Texas Healthcare Transformation and Quality Improvement Program
Quality Improvement Strategy

Since 1991, the Texas Health and Human Services Commission (HHSC) has overseen and coordinated the planning and delivery of health and human service programs in Texas. HHSC was established in accordance with Texas Government Code Chapter 531 and is responsible for the oversight of all Texas health and human service agencies. It is the goal of HHSC to use its Quality Improvement Strategy to:

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

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

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

HHSC's fundamental commitment is to contract for results. HHSC defines a successful result as the generation of defined, measurable, and beneficial outcomes that satisfy the contract requirements and support HHSC's missions and objectives.

TEXAS HEALTH CARE TRANSFORMATION AND QUALITY IMPROVEMENT PROGRAM 1115 WAIVER

The Texas Healthcare Transformation and Quality Improvement Program 1115 Waiver, known as the 1115 Transformation Waiver, is a five-year demonstration waiver running through September 2016 that allows the state to expand Medicaid managed care, including pharmacy and dental services, while preserving federal hospital funding historically received as Upper Payment Level payments.

There are multiple programs included in the 1115 Transformation Waiver:

STAR

Medicaid's State of Texas Access Reform (STAR) program is the managed care program in which HHSC contracts with managed care organizations to provide, arrange for, and coordinate preventative, primary, and acute care covered services, including pharmacy.

As of March 1, 2012, adults receiving SSI and residing in the Medicaid Rural Service Area were mandatorily enrolled in STAR, as were adults residing in the Medicaid Rural Service Area who were enrolled in Department of Aging and Disability Services' 1915(c) waiver programs. Children

receiving SSI and residing in the Medicaid Rural Service Area were voluntarily enrolled in STAR. Some children residing in the Medicaid Rural Service Area and receiving Department of Aging and Disability Services 1915(c) waiver program services were voluntarily enrolled in STAR, while others were required to enroll.

Beginning January 1, 2014, children who previously received foster care and who are ages 18-20 years old will be mandated into the managed care model, but allowed to choose between STAR or STAR Health. STAR Health is the existing managed care program for children in foster care. Children who previously received foster care and who are ages 21 to 25 will be mandatory in STAR.

Beginning September 1, 2014, individuals residing in the Medicaid Rural Service Area and receiving SSI or Department of Aging and Disability Services 1915(c) waiver services will be mandatorily enrolled in STAR+PLUS.

STAR+PLUS

STAR+PLUS is the agency's program for integrating the delivery of acute and long-term services and supports through a managed care system. STAR+PLUS enrollment is mandatory for adults receiving SSI and non-SSI adults who qualify for STAR+PLUS home and community-based services. STAR+PLUS operates in the Bexar, Dallas, El Paso, Harris, Hidalgo, Jefferson, Lubbock, Nueces, Tarrant and Travis Service areas. Acute, pharmacy, and long-term services and supports are coordinated and provided through a provider network contracted with managed care organizations. Children under age 21 who receive SSI may voluntarily enroll in STAR+PLUS.

Beginning September 1, 2014, STAR+PLUS will expand to the Medicaid Rural Service Area, becoming a statewide program. Enrollment will be mandatory for acute care services for individuals not enrolled in Medicare who are receiving 1915(c) waiver services through Community Living Assistance and Support Service, Deaf Blind with Multiple Disabilities, Home and Community-based Services program, and Texas Home Living, and individuals in an intermediate care facility for individuals with intellectual disabilities or a related condition. STAR+PLUS enrollment will be voluntary for acute care services for children under the age of 21 receiving services from one of the above listed 1915(c) waivers as well as the Medically Dependent Children Program and the Youth Empowerment Services program. Adult residents of nursing facilities who receive Medicaid will also be mandatorily enrolled into STAR+PLUS.

STAR+PLUS Home and Community-based Services

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

On September 1, 2014, the Department of Aging and Disability Services Community Based Alternatives waiver program will be terminated. All remaining individuals receiving Department of Aging and Disability Services Community Based Alternatives services will transition into the STAR+PLUS home and community based services program.

Dental

Effective March 1, 2012, children's Medicaid dental services are provided through a managed care model to children under age 21 who are eligible for Medicaid Texas Health Steps Comprehensive Care services or SSI. Children residing in institutional settings or receiving STAR Health services receive dental through a fee-for-service model. Members who receive dental services through a Medicaid managed care dental plan are required to select a dental plan and a main dentist. A main dentist serves as the client's dental home and is responsible for providing routine care, maintaining the continuity of patient care, and initiating referrals for specialty care.

The 1115 Transformation Waiver does not include any provisions for the Children's Health Insurance Program (CHIP) or STAR Health programs, which are covered under separate agreements.

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

Uncompensated Care Pool

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

Delivery System Reform Incentive Payment Pool

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

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

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

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

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

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

In order to achieve and sustain success at responding to community needs, providers and communities will need to apply best practices in continuous quality improvement. Most notably, learning collaboratives are essential to the success of high quality health systems that have achieved the highest level of performance. Participants are strongly encouraged to form learning collaboratives to promote sharing of challenges and testing of new ideas and solutions by providers implementing similar projects in each Regional Healthcare Partnership. These regionally-focused learning collaboratives also can inform the learning collaborative conducted annually during demonstration years three through five to share learning, experiences, and best practices acquired from the Delivery System Reform Incentive Payment program across the State.

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

BASIS FOR QUALITY IMPROVEMENT STRATEGY

In accordance with Federal regulations, the State must develop a quality strategy to reflect all managed care programs and plans operating under the 1115 Transformation Waiver. The State must also provide the Centers for Medicare and Medicaid Services (CMS) with annual reports on the implementation and effectiveness of the updated comprehensive Quality Strategy as it affects the 1115 Transformation Waiver. The Code of Federal Regulations includes requirements outlining the components of a state quality strategy. The underlying requirement is that the contract between the State and the managed care organizations must include specified elements related to quality. The Uniform Managed Care Contract can be accessed at http://www.hhsc.state.tx.us/medicaid/UniformManagedCareContract.pdf and the Uniform Managed Care Manual can be accessed at http://www.hhsc.state.tx.us/medicaid/UMCM/index.shtml.

STRUCTURE OF QUALITY IMPROVEMENT STRATEGY

The 1115 Quality Improvement Strategy encompasses multiple programs and divisions within HHSC, including Quality Assurance, Health Plan Management, the Office of Health Policy and Clinical Services, as well as advisory committees, and the external quality review organization. This section describes each of these programs and their role in the Strategy.

External Quality Review Organization

The Balanced Budget Act of 1997 requires state Medicaid agencies to provide an annual external independent review of quality outcomes, timeliness of services, and access to services provided by a Medicaid managed care organization and prepaid inpatient health plans. To comply with this requirement, and to provide HHSC with data analysis and information to effectively manage its Medicaid managed care programs, HHSC contracts with an external quality review organization for Medicaid managed care and CHIP. In collaboration with the external quality review organization, HHSC evaluates, assesses, monitors, guides, and directs the Medicaid managed care programs and organizations for the State. Since 2002, Texas has contracted with the University of Florida's Institute on Child Health Policy to conduct external quality review organization activities.

The Institute of Child Health Policy performs the following three CMS-required functions:

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

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

HHSC Medicaid/CHIP Division

The Medicaid/CHIP Division develops and oversees the Texas Medicaid and CHIP policies that determine client services and provider reimbursements while complying with federal program mandates. The Medicaid/CHIP Division develops fee-for-service and managed care services through key program areas such as implementation and operations of the 1115 Transformation Waiver and Cost Containment, Policy Development, Medicaid-related Health Information Technology, the Vendor Drug Program, Program Operations, Project Management, and Operations Coordination.

HHSC Medicaid/CHIP- Program Operations

Program Operations' objectives are to provide better access to healthcare services, improve quality of services and service delivery, promote service-appropriate utilization, and contain costs. Program Operations' major activities include developing and operating managed care models to provide a medical and dental home; developing and maintaining provider networks; performing utilization reviews and utilization management; managing Medicaid and CHIP contracts; and quality assessment and performance improvement.

Program Operations- Program Management

Program Management implements initiatives that directly affect Medicaid and CHIP service delivery. Program Management provides program expertise and coordinates with HHSC managed care organization managers, quality analysts, and HHSC contracts, finance, and policy development units to refine existing or implement new healthcare delivery models. Program Management staff manage program and policies of the various managed care programs, including STAR, STAR+PLUS, CHIP, and Dental, and the fee-for-service Texas Medicaid Wellness Program. Program Management also manages certain state or federally-directed projects for the Medicaid/CHIP division, monitors managed care organization compliance with the Linda Frew, et al. vs. Kyle Janek lawsuit, and works with the external quality review organization on quality-improvement initiatives.

Program Operations- Quality Assurance

The Quality Assurance unit of Program Management is the primary liaison between HHSC and the external quality review organization, and between the managed care organizations and the external quality review organization. This includes providing oversight of the external quality review organization contract. The unit is responsible for working with the external quality review organization to develop and implement quality programs, including pay for performance programs, and reviewing and analyzing data produced by the external quality review organization related to those quality programs. The Quality Assurance unit also provides technical assistance to other areas of HHSC and to the various providers, managed care organizations, and stakeholder groups.

Program Operations- Finance

The Finance section monitors managed care organization financial compliance with the Uniform Managed Care Contact and the Uniform Managed Care Manual. This group has primary responsibility for monitoring financial performance of managed care organizations, including the financial aspects of subcontracts and affiliate relationships, and recommending strategies to address issues and concerns; reviewing and validating managed care organization financial deliverables; administering the recovery of excess profits through the experience rebate process; managing the managed care organization external audit process; developing financial reporting principles; supporting Health Plan Management and other stakeholders within the Medicaid/CHIP Division regarding financial reporting and related issues; providing ad hoc analysis as requested; providing financial expertise for request for proposal and contract amendments; responding to and implementing recommendations of State and HHSC internal auditors; and performing financial aspects of managed care organization readiness reviews. The Finance section calculates the amounts of payments and recoupments based on results of managed care organization financial incentive programs.

