HHSC: Value-Based Payment and Quality Improvement Advisory Committee, November 10, 2020

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

• Dana Danaher, Austin • Frank Dominguez, El Paso • Cliff Fullerton MD, Dallas • Adam M. Garrett, Lewisville • Beverly Hardy-Decuir, DNP, Dallas • Carol Huber, San Antonio • Janet Hurley, Whitehouse • Daverick Isaac, Austin • Andy Keller, PhD, Dallas • Kathy Lee, Gatesville • Melissa Matlock, Canyon • Benjamin, McNabb, Pharm. D., Eastland • Binita Patel, Houston • Rachana Patwa, Missouri City	• Mary Dale Peterson, MD, Chair, Corpus Christi • Alejandro Posada, Houston • Joseph Ramon III, R.Ph., McAllen • Michael Stanley, MD, Dallas • Vincent Sowell, Kenedy **Ex Officio Representatives** • Mark Chassay, Fort Worth • Lisa C. Kirsch, Austin • Shayna Spurlin, College Station

1. Welcome and introductions. The meeting was convened by Dr. Peterson.

2. Review and approval of meeting minutes from August 25, 2020, meeting. The minutes were approved as written.

3. Presentation: Dell Medical School Factor Health Team, work related to social determinants of health.

Overview:

- Health programs delivered outside the clinic can rapidly & meaningfully improve health and save costs.
- Factor Health builds tests and scales such "mid-stream" health programs outside the clinic.
- First results from a program delivered during COVID-19 focused on loneliness and depression for older adults show promise.
- Questions & opportunities.

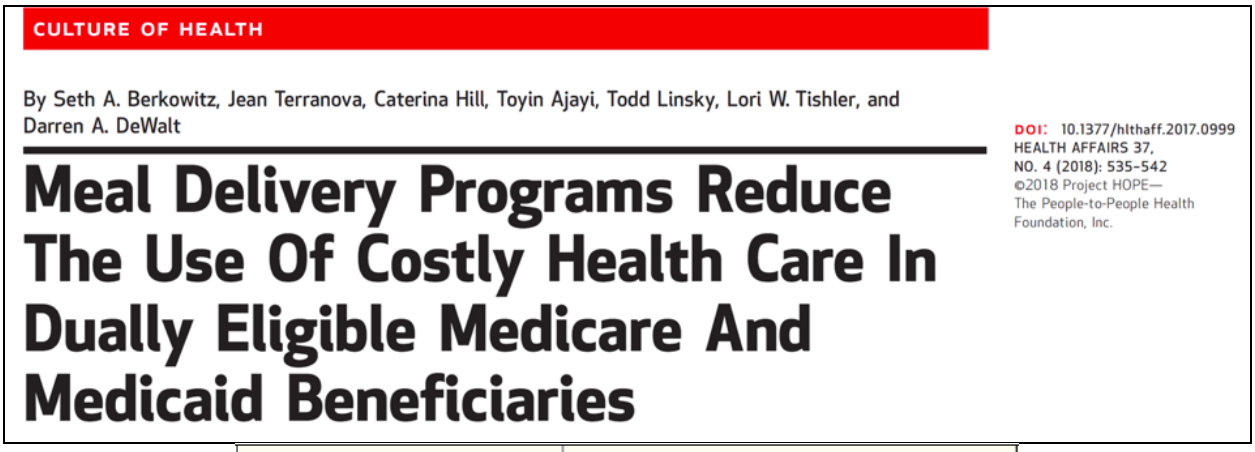
1. Health programs delivered outside the clinic can meaningfully improve health and save costs.

- "Mid-stream" interventions that better manage chronic conditions or disease risk.

807 BRAZOS ST, SUITE 607, AUSTIN, TX 78701 TEL: 512-708-8424, WWW.THBI.COM

- Interventions < 1 year, Savings < 2 years.

Emerging evidence shows that brief programs (<6 months) can have significant, clinically relevant results.



