviewers should be cautious regarding the interpretation of these results as causality cannot be assessed. Some of these trends may be related to general changes in the health care system over time, in addition to differential characteristics of providers that have either dropped out of the DSRIP program or joined over time.

DSRIP CLAIMS BASED ANALYSIS

Hypothesis 1.2 DSRIP incentivized performing providers to improve continuity, quality, and cost of care for Medicaid clients with diabetes.

HHSC will be submitting a revised Evaluation Design Plan to Centers for Medicare and Medicaid Services (CMS) with adjustments to the sampling strategy, analyses, and all measures associated with Hypothesis 1.2. This adjusted analysis is presently underway.

CATEGORY C POPULATION-BASED CLINICAL OUTCOME MEASURE

Hypothesis 1.3 DSRIP incentivized performing providers to improve quality-related outcomes, specified as Category C population-based clinical outcome measures.

This hypothesis question was evaluated using the following measures for performing providers focused on serving the Medicaid and low-income uninsured (MLIU) population:

- Improved Chronic Disease Management: Diabetes Care (A1-508)
- Improved Chronic Disease Management: Heart Disease (A2-509)
- Behavioral Health and Appropriate Utilization (H2-510)
- Primary Care Prevention - Healthy Texans (C1-502)
- Pediatric Primary Care (D1-503)

Example measure:

Improved Chronic Disease Management: Diabetes Care (A1-508)

- The objective of the A1: Improved Chronic Disease Management measure bundle is to develop and implement chronic disease management interventions that are geared toward improving management of diabetes and comorbidities, improving health outcomes and quality of life, preventing disease complications, and reducing unnecessary acute and emergency care utilization among the Medicaid and low-income (MLIU) population.
- Activities that performing providers participated in were targeted towards lowering HbA1c levels, providing timely education and medication for self-management,

improving care coordination and diabetes management at the health system level, delivering exercising and cooking classes, hiring and training community health worker (CHW) diabetic educators, promoting behavior change and self-management strategies, expanding chronic disease screening opportunities, and developing as well as delivering evidence-based diabetes prevention programs.

- Providers reported baseline and DY7 MLIU rates. Weighted mean rates were created for the A1-508: Reduce Rate of Emergency Department visits for Diabetes measure in order to adjust for the volume of the baseline MLIU as well as DY7 MLIU rates of each performing provider. The denominators of the MLIU baseline population for each performing provider were added up to find the overall denominator, multiplied by the unweighted rate, and summed to get the final weighted mean rates.

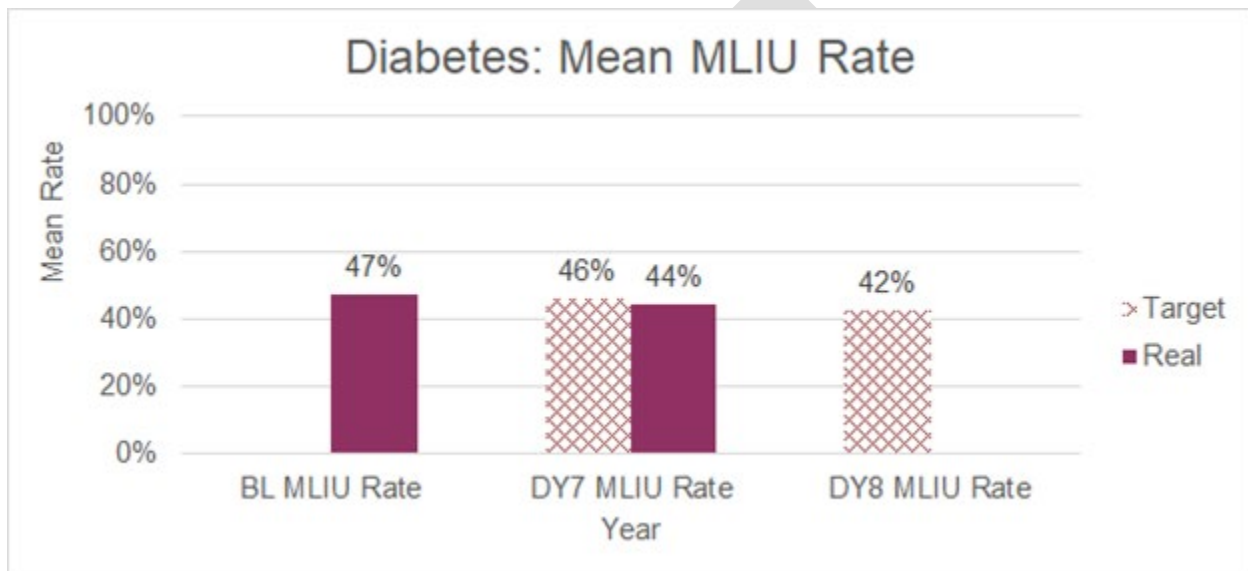


Figure A.3.1. MLIU Mean Rate for Diabetes, Measure ID=A1-508 (N=22)

- Numerator: Total number of ED visits with a primary or secondary diagnosis of diabetes (E101, E131, E110, E130, E10641, E11641, E106, E116, E108, E118, E109, E119)
- Denominator: DSRIP attributed target population for the provider system.
- Difference between baseline rate and DY7 rate not statistically significant after conducting Wilcoxon Signed Rank Sum test ($p=0.1021$).

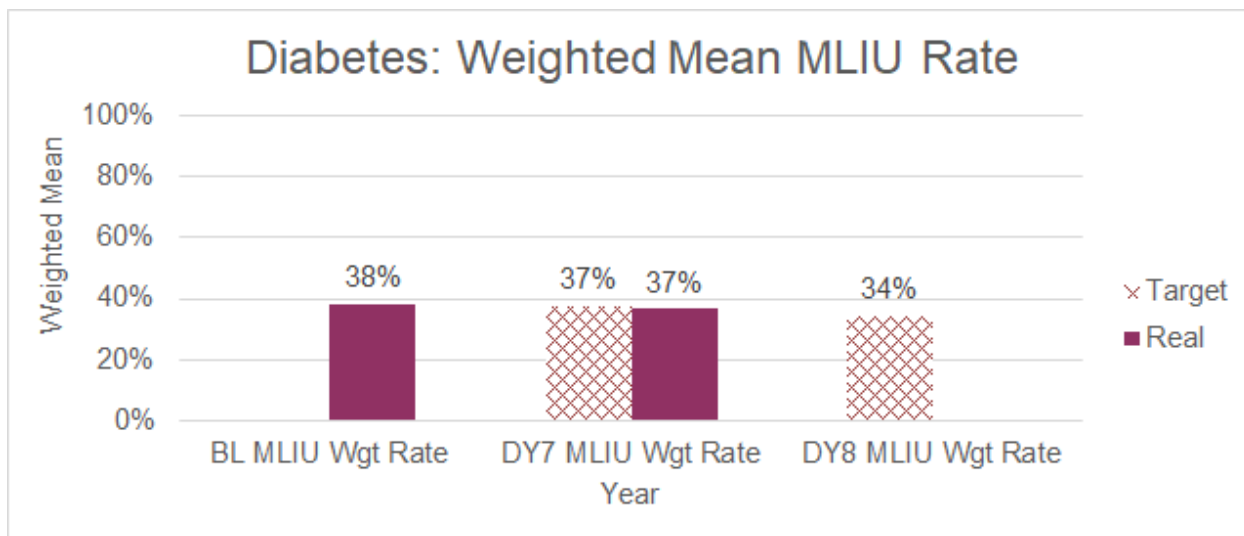


Figure A.3.2. MLIU Weighted Mean Rate for Diabetes, Measure ID=A1-508 (N=22)

- Numerator: Total number of ED visits with a primary or secondary diagnosis of diabetes (E101, E131, E110, E130, E10641, E11641, E106, E116, E108, E118, E109, E119)
- Denominator: DSRIP attributed target population for the provider system
- Difference between baseline rate and DY7 rate not statistically significant after conducting Wilcoxon Signed Rank Sum test ($p=0.1021$).

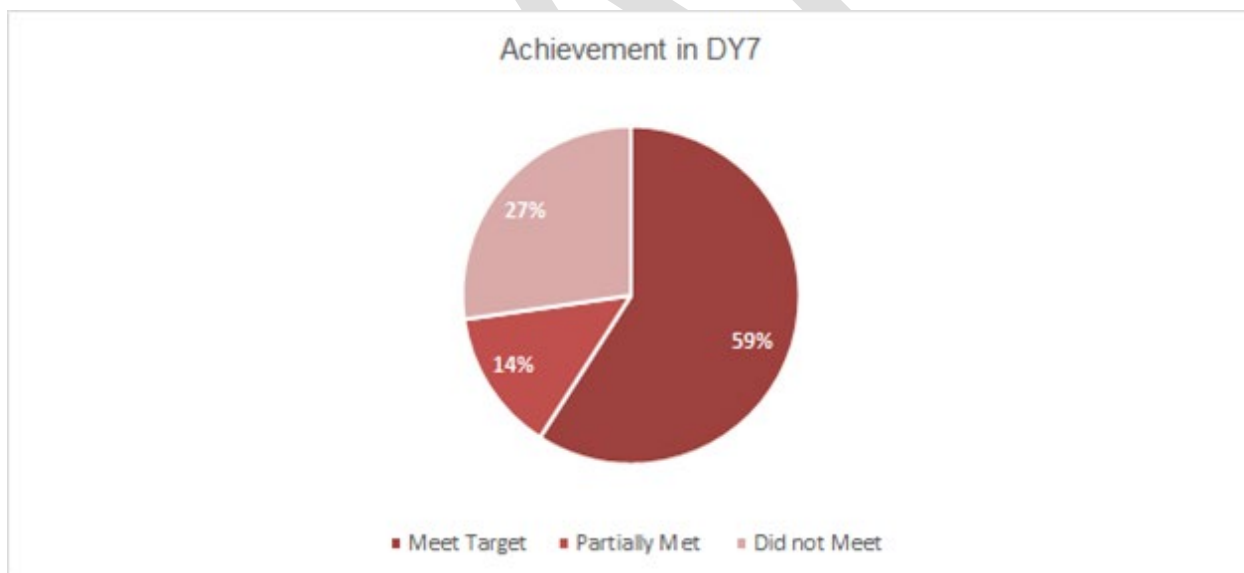


Figure A.3.3. Achievement in DY7 for Diabetes, Measure ID=A1-508 (N=22)

- DY7 goal = 2.5% improvement over baseline
- Partially met indicates that although an improvement was seen these providers did not meet the DY7 goal

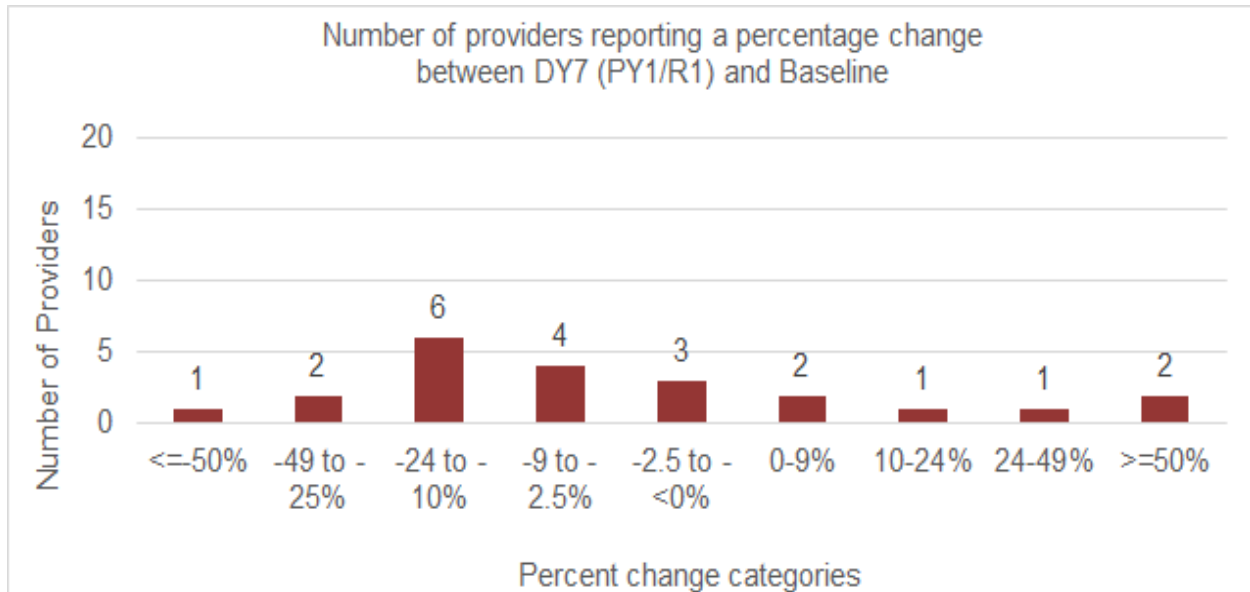


Figure A.3.4. Number of providers reporting a percentage change between DY7 (PY1/R1) and Baseline for Diabetes, Measure ID=A1-508 (N=22)

- DY7 goal = 2.5% improvement over baseline
- DY8 goal = 10% improvement over baseline (DY8 results are not available at this time, however, some providers saw a 10% or greater improvement in DY7)
- On the x-axis, the negative values represent favorable improvement

For each of the remaining measures:

- Improved Chronic Disease Management: Heart Disease (A2-509)
- Behavioral Health and Appropriate Utilization (H2-510)
- Primary Care Prevention - Healthy Texans (C1-502)
- Pediatric Primary Care (D1-503)

The weighted mean rates between baseline and DY8 are shown in the graphs below. The goals of 2.5% and 10% improvement for DY7 and DY8 remain the same for each measure.

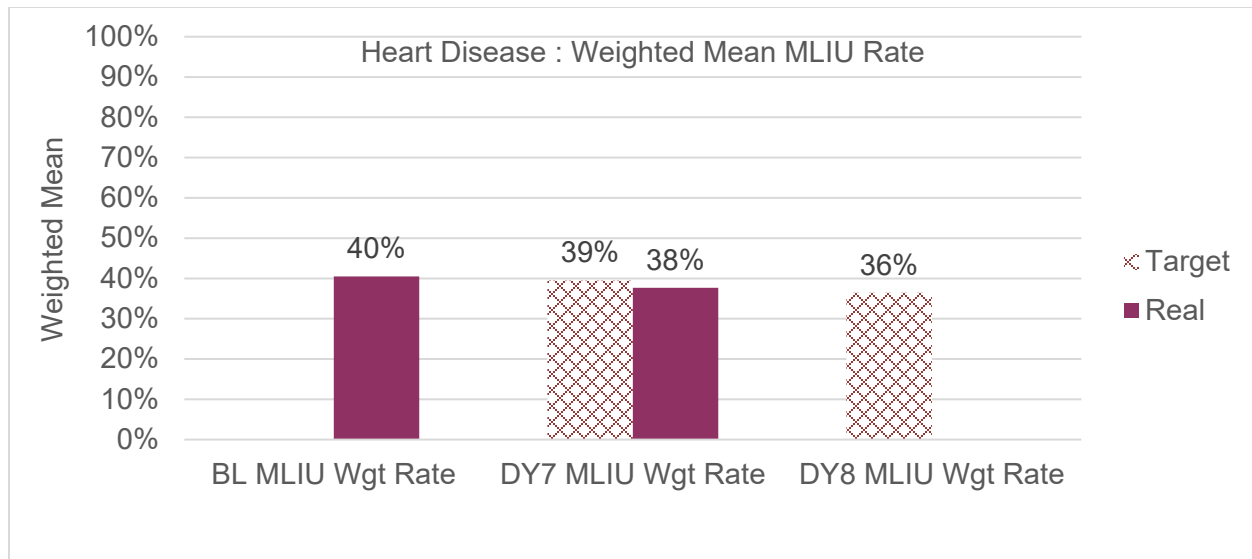


Figure A.3.6. MLIU Weighted Mean Rate for Heart Disease, Measure ID=A2-509 (N=12)

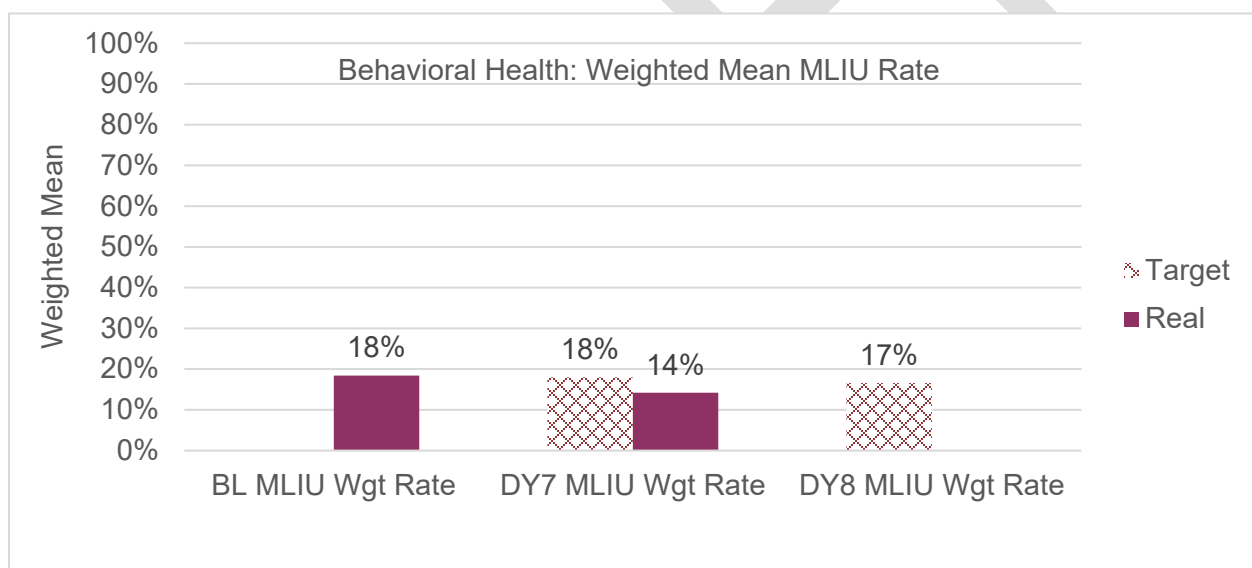


Figure A.3.7. MLIU Weighted Mean Rate for Behavioral Health, Measure ID=H2-510 (N=7)

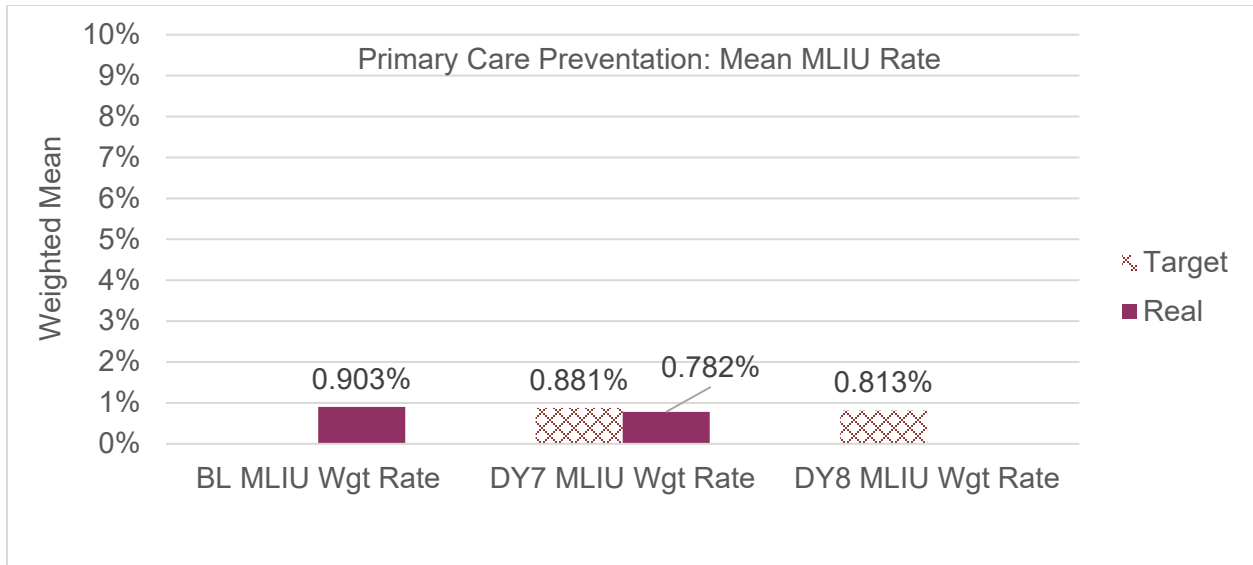


Figure A.3.8. MLIU Weighted Mean Rate for Primary Care Prevention, Measure ID=C1-502 (N=18)