Program Operations- Health Plan Management

Health Plan Management monitors managed care organization compliance with the Uniform Managed Care Contract, the Uniform Managed Care Manual, and Texas Government Code §533 and §353. Health Plan Management's major activities include monitoring of service delivery, provider networks, claims processing, deliverables, and marketing and other administrative requirements. Monitoring of service delivery includes evaluating and trending provider and client complaints. It also includes monitoring service coordination, managed care organization call center services, claims processes, and encounters. Monitoring provider networks involves analyzing managed care organization provider data and geographic access reports, and includes review of provider turnover rates, network panel status reports, and provider directories. Health Plan Management also assists with the resolution of complex issues; facilitates internal and external stakeholder meetings; obtains and develops policy clarifications; resolves encounter data and premium payment issues; and clarifies contract requirements. Health Plan Management staff reviews managed care organization marketing materials for compliance with the Uniform Managed Care Marketing Policy and Procedures Manual.

Managed care organizations report specific data to Health Plan Management each fiscal quarter. Health Plan Management staff compiles this information by managed care organization, program, and service area. Each managed care organization may have multiple quarterly reports, which are used for monitoring purposes. These reports capture data on the following elements:

- Enrollment
- Provider network status
- Member hotline, behavioral health crisis hotline, and provider hotline performance
- Managed care organization complaints and appeals (member and provider)
- Complaints received by state agencies (member and provider)
- Claims
- Encounter reconciliation

While the managed care organization is the initial point of contact to address member or provider concerns, Health Plan Management will assist with issues that have been escalated to HHSC. Inquiries and complaints are referred to Health Plan Management from a variety of sources including elected officials, the Office of the Ombudsman, and other agencies and departments. Provider inquiries and complaints are received directly from providers through email. Health Plan Management also receives information on cases that have been overturned on appeal to track and address any issues in which it appears managed care organizations may have denied services inappropriately.

Based on findings from monthly and quarterly self-reported performance data, onsite visits, member or other complaints, financial status, and any other source, Health Plan Management may impose or pursue one or more of the following remedies for each item of material non-compliance in accordance with the Uniform Managed Care Contract:

- Assessment of liquidated damages.

- Accelerated monitoring of the managed care organization, which includes more frequent or extensive monitoring by HHSC.
- Requiring additional financial or programmatic reports to be submitted by the managed care organization.
- Requiring additional or more detailed financial or programmatic audits or other reviews of the managed care organization.
- Terminating or declining to renew or extend a managed care organization contract.
- Appointing temporary managed care organization management under the circumstances described in 42 CFR §438.706.
- Initiating or suspending member disenrollment.
- Withholding or recouping payment to the managed care organization.
- Requiring forfeiture of all or part of the managed care organization's performance bond.

Health Plan Management will determine the scope and severity of the remedy on a case-by-case basis.

HHSC Medicaid/CHIP- 1115 Healthcare Transformation and Quality Improvement Waiver Operations

The 1115 Transformation Waiver Operations area oversees the implementation and roll-out of the Delivery System Reform Incentive Payment portion of the waiver. Major activities have included: review and submission of more than 1,300 proposed Delivery System Reform Incentive Payment projects from all 20 Regional Healthcare Partnerships to CMS; review and submission of outcome measures associated with each project; development of policies and protocols, reporting process, tools, and guidelines; provision of ongoing and extensive technical assistance for Regional Healthcare Partnership anchoring entities and providers related to areas including project plan corrections, milestone and metrics reporting, and outcome measures; ongoing and extensive submission of information to CMS to support waiver implementation; review of metric reporting; establishing formal waiver evaluation in coordination with HHSC Strategic Decision Support; and development of the monitoring for Delivery System Reform Incentive Payment projects that will occur through contract procurement.

HHSC Medicaid/CHIP- Operations Coordination

The Operations Coordination area develops, oversees, and performs functions related to information technology operational systems processing, data management, analysis, and reporting. Operations Coordination works on eligibility and enrollment operations within the Medicaid/CHIP Division, information technology program development and oversight, and provider claims oversight. This section of HHSC provides data that is used for multiple quality purposes, including tracking rates of potentially preventable events and sharing encounter data with the external quality review organization. Operations Coordination also manages the vendor responsible for housing the data.

HHSC Financial Services- Actuarial Analysis

Actuarial Analysis calculates the capitated premium rates paid to the Medicaid and CHIP managed care organizations. HHSC uses an external actuary to certify these rates as meeting the actuarial soundness guidelines established by CMS. Actuarial Analysis is also involved with benefit and rate changes, program expansions, and legislative mandates that affect managed care

organizations. Finally, Actuarial Analysis provides actuarial support services for other HHSC activities, including initiatives related to the 1115 Transformation Waiver. Key quality-related activities with which Actuarial Analysis is involved include financial incentive programs, data certification, and implementation of provider-level and managed care organization-level disincentives related to potentially preventable events.

HHSC Financial Services- Strategic Decision Support

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

HHSC Office of Health Policy and Clinical Services

The Office of Healthcare Quality Analytics, Research, and Coordination Support works within the health and human services system and with external stakeholders to improve enterprise collaboration and coordination on quality initiatives, and to reduce duplication of efforts. The program is charged with identifying initiatives that focus on increased quality and cost effectiveness, promote transparency and efficiency, and enhance internal and external understanding of quality and performance. The Office of Healthcare Quality Analytics, Research, and Coordination Support is responsible for several special projects related to quality and efficiency improvement. Several examples of high impact projects are listed below.

Behavioral Health Organization and Managed Care Organization Coordination

The Office of Healthcare Quality Analytics, Research, and Coordination Support has spearheaded an effort to better coordinate behavioral healthcare and physical healthcare by improving the communication capabilities of the NorthSTAR behavioral health organization and the managed care organizations operating in the NorthSTAR service area. A successful outcome will be improved quality of care, largely demonstrated by a reduction in potentially preventable events, particularly potentially preventable emergency department visits.

Alternative Provider Payment Structures

Using initial funding from an Agency for Healthcare Research and Quality grant administered by Rutgers University, HHSC has focused on a series of quality measures related to antipsychotic medication prescribing and mental health treatment practices within the managed care organization/behavioral health organization model. HHSC has begun to share performance related information with the managed care organizations and behavioral health organizations and is engaging them in discussions regarding intervention strategies.

Interagency collaboration on strategies to promote improved birth outcomes

Prenatal care, delivery, newborn care and postpartum care represent areas of ongoing quality improvement and cost savings. HHSC recognizes that often his requires close coordination among the HHS agencies, namely the Department of State Health Services. The Department of State Health Services is Texas' public health agency. HHSC and the Department of State Health

Services have formed interagency workgroups focused on targeted projects of mutual concern in this area.

Committees

Multiple quality-focused advisory committees provide HHSC and the Legislature recommendations on quality-related activities. The Medicaid and CHIP Quality-Based Payment Advisory Committee was established by S.B. 7, 82nd Legislature to advise HHSC on establishing reimbursement policies and systems that reward high quality and cost-effective care, and to advise HHSC on outcome and process measures, and standards and benchmarks used to measure performance. SB 7 of the 83rd Legislature created the STAR+PLUS Quality Council, which will begin meeting in 2014. This Council is charged with advising HHSC on the development of policy recommendations that will ensure eligible recipients receive quality, person-centered, consumer-directed acute care services and long-term services and supports under the STAR+PLUS program.

Texas Institute of Healthcare Quality and Efficiency

The Legislature established the Texas Institute of Healthcare Quality and Efficiency (the Institute) during the 82nd Legislature, First Called Session, 2011, to improve health care quality, accountability, education, and cost containment by encouraging provider collaboration, effective delivery models, and coordination of services. The Institute has a wide scope, encompassing the broader health care system in Texas, including Medicaid and CHIP. The Institute is charged with making legislative recommendations in three key areas: improving quality and efficiency of health care delivery; improving reporting, consolidation, and transparency of health care information; and implementing and supporting innovative health care collaborative payment and delivery systems. Within this overarching framework, the Institute will study and issue recommendations on various aspects of health care, including quality-based payment systems that align payment incentives with high-quality, cost-effective health care; alternative health care delivery systems that promote health care coordination and provider collaboration; quality of care and efficiency outcome measurements that are effective measures of prevention, wellness, coordination, provider collaboration, and cost-effective health care; improvements related to the reporting of health-related data collected by the state that reduce administrative burdens associated with reporting, while increasing consumer access to and use of data; and methods to evaluate health care collaborative effectiveness. The Institute draws expertise from a governor-appointed board of directors that is composed of health care providers, payors, consumers, and health care quality experts, in addition to representatives from several state agencies. HHSC has also established an Executive Steering Committee of the HHS System agencies to support the Institute in a coordinated and collaborative manner across the HHS System.

Management Information System Requirements

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

- Enrollment/Eligibility
- Provider Network

- Encounter/Claims Processing
- Financial System
- Utilization/Quality Improvement
- Reporting
- Interfaces
- Third Party Liability Reporting

Intersection of Roles

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

EVIDENCE-BASED CARE AND QUALITY MEASUREMENT

HHSC's mission is to create a customer-centered, innovative, and adaptable managed care system that provides the highest quality of care to individuals served by the agency while at the same time ensures access to services. To this end, the 1115 Transformation Waiver goals and objectives include improving outcomes and transitioning to quality-based payment systems across managed care and hospitals. The 1115 Quality Improvement Strategy is intended to outline the internal and external resources, mechanisms, and initiatives that together will achieve these goals.

Measurement

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

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

Tools for obtaining and disseminating information related to quality

The analysis and dissemination of quality data is primarily conducted using managed care organization-generated data and reports and external quality review organization data analysis and summary reports.

Mechanism for identifying race, ethnicity, and primary language of members

The State obtains race, ethnicity, and primary language spoken by a member from the Medicaid/CHIP application completed by that member. Applications are processed through the

Texas Integrated Eligibility Redesign System (TIERS) and transmitted to a third-party enrollment broker. The enrollment broker transmits a file containing the race/ethnicity and primary language of each enrollee to the managed care organizations monthly.

