



# **Quality-Based Payment and Delivery Reforms in Medicaid and the Children's Health Insurance Program (CHIP) Annual Report**

**As Required By S.B. 7, 82<sup>nd</sup> Legislature, First Called Session,  
2011, and the 2012-13 General Appropriations Act, H.B. 1,  
82<sup>nd</sup> Legislature, Regular Session, 2011 (Article II, Health and  
Human Services Commission, Rider 64)**



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## **Executive Summary**

The *Quality-Based Payment and Delivery Reforms in Medicaid and the Children's Insurance Program (CHIP) Annual Report* provides an overview of progress on the implementation of two pieces of legislation. This report is required by both S.B. 7, 82<sup>nd</sup> Legislature, First Called Session, 2011, and the 2012-13 General Appropriations Act (G.A.A.), H.B. 1, 82<sup>nd</sup> Legislature, Regular Session, 2011 (Article II, Health and Human Services Commission, Rider 64). The Texas Health and Human Services Commission (HHSC) submits this report to satisfy both requirements.

This legislation directs HHSC to develop and implement various quality initiatives and requires the agency to provide an annual report that includes the following:

- The quality-based outcomes and process measures developed, reported on by health service region and delivery model.
- The progress on implementation of quality-based payment systems and other related initiatives.
- The cost-effectiveness of quality-based payment systems and other related initiatives.

HHSC is in the process of appointing three separate quality-related committees as part of its first steps in developing and implementing various quality-based reforms and initiatives within Medicaid and CHIP. These committee meetings will commence in early 2012. Initially, meetings will focus on establishing the scope of work, timelines, and defined outputs for HHSC consideration. Once these parameters are established, committee work will consist of identifying and recommending selected outcome measures, defining benchmarks for achievement, and defining reimbursement methodologies.

HHSC anticipates reporting on additional development and implementation of quality-based initiatives in the December 2012 report. The current report, therefore, reviews the legislation, requirements, and progress to date.

## **Introduction**

### **Background**

Both S.B. 7 and Rider 64 direct HHSC to:

1. Develop acute care and long-term care quality and outcome measures that promote the provision of efficient, quality health care and that can be used to implement quality-based payments for acute and long-term care services across delivery models and payment systems.

Further, under S.B. 7, the outcome and process measures must be similar to measures used in the private sector, to the extent feasible and appropriate. The measures must be developed consistently across all CHIP and Medicaid program delivery models and payment systems in a manner that accounts for appropriate patient risk factors and that will have the greatest effect on improving quality of care and efficient use of services.

2. Implement quality-based payment systems for compensating a health-care provider or facility participating in Medicaid and CHIP.
3. Implement quality-based payment initiatives to reduce potentially preventable readmissions and potentially preventable complications.
4. Implement alternative payment systems for Medicaid and CHIP.

These reforms are associated with other legislation from the 82<sup>nd</sup> Legislative Session that also addresses health-care cost containment, payment incentives, and outcomes-based reimbursement to promote quality health care across HHSC delivery models. These include:

1. The 2012-13 G.A.A., H.B. 1, 82nd Legislature, Regular Session, 2011 (Article II, Health and Human Services Commission, Rider 68) directs HHSC to establish a committee of Texas physicians and HHSC representatives to identify the ten most overused, unnecessary medical services performed by physicians in Texas Medicaid. HHSC will decrease Medicaid payments for those services that should not be provided.
2. H.B. 2636, 82<sup>nd</sup> Legislature, Regular Session, 2011, creates a Neonatal Intensive Care Unit Council that will study and make recommendations regarding neonatal intensive care unit operating standards and reimbursement through the Medicaid program for services provided to infants admitted to neonatal intensive care units.

3. S.B.7 creates a Medicaid and CHIP Quality-Based Payment Advisory Committee that will advise HHSC on:
  - Establishing Medicaid and CHIP reimbursement systems that reward health-care providers for the provision of high-quality, cost-effective health care and quality performance and quality-of-care outcomes for health-care services.
  - Developing standards and benchmarks for quality performance, quality-of-care outcomes, efficiency, and accountability by managed care organizations and health-care providers and facilities.
  - Developing programs and reimbursement policies that encourage high-quality, cost-effective health-care delivery models that increase appropriate provider collaboration, promote wellness and prevention, and improve health outcomes.
  - Developing outcome and process measures that can be used to support these initiatives.

### **Reporting Requirements**

Rider 64 requires HHSC to report annually and S.B. 7 requires HHSC to report at least every two years the following information:

- The quality-based outcomes and process measures developed, reported on by health service region and delivery model.
- The progress on implementation of quality-based payment systems and other related initiatives.
- The cost-effectiveness of quality-based payment systems and other related initiatives.

As no new quality-based initiatives have been implemented since the legislation became law, HHSC will report on additional development and implementation of quality-based initiatives in next year's report. The current report, therefore, reviews the legislation, requirements, and progress to date.

### **Implementation Progress Report**

To better support quality initiatives, HHSC has dedicated staff to lead the required quality work and initiatives. As the basis for developing and implementing initiatives, HHSC is creating three external stakeholder committees:

1. The Neonatal Intensive Care Unit Council required by H.B. 2636.
2. The Quality-Based Payment Advisory Committee required by S.B. 7.
3. The Physician Payment Committee required by Rider 68.

Staff will support these committees by providing information, agency expertise, and collaboration with other state agencies as needed. Currently, staff is working on the development of background and information packets for each committee that will highlight the relevant charges, deliverables, and competing interests as well as

information to provide members with an understanding of Medicaid and CHIP delivery systems and reimbursement methodologies.

For the Neonatal Intensive Care Unit Council work, HHSC staff has worked closely with the Department of State Health Services (DSHS) on a Neonatal Intensive Care Unit survey and a Maternal-Fetal Hospital Services survey to identify the level of neonatal and maternal-fetal care available in each facility. The surveys were due to DSHS by November 30, 2011. The survey results will be provided to the Neonatal Intensive Care Unit Council members.

For the Quality-Based Payment Advisory Committee, staff is compiling information on the status of current and pending HHSC quality improvement and payment initiatives to provide to the committee.

Additionally, HHSC is in the process of identifying potential vendor assistance to support the research, reimbursement, payment, quality, technical, and clinical information needs of the committees. The initiatives that may be pursued include, but are not limited to, the following S.B. 7 initiatives:

- Quality-based payment systems for compensating a health-care provider or facility participating in the Medicaid and CHIP programs.
- Quality-based payment initiatives to reduce potentially preventable readmissions and potentially preventable complications.
- A bundled payment initiative in the Medicaid program, including a program that shares savings with providers that meet quality-based outcomes.

The announcement requesting applications for these new committees was distributed on September 23, 2011. Applications for all three committees were due by October 12, 2011. HHSC received 94 applications for the three committees. Committee appointments will be decided by December 31, 2011.

These committee meetings will commence in early 2012. Initially, meetings will focus on establishing the scope of work, timelines, and defined outputs for HHSC consideration. Once these parameters are established, committee work will consist of identifying and recommending selected outcomes measures, defining benchmarks for achievement, and defining reimbursement methodologies.

## **Conclusion**

HHSC is currently on track to implement these initiatives by the stated legislative deadlines. The December 1, 2012, report will include progress on meeting the specific goals, objectives, and planning activities in preparation for the committee work.