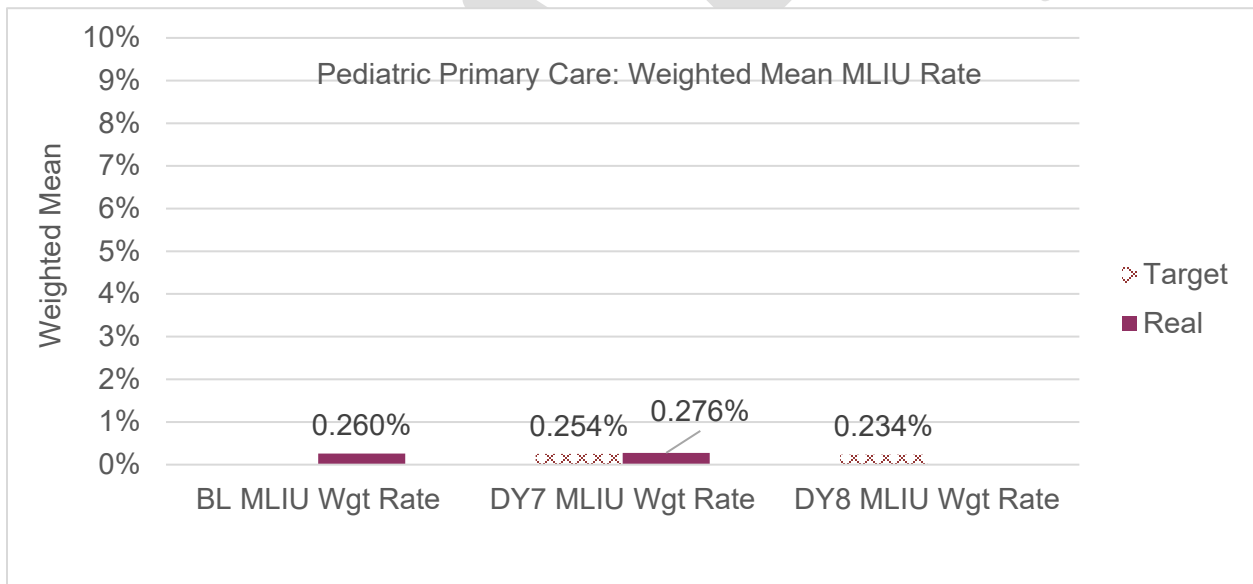


Figure A.3.9. MLIU Weighted Mean Rate for Pediatric Primary Care, Measure ID=D1-503 (N=10)

Tentative Observations

- Performing providers had a mixture of successes and challenges with meeting their DY7 and DY8 targets. While some were able to meet both of their goals in one year, others reported an increase from baseline or did not see enough of a decrease from baseline to meet specified targets for the MLIU population.

- The Primary Care and CHF/Angina/Heart failure measures (2 out of 5 measures for this evaluation question) revealed statistically significant decreases from baseline thus indicating that there is some improvement which may be linked to DSRIP activities of performing providers.

CATEGORY D POPULATION HEALTH OUTCOMES

Hypothesis 1.4 DSRIP transformed the health care system, resulting in improvements in population health, specified as DSRIP Category D outcomes.

This hypothesis question was evaluated using the following measures for performing providers:

- Potentially preventable admissions (PPA)
- Potentially preventable emergency department visits (PPV)
- Potentially preventable readmissions (PPR)
- Potentially preventable complications (PPC)

Example measure:

Potentially preventable Admissions (PPA)

- Potentially preventable admissions (PPA) are facility admissions that may have resulted from the lack of adequate access to care or ambulatory care coordination. This measure is 1 of 4 in the Category D Hospital Statewide Reporting Measure Bundle specified in the Measure Bundle Protocol.
- This RHP-level measure includes hospital admissions for any of the following ambulatory care sensitive conditions: congestive heart failure, diabetes, behavioral health/substance abuse, chronic obstructive pulmonary disease, adult asthma, pediatric asthma, angina and coronary artery disease, hypertension, cellulitis, respiratory infection, pulmonary edema and respiratory failure, and other.
- Providers reported PPA ratios for DY7 and DY8. Weighted mean ratios were created for the PPA measure in order to adjust for the volume of PPAs in each RHP using the actual number of PPAs reported for each performing provider. The actual number of PPAs reported for each provider was added up to find the overall denominator, multiplied by the unweighted ratio, and summed to get the final weighted ratio.

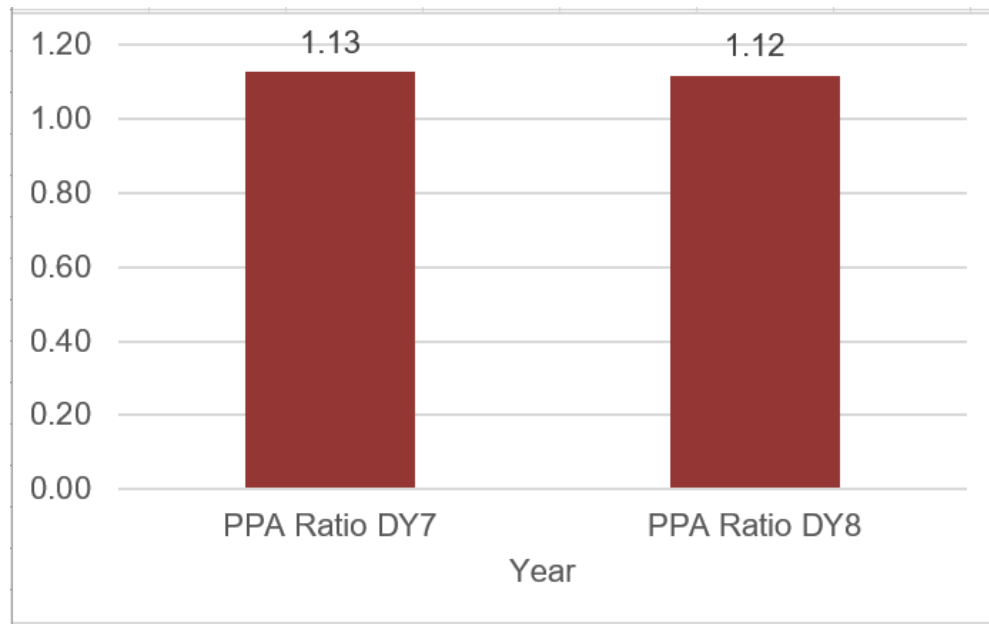


Figure A.4.1. Potentially preventable admissions (PPA) unweighted mean ratio, N=21

- Includes 20 RHPs and one NA group. The NA group consists of performing providers that could not be linked to an RHP.
- Difference between 2017 and 2018 ratio not statistically significant after conducting Wilcoxon Signed Rank Sum test ($p=0.37$).

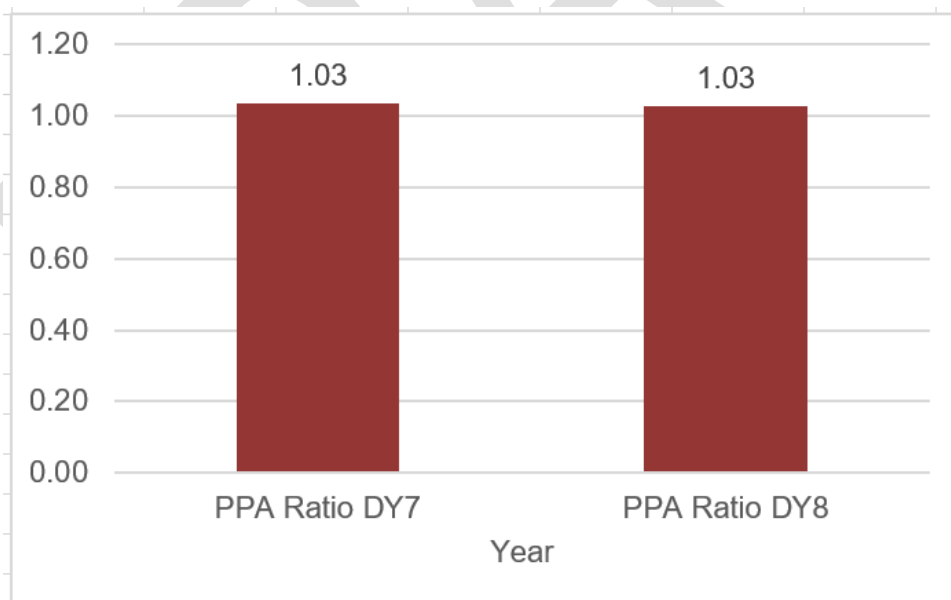


Figure A.4.2. Potentially preventable admissions (PPA) weighted mean ratio, N=21

- Includes 20 RHPs and one NA group. The NA group consists of performing providers that could not be linked to an RHP.
- Difference between 2017 and 2018 ratio not statistically significant after conducting Wilcoxon Signed Rank Sum test ($p=0.37$).

For each of the remaining measures:

- Potentially preventable emergency department visits (PPV)
- Potentially preventable readmissions (PPR)
- Potentially preventable complications (PPC)

The weighted mean rates between baseline and DY8 are shown in the graphs below.

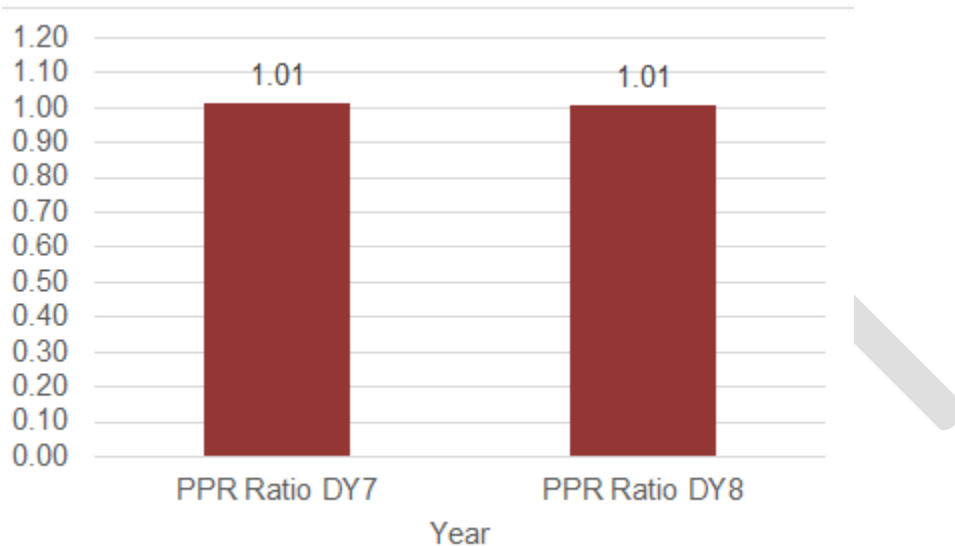


Figure A.4.2. Potentially preventable readmissions (PPR) weighted mean ratio, N=21

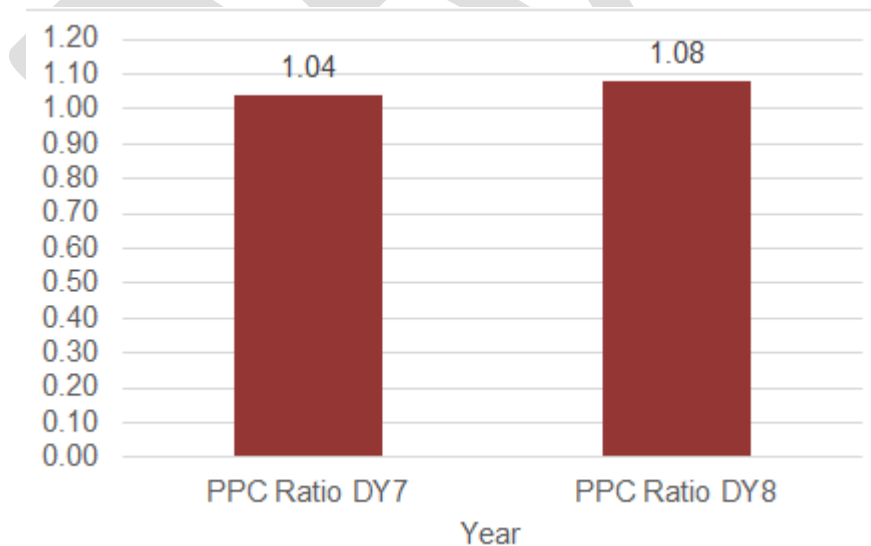


Figure A.4.2. Potentially preventable complications (PPC) weighted mean ratio, N=21

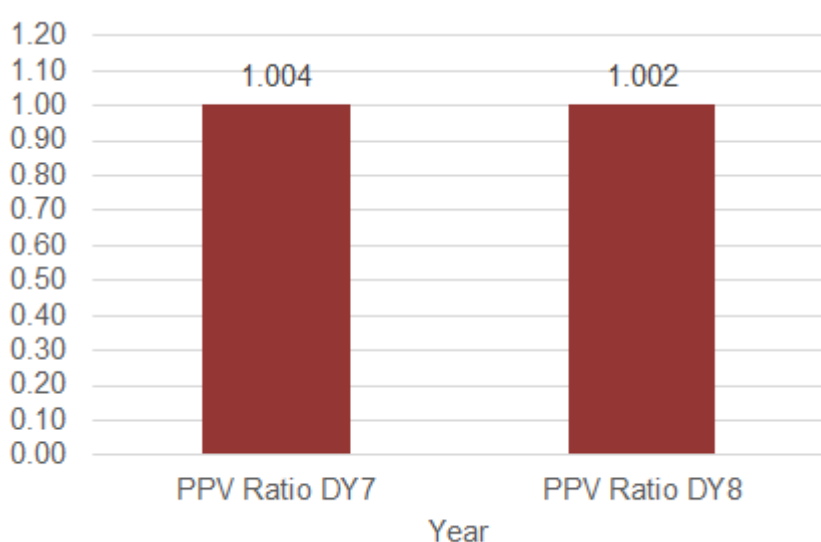


Figure A.4.2. Potentially preventable ED visits (PPV) weighted mean ratio, N=21

Tentative Observations

- At the RHP level, potentially preventable events- including potentially preventable admissions (PPA), potentially preventable emergency department visits (PPV), potentially preventable complications (PPC), and potentially preventable readmissions (PPR)- did not decrease significantly between DY7 and DY8 (i.e. after weighting, the ratios were not different from 1).
- These results only include data for DY7 to DY8. The overall measure will be calculated using data from DY7-DY11. As a result there is still time to assess if DSRIP transformed the health care system, resulting in improvements in population health.

SUMMARY OF EARLY RESULTS FROM THE DSRIP EVALUATION

Evaluation Question 1: Did the DSRIP program incentivize changes to transform the health care system for the MLIU population in Texas?

While many of the analyses remain underway, DSRIP providers have shown increased collaboration in a few areas (tangible resource sharing and data sharing agreements) but less in others (joint service delivery) since the beginning of the 1115 Waiver. Improvements have been seen for certain Category C clinical outcome measures [Improved Chronic Disease Management: Heart Disease (A2-509) and Primary Care Prevention - Healthy Texans (C1-502)] since the beginning of the Waiver renewal, when measures began to be evaluated at the provider level. Significant changes in Category D population health measures have not yet been found since the beginning of the Waiver renewal. As these are descriptive trends, causal inferences should not be made at this time. Once additional data are available and the claims analysis is complete, a better sense of the impact of the program on the measures outlined in the DSRIP Claims Based Analysis will be feasible.

B. UNCOMPENSATED CARE

Evaluation Question 2: Did the Demonstration impact unreimbursed costs associated with the provision of care to the MLIU population for UC providers?

Hypothesis 2.1 The percentage of UC costs reimbursed through UC payments for each type of UC (overall, Medicaid shortfall, uninsured shortfall) will decrease throughout DY1-DY8.

We measure the percentage of UC cost reimbursed for each hospital by dividing the total amount of UC reimbursed received by the hospital's total UC costs among hospitals receiving UC payments. To provide a comparable time trend across DY1 to DY8, we restricted the data to hospitals who received UC payments in seven or all (eight) demonstration years. We then plotted the average annual reimbursement rate in each year for all hospitals in Figure B.1. Unfortunately, we could not perform the same analysis at the Medicaid and uninsured shortfall reimbursed costs because only overall reimbursement data was collected.

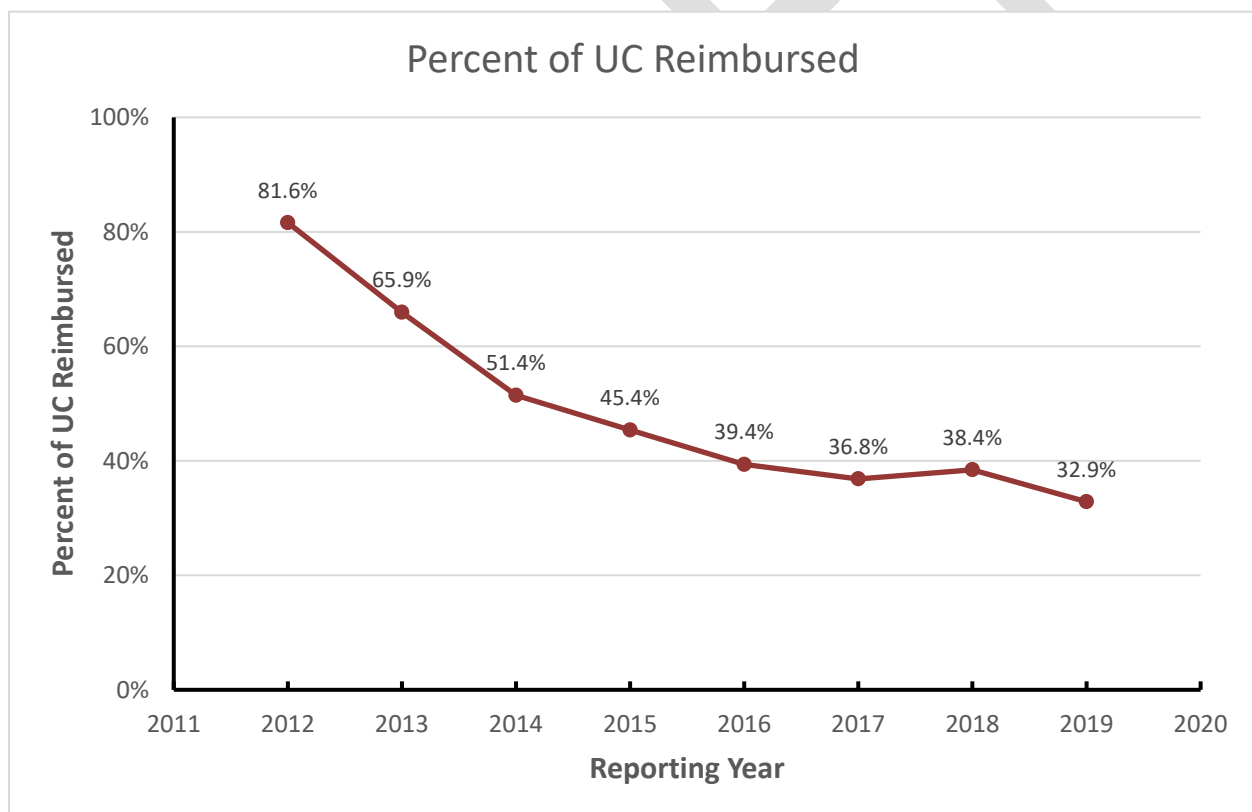


Figure B.1. Percentage of Overall UC cost reimbursed through UC payments

Notes: X-axis displays results for DY1 (2012 UC report using 2010 data) to DY8 (2019 UC report using 2017 data). The vertical red line separates the time period of the first waiver to the current waiver.