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

HHSC contracts with the external quality review organization to certify the accuracy and completeness of managed care organization encounter data. The data certification reports support rate-setting activities and provide information relating to the quality, completeness, and accuracy of the managed care organization encounter data. Certification reports include a quality assessment analysis to assure data quality within agreed standards for accuracy, a summary of amounts paid by service type and month of service, and a comparison of paid amounts reported in the encounter data to financial statistical reports provided by the managed care organizations.

Encounter data must follow the format and data elements as described in the Health Insurance Portability and Accounting Act-compliant 837 Companion Guides and Encounter Submission Guidelines. HHSC will specify the method of transmission, the submission schedule, and any other requirements in the Uniform Managed Care Manual. Original records must be made available for inspection by HHSC for validation purposes. Encounter data that does not meet quality standards must be corrected and returned within a time period specified by HHSC.

Managed care organization-generated data and reports

Quality Assessment and Performance Improvement
Each managed care organization must develop, maintain, and operate a Quality Assessment and Performance Improvement Program that meets state and federal requirements. The managed care organization must approach all clinical and nonclinical aspects of quality assessment and performance improvement based on principles of Continuous Quality Improvement/Total Quality Management and must:

- Evaluate performance using objective quality indicators.
- Foster data-driven decision-making.
- Recognize that opportunities for improvement are unlimited.
- Solicit member and provider input on performance and Quality Assessment and Performance Improvement activities.
- Support continuous ongoing measurement of clinical and non-clinical effectiveness and member satisfaction.
- Support programmatic improvements of clinical and non-clinical processes based on findings from ongoing measurements.

- Support re-measurement of effectiveness and member satisfaction, and continued development and implementation of improvement interventions as appropriate.

The managed care organization must adopt at least two evidence-based clinical practice guidelines per program (e.g., STAR, STAR+PLUS). Practice guidelines must be based on valid and reliable clinical evidence, consider the needs of the managed care organization's members, be adopted in consultation with network providers, and be reviewed and updated periodically, as appropriate. The managed care organization must adopt practice guidelines based on members' health needs and opportunities for improvement identified as part of the Quality Assessment and Performance Improvement Program.

Performance Improvement Projects
The external quality review organization recommends topics for performance improvement projects based on managed care organization performance results, data from member surveys, administrative and encounter files, medical records, and the immunization registry. HHSC selects two of these goals, which become projects that enable each managed care organizations to target specific areas for improvement that will affect the greatest numbers of members. These projects are specified and measurable, and reflect areas that present significant opportunities for performance improvement for each managed care organization. When conducting performance improvement projects, managed care organizations are required to follow the ten-step CMS protocol published in the CMS External Quality Review Organization Protocols.

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

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External quality review organization processes and reports

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

- organizational structure,
- children's programs,
- care coordination and disease management programs,
- utilization and referral management,
- provider network and contractual relationships,
- provider reimbursement and incentives,
- member enrollment and enrollee rights and grievance procedures, and
- data acquisition and health information management.

The managed care organizations complete the administrative interview tool online and are required to provide supporting documentation. For example, when describing disease management programs, the managed care organization must also provide copies of all evidenced-based guidelines used in providing care to members. The external quality review organization analyzes all responses and documents and generates follow-up questions for each managed care organization as necessary. The follow-up questions are administered during in-person site visits and conference calls.

Data Certification Reports
The information contained in these data certification reports is used for actuarial analysis and rate setting, and meets the requirements of Texas Government Code §533.0131, Use of Encounter Data in Determining Premium Payment Rates. Analyses include volume analysis based on service category, data validity and completeness, consistency analysis between encounter data and managed care organization financial summary reports, and validity and completeness of provider information (not performed for pharmacy data).

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

Quarterly Topic Reports

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

Summary of Activities Report
Texas provides the Summary of Activities report to CMS annually as evidence of external quality review organization activities. The report includes an annual summary of all quality of care activities, performance improvement project information, managed care organization structure and processes, and a description of all findings and quality improvement activities.

Survey Reports
The external quality review organization conducts member surveys using validated and nationally accepted instruments, including the CAHPS® surveys, the Experience of Care and Health Outcomes survey, and the Medicare Health Outcomes Survey. This process helps to ensure that members' perspectives about their experiences with care are captured and communicated to stakeholders and the managed care organizations. In addition, information about member-reported health and functioning are obtained from these surveys. For example, the Medicare Health Outcomes Survey contains the SD-12, which provides information about the members' physical and emotional functioning. Additionally, reporting of certain CAHPS® survey measures for children is a Children's Health Insurance Program Reauthorization Act federal reporting requirement. The results of these surveys are analyzed and reported by program. In an effort to streamline reporting activities and allow for more focused analysis, beginning in 2014 CAHPS® surveys and the Experience of Care and Health Outcomes survey measure information will primarily be communicated through the annual Summary of Activities Report.

Quality of Care Reports
CMS requires the external quality review organization to validate performance measures. This is done through analysis of data used to develop quality of care reports. Additionally, the external quality review organization calculates the quality of care measures that rely on administrative data (i.e., enrollment, health care claims and encounter data). This provides the state with a comprehensive set of measures calculated using National Committee for Quality Assurance-certified software and audited by a National Committee for Quality Assurance-certified auditor. Historically, this data has been used to develop program-specific quality of care reports. Beginning in 2014, these reports will be consolidated into a single behavioral and physical health report and a single dental report. Data tables will still be available by program.

FREW Report
The Institute of Child Health Policy calculates rates by plan code for Texas Health Steps checkups given to new and existing members based on the Medicaid Managed Care Texas Health Steps Medical Checkups Utilization Report instructions. The results are compiled and compared with managed care organization-submitted reports to determine if the managed care organization-submitted reports are within an eight percent threshold of external quality review organization calculated rates.

TEXAS QUALITY INITIATIVES

HHSC, together with the Institute of Child Health Policy, has developed multiple quality initiatives that are in various stages of implementation.

Financial Incentive Programs

Performance Based At-Risk Capitation and Quality Challenge Award[1]
The managed care contract stipulates that up to five percent of a managed care organization's capitation can be recouped based on performance based measures. This initiative gives HHSC an opportunity to focus managed care organization performance on specific measures that foster achievement of HHSC program goals and objectives.

Each managed care organization has the opportunity to achieve performance levels that enable it to receive the full at-risk amount. However, should a managed care organization not achieve those performance levels, HHSC will recoup a portion of the five percent at-risk amount. Some of the performance indicators are standard across the managed care programs while others may apply to a specific program.

Minimum achievement targets are developed based in part on:

- HHSC managed care organization program objectives of ensuring access to care and quality of care.
- Past performance of the HHSC managed care organizations.
- National performance of Medicaid managed care organizations on HEDIS® and CAHPS® survey measures.

HHSC reallocates any unearned funds from the performance-based, at-risk portion of a managed care organization's capitation rate to the managed care organization program's Quality Challenge Award. HHSC uses these funds to reward managed care organizations that demonstrate superior clinical quality, service delivery, access to care, or member satisfaction. HHSC determines the number of managed care organizations that will receive Quality Challenge Award funds annually based on the amount of the funds to be reallocated. Separate Quality Challenge Award payments are made for each of the managed care organization programs.

HHSC considered the following factors when determining which measures are to be used in the At-Risk and Quality Challenge Program:

- Necessity of effective administrative processes and contract compliance for the five percent at-risk in the first measurement year.
- Emphasis on clinical process and outcome measures in the Quality Challenge Award in the first measurement year and the five percent At-Risk measures in the second measurement year.

[1] The Performance Based At-Risk Capitation and Quality Challenge Award is ending December 31, 2013. Final payment or recoupment based on performance in this program will be made in the fall of 2014.

- HEDIS® measure limitations due to data requirements. Some HEDIS® measures require one to two years of historical data to calculate and thus were not feasible for use at the newly established STAR and STAR+PLUS program sites. Measures with a history of low denominators (e.g., not enough members meeting inclusion criteria for the measure) were excluded.
- Identifying the appropriate number of measures. Choosing too many measures can diffuse the focus and make it difficult to have meaningful impact while choosing too few can place too much risk on each measure.

HHSC evaluates the performance-based At-Risk and Quality Challenge Award methodology annually in consultation with the managed care organizations. HHSC may then modify the methodology as it deems necessary and appropriate to motivate, recognize, and reward managed care organizations for performance.

Pay-for-Quality Program
S.B. 7, 83rd Legislature, Regular Session, 2013, focuses on the use of outcome and process measures in quality-based payment systems that focus on measuring potentially preventable events; rewarding use of evidence based practices; and promoting healthcare coordination, collaboration and efficacy. To comply with legislative direction and to best identify quality of care measures that reflect the needs of the population served and areas of needed improvement, the Medicaid/CHIP Division is implementing the Pay-for-Quality Program, which will replace the At-Risk Quality Challenge program beginning in 2014. The Pay-for-Quality Program uses an incremental improvement approach that provides financial incentives and disincentives to managed care organizations based on year-to-year incremental improvement on pre-specified quality goals. The quality of care measures used in this initiative are a combination of process and outcome measures which include select potentially preventable events as well as other measures specific to the program's enrolled populations.

The Pay-for-Quality Program includes an at-risk pool that is four percent of the managed care organization capitation rate. In the Pay-for-Quality Program, points are assigned to each plan based on incremental performance on each quality measure, with positive points assigned for year-to-year improvements over a minimum baseline. Negative points are assigned for most year-to-year declines, with the exception of modest decreases of plans whose performance is already performing within a specified range of the attainment goal rate. The Pay-for-Quality Program model sets minimum baseline performance levels for the measures so that low performing managed care organizations would not be rewarded for substandard performance. Rewards and penalties are based on rates of improvement or decline over the baseline. All funds recouped from managed care organizations through the assignment of negative points are redistributed to managed care organizations through the rewarding of positive points. Each managed care organization pays in proportion to its total negative points and receives funds in proportion to its total positive points. No funds are returned to the State. Participation in this program is required for all Texas managed care organizations.