CULTURE OF HEALTH

By Seth A. Berkowitz, Jean Terranova, Caterina Hill, Toyin Ajayi, Todd Linsky, Lori W. Tishler, and Darren A. DeWalt

DOI: 10.1377/hlthaff.2017.0999
HEALTH AFFAIRS 37,
NO. 4 (2018): 535–542

Meal Delivery Programs Reduce The Use Of Costly Health Care In Dually Eligible Medicare And Medicaid Beneficiaries

	Emergency Department Visits	
	Incidence rate ratio	**P**
Medically Tailored Meals	0.36	***
Non-Tailored Food	0.54	***
	Inpatient Admissions	
	Incidence rate ratio	P
Medically Tailored Meals	0.41	**
Non-Tailored Food	0.81	
	Emergency Transportation Events	
	Incidence rate ratio	P
Medically Tailored Meals	0.18	***
Non-Tailored Food	0.52	***
	Average Monthly Costs	
	Difference in gross costs	P
Medically Tailored Meals	−$802	***
Non-Tailored Food	−$228	**

From Evidence to Proof Points

1. Does it work as an intervention?
2. How much is needed, how much of an effect, at what price point?

Medically Tailored Meal Delivery for Diabetes Patients with Food Insecurity: a Randomized Cross-over Trial
Berkowitz et al 2019.

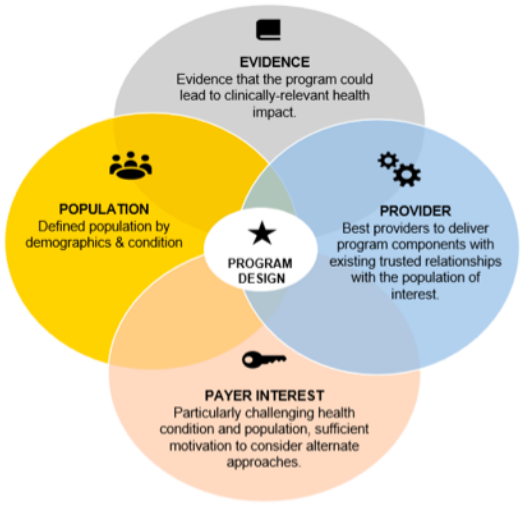
- N=44
- Measured: Diet improvements; self-reported hypoglycemia

Comprehensive Diabetes Self-Management Support From Food Banks: A Randomized Controlled Trial
Hilary K. Seligman et al 2018

- N=568, 3 cities/sites.
- Food security & fruits & vegetable intake significantly improved.
- *No* differences in self-management (depressive symptoms, diabetes distress, self-care, hypoglycemia, self-efficacy) or HbA1c

2. Factor Health builds tests and scales "mid-stream" health programs outside the clinic
   - Triangulates between payers, providers and the evidence to identify programs with greatest potential for improving health and lowering costs, rapidly.
   - Partners with payers and providers to design test and scale health programming