TENATIVE RESULTS & OBSERVATIONS:

- The percentage of UC cost reimbursed as measured decreased from about 81.6% in DY1 to about 32.9% in DY8.
- However, some of this decline over time may be attributable to changes over time in specific details in the UC payment system used to determine hospital UC costs eligible for reimbursement. Thus, annual estimates of percentage of UC cost reimbursed may not be directly comparable overtime without additional adjustments.

Hypothesis 2.2 The UC cost growth rate will slow over time for UC providers participating in the Demonstration.

We measure the change in UC cost growth from DY1 to DY8 by estimating a linear relationship between the UC growth rate and time in a regression model that adjusted for time varying hospital changes to account for hospital specific differences over time that may affect UC cost growth. We included hospital information from the American Hospital Association (AHA) on the hospital's bed size, ownership status, whether it had an HMO contract, whether it had a PPO contract, and total hospital admissions volume. We also included information from the UC hospital data, including the Disproportionate Share Hospital (DSH) payment to the hospital, the hospitals UC pool size, the number of hospitals in each UC pool, and hospitals rural hospital classification status. With all this information we estimated the following regression model to evaluate the impact on cost growth:

$$\text{UC Growth Rate}_{it} = \gamma_0 + \gamma_1 \text{Time}_t + \gamma_2 \text{hospital}_{it} + \beta \mathbf{X}_{it} + \theta_i + \varepsilon_i$$

The term "UC growth rate" is defined as (UC costs – UC costs previous year) / (UC costs previous year). Time_t is a continuous time trend variable and is the variable of interest. Hospital_{it} describes the hospital based on the data in the American Hospital Association survey (total beds, type, HMO contract, etc.). θ_i represents hospital fixed effects (this variable takes care of time-invariant differences between hospitals). Lastly, $\mathbf{X}_{it}$ includes other UC related hospital characteristics, such as the UC program, DSH payment, UC budget pool, number of hospitals in the budget pool, and Rider 38 status.

This analysis is presently underway.

C. MEDICAID MANAGED CARE (MMC)

Evaluation Question 3: Did the expansion of the MMC health care delivery model to additional populations and services improve healthcare (including access to care, care coordination, quality of care, and health outcomes) for MMC clients?

METHODS

Evaluation Question 3 was answered through two approaches and four primary data sources, as described below.

Descriptive Analysis

The Nursing Facility Quality Review (NFQR) Survey and the Consumer Assessment of Healthcare Providers and Systems Health Plan (CAHPS) Survey were utilized. The analysis for these surveys were descriptive statistics that were explored temporally as data was available. No pre-data was available for the CAHPS survey as the first year the child survey was conducted was 2019 and adults was 2020. Pre-data for the NFQR survey includes 2010, 2013, and 2015. The only NFQR post-data currently available is 2015.

In addition to the two surveys, a few of the other measures used descriptive analysis when Interrupted Time Series was not appropriate.

Interrupted Time Series Approach

To address many of the hypotheses under evaluation question 3, fee-for-service (FFS) claims and MMC encounter data were used to examine the impact of transitioning from FFS to MMC. We constructed interrupted time series (ITS) models, as indicated in Attachment A and where feasible given available data. The ITS models were used to identify two types of changes pre-versus post MMC implementation: a change in slope or trend and a change in intercept or level. One change point was included in most cases unless there was a clear rationale for modeling additional change points. Statistically significant changes were indicated at the $p < 0.05$ level of significance. The pre-period was defined as the 24 months prior to MMC implementation. For measures where insufficient data were available, fewer months were included. The ITS models were specified as follows:

For One change point:

$$Y_t = \beta_0 + \beta_1 * \text{time} + \beta_2 * \text{MMC} + \beta_3 * \text{postslope} + \epsilon_t$$

For two change points

$$Y_t = \beta_0 + \beta_1 * \text{time} + \beta_2 * \text{MMC1} + \beta_3 * \text{postslope1} + \beta_4 * \text{MMC2} + \beta_5 * \text{postslope2} + \epsilon$$

Where β_0 = baseline level of outcome at beginning of pre-MMC period

β_1 = trend pre-MMC (slope)

β_2 = immediate impact of MMC (level)

β_3 = trend post-MMC (slope)

ACCESS TO CARE

Hypothesis 3.1 Access to care will improve among clients whose Medicaid benefits shift from FFS to a MMC health care delivery model.

Hypothesis 3.1 was addressed mainly through ITS modeling based on the FFS claims and MMC encounter data. Figure C.1.1 displays the percent of child clients who received at least one preventive dental visit during the reporting period. Initially post-MMC implementation, there was a decrease in the percentage level and a change to a steeper increasing slope, both statistically significant. The observed patterns support hypothesis 3.1.

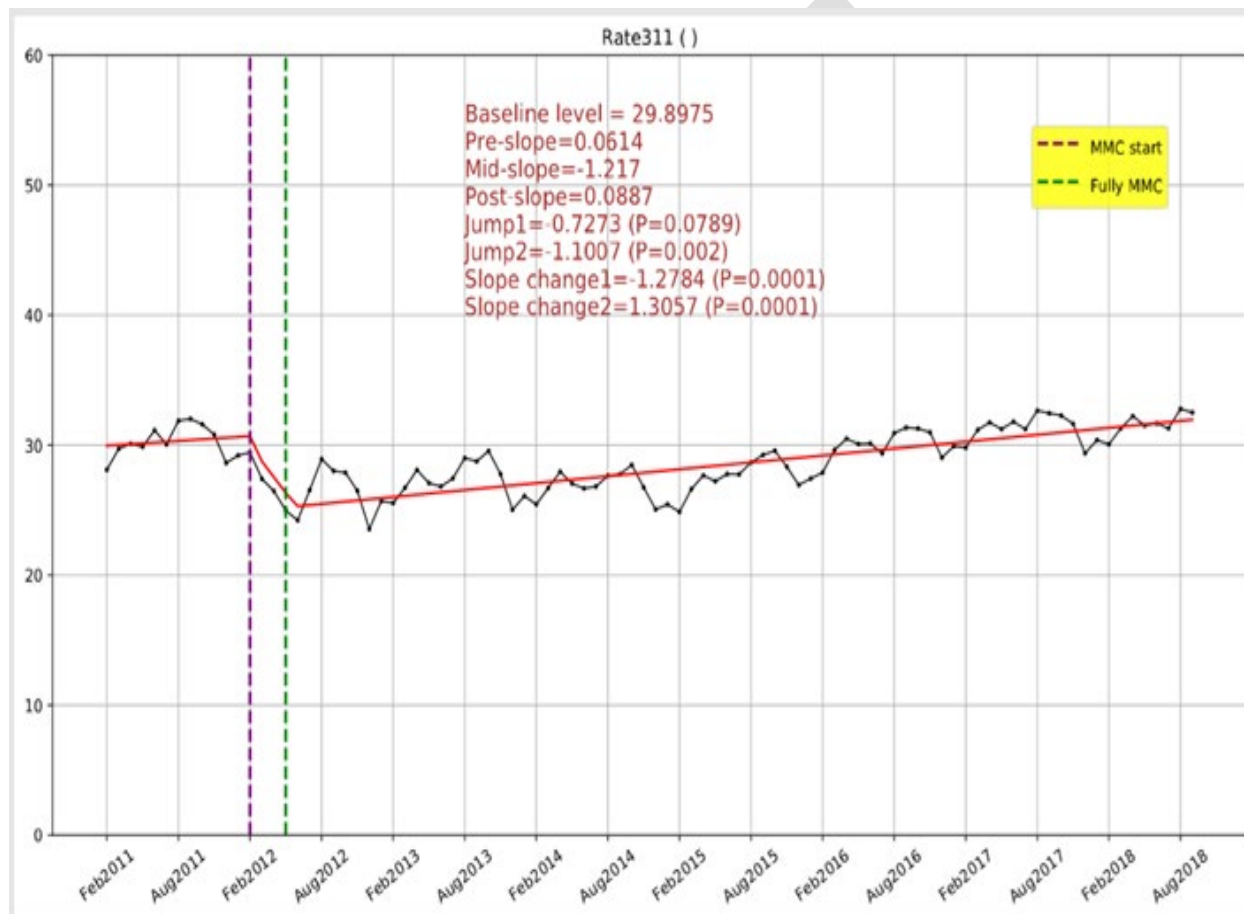


Figure C.1.1. Percent of child clients who received at least one preventive dental visit (Measure 3.1.1)

Figure C.1.2 displays the percent of FFCC members who had at least one ambulatory or preventive care visit in the last year. There was a change from an increasing trend to a decreasing trend from September 2017 to September 2018. However, MMC was not fully implemented until after September 2018. Therefore, additional months of data are needed to fully assess this measure.

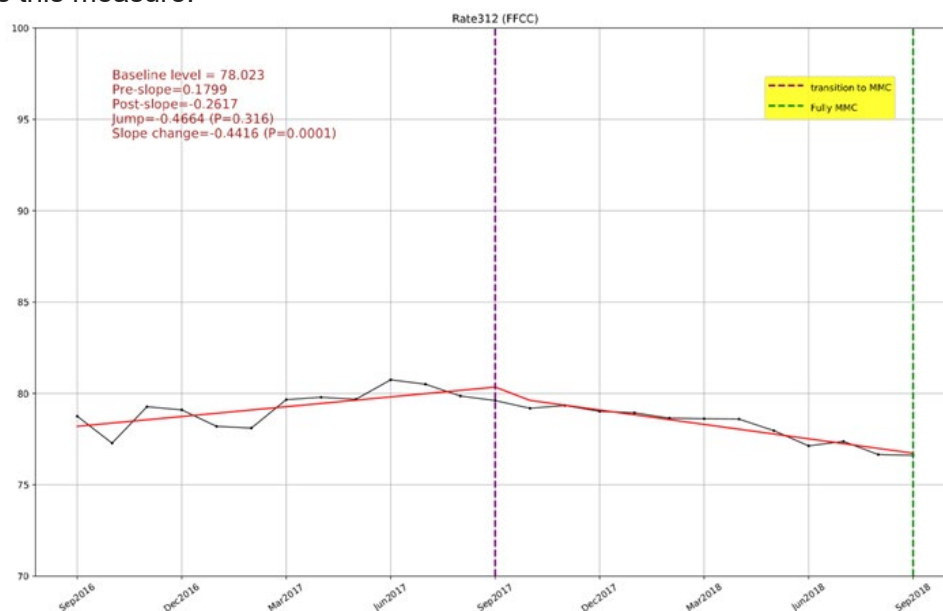


Figure C.1.2. Percent of FFCC members who had at least one ambulatory or preventive care visit in the last year (Measure 3.1.2)

Figure C.1.3 displays the percentage of MBCC members who had at least one ambulatory or preventive care visit in the last year. There was no observed difference after implementation of MMC. However, MMC was not fully implemented until after September 2018. Therefore, additional months of data are needed to fully assess this measure.

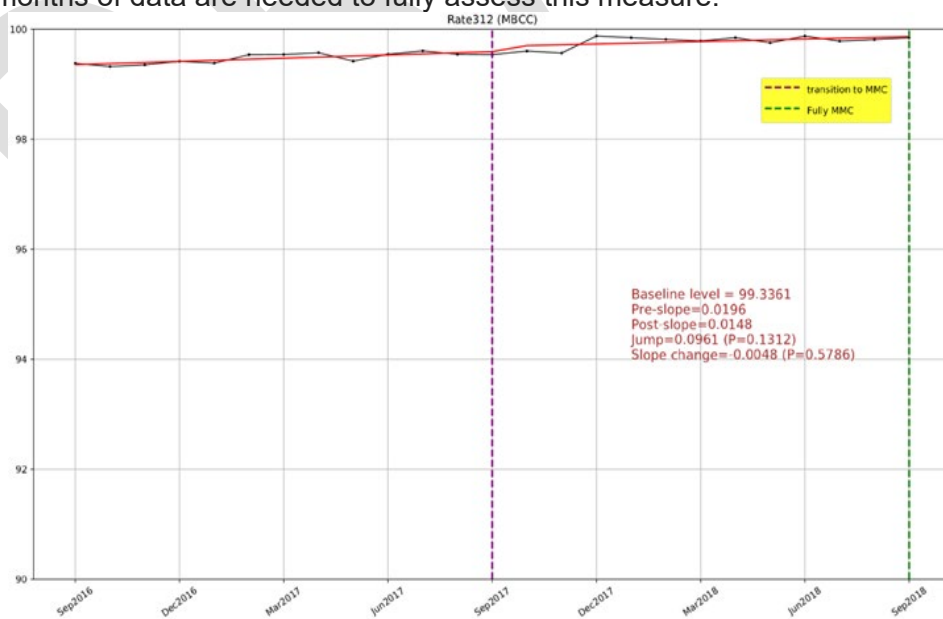


Figure C.1.3. Percent of MBCC members who had at least one ambulatory or preventive care visit in the last year (Measure 3.1.2)

Figure C.1.4 displays the percentage of NF members who had at least one ambulatory or preventive care visit in the last year. Immediately post-MMC implementation, there was a statistically significant change in slope to become steeper than the increasing trend pre-MMC. Once MMC was fully implemented in March 2016, the slope changed again (statistically significant) to become less steep, but still increasing.

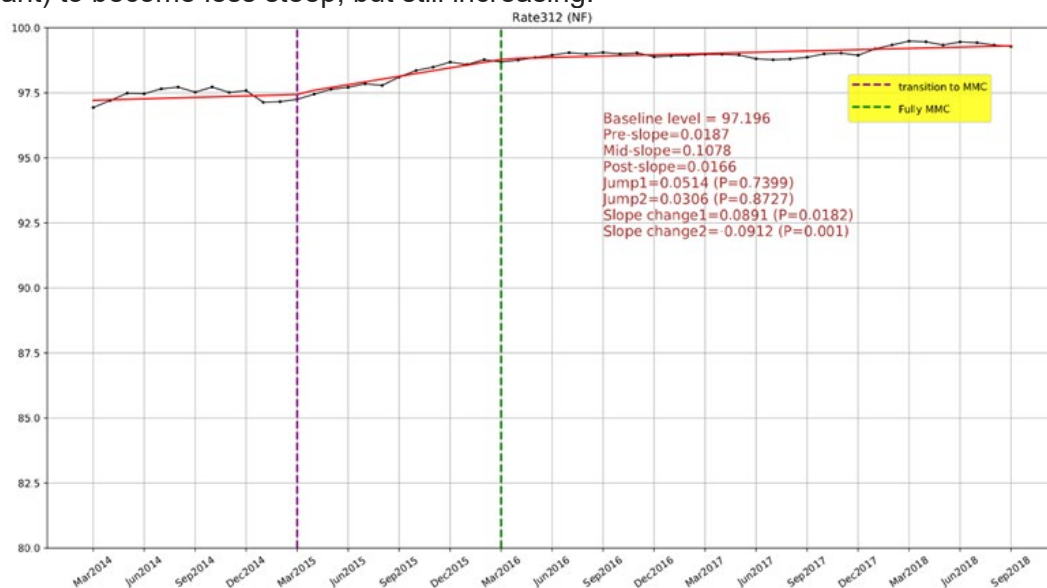


Figure C.1.4. Percent of NF members who had at least one ambulatory or preventive care visit in the last year (Measure 3.1.2)

Figure C.1.5 displays the percentage of AA members who had at least one visit with a PCP in the measurement year. There was a statistically significant change immediately following implementation of MMC in September of 2017 with respect to an increase in the percentage level and the slope remained increasing but steeper.

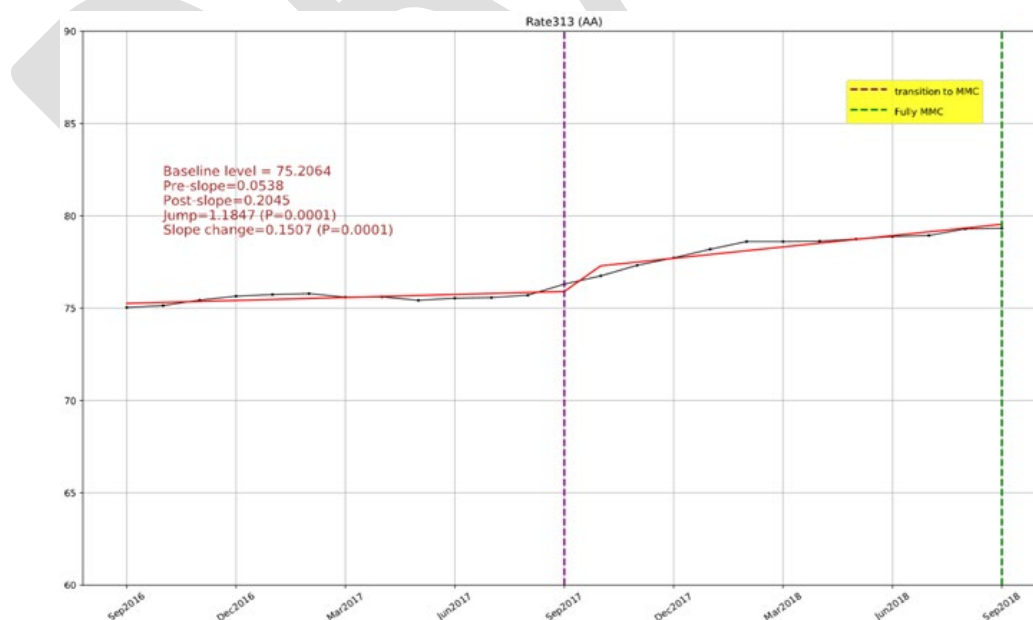


Figure C.1.5. Percent of AA members who had at least one visit with a PCP in the measurement year (Measure 3.1.3)

Table C.1.1 presents a summary of the ITS findings for hypothesis 3.1. Statistics are presented for the baseline level, the slope/trend values pre and post MMC, and level changes post-MMC implementation.

Table C.1.1. Summary of ITS results for Hypothesis 3.1

Measure	Baseline Value	Pre MMC Trend	Post MMC Level Change I	Post MMC Trend I	Post MMC Level Change II	Post MMC Trend II
3.1.1: Percent of child clients who received at least one preventive dental visit	29.90	0.06	0.72	-1.22	-1.10	0.09
3.1.2: Percent of FFCC members who had at least one ambulatory or preventive care visit in the last year.	78.02	0.18	-0.47	-0.26	n/a	n/a
3.1.2: Percent of MBCC members who had at least one ambulatory or preventive care visit in the last year.	99.34	0.02	0.10	0.015	n/a	n/a
3.1.2: Percent of NF members who had at least one ambulatory or preventive care visit in the last year.	97.20	0.02	0.05	0.11	0.03	0.02
3.1.3: Percent of AA members who had a visit with a PCP in the measurement year.	97.20	0.02	0.05	0.11	0.03	0.02

Note: Results in bold are significant at the $p < 0.05$ level.

Key takeaways:

- There was an increasing trend in preventive dental care visits among child clients after full implementation of MMC. This trend was statistically significant. This finding is in line with the findings from 3.4.1 where a decreasing trend was observed for the percent of child clients who had tooth decay. This finding supports hypothesis 3.1.
- For MBCC members, significant changes were not observed for the percentage of members who had at least one ambulatory or preventive care visit in the last year. However, the baseline values for both populations were already close to 100 percent.
- For the FFCC members, additional months of data are needed to be able to adequately assess the impact of MMC implementation.
- For the NF members, the baseline increasing slope/trend became steeper (statistically significant) with no change in level. At full implementation of MCC one year after initial implementation, the slope changed again to become less steep, although still increasing and was statistically significant. This finding supports hypothesis 3.1.
- For the percentage of AA members who had at least one visit with a PCP in the measurement period, there was a statistically significant increasing trend post MMC implementation. This finding supports hypothesis 3.1.

CARE COORDINATION

Hypothesis 3.2 Care coordination will improve among clients whose Medicaid benefits shift from FFS to a MMC health care delivery model.

Hypothesis 3.2 was addressed mainly through ITS modeling based on the FFS claims and MMC encounter data.