Dental Pay-for-Quality Program
The 2014 Dental Pay-for-Quality Program includes an at-risk pool that is a "to be determined" amount of the dental maintenance organization capitation rate. In the Dental Pay-for-Quality

Program, points are assigned to each plan based on its incremental performance on each quality measure, with positive points assigned for year-to-year improvements over the minimum baseline and negative points assigned for most year-to-year declines. The Dental Pay-for-Quality Program model sets minimum baseline performance levels for the measures so that low-performing dental maintenance organizations would not be rewarded for substandard performance. Rewards and penalties are based on rates of improvement or decline over the baseline. Plans would earn back their own at-risk premium based on performance of quality of care measures. In no instance would funding be redistributed from one dental maintenance organization to another; plans can only earn back their own four percent premium that is at-risk.

Performance Comparisons

Performance Indicator Dashboards
The Performance Indicator Dashboard includes a series of measures that identify key aspects of performance to support transparency and managed care organization accountability. The Performance Indicator Dashboard is not an all-inclusive set of performance measures; HHSC measures other aspects of the managed care organization's performance as well. Rather, the Performance Indicator Dashboard assembles performance indicators that assess many of the most important dimensions of managed care organization performance and includes measures that incentivize excellence. The Dashboard is shared on the HHSC website and includes minimum threshold standards as a means to gauge performance. Additionally, HHSC plans to begin including managed care organization performance data on these measures and sharing this information on the HHSC website.

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

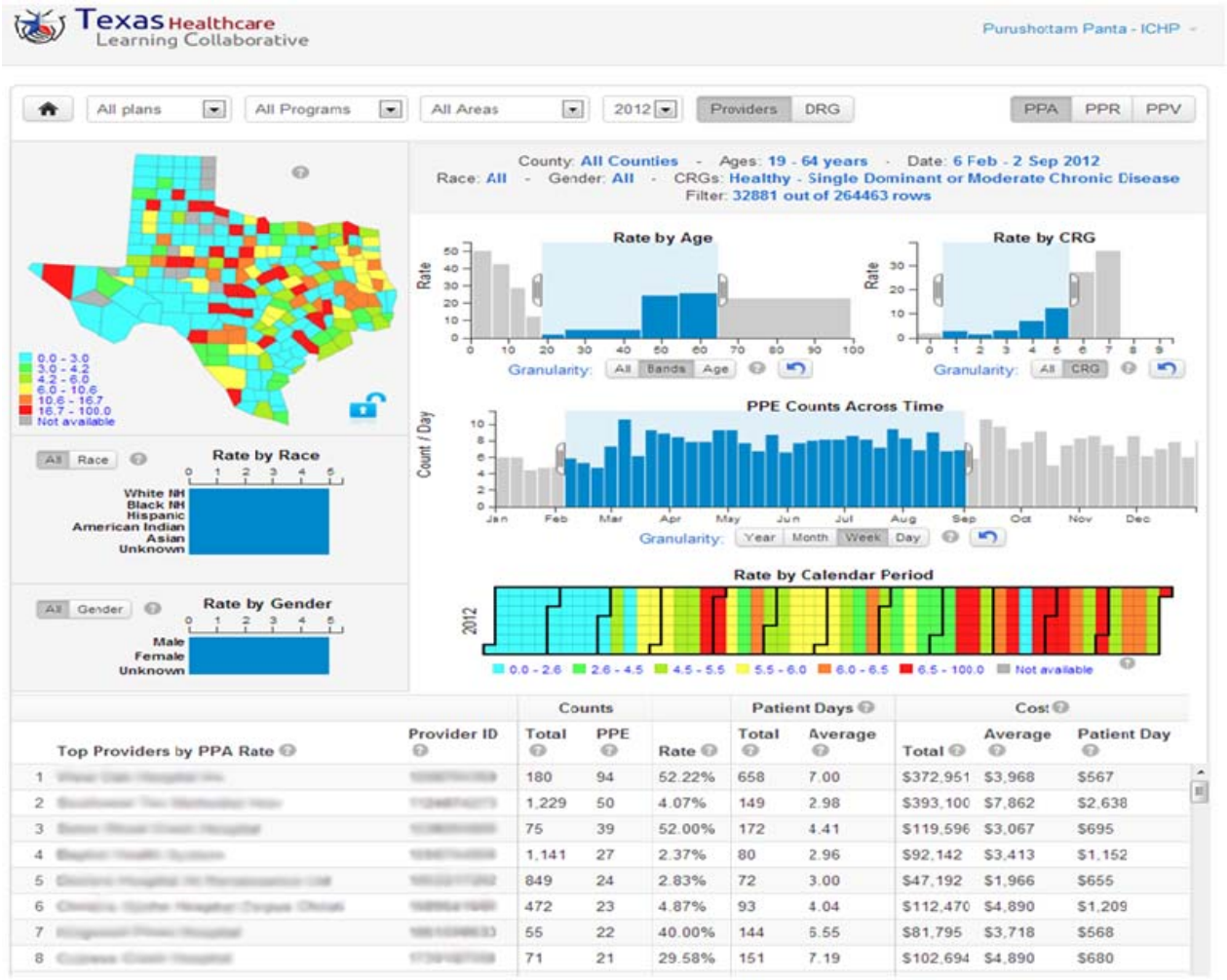
Data sharing and Transparency

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

Through the Texas Healthcare Learning Collaborative Portal, HHSC and the Institute of Child Health Policy share monthly and quarterly reports with the managed care organizations about

potentially preventable events. The reports are interactive and the managed care plans can query the data to create more customized summaries of the quality results.

Figure 1: Screenshot of the Texas Healthcare Learning Collaborative Portal



Top Providers by PPA Rate	Provider ID	Counts Total	Counts PPE	Rate	Patient Days Total	Patient Days Average	Cost Total	Cost Average	Cost Patient Day
1		180	94	52.22%	658	7.00	$372,951	$3,968	$567
2		1,229	50	4.07%	149	2.98	$393,100	$7,862	$2,638
3		75	39	52.00%	172	4.41	$119,596	$3,067	$695
4		1,141	27	2.37%	80	2.96	$92,142	$3,413	$1,152
5		849	24	2.83%	72	3.00	$47,192	$1,966	$655
6		472	23	4.87%	93	4.04	$112,470	$4,890	$1,209
7		55	22	40.00%	144	5.55	$81,795	$3,718	$568
8		71	21	29.58%	151	7.19	$102,694	$4,890	$680

Medicaid Quality Assurance and Improvement Website

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

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

- Background and historical information on the waiver
- New and updated policies, procedures, tools, and guidelines for Delivery System Reform Incentive Payment anchors and providers
- Provider and Regional Healthcare Partnership-specific Excel workbooks used for reporting purposes
- Key Delivery System Reform Incentive Payment program dates and deadlines.

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

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

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

- Category I (Infrastructure Development) lays the foundation for the delivery system through investments in people, places, processes and technology.
- Category II (Program Innovation & Redesign) tests and replicates innovative care models.
- Category III (Quality Improvements) assesses the effectiveness of Category 1 and 2 interventions.
- Category IV (Population-based Improvements) requires all regional health partnerships to report on the same measures.

Long-Term Services and Supports Performance Measures
The STAR+PLUS home and community-based services program provides assistance with activities of daily living to allow members to remain in the most community-integrated setting

available. It includes services available to all STAR+PLUS members as well as those services available only to STAR+PLUS members from the following groups:

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

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

In the fall of 2013, HHSC convened a workgroup consisting of external stakeholders and representatives from the external quality review organization to develop a comprehensive set of performance measures that will provide data that allows the State to evaluate the quality home and community-based services long-term services and supports provided through Medicaid managed care. Attachment D outlines the timeline for completion of this project.

Senate Bill 7
Senate Bill (SB) 7, passed during the 83rd Legislature, is a broadly scoped bill that redesigns multiple aspects of Texas Medicaid, focusing on improved service delivery quality and efficiency. Key components of SB 7 include:

- Establishment of a managed care clinical improvement program.
- The option for HHSC to create an incentive program that enrolls a higher proportion of members eligible for auto-enrollment into a managed care organizations that meet pre-determined performance levels on selected metrics.
- Builds upon §536.003 in the Government Code requiring HHSC to include outcome and process measures based on potentially preventable events. Potentially preventable event outcome measures must allow for rate-based determination of health care provider performance compared to statewide norms and be risk-adjusted based on severity of illness. Requirements are also added for the process and outcome measures developed by HHSC, including effective coordination of acute and long-term care services and reduction of preventable health care utilization and costs.
- Requires HHSC to develop quality-based payment systems in conjunction with stakeholders and to require managed care organizations to develop quality-based payment systems.
- Adds a requirement for HHSC to develop a web-based system to provide data to managed care organizations and providers on their quality metrics and how they measure against comparable peers.
- Requires HHSC to base a percentage of premiums paid to managed care organizations on performance measures that address potentially preventable events and advance quality improvement and innovation.

- Directs HHSC to allow managed care organizations increased flexibility to implement quality initiatives, including allowing for reductions in the incidence of unnecessary institutionalization and using alternative payment systems such as shared savings models.
- Directs HHSC to adopt rules related to potentially preventable events and directs HHSC to report to hospitals on their performance related to these events. The bill also requires HHSC to release hospital reports after one year only after receiving stakeholder input on the content included.
- Allows HHSC to exclude payments made under the Disproportionate Share Hospital and Upper Payment Limit systems to be based on the hospitals performance related to potentially preventable readmissions and other potentially preventable events.
- Directs HHSC to develop payment initiatives for health care providers that will, among other things, encourage the integration of acute care services and long-term care services and supports, including discharge planning from acute care services to community based long-term services and supports.
- The bill allows HHSC to implement quality-based payments for long-term services and supports if cost-effective and feasible.
- Requires HHSC to adopt rules related to preventable costly service utilization by members receiving long-term care.

HHSC is working to develop and enhance programs, systems, and polices to meet these directives.

Potentially Preventable Events
Potentially preventable events include inpatient stays, hospital readmissions, potentially preventable complications, and emergency department visits that may have been avoidable had the patient received high quality primary and preventive care prior to or after the event in question. High potentially preventable event rates may reflect inadequacies in the health care provided to the patient in multiple settings, including inpatient and outpatient facilities and clinics. A better understanding of the factors that contribute to potentially preventable events in STAR and STAR+PLUS can assist HHSC and managed care organizations in developing intervention strategies to reduce their occurrence and to estimate the potential cost savings associated with implementing these interventions.

Potentially Preventable Admissions: These events are considered an indicator of poor availability, accessibility, and effectiveness of primary care, and the added burden to hospital resources can adversely influence the quality of care for all in need of inpatient services.

Potentially Preventable Readmissions: Potentially preventable readmissions to the hospital are costly, and present a particularly relevant challenge for the efficient delivery of health services in state Medicaid programs. Medicaid beneficiaries were also 70 percent more likely than people with private insurance to have had an inpatient readmission. While a number of individual factors are known to influence potentially preventable readmissions – including age, severity of illness, and co-morbidities – poor access to primary care is thought to be a major contributing factor.

Potentially Preventable Emergency Department Visits: These events are considered an indicator of poor availability, accessibility, and effectiveness of primary care, and their added burden to emergency department resources can adversely affect the quality of care for all in need of urgent medical attention. Potentially preventable emergency department visits present a particularly relevant challenge for the efficient delivery of health services in state Medicaid programs. Research has found that Medicaid beneficiaries make up a disproportionate share of emergency department visits for ambulatory care sensitive conditions, such as asthma, chronic obstructive pulmonary disease, congestive heart failure, diabetes, and hypertension. The occurrence of preventable emergency department visits can be influenced by chronic illness burden. However, compared to the general population, higher rates of potentially preventable emergency department visits for Medicaid beneficiaries were not explained by differences in disease prevalence or severity, but rather suggested a reduced likelihood of ongoing primary care.

Potentially Preventable Complications: HHSC defines a potentially preventable complication as a harmful event or negative outcome with respect to a person, including an infection or surgical complication, that occurs after the person's admission to a hospital or long-term care facility; and may have resulted from the care, lack of care, or treatment provided during the hospital or long-term care facility stay rather than from a natural progression of an underlying disease (Texas Administrative Code, §354.1446).

FUTURE GOALS AND PROJECTS

Administrative and State-Level Initiatives

HHSC has concrete and specific goals for current and future projects. These include:

- Improving internal HHSC coordination related to quality issues;
- Creating provider incentive programs;
- Fine-tuning a vision that will inform HHSC's goals and guide HHSC in meeting those goals;
- Administrative simplification for managed care organizations and within HHSC;
- Program and policy changes as needed; and
- Improving access by expanding the provider network and enhancing the timeliness of care.

To this end, in December 2013, HHSC formed a quality steering committee that will be responsible for developing a vision for the quality improvement system for Texas services, and for guiding future quality work. This group consists of cross-divisional staff and is co-chaired by representatives of the Office of Healthcare Quality Analytics, Research, and Coordination Support and the Medicaid/CHIP Division's Health Information Technology section. The committee will coordinate the quality improvement system effort across the Texas Health and Human Services Enterprise.

Data Analytic Unit
In response to a directive from S.B. 8, 83rd Legislature, Regular Session, 2013, a new data analytic unit, is being created in the Operations Coordination section of the Medicaid/CHIP Division. This unit will be responsible for establishing and overseeing a data analysis processes that is designed to:

- improve contract management;
- detect data trends; and
- identify anomalies relating to service utilization, providers, payment methodologies, and compliance with requirements in Medicaid and child health plan program managed care and fee-for-service contracts.

This unit will also be responsible for providing quarterly legislative reports.

HHSC is also planning to update this Strategy to include all other Texas Medicaid managed care programs, creating a comprehensive strategy rather than using multiple, program-specific strategies.

Future of the 1115 Transformation Waiver

Senate Bill 7, 83rd Legislature, Regular Session, 2013, requires HHSC to carve nursing facility services into managed care. HHSC is currently working with the Department of Aging and Disability Services to develop a set of performance measures that will be appropriate to gauge quality of care in the nursing facility environment, and that will incentivize managed care organizations to ensure a high level of quality of care. The workgroup tasked with developing this process includes both HHSC and Department of Aging and Disability Services staff, and is striving to leverage existing Department of Aging and Disability Services' processes to the greatest extent possible, while also taking into consideration service delivery factors that might benefit from additional focus after the nursing facility transition to managed care. A timeline for the activities of this group is included in Attachment E of this Strategy.

Senate Bill 7, 83rd Legislature, Regular Session, 2013, also requires HHSC to conduct pilot initiatives and to evaluate carving additional long term services and supports into a managed care model between 2016 - 2020. These LTSS services have traditionally been provided by the Department of Aging and Disability Services in a fee-for-service model through 1915(c) waivers or ICF-IID facilities. The Quality Improvement Strategy will be expanded to include those activities as appropriate through the transition and after final implementation.

Senate Bill 58, 83rd Legislative, Regular Session, 2013, directs HHSC to carve-in mental health targeted case management and mental health rehabilitative services into Medicaid managed care in order to provide better coordination of care by integrating physical and behavioral health care for Medicaid recipients no later than September 1, 2014. These new services are anticipated to be added to STAR and STAR+PLUS by this required effective date. To help ensure this transition is successful, the external quality review organization will continue to conduct member surveys of individuals receiving behavioral health services in both STAR and STAR+PLUS.

Future Initiatives

Focused analysis and quality improvement efforts with managed care organizations on "superutilizers"
A recently added Uniform Managed Care Contract provision strengthens the requirements for managed care organizations to focus on the unique needs of high cost, high utilizing populations (called "superutilizers"). This requires managed care organizations to submit to HHSC their plans for targeting this group, including intervention strategies, and resources dedicated to care management of this group. HHSC will have regular conference calls with managed care organizations over the year to discuss their efforts and encountered successes and barriers. This will allow HHSC to better assess managed care organization progress in this area. This also may help inform HHSC on certain aspects of the mental health rehabilitative services and targeted case management "carve-in" to managed care, as many members identified as "superutilizers" are also recipients of those behavioral health services.

Quality-Based Managed Care Organization Enrollment Incentive Algorithm
There are significant numbers of members who qualify for Medicaid who do not choose a managed care organization at the time of enrollment. While HHSC currently has an auto-enrollment process for these members, HHSC is exploring potential algorithms that may be utilized to assign these members to high quality and high efficiency managed care organizations and dental management organizations. HHSC will first evaluate the effects of the managed care organization report cards initiative (see page 16) to determine if the initiative shrinks the pool of members who do not actively choose a managed care organization. Based on that assessment, HHSC will determine whether to implement this initiative.

Other State Strategies Regarding Managed Care Organization Incentive and Disincentive Approaches
Currently staff are working with an actuarial firm on assessing and inventorying strategies utilized by certain states, as well as having this firm assess HHSC's current approach. The goal is to identify promising practices that may further promote provider payment reform and more efficient service delivery and provider practices.

Alternative Provider Payment Structures
A recently added Uniform Managed Care Contract provision strengthens the requirements for managed care organization and dental management organization provider payment structures to focus on quality, not volume. This requires managed care organizations and dental management organizations to submit to HHSC their plans for alternative payment structures with providers, including the type of structure they plan to use they are, the metrics used, the approximate dollar amount and number of members impacted, and the evaluation process. This will allow HHSC to better assess managed care organization progress in this area.

Review and Update of Quality Improvement Strategy

The quality strategy will be reviewed and updated every two years at a minimum. The 1115 Waiver also requires the state to revise the strategy whenever significant changes are made. Significant changes include:

- Changes made through the 1115 Transformation Waiver
- Adding new populations to the managed care programs
- Expanding managed care programs to new parts of the state
- Carving new services into the managed care programs

Attachment A- CFR and External Quality Review Organization Activities Crosswalk

A note regarding Quality of Care reports:
In the past, HHSC received individual quality of care reports for each managed care program. In the Fall 2013 HHSC decided to move to a more comprehensive annual Summary of Activities report. This annual report will offer a more in-depth analysis of the required consolidated information. For this reason, where Quality of Care reports are listed as a source, it should be noted that beginning in Fall 2013 only the quality of care tables will be available.

A note regarding NorthSTAR:
Until Fall 2013, the external quality review organization did not conduct PIP or QAPI evaluations for NorthSTAR.

	CMS Requirement	HHSC Report	Included in Summary of Activities Report?
§438.364(a)(1)	A detailed technical report that describes the manner in which the data from all activities conducted in accordance with §438.358 were aggregated and analyzed, and conclusions were drawn as to the quality, timeliness, and access to the care furnished by the MCO or PIHP.	Summary of Activities Report	N/A
§438.364(a)(2)	Assessment of each MCOs' and PIHPs' strengths and weaknesses with respect to quality, timeliness, and access to health care services furnished to Medicaid beneficiaries.	Administrative Interview Reports Member Survey Reports Quality of Care data tables/reports QAPI Evaluations PIP Evaluations	Yes
§438.364(a)(3)	Recommendations for improving quality of health care services furnished by each MCO or PIHP.	Administrative Interview Reports Member Survey Reports Quality of Care reports	Yes

	CMS Requirement	HHSC Report	Included in Summary of Activities Report?
		QAPI Evaluations PIP Evaluations Summary of Activities Report	
§438.364(a)(4)	Methodologically appropriate, comparative information for all MCOs/PIHPs. This information should align with what the state outlines in its quality strategy as methodologically appropriate.	Member Survey Reports Quality of Care data tables/reports Administrative Interview Reports QAPI Evaluations PIP Evaluations	Yes
§438.364(a) (5)	Assessment of the degree to which each MCO or PIHP has addressed effectively the recommendations for quality improvement made by the External Quality Review Organization (EQRO) during the previous year's EQR.	QAPI Program Evaluation Summaries	Yes[2]
Validation of Performance Improvement Projects (PIPs) [not currently met for NorthSTAR]			
§438.358(b)(1)	Information on the validation of PIPs required by the state to comply with requirements set forth in §438.240(b)(1) and that were underway during the preceding 12 months.	PIP Evaluation Summaries PIP Template Summary of Activities Report	Yes