Figure C.2.1 displays the rate of service coordination utilization in NF members. The rate is presented as the number of encounters per 1,000 member months. There was a small but statistically significant decrease in the level of the rate post-MMC implementation. There was no change in slope/trend, which remained increasing.

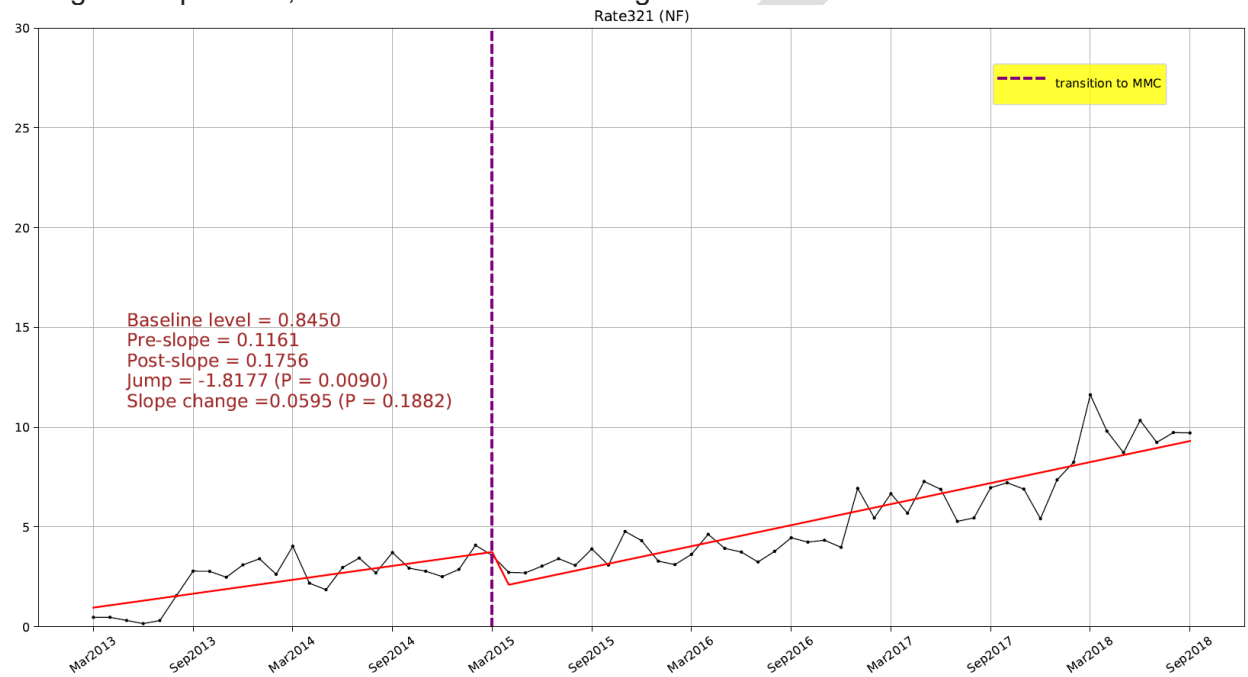


Figure C.2.1. Rate of service coordination utilization per 1,000 member months in NF (Measure 3.2.1)

Figure C.2.2 displays the rate of service coordination utilization in FFCC members. As with Figure C.2.1, the rate is presented as the number of encounters per 1,000 member months. There was a small decrease in level for the rate post-MMC implementation that was not statistically significant. There was no change observed in slope/trend and it remained increasing.

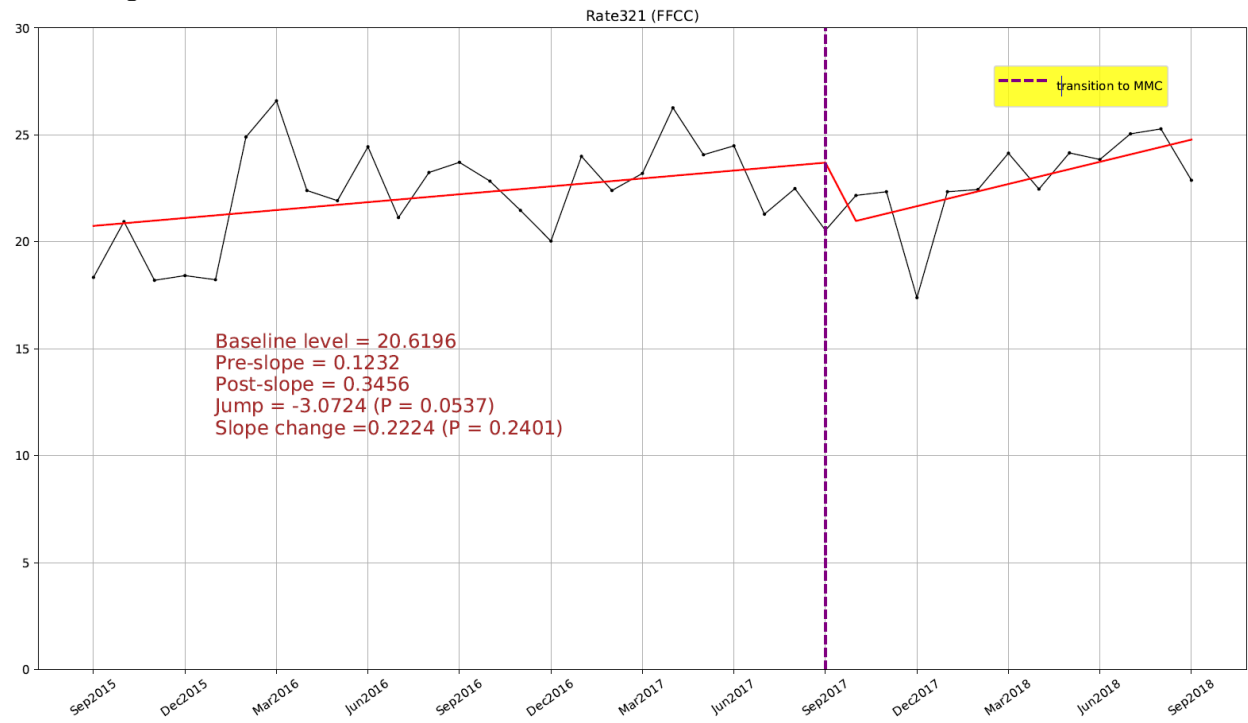


Figure C.2.2. Rate of service coordination utilization per 1,000 member months in FFCC (Measure 3.2.1)

Figure C.2.3 displays the rate of service coordination utilization in MBCC members. In line with Figures C.2.1 and C.2.2, the rate is presented as the number of encounters per 1,000 member months. There were no observed changes in level or slope/trend. The slope/trend remained relatively flat.

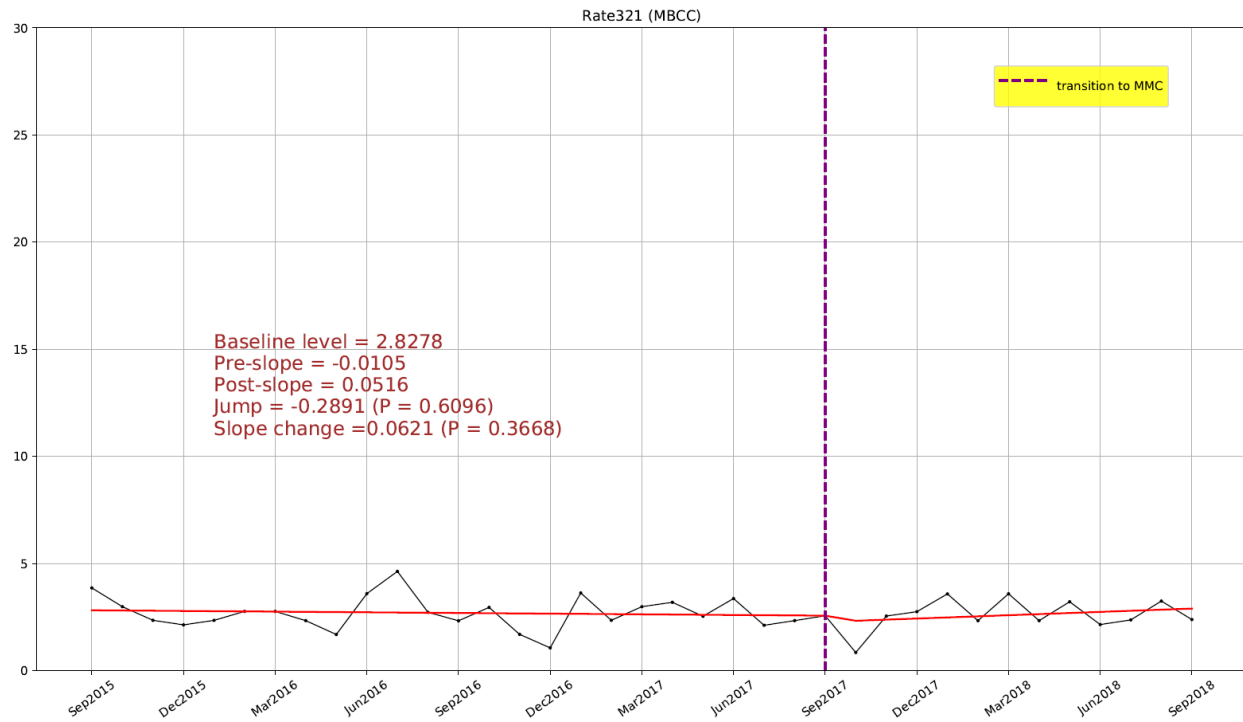


Figure C.2.3. Rate of service coordination utilization per 1,000 member months in MBCC (Measure 3.2.1)

Figure C.2.4 displays the rate (i.e., percentage) of the level of utilization of targeted case management among FFCC clients with SPMI. There was a statistically significant decrease in the level of the rate post-MMC, but the slope/trend remained unchanged and increasing.

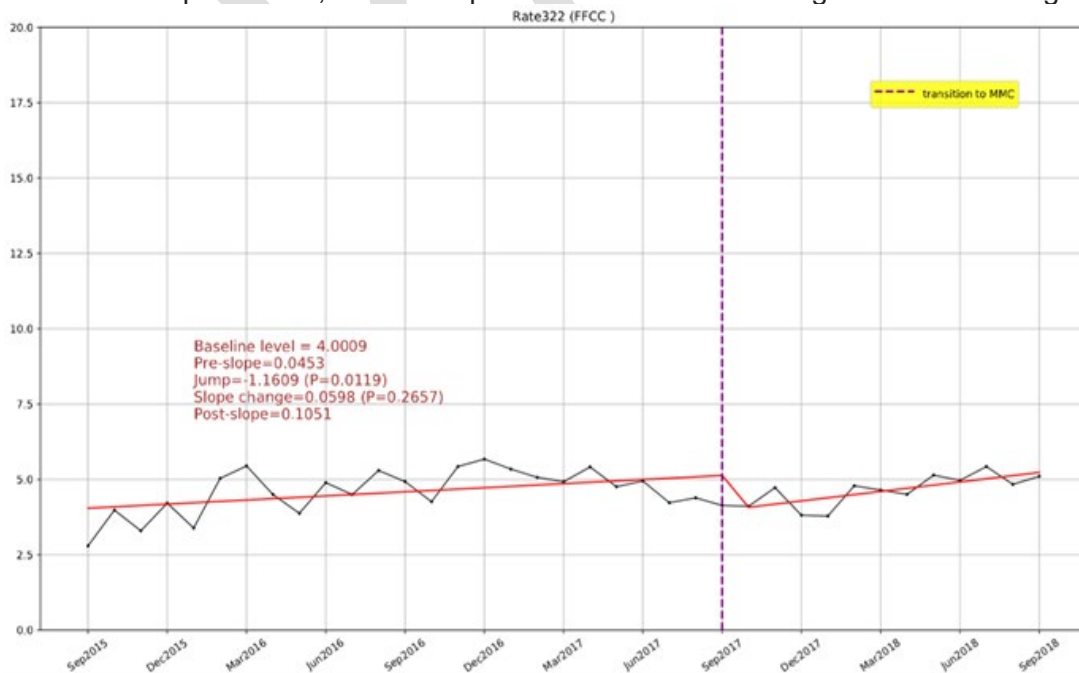


Figure C.2.4. Rate of the level of utilization of targeted case management among FFCC clients with SPMI (Measure 3.2.2)

Figure C.2.5 displays the rate (i.e., percentage) of the level of utilization of targeted case management among AA clients with SPMI. There was a statistically significant increase in the level of the rate post-MMC, but the slope/trend remained unchanged and increasing.

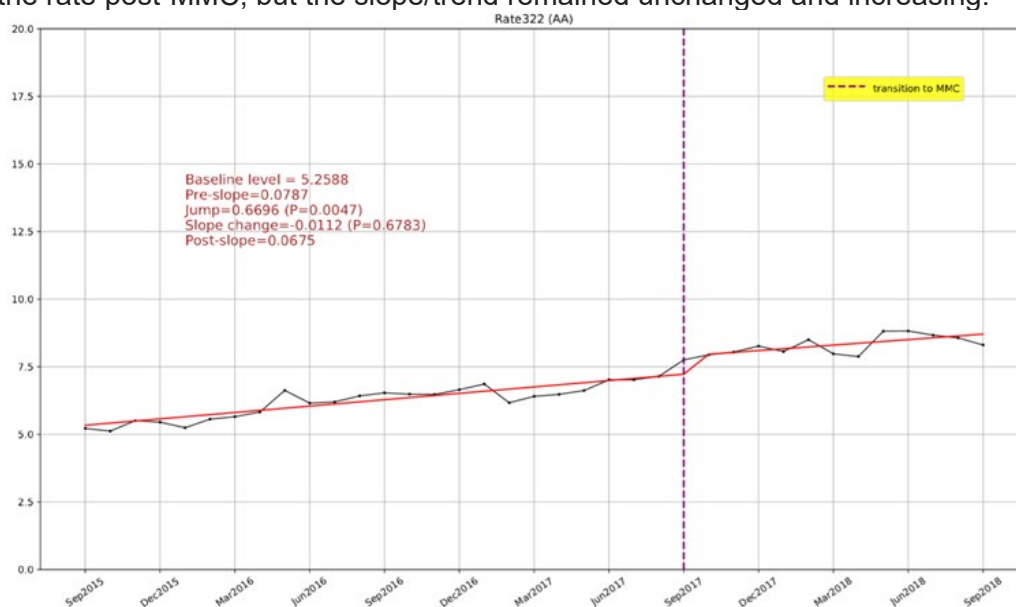


Figure C.2.5. Rate of the level of utilization of targeted case management among AA clients with SPMI (Measure 3.2.2)

Figure C.2.6 displays the rate (i.e., percentage) of the level of utilization of targeted case management among PCA clients with SPMI. There was no change in level of the rate post-MMC, and the slope/trend remained unchanged and increasing.

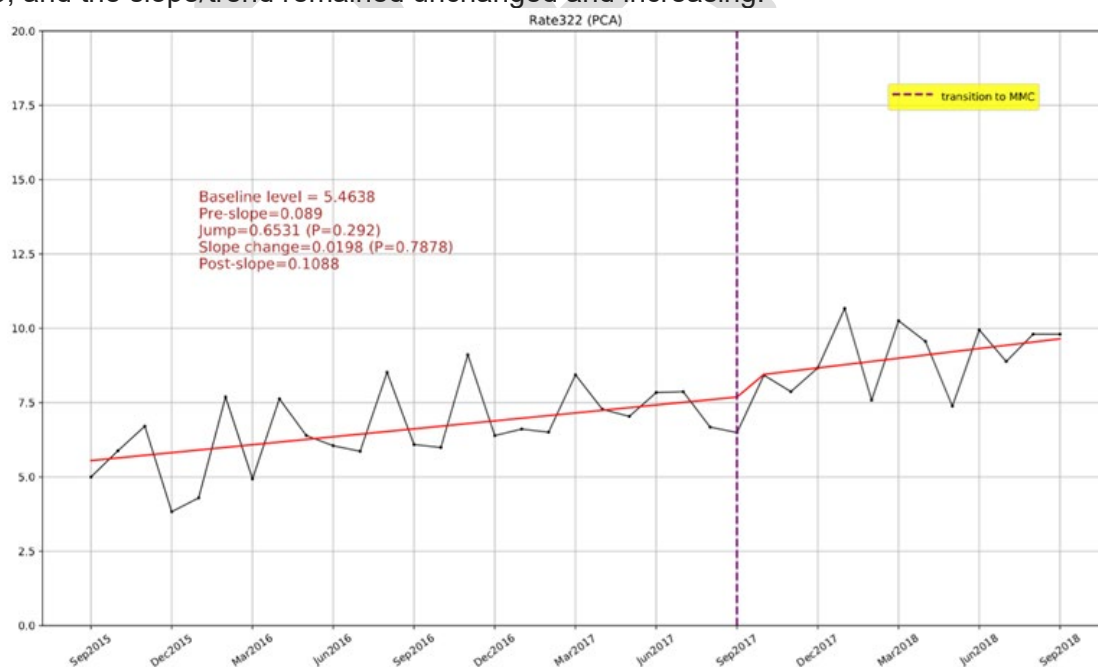


Figure C.2.6. Rate of the level of utilization of targeted case management among PCA clients with SPMI (Measure 3.2.2)

Table C.2.1 presents a summary of the ITS findings for hypothesis 3.2. Statistics are presented for the baseline level, the slope/trend values pre and post MMC, and level changes post-MMC implementation.

Table C.2.1. Summary of ITS results for Hypothesis 3.2

Measure	Baseline Value	Pre MMC Trend	Post MMC Level Change I	Post MMC Trend I
3.2.1: Rate of service coordination utilization in NF.	0.85	0.12	-1.82	0.18
3.2.1: Rate of service coordination in FFCC.	20.62	0.12	-3.07	0.35
3.2.1: Rate of service coordination in MBCC.	2.83	-0.01	-0.30	0.05
3.2.2: Rate of the level of utilization of targeted case management among FFCC clients with SPMI.	4.00	0.05	-1.16	0.11
3.2.2: Rate of the level of utilization of targeted case management among AA clients with SPMI.	5.26	0.08	0.67	0.07
3.2.2: Rate of the level of utilization of targeted case management among PCA clients with SPMI.	5.46	0.09	0.65	0.11

Note: Results in bold are significant at the $p < 0.05$ level.

Key takeaways:

- For the rate of encounters per 1,000 member months for service coordination among FFCC and MBCC, there was no evidence of changes due to the transition to MMC. This finding does not support hypothesis 3.2.
- For the rate of encounters per 1,000 member months for service coordination among NF, there was an initial and minimal decrease in level that was statistically significant, but no change in slope/trend. This finding does not support hypothesis 3.2.
- For clients who have SPMI, the rate (i.e., percentage) of targeted case management did not change among PCA clients. For AA clients, there was a statistically significant increase in level post MMC, but not the slope/trend. For FFCC clients, there was a statistically significant, minimal decrease in level, but no change in slope. These findings are mixed with respect to hypothesis 3.2.

QUALITY OF CARE

Hypothesis 3.3 Quality of care will improve among clients whose Medicaid benefits shift from FFS to a MMC health care delivery model.

The claims analysis is pending.

In addition to the claim analysis, the NFQR survey was used to examine behavior modification in clients whose Medicaid benefits shifted from FFS to an MMC health care delivery model (measure 3.3.4). Specifically, the NFQR survey was used to examine the percentage of NF clients on psychotropic medications with behavior modifications in their care plan. The two survey questions examined, included:

- 1) Is there an active prescription for any psychoactive medication (including antipsychotics/neuroleptics, anti-anxiety agents, antidepressants, sedative/hypnotics or psychomotor stimulants), on a routine and/or as needed basis?
- 2) Does the resident's care plan include behavior modification interventions, addressing the specific behaviors for which psychoactive medications were prescribed?

The questions to examine psychotropic medications use were not added until 2015; thus, only post MMC implementation data is reported. The 2015 NFQR survey found that 78.4% of NF clients had an active prescription for psychoactive medications with behavior modifications included in their care plan.