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

	CMS Requirement	HHSC Report	Included in Summary of Activities Report?
§438.364(a)(1)	Description of the manner in which the data from the validation of PIPs were aggregated and analyzed, and conclusions were drawn as to the quality, timeliness, and access to the care furnished by the MCO or PIHP.	PIP Evaluation Summaries PIP Template Summary of Activities Report	Yes
§438.364(a)(1)(i-iv)	The following information related to the validation of PIPs: • Objectives; • Methods of data collection and analysis (Note: this should include a description of the validation process/methodology, e.g., was the CMS PIP validation protocol used, or a method consistent with the CMS protocol); • Description of data obtained; and • Conclusions drawn from the data.	PIP Evaluation Summaries PIP Template Summary of Activities Report	Yes
	Assessment of the overall validity and reliability of study results and includes any threats to accuracy/confidence in reporting.	PIP Evaluation Summaries PIP Template Summary of Activities Report	Yes[3]
§438.358(b)(1)	Validation results for all state-required PIP topics for the current EQR review cycle.	PIP Evaluation Summaries PIP Template Summary of Activities Report	Yes[4]
	Description of PIP interventions and	PIP Evaluation	No[5]

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

	CMS Requirement	HHSC Report	Included in Summary of Activities Report?
	outcomes information associated with each state-required PIP topic for the current EQR review cycle.	Summaries PIP Template	
Validation of Performance Measures (PMs)			
§438.358(b)(2)	Information on the validation of MCO or PIHP PMs reported (as required by the state) or MCO or PIHP PMs calculated by the state during the preceding 12 months to comply with requirements set forth in §438.240(b)(2).	Quality of Care Tables/Reports Summary of Activities-MCO Profiles	Yes
§438.364(a)(1)	Description of the manner in which the data from the validation of PMs were aggregated and analyzed, and conclusions were drawn as to the quality, timeliness, and access to the care furnished by the MCO or PIHP.	Quality of Care Reports	Yes
§438.364(a)(1)(i-iv)	The following information related to the validation of PMs: • Objectives; • Methods of data collection and analysis (Note: this should include a description of the validation process/methodology, e.g., was the CMS PM validation protocol used, or a method consistent with the CMS protocol); • Description of data obtained; and • Conclusions drawn from the data.	Quality of Care Reports	Yes
	Documentation of which PMs the state required the EQRO to validate for the current EQR review cycle (Note: this may be a subset of reported PMs or all reported PMs).	Quality of Care Reports	Yes

[5] The Summary of Activity report typically focuses on selected PIP interventions.

	CMS Requirement	HHSC Report	Included in Summary of Activities Report?
	EQR assessment of the MCO/PIHP information system as part of the validation process.	Administrative Interview Reports	Yes[6]
	Outcomes information associated with each PM for the current EQR review cycle.	Quality of Care data tables/reports Summary of Activities Report-MCO profiles	Yes
§438.358(b)(3)	Information on a review, conducted within the previous 3-year period, to determine the MCO's or PIHP's compliance with standards established by the state to comply with the requirements of §438.204(g).	Administrative Interview Reports Quality of Care Tables Member Survey Reports QAPI Evaluation Summaries	Yes[7]
§438.364(a)(1)	Description of the manner in which the data from the compliance review were aggregated and analyzed, and conclusions were drawn as to the quality, timeliness, and access to the care furnished by the MCO or PIHP.	Administrative Interview Reports Quality of Care Reports Member Survey Reports QAPI Evaluation	Yes[8]

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

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

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

	CMS Requirement	HHSC Report	Included in Summary of Activities Report?
		Summaries	
§438.364(a)(1)(i-iv)	The following information related to the compliance review: • Objectives; • Methods of data collection and analysis (Note: this should include a description of the validation process/methodology, e.g., was the CMS PM validation protocol used, or a method consistent with the CMS protocol); • Description of data obtained; and • Conclusions drawn from the data.	Administrative Interview Reports Quality of Care Reports Member Survey Reports QAPI Evaluation Summaries	Yes[9]
§438.358(b)(3)	Compliance assessment results for each MCO/PIHP from within the past three years.	Administrative Interview Reports Quality of Care Tables/Reports Member Survey Reports QAPI Evaluation Summaries	Yes[10]
§438.364(a)(1)(i-iv)	If appropriate, the following information related to encounter data validation: • Objectives; • Methods of data collection and analysis; • Description of data obtained; and	Encounter Data Validation Report	Yes

[9] A summary of methodologies has been present in some, but not all prior Summary of Activity reports. It will be included consistently in reports moving forward.
[10] Three-year trends have been shown in prior Summary of Activity reports, but typically only at the program level, and not the managed care organization level.

	CMS Requirement	HHSC Report	Included in Summary of Activities Report?
	• Conclusions drawn from the data.		
§438.364(a)(1)(i-iv)	If appropriate, the following information related to the administration or validation of consumer or provider surveys of quality of care: • Objectives; • Methods of data collection and analysis; • Description of data obtained; and • Conclusions drawn from the data.	STAR Adult and Parent of Child Member CAHPS® Survey Report STAR+PLUS Adult Member CAHPS® Report CHIP (Parent of) Child Member CAHPS® Survey Report STAR Health (Parent of) Child Member CAHPS® Survey Report	Yes
§438.364(a)(1)(i-iv)	If state contracts with the EQRO to calculate PMs in addition to those reported by an MCO or PIHP and validated by an EQRO (as described in §438.358(c)(3)), the technical report must include the following related to that EQR activity: • Objectives; • Methods of data collection and analysis; • Description of data obtained; and • Conclusions drawn from the data.	Quality of Care Reports	Yes
§438.364(a)(1)(i-iv)	The following information related to the conducting of PIPs: • Objectives; • Methods of data collection and analysis;	PIP Evaluation Summaries	Yes

	CMS Requirement	HHSC Report	Included in Summary of Activities Report?
	• Description of data obtained; and • Conclusions drawn from the data.		
§438.364(a)(1)(i-iv)	If appropriate, the following information related to studies on quality that focus on a particular aspect of clinical or nonclinical services at a point in time: • Objectives; • Methods of data collection and analysis; • Description of data obtained; and • Conclusions drawn from the data.	Ad Hoc Focus Studies Ad Hoc Quarterly Topic Reports	Yes

Attachment B- Initiative Performance Measures[11]

Pay-for-Quality (2014)

Measure	Measure Description	STAR	STAR+PLUS
Well-Child Visits at 3, 4, 5, & 6 Yrs.	The percentage of members 3–6 years of age who had one or more well-child visits with a PCP during the measurement year.	x	
Adolescent Well-Care Visits	The percentage of enrolled members 12–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.	x	
Potentially Preventable ED Visits		x	x
Potentially Preventable Hospital Admissions		x	x
Potentially Preventable Hospital Re-admissions		x	x
Prenatal and Postpartum Care	The percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year. For these women, the measure assesses the following facets of prenatal and postpartum care. • Timeliness of Prenatal Care. The percentage of deliveries that received a prenatal care visit as a member of the organization in the first trimester or within 42 days of enrollment in the organization. • Postpartum Care. The percentage of deliveries that had a postpartum visit on or between	x	

[11] Long-term services and supports and nursing facility measures are in development and will be added upon completion.

Measure	Measure Description	STAR	STAR+PLUS
	21 and 56 days after delivery.		
Anti-depressant Medication Management-Acute Phase	The percentage of members 18 years of age and older with a diagnosis of major depression and were newly treated with antidepressant medication, and who remained on an antidepressant medication treatment. • Effective Acute Phase Treatment. The percentage of newly diagnosed and treated members who remained on an antidepressant medication for at least 84 days (12 weeks).		x
Anti-depressant Medication Management-Continuation	The percentage of members 18 years of age and older with a diagnosis of major depression and were newly treated with antidepressant medication, and who remained on an antidepressant medication treatment. • Effective Continuation Phase Treatment. The percentage of newly diagnosed and treated members who remained on an antidepressant medication for at least 180 days (6 months).		x
HbA1c Control <8	The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had HbA1c Control <8.		x

At Risk Measures (2013)

Measure	Measure Description	STAR	STAR+PLUS
Childhood Immunization Status	The percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three H	x	

Measure	Measure Description	STAR	STAR+PLUS
	influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday.		
Well-Child Visits at 3, 4, 5, & 6 Yrs.	The percentage of members 3–6 years of age who had one or more well-child visits with a PCP during the measurement year.	x	
Adolescent Well-Care Visits	The percentage of enrolled members 12–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.	x	
Prenatal Care	The percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year. For these women, the measure assesses the following facets of prenatal care. • Timeliness of Prenatal Care. The percentage of deliveries that received a prenatal care visit as a member of the organization in the first trimester or within 42 days of enrollment in the organization.	x	
Use of Appropriate Medication for People With Asthma	The percentage of members 5–64 years of age during the measurement year who were identified as having persistent asthma and who were appropriately prescribed medication during the measurement year.	x	x
Cholesterol Management	The percentage of members 18–		x

Measure	Measure Description	STAR	STAR+PLUS
for Patients With Cardiovascular Conditions	75 years of age who were discharged alive for AMI, coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCI) from January 1–November 1 of the year prior to the measurement year, or who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and the year prior to the measurement year, who had each of the following during the measurement year: • LDL-C screening. • LDL-C control (<100 mg/dL).		
HbA1c Testing	The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had HbA1c testing.		x

Quality Challenge Measures (2013)

Measure	Measure Description	STAR	STAR+PLUS
Appropriate Testing for Children with Pharyngitis (2-18 yrs.)	The percentage of children 2–18 years of age who were diagnosed with pharyngitis, dispensed an antibiotic and received a group A streptococcus (strep) test for the episode.	x	
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	The percentage of members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of the following during the measurement year. • BMI percentile documentation. • Counseling for nutrition. • Counseling for physical activity.	x	
Member using Inpatient	Pediatric Quality Indicators	x	

Measure	Measure Description	STAR	STAR+PLUS
Services for ACSC (AHRQ-Pediatric Quality Indicators (PDI)	(PDIs) for child members: (1) Asthma (2) Diabetes Short-Term Complications (3) Gastroenteritis (4) Perforated Appendix (5) Urinary Tract Infection (The age eligibility for these measures is 17 years old and younger.)		
Member using inpatient services for ACSC (AHRQ- Prevention Quality Indicators (PQIs)	Prevention Quality Indicators (PQIs) for adult members: (1) Diabetes Short-Term Complications (2) Perforated Appendix (3) Diabetes Long-Term Complications (4) Chronic Obstructive Pulmonary Disease (5) Low Birth Weight (6) Hypertension (7) Congestive Heart Failure (8) Dehydration (9) Bacterial Pneumonia (10) Urinary Tract Infection (11) Angina without Procedure (12) Uncontrolled Diabetes (13) Adult Asthma (14) Rate of Lower Extremity Amputation among Patients		x
Follow-up Care for Children Prescribed ADHD Medication: Initiation Phase	The percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed. • Initiation Phase. The percentage of members 6–12 years of age as of the IPSD with	x	