HEALTH AND HEALTH CARE OUTCOMES

Hypothesis 3.4 Health and health care outcomes will improve among clients whose Medicaid benefits shift from FFS to a MMC health care delivery model.

Initially, FFS claims and MMC encounter data were used to examine the impact of the implementation of MMC on health and health care outcomes (measures 3.4.1 and 3.4.2). ITS models were constructed to examine the impact on tooth decay and cavities in children and pressure ulcers in the NF population.

Figure C.4.1 displays the percentage of children ages 0-20 years who had tooth decay or cavities during the measurement period. Post-MMC implementation there were statistically significant changes in the level and slope/trend. The percentage level dropped and the slope changed direction from increasing pre-MMC to decreasing post-MMC.

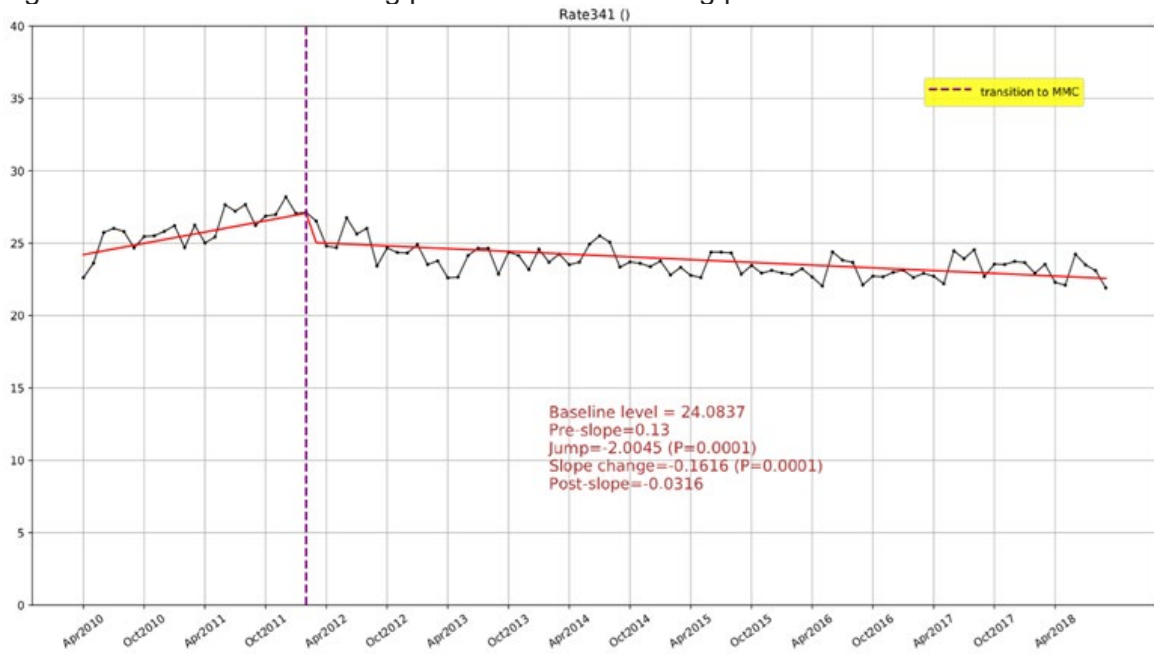


Figure C.4.1. Percentage of children, ages 0-20 years, who have had tooth decay or cavities during the measurement period (CMS Core Child Measure) (Measure 3.4.1)

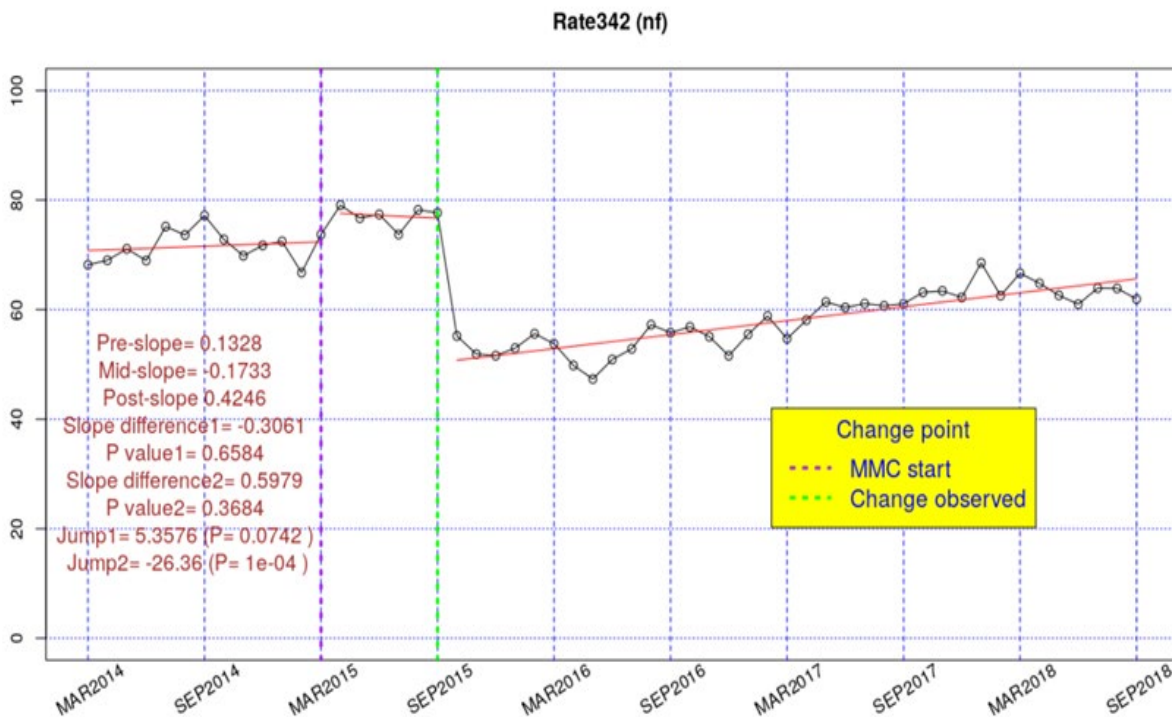


Figure C.4.2. Rate (number of pressure ulcers/1,000 member months) of pressure ulcers among NF clients (Measure 3.4.2)

Table C.4.1 presents a summary of the ITS findings for hypothesis 3.4. Statistics are presented for the baseline level, the slope/trend values pre and post MMC, and level changes post-MMC implementation.

Table C.4.1. Summary of ITS results for Hypothesis 3.4

Measure	Baseline Value	Pre MMC Trend	Post MMC Level Change I	Post MMC Trend I	Post MMC Level Change II	Post MMC Trend II
3.4.1: Percentage of children, ages 0-20 years, who have had tooth decay or cavities during the measurement period.	24.08	0.13	-2.00	-0.03	n/a	n/a
3.4.2: Rate of pressure (number of pressure ulcers/1,000 member months) ulcers among NF clients.	70.6451	0.13	5.36	-0.17	-26.36	0.42

Note: Results in bold are significant at the $p < 0.05$ level.

Key takeaways:

- For the percentage of child clients who had tooth decay, the slope/trend was increasing pre-MMC, and post-MMC the slope/trend changed direction to decreasing (statistically significant). There was also a statistically significant decrease in level. This finding corroborates the pattern observed for 3.1.1 where a pattern of increased preventive dental care visits was observed. This finding supports hypothesis 3.4.1.
- For the rate of pressure ulcers per 1,000 member months, there was a level decrease post-MMC that was statistically significant, but this decrease was observed approximately 5 to 6 months after MMC implementation. There was no change in the increasing slope/trend pre-MMC to post-MMC. This finding provides some support for hypothesis 3.4.2.

In addition to the claim analysis, the NFQR survey was used to examine health and health care outcomes following the shift from FFS to a MMC health care delivery model (Measure 3.4.3). The NFQR survey examined NF residents with improvements in depressive symptoms with treatments by exploring the percentage of clients diagnosed with depression who reported improvement with treatment. The NFQR survey questions examined, included:

- 1) Has the resident been diagnosed with a depressive disorder (major depression, clinical depression, bipolar disorder, seasonal-affective disorder or dysthymia)?
- 2) What type of treatment is the resident receiving for depression?
- 3) Does the chart indicate that the resident has responded to treatment?

The questions to examine depression were not added until 2010. Overall on average the NFQR survey found that 60% of NF clients with depression reported an improvement with treatment. The percentage has been increasing since 2010, from 48% to 72.6% in 2015 (see Figure C.4.3).

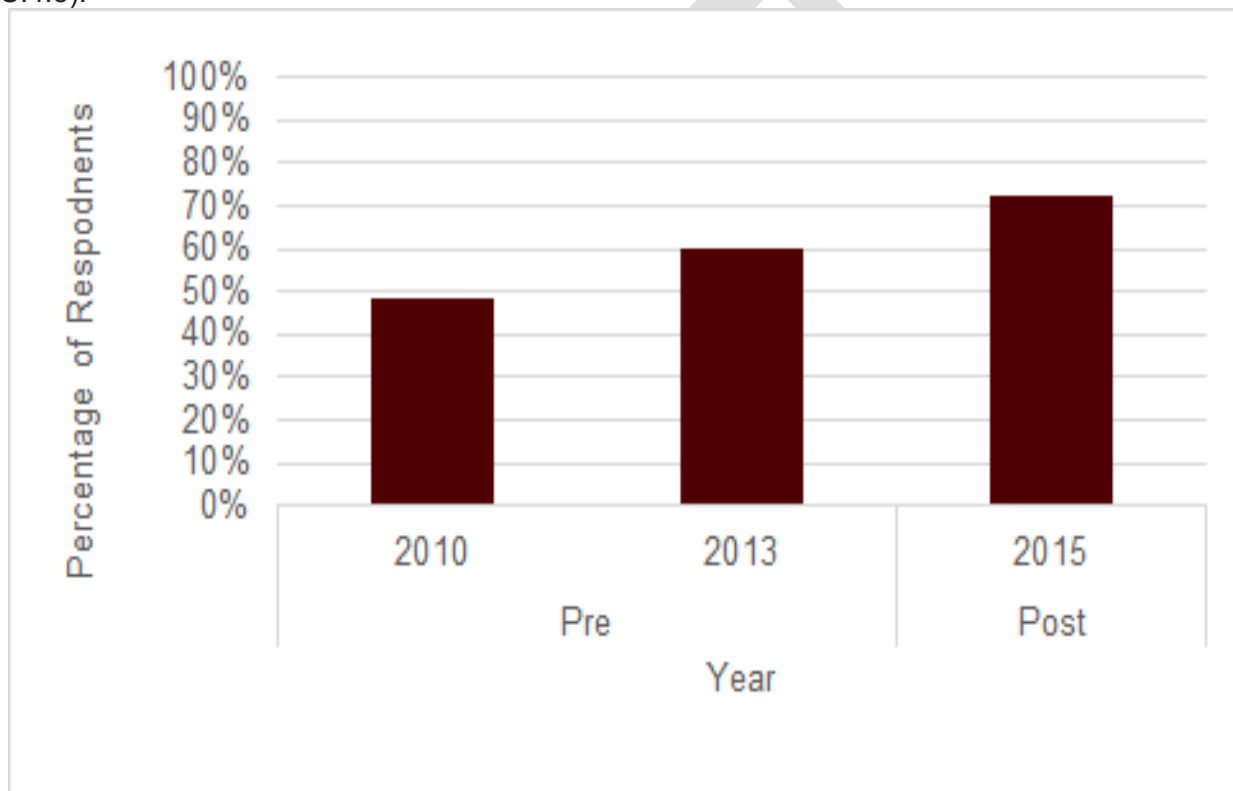


Figure C.4.3. Nursing Facility Quality Review (NFQR) Reported Percentage of NF Clients with Depression with an Improvement with Treatment, by Survey Year (Measure 3.4.3)

CLIENT SATISFACTION

Hypothesis 3.5 Client satisfaction will improve among clients whose Medicaid benefits shift from FFS to a MMC health care delivery model.

Hypothesis 3.5 was answered using NFQR and CAHPS surveys. The NFQR survey was used to examine client satisfaction with the nursing facility population through four survey questions (Measure 3.5.1). The questions included:

1. Overall, how satisfied are you with your (or your family member's) experience in this nursing facility?

Figure C.5.1. below displays the responses by survey year. Overall the average percentage of respondents who reported being satisfied with their experience in the nursing facility was 89.4% which was consistent over time. There was no difference between pre- and post-MMC implementation.

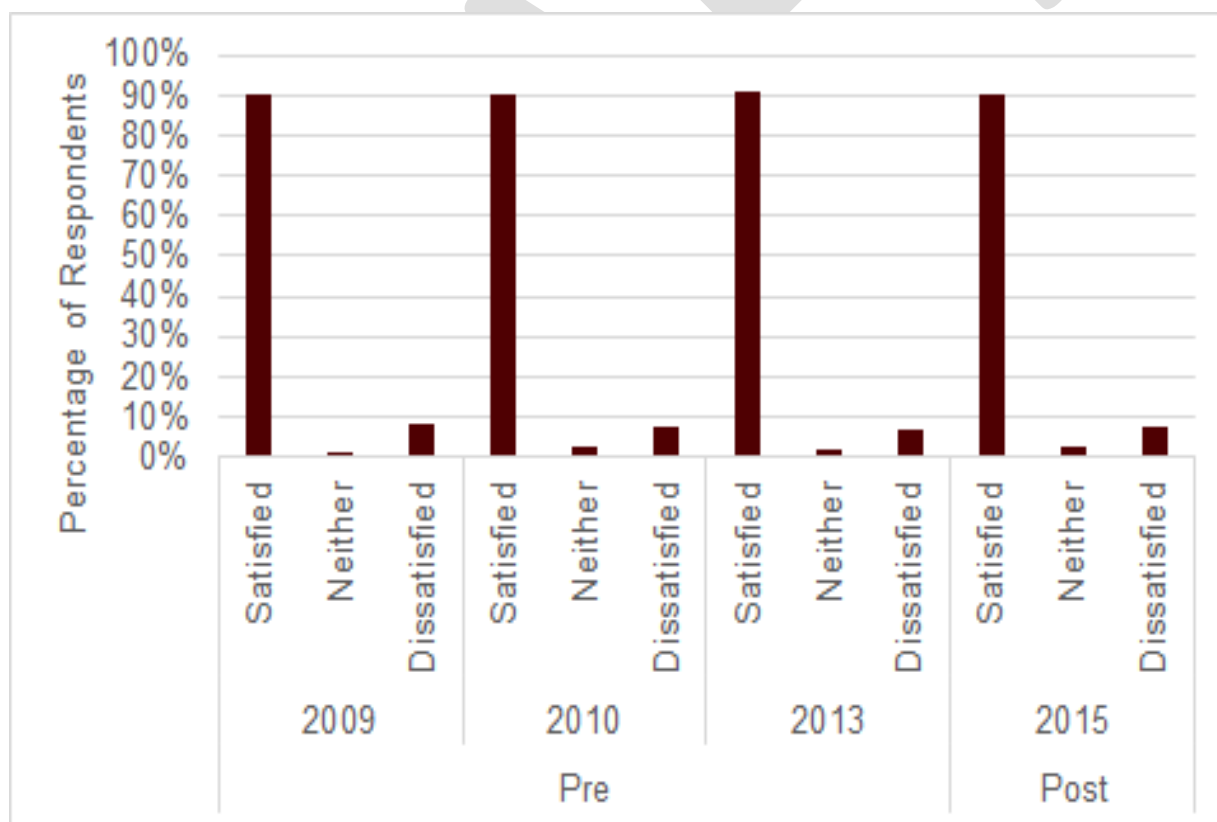


Figure C.5.1. Nursing Facility Quality Review (NFQR) Reported Satisfaction with Experience in Nursing Facility, by Survey Year (Measure 3.5.1)

2. Overall, how satisfied are you with your (or your family member's) health care services?

Figure C.5.2. below displays the responses by survey year. Overall the average percentage of respondents who reported being satisfied with their (or their family member's) health care services was 90.2% which was overall consistent. The highest percentage reported was in 2013 with 90.9% of respondents. There was a slight difference between pre- and post-MMC implementation, 90.3% vs. 89.4%, respectively.

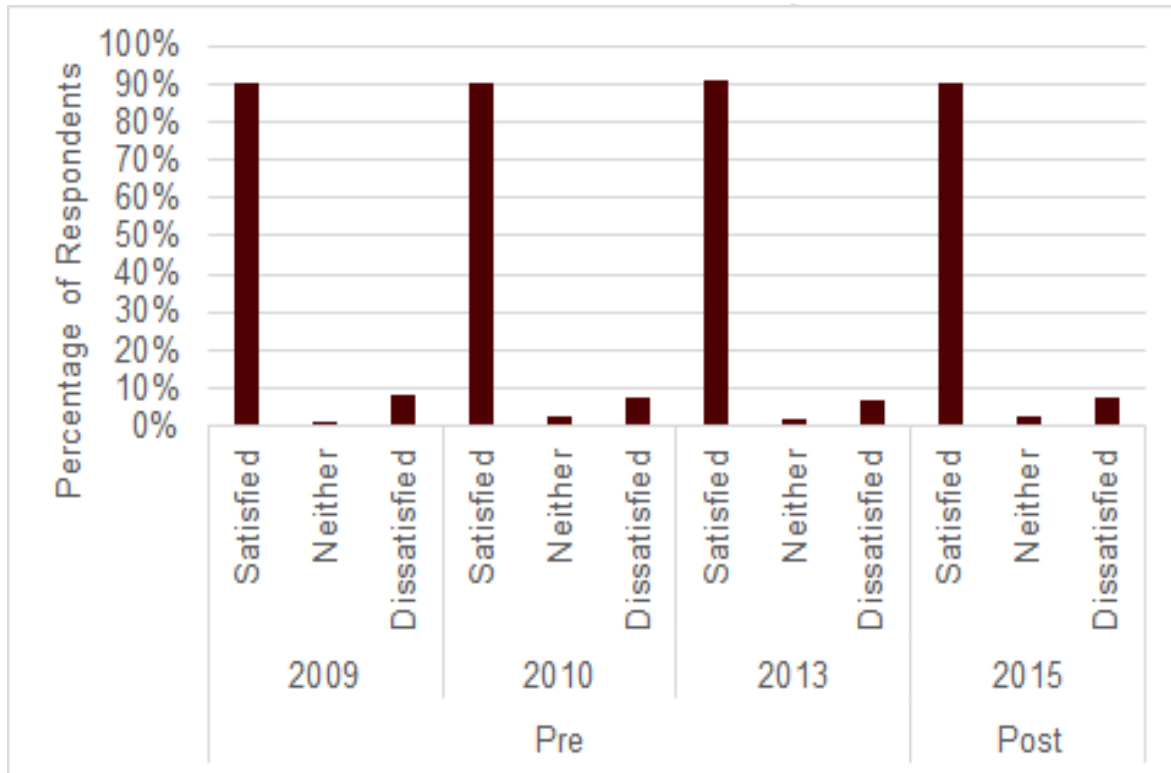


Figure C.5.2. Nursing Facility Quality Review (NFQR) Reported Satisfaction with Health Care Services Received, by Survey Year (Measure 3.5.1)

3. Do you ever have concerns that the facility does not address?

Figure C.5.3. below displays the responses by survey year. Overall the average percentage of respondents who reported having concerns that the facility did not address was 15.4%. There was a slight difference between pre- and post-MMC implementation, 13.8% vs 20.2%, respectively.