Measure	Measure Description	STAR	STAR+PLUS
	an ambulatory prescription dispensed for ADHD medication, who had one follow-up visit with practitioner with prescribing authority during the 30-day Initiation Phase.		
Antidepressant Medication Management	The percentage of members 18 years of age and older with a diagnosis of major depression and were newly treated with antidepressant medication, and who remained on an antidepressant medication treatment. Two rates are reported. • Effective Acute Phase Treatment. The percentage of newly diagnosed and treated members who remained on an antidepressant medication for at least 84 days (12 weeks). • Effective Continuation Phase Treatment. The percentage of newly diagnosed and treated members who remained on an antidepressant medication for at least 180 days (6 months).		x
Adult BMI Assessment	The percentage of members 18–74 years of age who had an outpatient visit and whose body mass index (BMI) was documented during the measurement year or the year prior to the measurement year.		x
Members Utilizing CDS Option: HCBS SPW PAS HCBS Non-SPW PHC	0.5% Increase in Members utilizing Consumer Directed Services		x
Diabetic Eye Exam	The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had an eye exam.		x

Dashboard- STAR, STAR+PLUS, CHIP (2014)

Performance Indicator	HHSC STAR	HHSC STAR+PLUS	HHSC CHIP
I. POTENTIALLY PREVENTABLE EVENTS			
% of Emergency Department Procedures that were Potentially Preventable [PPV]	x	x	x
% of Inpatient Admissions that had a Potentially Preventable Readmission Within 30 Days [PPR]	x	x	x
% of Eligible Inpatient Admissions that were Potentially Preventable [PPA]	x	x	x
II. ACCESS TO CARE			
Access/Availability of Care			
% of Children with Access to PCP (CAP) (12 - 24 months)	x		x
% of Children with Access to PCP (CAP) (25 months - 6 yrs.)	x		x
% of Children with Access to PCP (CAP) (7 - 11 yrs.)	x		x
% of Children with Access to PCP (CAP) (12 - 19 yrs.)	x		x
III. QUALITY OF CARE			
Member Satisfaction - Adult			
% of Members with Good Access to Urgent Care	x	x	
% of Members with Good Access to Specialist Referral	x	x	
% of Members with Good Access to Routine Care	x	x	
% of Members with Good Access to Special Therapies	x	x	
% of STAR+PLUS Members with Good Access to Service Coordination		x	
% of Members with Good Access to Behavioral Health Treatment or Counseling	x	x	
% of Members Rating Their Personal Doctor a "9" or "10"	x	x	
% of Members Rating Their Health Plan a "9" or "10"	x	x	
% of Members having Good Experience with Doctor's Communication	x	x	

Performance Indicator	HHSC STAR	HHSC STAR+PLUS	HHSC CHIP
% Members Utilizing Consumer Directed Services (CDS) that includes: 1. Non-HCBS Program Primary Home Care 2. HCBS Personal Attendant Services		x	
Member Satisfaction - Child (Parent/Caregiver)			
% of Members with Good Access to Urgent Care	x		x
% of Members Good Access to Specialist Referral	x		x
% of Members with Good Access to Routine Care	x		x
% of Members with Good Access to Behavioral Health Treatment or Counseling	x		x
% Rating Their Child's Personal Doctor a "9" or "10"	x		x
% Rating Their Child's Health Plan a "9" or "10"	x		x
% Good Experience with Doctor's Communication	x		x
Children's Preventive Health			
Well-Child Visits - First 15 Months: 6+ visits (W15)	x		
Well-Child Visits - 3rd, 4th, 5th, & 6th years (W34)	x	x	x
Well-Child Visits - Adolescents (AWC)	x	x	x
Childhood Immunization Status (CIS) - Combination 4	x		x
Women's Preventive Health			
Cervical Cancer Screening (CCS)	x	x	
Prenatal Care (PPC)	x	x	
Postpartum Care (PPC)	x	x	
Breast Cancer Screening (BCS)		x	
Chlamydia Screening in Women (CHL)	x		x
Prevention and Screening			
Adult BMI Assessment (ABA)		x	
Child/Adolescent BMI Percentile Documented (WCC)	x		x
Counseling for Nutrition for Children/Adolescents (WCC)	x		x
Counseling for Physical Activity for Children/Adolescents (WCC)	x		x
AHRQ Prevention Quality Indicators [PQI] (Adults ≥ 18 yrs.)			

Performance Indicator	HHSC STAR	HHSC STAR+PLUS	HHSC CHIP
Diabetes Short-Term Complications Admission Rate {PQI 01}	**x**	**x**	
Diabetes Long-Term Complications Admission Rate {PQI 03}	**x**	**x**	
Chronic Obstructive Pulmonary Disease Admission Rate {PQI 05}	**x**	**x**	
Hypertension Admission Rate {PQI 07}	**x**	**x**	
Congestive Heart Failure Admission Rate {PQI 08}	**x**	**x**	
Low Birth Weight Admission Rate {PQI 09}	**x**	**x**	
Dehydration Admission Rate {PQI 10}	**x**	**x**	
Bacterial Pneumonia Admission Rate {PQI 11}	**x**	**x**	
Urinary Tract Infection Admission Rate {PQI 12}	**x**	**x**	
Angina w/o Procedure Admission Rate {PQI 13}	**x**	**x**	
Uncontrolled Diabetes Admission Rate {PQI 14}	**x**	**x**	
Adult Asthma Admission Rate {PQI 15}	**x**	**x**	
Lower Extremity Amputation due to Uncontrolled Diabetes Admission Rate {PQI 16}	**x**	**x**	
AHRQ Pediatric Quality Indicators [PDI] (Children < 18 yrs.)			
Asthma Admission Rate {PDI 14}	x	x	x
Diabetes Short-Term Complications Admission Rate {PDI 15}	x	x	x
Gastroenteritis Admission Rate {PDI 16}	x	x	x
Perforated Appendix Admission Rate {PDI 17}	x	x	x
Urinary Tract Infection Admission Rate {PDI 18}	x	x	x
IV. CARE FOR CHRONIC ILLNESS			
Asthma			
Use of Appropriate Medication for People with Asthma (all ages) (ASM)	x	x	x
Medication Management for People with Asthma- Medication Compliance 75% (MMA)	x	x	x
Appropriate Treatment for Children with Upper Respiratory Infection (URI)	x		x
Avoidance of Antibiotic Treatment in Adults		x	

Performance Indicator	HHSC STAR	HHSC STAR+PLUS	HHSC CHIP
with Acute Bronchitis (AAB)			
Appropriate Testing for Children with Pharyngitis (CWP)	x		x
Behavioral Health			
7-day Follow-Up After Hospital Stay for Mental Health (FUH)	x	x	x
30-day Follow-Up After Hospital Stay for Mental Health (FUH)	x	x	x
Antidepressant Medication Management: Acute Phase (AMM)		x	
Antidepressant Medication Management: Continuation Phase (AMM)		x	
Follow-Up Care for Children Prescribed ADHD Medication: Initiation (ADD)	x		x
Follow-Up Care for Children Prescribed ADHD Medication: Maintenance (ADD)	x		x
Initiation of Alcohol and Other Drug Dependence Treatment (IET)	x	x	
Engagement of Alcohol and Other Drug Dependence Treatment (IET)	x	x	
Diabetes (Adults ≥ 18 yrs.)			
HbA1c Tested (CDC)	x	x	
Poor HbA1c Control < 8% (CDC)	x	x	
Diabetic Eye Exam (CDC)	x	x	
LDL-C Screened (CDC)	x	x	
LDL-C Controlled (CDC)	x	x	
Nephropathy Monitored (CDC)	x	x	
High Blood Pressure			
High Blood Pressure Controlled (CBP)	x	x	
Smoking Prevention			
Advising Smokers to Quit	x	x	
V. LONG TERM SERVICES AND SUPPORT			
Nursing Facility Admission Rate			
Annual % Increase of STAR+PLUS Members Admitted to Nursing Facility (Medicaid only)		x	

Dashboard- Medicaid Dental (2014)

% of members (2 - 3 yrs) enrolled for at least 11 of the past 12 months who had at least one annual dental visit

% of members (4 - 6 yrs) enrolled for at least 11 of the past 12 months who had at least one annual dental visit
% of members (7 - 10 yrs) enrolled for at least 11 of the past 12 months who had at least one annual dental visit
% of members (11 - 14 yrs) enrolled for at least 11 of the past 12 months who had at least one annual dental visit
% of members (15 - 18 yrs) enrolled for at least 11 of the past 12 months who had at least one annual dental visit
% of members (19 - 21 yrs) enrolled for at least 11 of the past 12 months who had at least one annual dental visit
% of members (6 - 35 months) who had at least one First Dental Home Services visit

Preventive Dental Services

% of members (1 - 20 yrs) enrolled for at least 11 of the past 12 months who had at least one preventive dental service during the measurement year
% of members (1 - 20 yrs) enrolled for 12 consecutive months who had at least one preventive dental service during the measurement year
% of members (6 mo - 20 yrs) receiving at least one THSteps Dental Checkup per year
% of members (6 mo - 20 yrs) receiving two THSteps Dental Checkups per year
% of members (6 mo - 20 yrs) receiving more than two THSteps Dental Checkups per year
% of new members (6 mo - 20 yrs) receiving at least one THSteps Dental Checkup within 90 days of enrollment
% of members (2 - 5 yrs) receiving at least one sealant
% of members (6 - 9 yrs) receiving at least one sealant
% of members (10 - 14 yrs) receiving at least one sealant
% of members (15 - 20 yrs) receiving at least one sealant
Dental Quality Alliance: Sealants in 6-9 Years - % of members (6-9 yrs) continuously enrolled for at least 180 days who are at elevated risk for dental caries and who received a sealant on a permanent first molar tooth within the reporting year ***
Dental Quality Alliance: Sealants in 10-14 Years - % of members (10-14 yrs) continuously enrolled for at least 180 days who are at elevated risk for dental caries and who received a sealant on a permanent second molar tooth within the reporting year ***
% of members (1 - 20 yrs) enrolled for at least 11 of the past 12 months receiving at least one treatment for caries or a caries-preventive service*