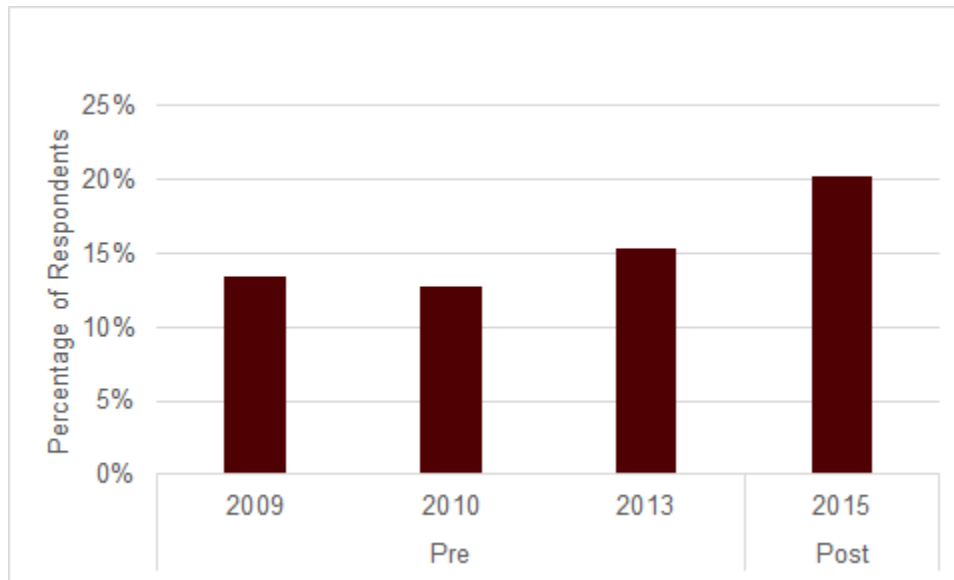


Figure C.5.3. Nursing Facility Quality Review (NFQR) Reported Percentage of Clients with Concerns the Facility Did not Address, by Survey Year (Measure 3.5.1)

4. Do you participate in meetings for planning your care?

Figure C.5.4. below displays the responses for 2015 the only year the survey question was asked. Overall almost 19% of respondents reported always or most of the time participating in meetings for planning their care.

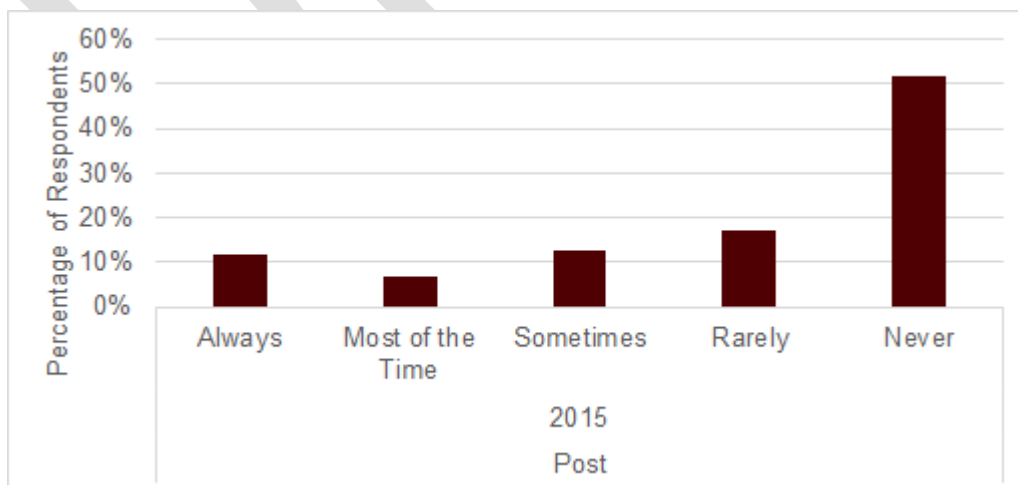


Figure C.5.4. Nursing Facility Quality Review (NFQR) Reported Participation in Care Plan Meetings, 2015 (Measure 3.5.1)

Next, the CAHPS Health Plan Survey was utilized to examine client satisfaction (Measure 3.5.2). At this time, only results from the 2019 CAHPS Health Plan Survey-Child were available. The 2020 CAHPS Health Plan Survey-Adult will be presented in the interim report. Client satisfaction was examined based on responses to “Using any number from 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate your child’s health plan?”. Overall 75% of the PCA population surveyed and 67% of the AA population surveyed rated their health plan as 9 to 10 (see Figure C.5.5.). The AA population had a higher percentage of respondents report ratings from 0 to 6, 14% vs 6%, respectively.

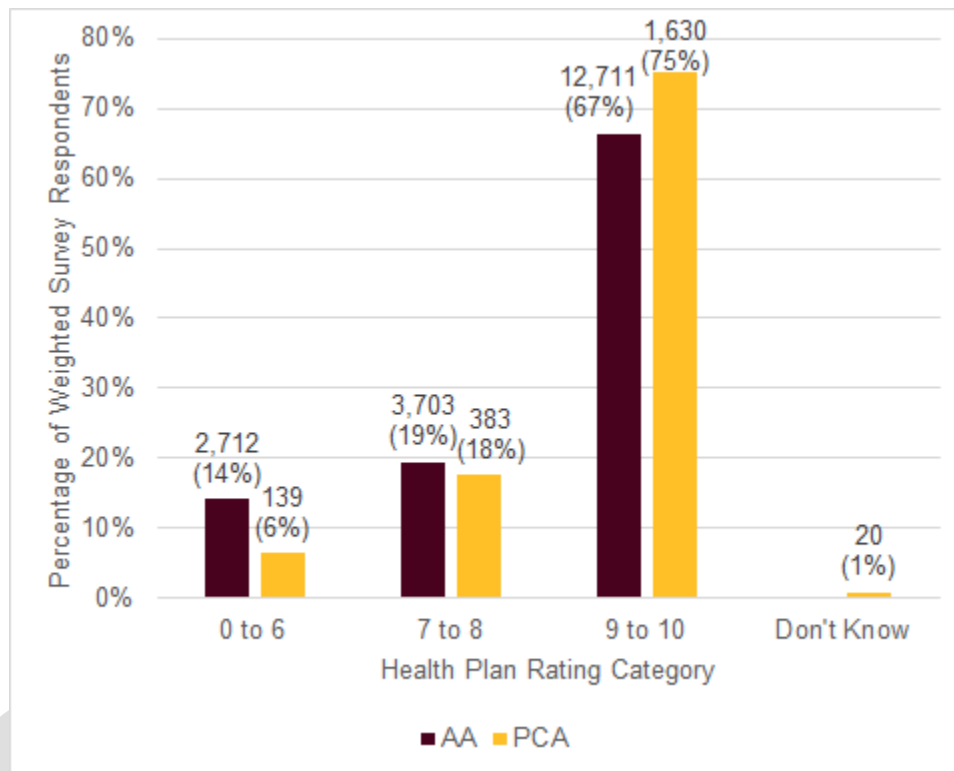


Figure C.5.5. Consumer Assessment of Healthcare Providers and System (CAHPS) Health Plan Rating by Population (Measure 3.5.2)

Key takeaways:

- The NFQR survey found:
 - Consistent percentages of survey respondents were satisfied with their experience in the nursing facility and health care services received pre- and post-MMC implementation.
 - A slightly higher percentage of survey respondents reported having concerns in the one post-demonstration available compared to pre-demonstration surveys.
 - Almost 19% of survey respondents reported participating in care plan meetings; unfortunately, there is no pre-data available to determine the impacts.
- The CAHPS survey demonstrated that a majority of those that completed the CAHPS Health Plan Survey-Child rated their health plan in the highest category. The survey was not conducted until 2019; thus, we are unable to make comparisons pre- and post-MMC implementation. There were slight differences between reported health plan ratings among AA and PCA populations.

SUMMARY OF EARLY RESULTS FROM THE MMC EVALUATION

Evaluation Question 3: Did the expansion of the MMC health care delivery model to additional populations and services improve healthcare (including access to care, care coordination, quality of care, and health outcomes) for MMC clients?

- The full impact of the expansion of MMC health care delivery model to additional populations and services cannot be fully examined until additional years of data are available
- Preliminary analysis provides some support for hypotheses:
 - 3.1: Access to care will improve among clients whose Medicaid benefits shift from FFS to MMC health care delivery model.
 - 3.4: Quality of care will improve among clients whose Medicaid benefits shift from FFS to an MMC health care delivery model.

DRAFT

D. OVERALL

ALTERNATIVE PAYMENT MODELS (APM)

Evaluation Question 4: Did the Demonstration impact the development and implementation of quality-based payment systems in Texas Medicaid?

The DSRIP program in the Texas Healthcare Transformation and Quality Improvement Program Medicaid 1115 Demonstration (Waiver) ran from 2012 sunsetting in September 2022. From there on out, managed care organizations (MCOs) and DSRIP providers will be required to move toward alternative payment models (APMs). Hence, it remains imperative to evaluate APMs throughout the Medicaid Program in Texas.

Development and Implementation of APMs

Hypothesis 4.1.1 The Demonstration will result in the development and/or implementation of a variety of APMs in Texas Medicaid.

We answered this question using Category A reporting data.

We described the pooled Category A reporting data for DY7 (2018) and DY8 (2019) through:

- Percentage of providers that have APMs
 - For Overall Texas
 - Per RHP
- Percentage of types of APM/value-based payment (VBP) arrangements for each DY
- Percentage of providers with types of APM framework for each DY

Results

Percentage of providers with APM/VBP arrangements by DY (overall Texas)

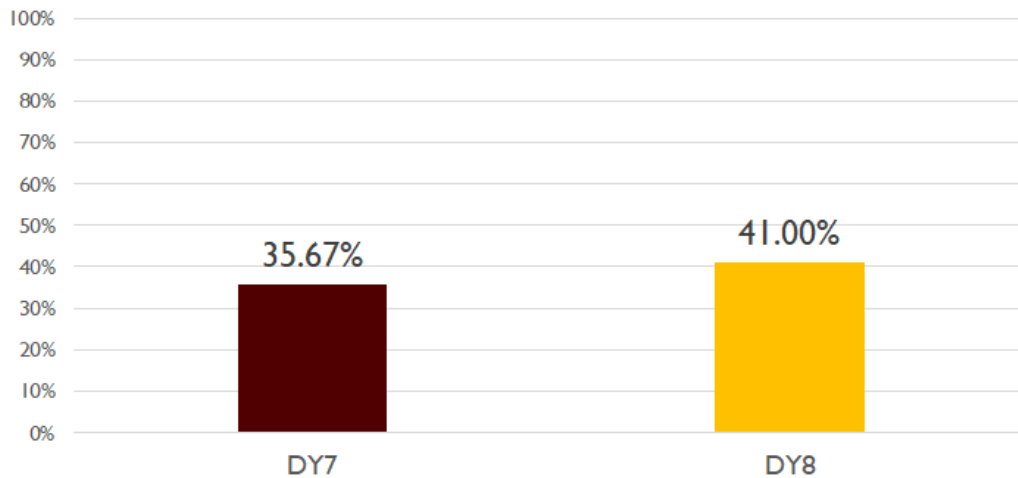


Figure D.1.1. Percentage of providers that have APMs (overall Texas)

Percentage of providers that have APM/VBP arrangement by RHP for each DY

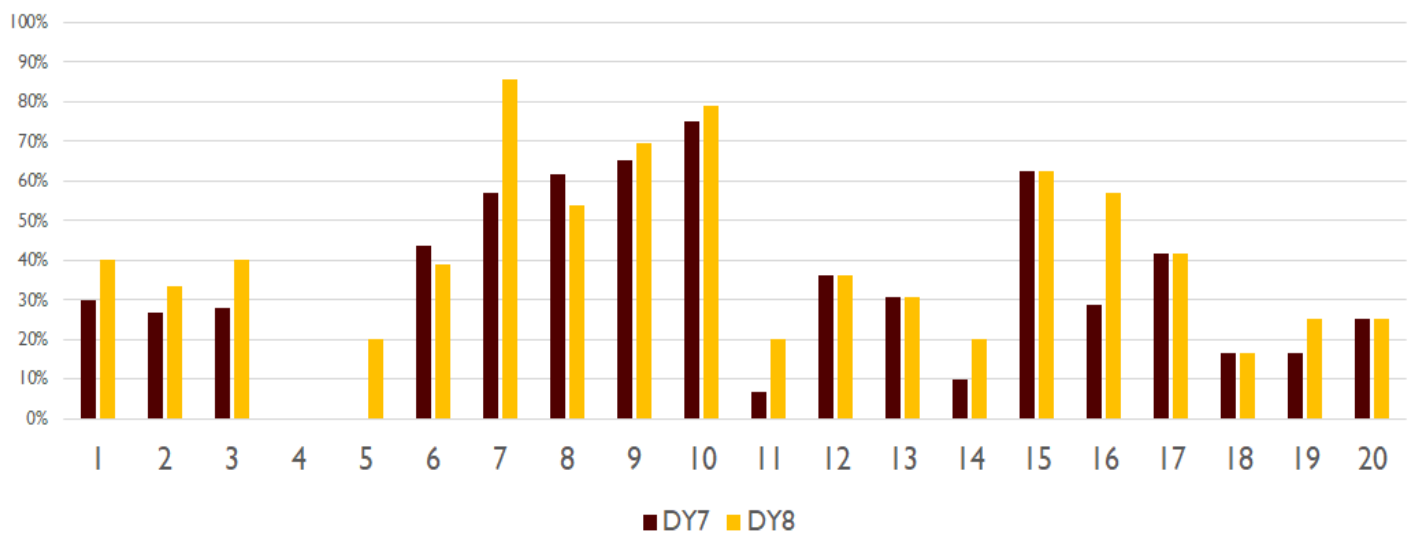


Figure D.1.2. Percentage of providers that have APMs (per RHP)

We divided the types of APM/VBP arrangements based on APM framework by the Health Care Payment Learning & Action Network (LAN) into the 4 categories shown in the figure D.1.3 below:

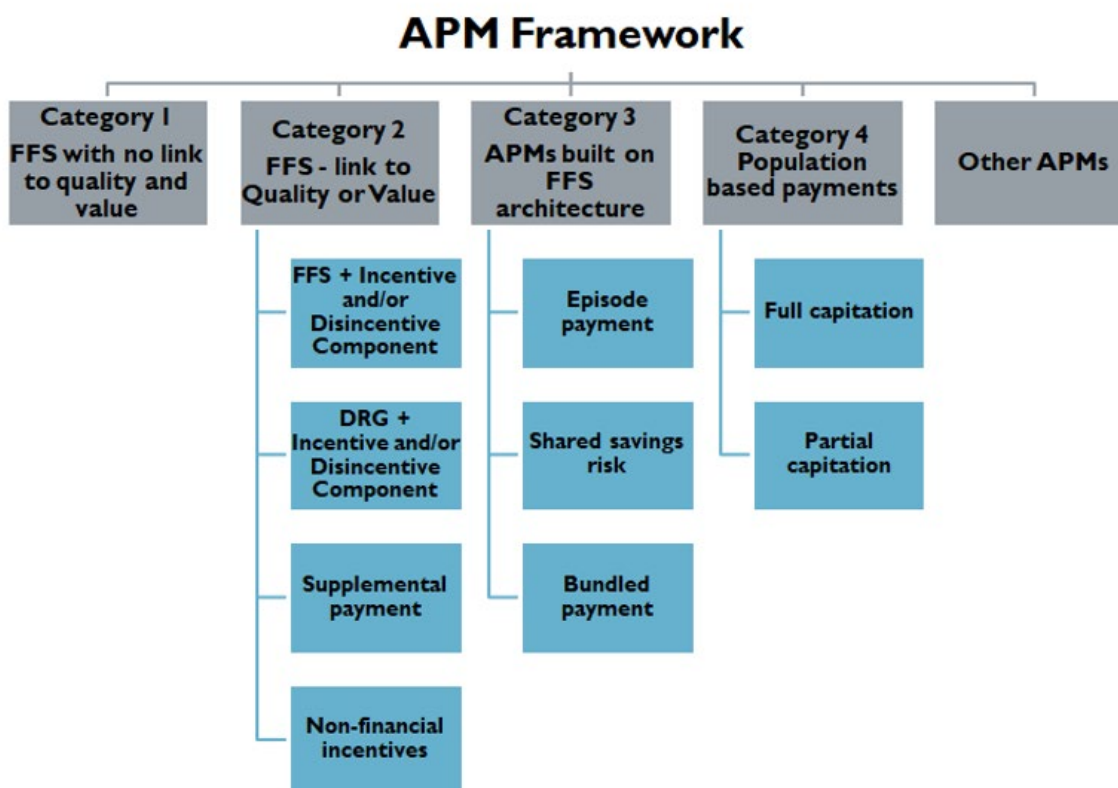


Figure D.1.3. APM framework.

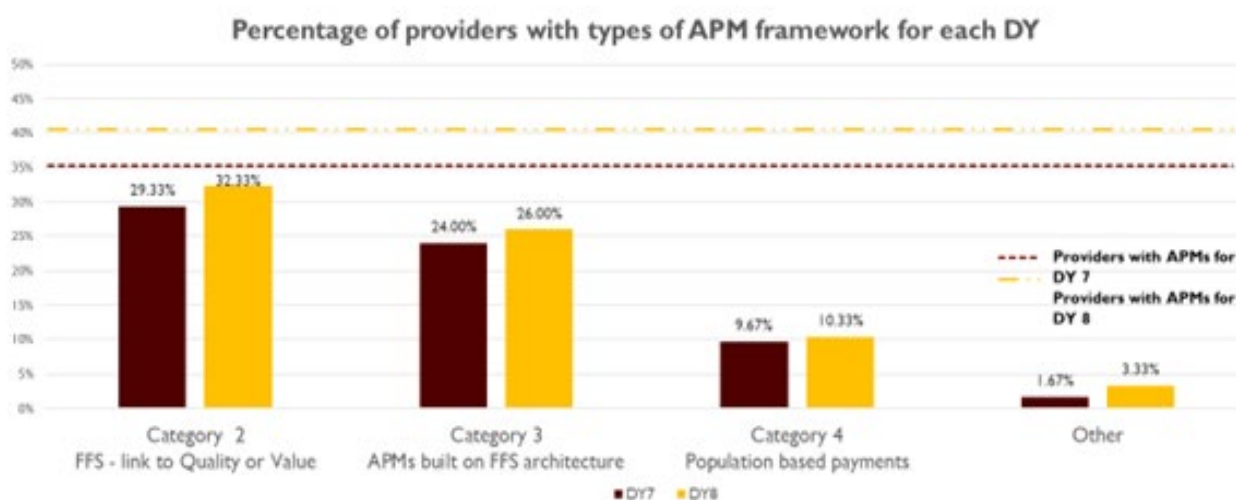


Figure D.1.4. Percentage of providers with types of APM framework for each DY

Barriers and benefits to developing and/or implementing APMs

Hypothesis 4.1.2 Perceived barriers to developing and/or implementing alternative payment models

Hypothesis 4.1.3 Perceived benefits to developing and/or implementing alternative payment models

Hypothesis 4.1.2 and 4.1.3 primarily used the APM section of the DSRIP wave 1 data (June 2020). The main analytical approach used was descriptive statistics for Likert scale questions and content analysis for the open-ended questions on benefits and challenges of APMs. Likert scale was 1 for strongly disagree and 5 for strongly agree.

Results

We received a total of 229 responses. Below are the graphs for mean scores by RHP with overall Texas average for the likert scale questions.