Continuity of Care

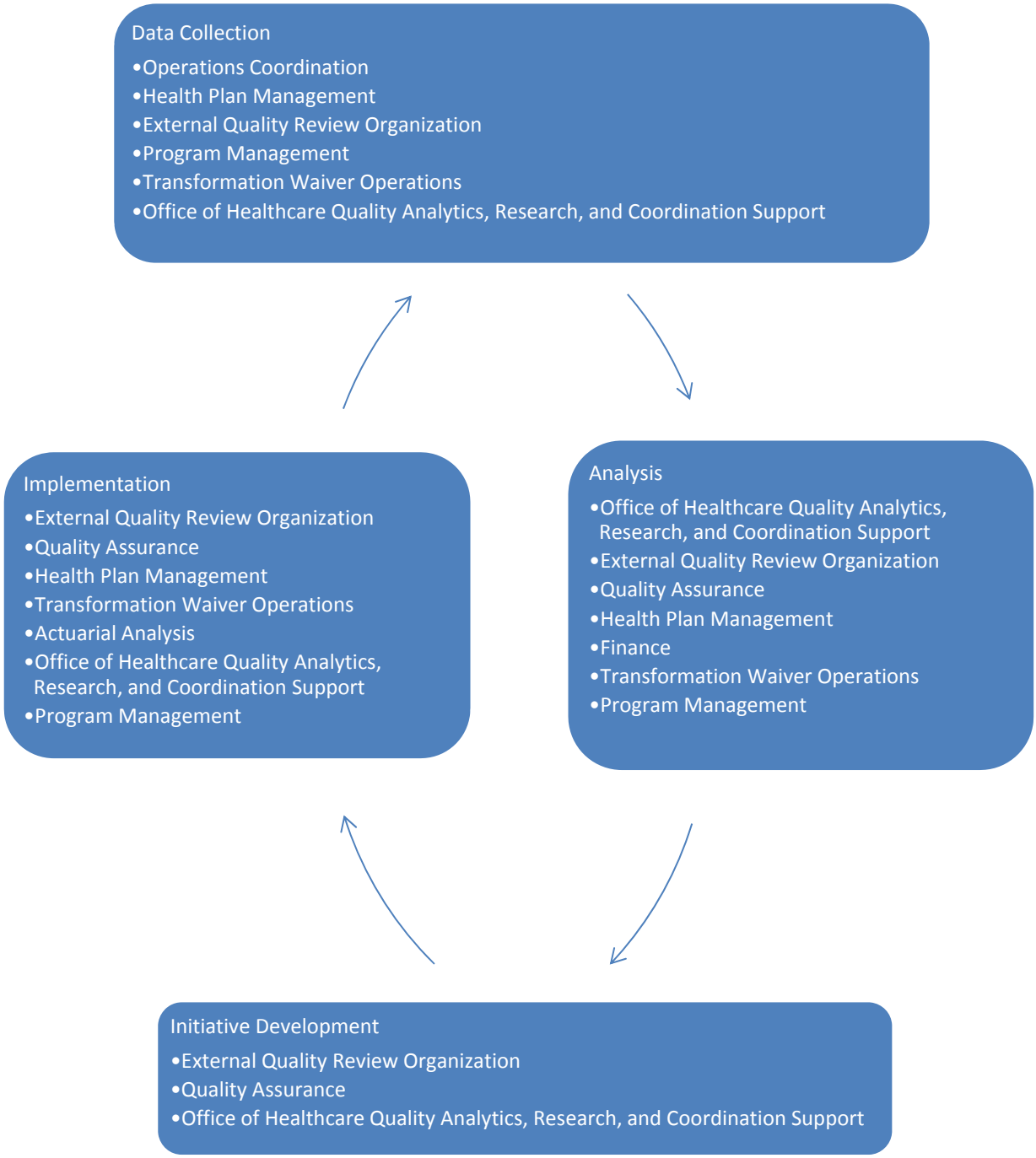
Dental Quality Alliance: Usual Source of Services- % of members (1-20 yrs) enrolled in two consecutive years for at least 6 months in each year who visited the same practice or clinical entity in both years

Quality of Care Measures Selected for 2014 Report Cards

Quality of Care Measure	Report Card Version		
	STAR Child	**STAR Adult**	**STAR+PLUS Adult**
Preventive care measures (HEDIS®)			
Well-child Visits in the First 15 Months of Life	x		
Well-child Visits in the 3rd, 4th, 5th, and 6th Years	x		
Adolescent Well-care Visits	x		
Prenatal Care		x	
Adults' Access to Preventive/Ambulatory Services			x
Breast Cancer Screening			x
Effectiveness measures (HEDIS®)			
Follow-up for Children Prescribed ADHD Medication[12]	x		
Comprehensive Diabetes Care – HbA1c Testing			x
Antidepressant Medication Management[13]			x
Effectiveness measures (AHRQ PDI/PQI)			
Asthma PDI	x		
Asthma PQI		✓	✓
Diabetes PQI		✓	
Hypertension PQI			✓
Satisfaction with Care (CAHPS®)			
Getting Care Quickly composite	✓	✓	✓
How Well Doctors Communicate composite	✓	✓	✓
Health Plan Rating	✓	✓	✓
Access to Specialist Care			✓

[12] ADD – Initiation Phase
[13] AMM – Effective Acute Phase

Attachment C- Interaction of Roles



Attachment D- Long-Term Services and Supports Performance Measure Timeline

Activity	Timeline
Develop measures	October 2013 - February 2013
Share with stakeholders	March 2014 - April 2014
Obtain CMS approval of measures	May 2014- June 2014
Changes to UMCC and UMCM	July 2014-August 2014
Implement measures	January 2015
Collect baseline data	January 1, 2015 - December 31, 2015
Analyze data	January 2016 - April 2016
Determine areas needing improvement based on data	May 2016 - June 2016
Develop quality-based payment incentives based on data	July 2016 - August 2016
Changes to UMCC and UMCM	September 2016 - November 2016
Implement quality-based payment system	January 2017
Assess success of quality program	Ongoing, report to CMS every two years
Revise program as needed	Ongoing

System maturity must be considered when assessing the success of quality strategy. Generally, it takes about four years from the time a new requirement is established to determine if state efforts are yielding expected results.

Attachment E- Timeline for Implementation of Nursing Facility Quality Program

Activity	Date Begin	Date Complete
Develop measures	October 2013	February 2014
Share with stakeholders	March 2014	May 2014
Changes to UMCC and UMCM	June 2014	August 2014
Implement measures	March 2015	March 2015
Collect baseline data	March 2015	February 2016
Analyze data	March 2016	April 2016
Determine areas needing improvement based on data	May 2016	May 2016
Develop quality-based payment incentives based on data	June 2016	August 2016
Share with stakeholders	September 2016	September 2016
Changes to UMCC and UMCM	October 2016	December 2016
Implement quality-based payment system	January 2017	December 2017
Assess success of quality program	Ongoing, report to CMS every two years	
Revise program as needed	Ongoing	

Attachment F- CFR and Relevant Managed Care Organization Contract Requirements

42 CFR	Element	Uniform Managed Care Contract Terms and Conditions
§ 438.200	Scope	
§ 438.202	State responsibilities	
§ 438.204	Elements of State quality strategies	
Access Standards		
§ 438.206	Availability of services	8.1.2 Covered Services; 8.1.3 Access to Care; 8.1.4 Provider Network; 8.1.5.8 Cultural Competency Plan; 8.1.12 Services for People with Special Health Care Needs; 8.1.13 Service Management for Certain Populations; 8.1.15 Behavioral Health (BH) Network and Services; 8.1.21 Pharmacy Services; 8.1.24 Immunizations; 8.1.25 Dental Coverage; 8.1.26 Health Home Services; 8.2.1 Continuity of Care and Out-of-Network Services; 8.2.2 Provisions Related to Covered Services for Medicaid Members
§ 438.207	Assurances of adequate capacity and services	8.1.3 Access to Care
§ 438.208	Coordination and continuity of care	8.2.1 Continuity of Care and Out-of-Network Providers; 8.2.7.2.3 Care Coordination; 8.3.2 Service Coordination
§ 438.210	Coverage and authorization of services	8.1.2 Covered Services
Structure & Operation Standards		
§ 438.214	Provider selection	8.1.4 Provider Network; 8.1.22 Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs); 8.2.3 Medicaid Significant Traditional Providers
§ 438.218	Enrollee information	8.1.5 Member Services
§ 438.224	Confidentiality	8.1.18.4 Health Insurance Portability and Accountability Act (HIPAA) Compliance
§ 438.226	Enrollment and disenrollment	5.0 Member Eligibility & Enrollment
§ 438.228	Grievance systems	8.1.5.9 Member Complaint and Appeal Process;

		8.2.4 Provider Complaints and Appeals; 8.2.6 Medicaid Member Complaint and Appeal System
§ 438.230	Subcontractual relationships and delegation	4.08 Subcontractors; 4.09 HHSC's Ability to Contract with Subcontractors; 8.1.20 General Reporting Requirements
Measurement & Improvement Standards		
§ 438.236	Practice guidelines	8.1.7.6 Clinical Practice Guidelines; 8.1.8 Utilization Management; 8.1.9 Early Childhood Intervention (ECI): 8.1.10 Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) – Specific Requirements; 8.1.12 Services for People with Special Health Care Needs; 8.1.14 Disease Management
§ 438.240	Quality assessment and performance improvement program	8.1.1.1 Performance Evaluation; 8.1.7 Quality Assessment and Performance Improvement
§ 438.242	Health information systems	8.1.18 Management Information System Requirements