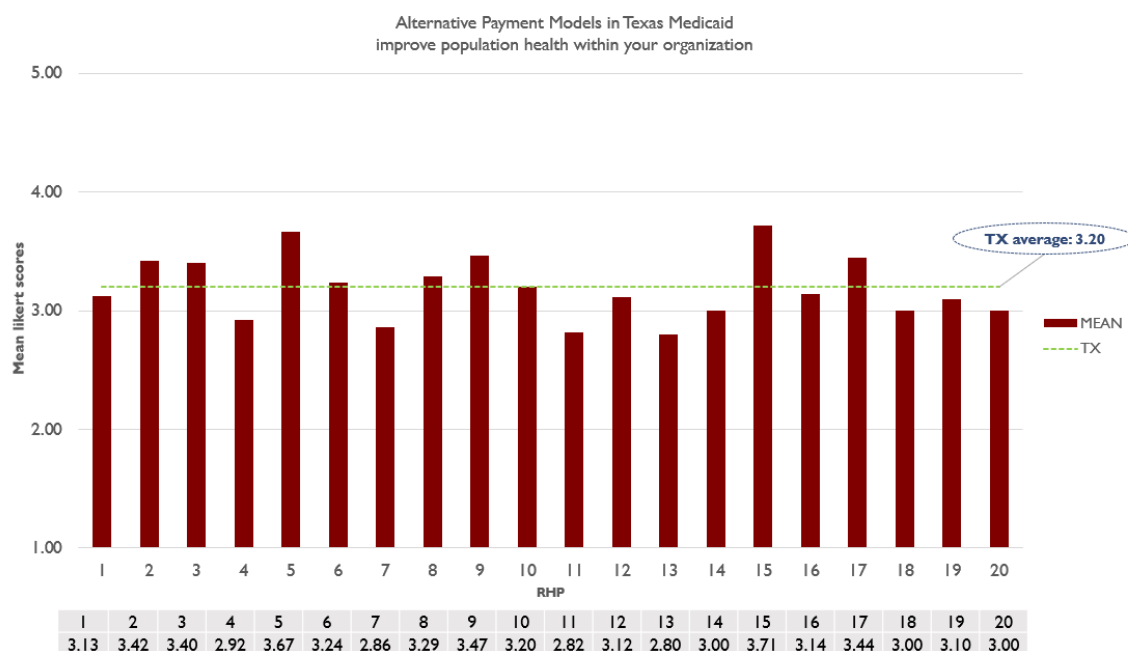


Figure D.1.5. Mean Likert Scores for APMs in Texas Medicaid improving population health within organizations

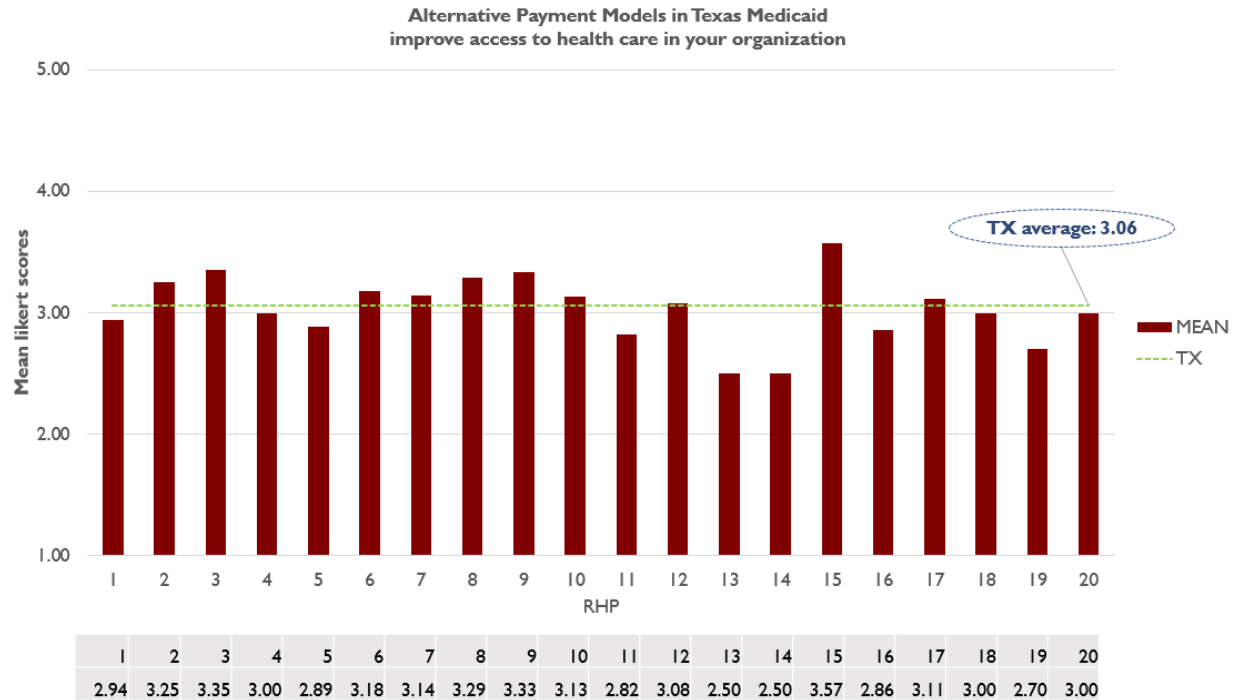


Figure D.1.6. Mean Likert Scores for APMs improving access within organizations

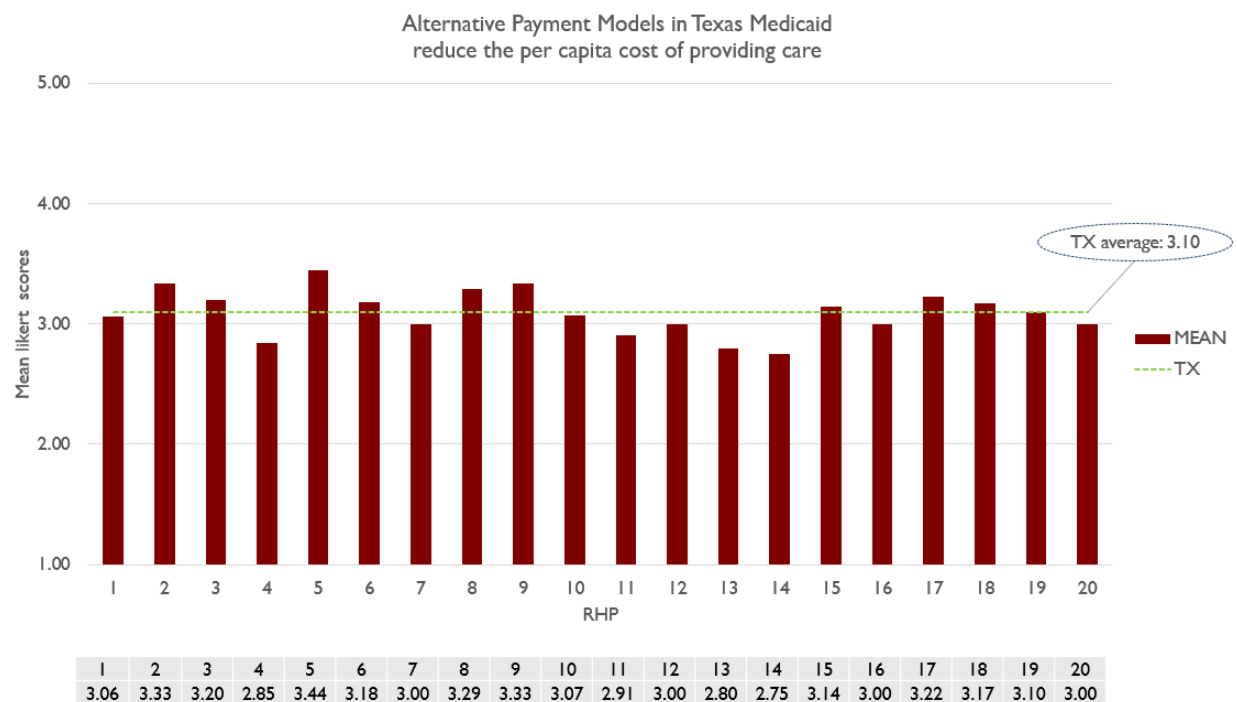


Figure D.1.7. Mean Likert Scores for APMs in Texas Medicaid reducing per capita cost of providing care within organizations

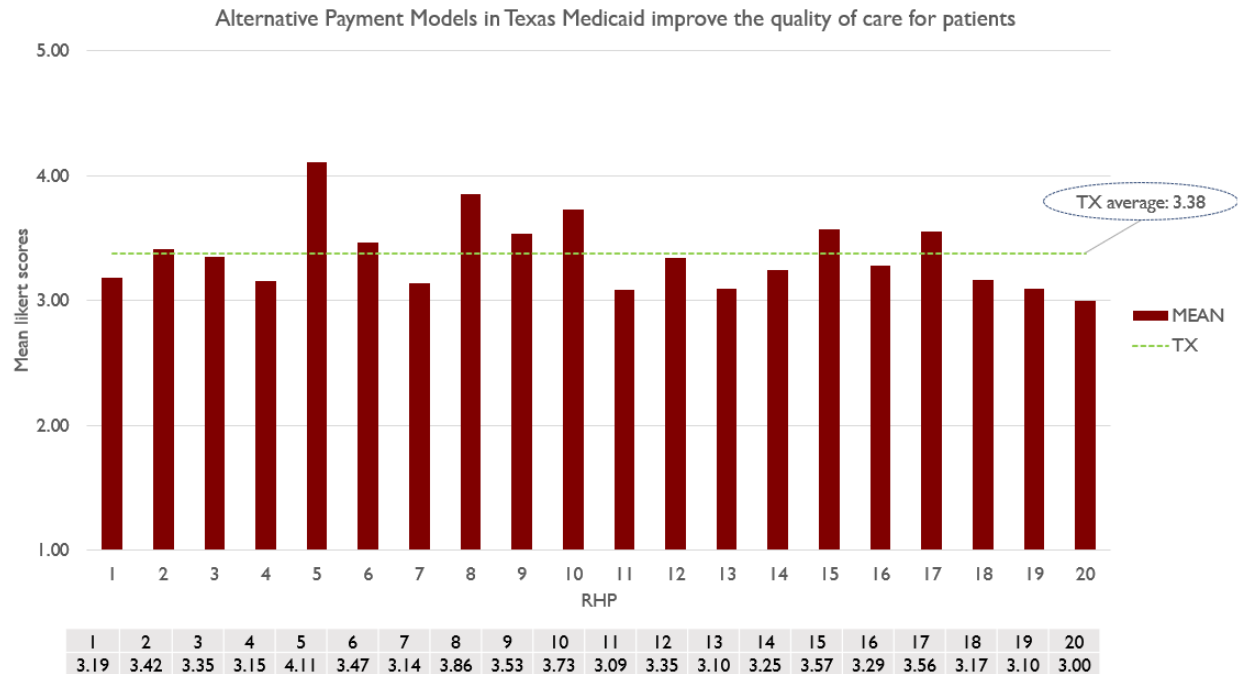


Figure D.1.8. Mean Likert Scores for APMs in Texas Medicaid improving quality of care for patients

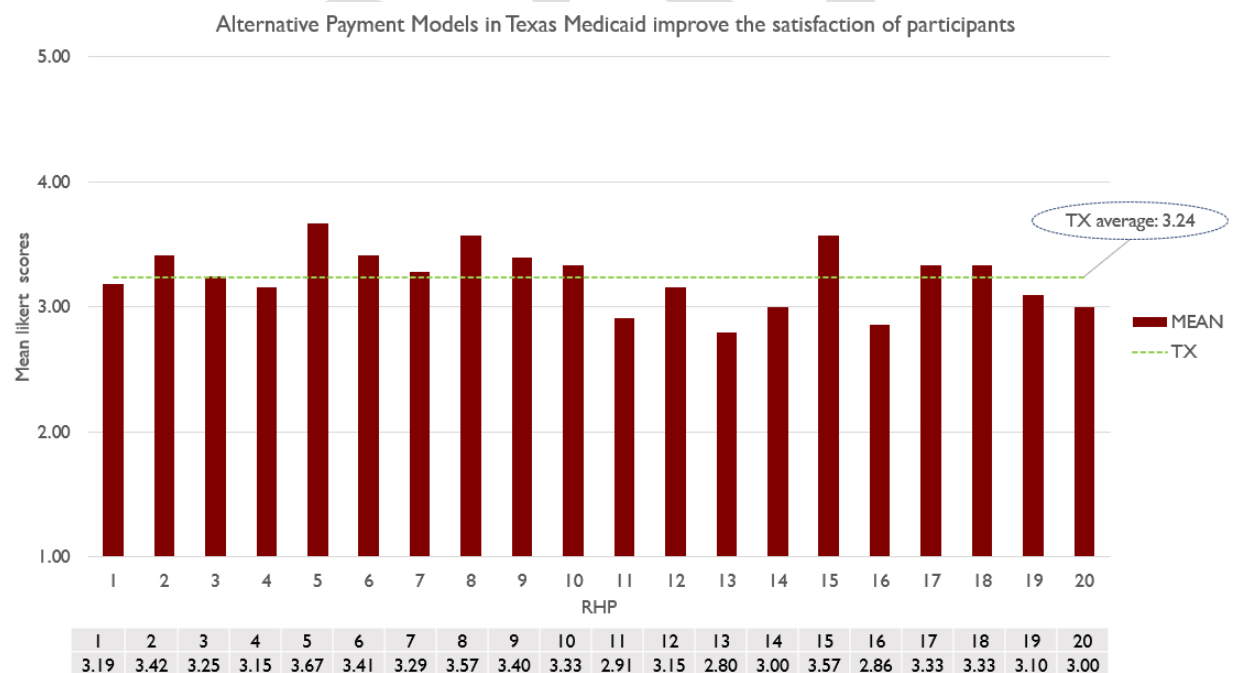


Figure D.1.9. Mean Likert Scores for APMs in Texas Medicaid improving satisfaction of participants

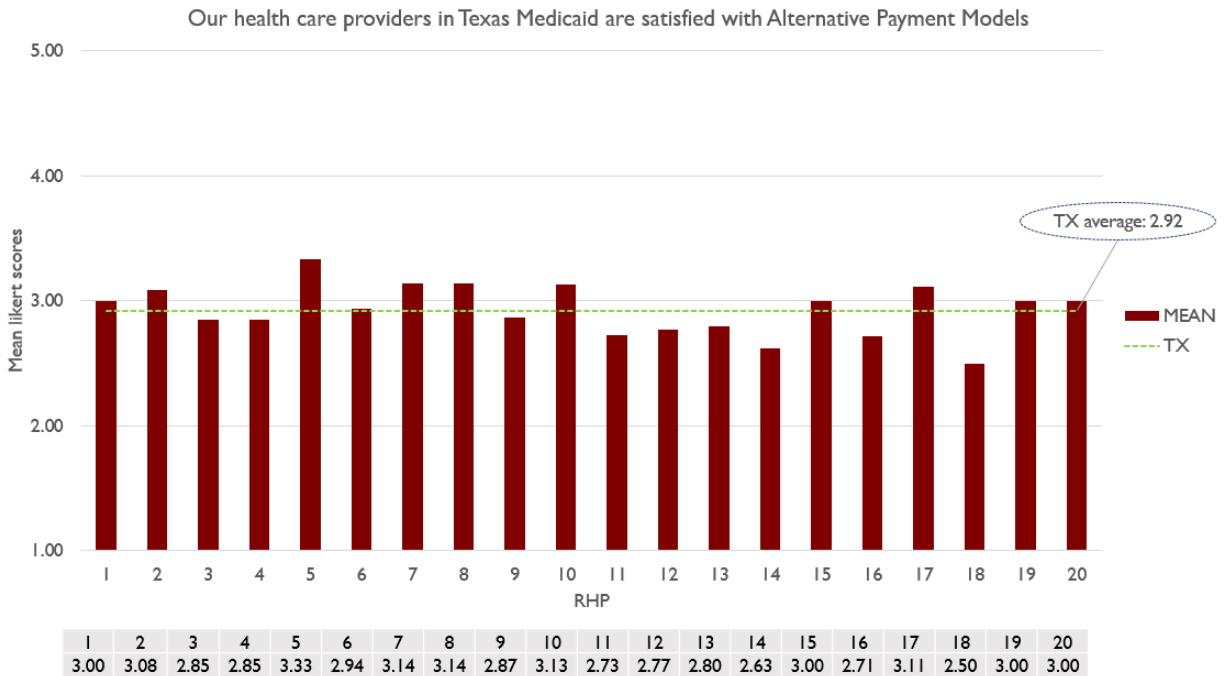


Figure D.1.10. Mean Likert Scores for provider satisfaction with APMs in Texas Medicaid

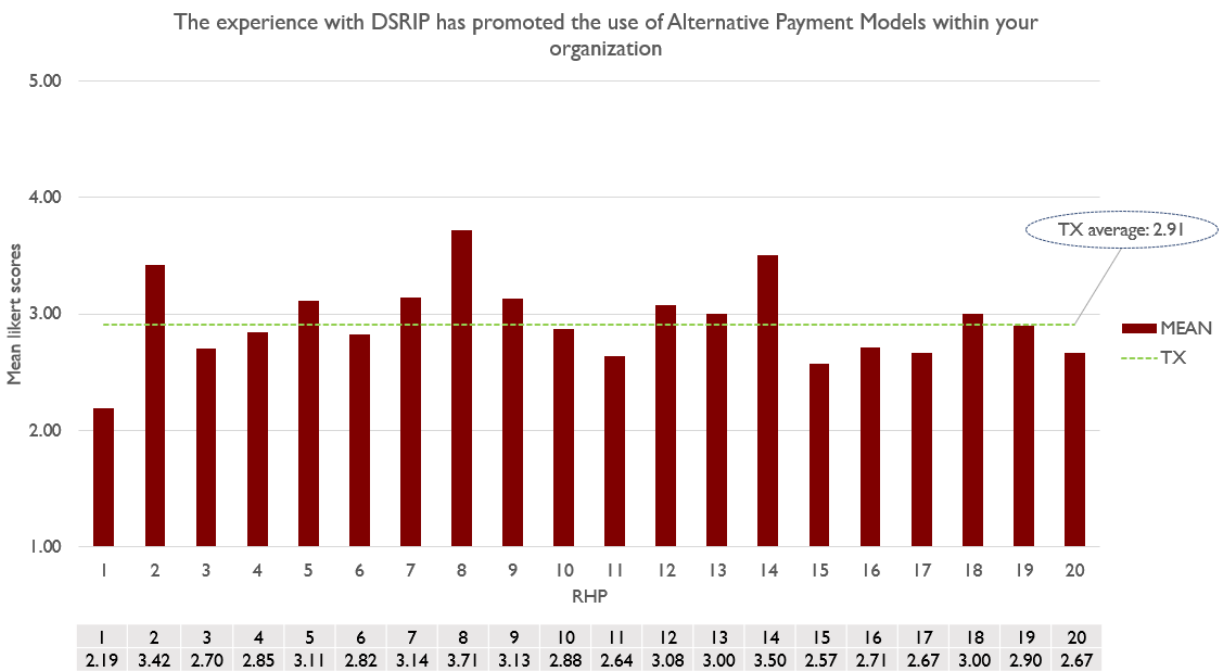


Figure D.1.11. Mean Likert Scores for DSRIP promoting use of APMs within organizations

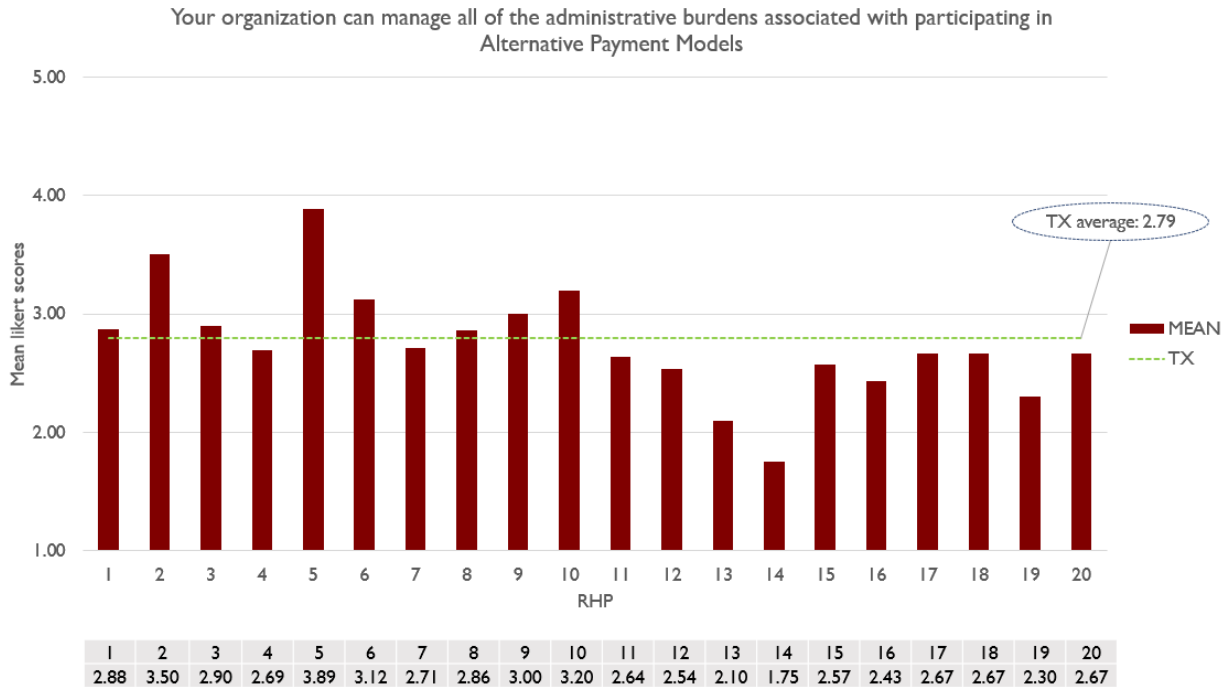


Figure D.1.12. Mean Likert Scores for organizations being able to manage all of the administrative burden associated with participating in APMs

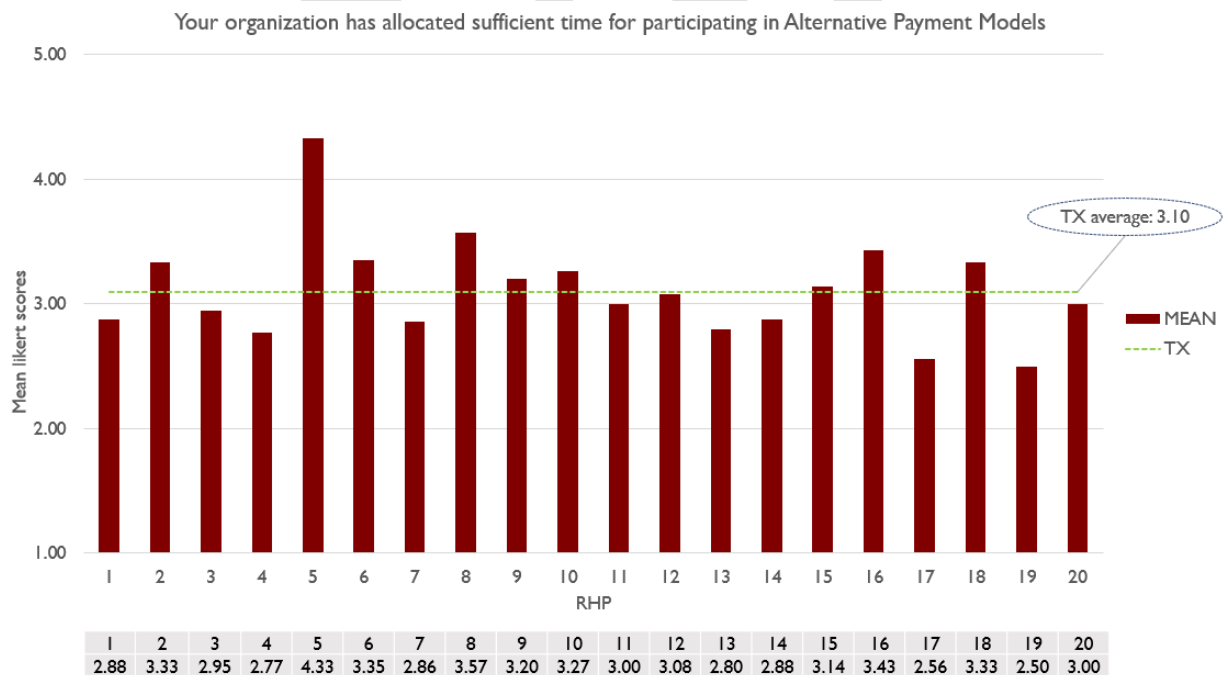


Figure D.1.13. Mean Likert Scores for organizations being able to allocate sufficient time for participating in APMs

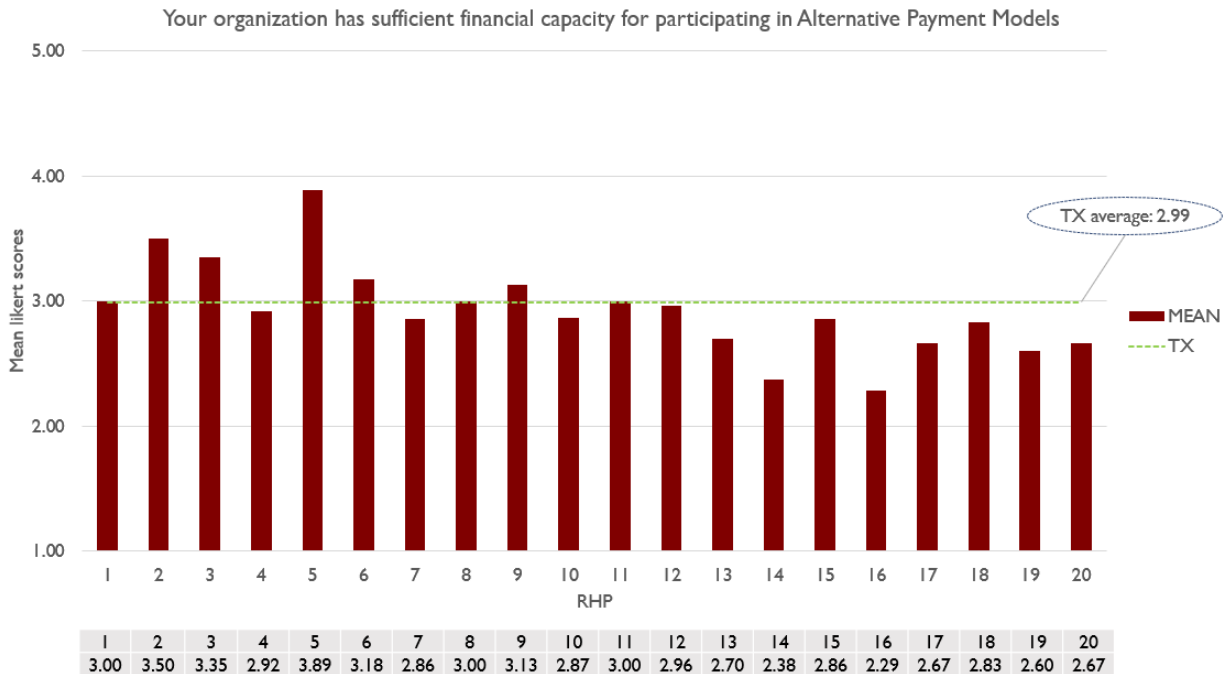


Figure D.1.14. Mean Likert Scores for organizations having sufficient financial capacity for participating in APMs

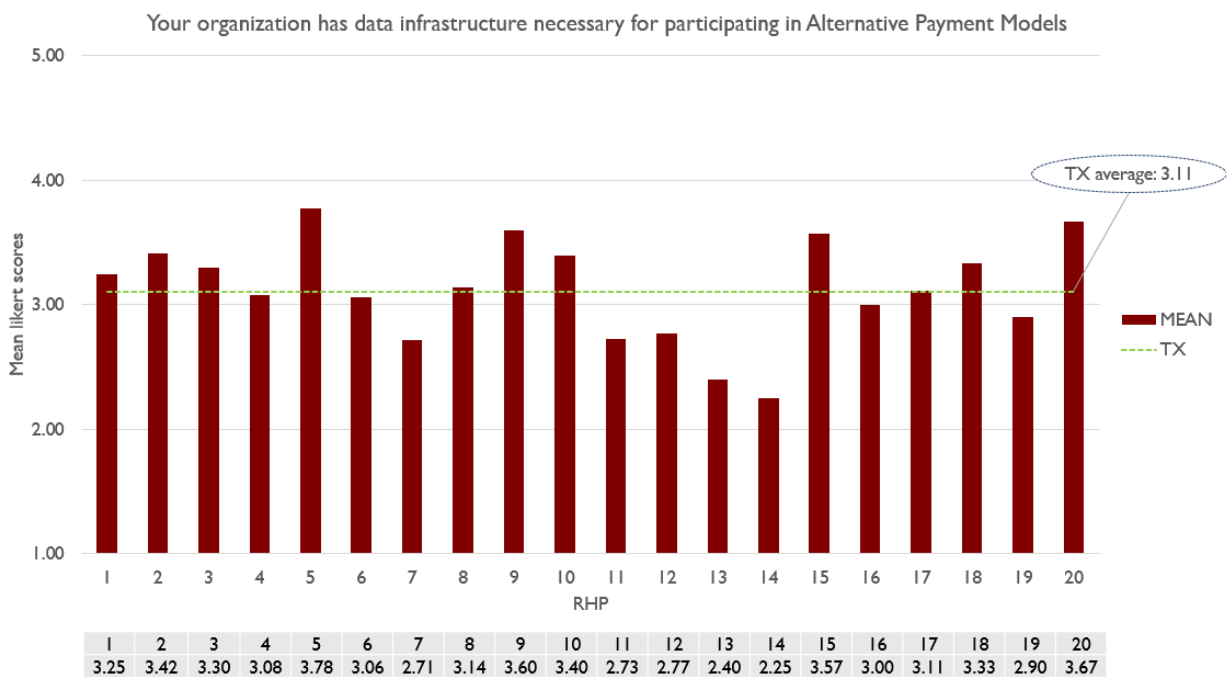


Figure D.1.15. Mean Likert Scores for organizations having data infrastructure necessary for participating in APMs

Content Analysis

Below are the results of content analysis of the open-ended questions to assess the perceived benefits and barriers to participating in Alternative Payment Model Initiatives.

Main themes for perceived benefits were financial efficiency, data sharing, quality of care, collaboration and care coordination are summarized in Table D.1.1

Table D.1.1. Main themes and quotes for perceived benefits to developing and/or implementing APMs

Themes	Quotes
Financial efficiency	"Participation in APMs have resulted in some increased revenue for the organization.."
Data sharing	"Finally, data sharing is a critical ingredient in the success for APMs. BTCS has recently seen an increased willingness from the MCOs to implement data sharing processes. Some MCOs are more advanced, having a more robust ability to share timely data reports. BTCS has also been able to grow the data sharing capacities through the implementation of Care Coordination, which has been incorporated into some of the APM agreements..."
Quality of care	"Benefits for alternative payment model participation include improved quality of patient care..."
Collaboration	"One of the benefits we have noted in participation in APMs is a better sharing of client data between Burke and the MCO. We have also been able to develop a more collaborative relationship with the MCOs, and have been able to demonstrate the value that Burke provides to the MCOs members.."
Care coordination	"Alternative arrangements have allowed Integral Care to invest in the areas demonstrably better for the client such as care coordination."

Main themes for perceived barriers were lack of MCO engagement, administrative burden, low volume setting, small organization, rurality, non-uniformity of quality/performance measures, and financial burden are described in Table D. 1.2.

Table D.1.2. Main themes and quotes for perceived barriers to developing and/or implementing APMs

Themes	Quotes
Lack of MCO engagement	"MCOs have not been very willing and open partners to this - they struggle to share data in a timely and meaningful way. It took over a year to come to an agreement, get data sources identified and vetted and then the payout was not all that significant.." "MCO's have not been willing to work due to the low volume of patients that we serve who receive Medicaid."
Administrative burden	"Challenges for alternative payment model participation include increased administrative burden regarding documentation and reporting..."
Low volume setting	"Organization is a small rural critical access hospital. Small volumes make it difficult to adopt APMs."

Small organization	“We are a small non-profit with very limited administrative bandwidth..” “As a smaller entity we don't have the resources..”
Rurality	“When a provider such as a small rural hospital does not have the depth of patients in any one insurance provider, participating in an APM would be tremendously risky financially.”
Non-uniformity of quality/performance measures	“A major challenge faced by entering into VBP arrangements is the disparity in performance measurement criteria from different payers, which may not align with an organizations quality goals or governmental performance criteria. Tracking multiple quality metrics in a meaningful way places a heavy burden on a health system's resources.”
Financial burden	“While we have definitely achieved success, it has been difficult to sustain positive performance and we continue to leave significant dollars on the table.”

Tentative Results & Observations:

- Percentage of providers with APM/VBP arrangements in Texas increased from 35.67% in DY7 to 41.00% in DY8
- Most RHPs showed an increase in APM/VBP arrangements with the exception of RHP 4, 6, and 8.
- Through the APM section of the DSRIP wave 1 survey, we found that most organizations had neutral responses about how APMs improved access, population health, reduced costs, improved quality of care and satisfaction for participants.
- We also found that the organizations slightly disagreed that providers were satisfied with APMs. They also slightly disagreed that DSRIP promoted the use of APMs and that APMs were an administrative burden.
- Through content analysis we explored the perceived benefits and barriers to participation in APMs.
 - Most organizations perceived financial efficiency as a benefit to participation in APMs.
 - Lack of MCO engagement was perceived as the top barrier to participation in APMs.

HEALTH CARE SYSTEM FOR THE MLIU POPULATION IN TEXAS

Evaluation Question 5: Did the Demonstration transform the health care system for the MLIU population in Texas?

Emergency Department (ED) Analysis use for the MLIU population

Hypothesis 5.1: The Demonstration will result in a reduction of potentially preventable ED use for the MLIU population.

HHSC will be submitting a revised Evaluation Design Plan to CMS with adjustments to Measure 5.1.1 (potentially preventable emergency department use). We have obtained 2018 data for a feasibility analysis that has been completed. We have submitted Texas DSHS IRB to obtain 2016, 2017, and 2019 data to conduct ITS. We expect to receive all data needed to complete this section by January 2020.

Budget Neutrality

Hypothesis 5.2: The Demonstration will result in overall cost savings compared to the Medicaid program without the Demonstration, as shown in the budget neutrality calculation.

HHSC provided the team with a Demonstration Budget Neutrality Worksheet which was used to examine annual growth rates pre- and post-demonstration (see figures D.2.2 and D.2.3).

Tentative Results & Observations:

- The Demonstration has resulted in overall cost savings compared to the Medicaid program without the demonstration, as shown in the budget neutrality calculation.
- The projected spending also suggests that this trend in cost savings will continue.

Expenditure Annual Growth Rates (Aggregate)

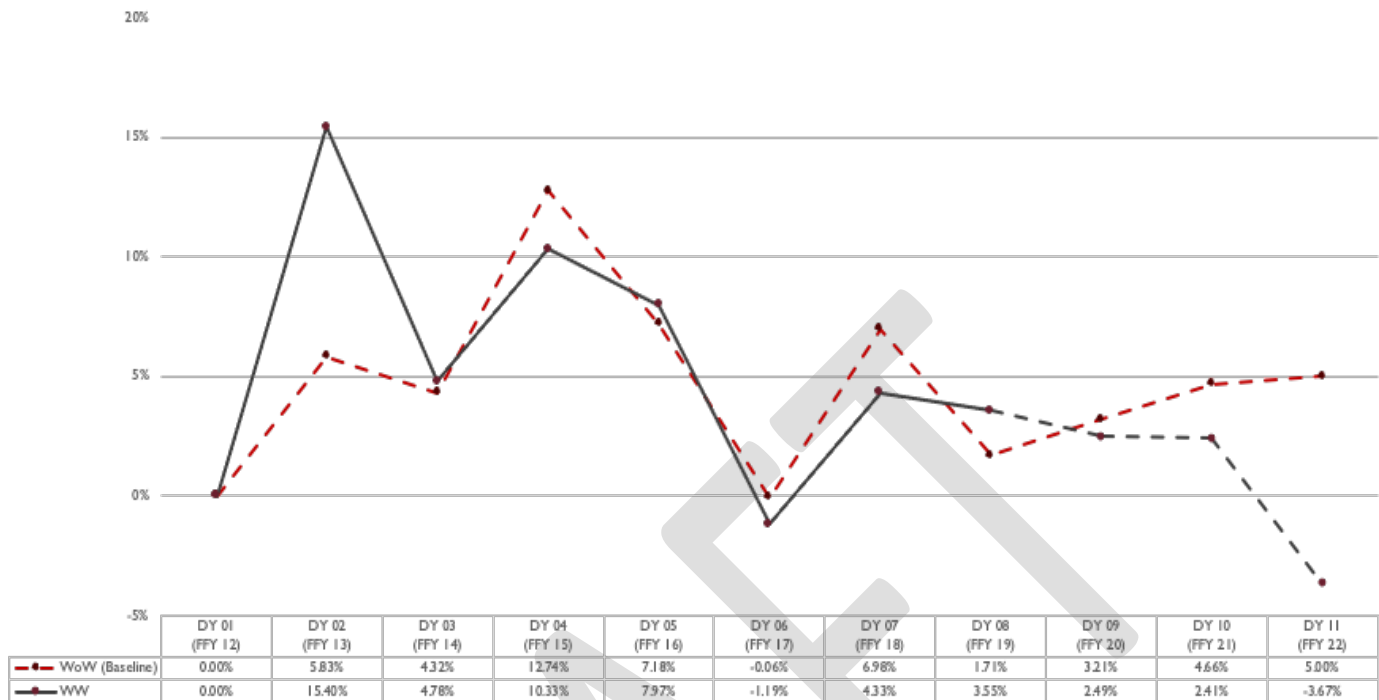


Figure D.2.2. Expenditure Annual Growth Rate (Aggregate)

Eligible Groups Served Comparison (Aggregate)

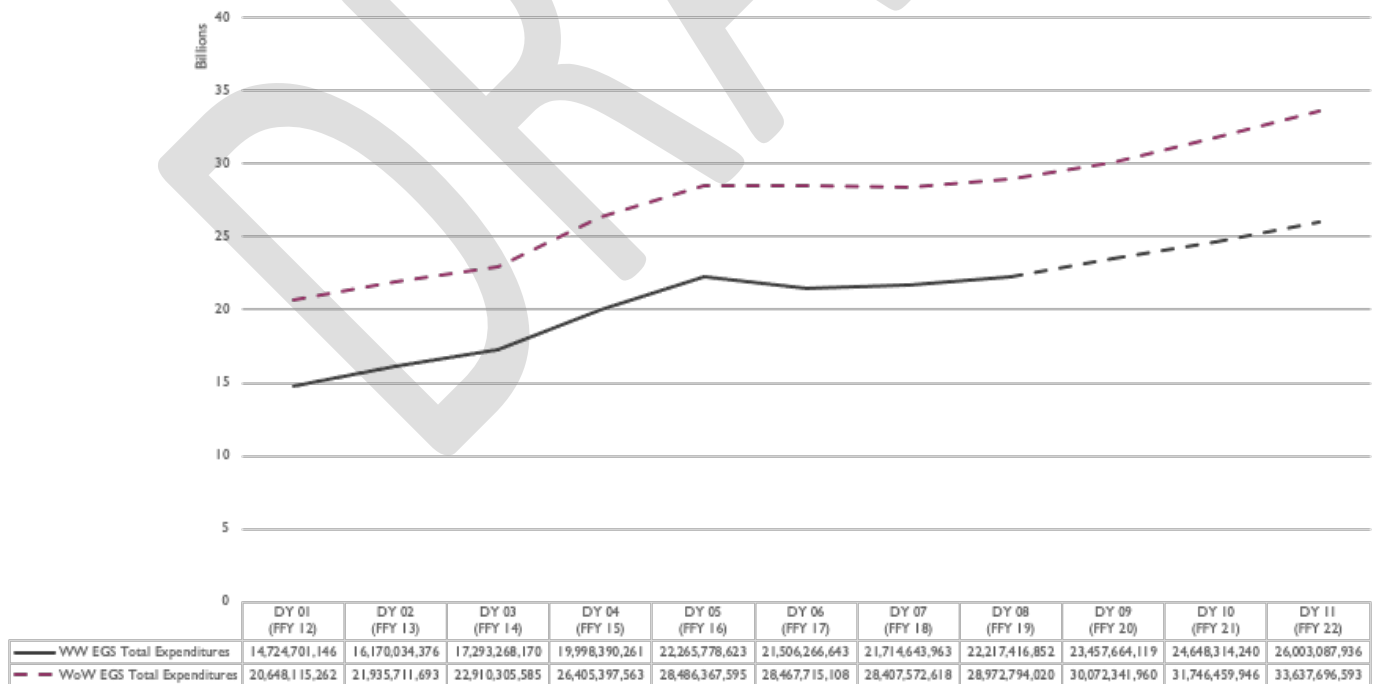


Figure D.2.3. Eligible Groups Served (Aggregate)