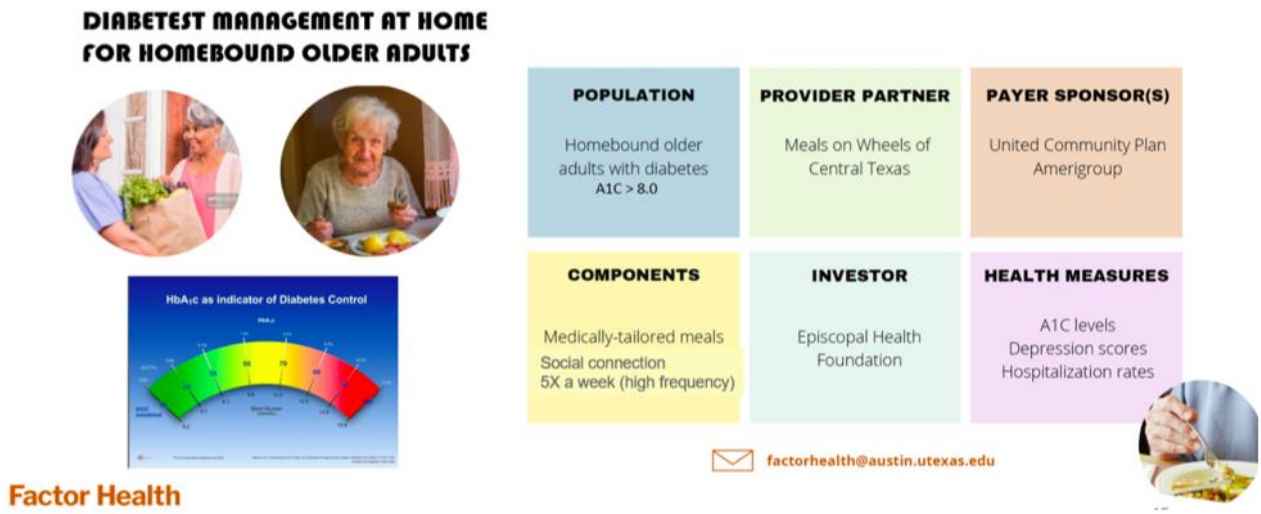
Approach to identifying similar opportunities



1. Currently in Austin, Houston, Dallas
2. Programming for populations served by-
   i. Medicaid STAR PLUS & STAR
   ii. Hospital Districts
   iii. Medicare Advantage.

807 BRAZOS ST, SUITE 607, AUSTIN, TX 78701 TEL: 512-708-8424, WWW.THBI.COM

Factor Health Example Program



Getting to Proof points – what's enough?

Examples

1. Hospitalization Rates – larger numbers and longer time frames necessary to prove.
2. Hemoglobin A1C levels – smaller numbers and shorter timeframes, but more collaboration with payer necessary to demonstrate savings.

Another Example: Loneliness & Depression

3. First results from a COVID-initiated program focused on loneliness and depression for older adults show promise.

Sunshine Calls: A lay person delivered program to address loneliness and depression in older adults.

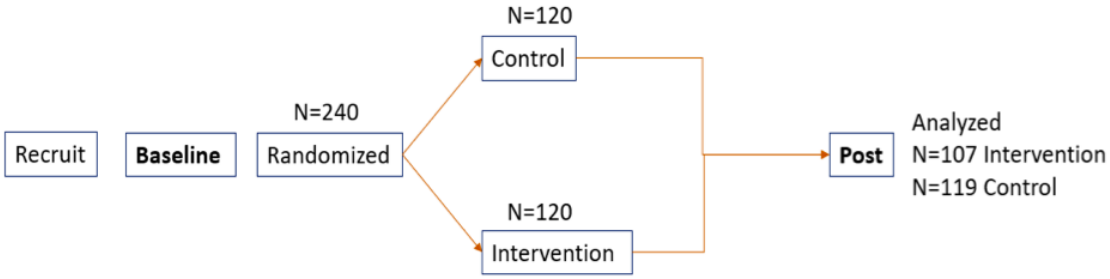
1. Older adults at risk of further isolation – loneliness & depression.
2. No physical contact – need the phone to deliver the services.
3. Rapid design and deployment after COVID struck.
4. Factor Health well-prepared with partnership with Central Texas Meals on Wheels and a framework to assess the value of empathy in improving health.
5. Importance of being heard and listened to, by empathetic callers.

- This is lighter touch than any other 'light touch' mental health program, for example that includes lay person delivered behavioral activation.

6. Need for authentic connection. Any lay person who is genuinely interested in connecting and is able to be empathetic could benefit lonely individuals.
7. Agency in Deciding What One Needs. Wherever possible, even though we might design a program to help, we should customize to individuals needs and preferences, providing them agency in creating the support they need.

Protocol: Week 1: 5 calls a week, then standardize to whatever the recipient chooses, from 2 to 5 calls a week.
Time course: 4 weeks
Callers: Graduate and Undergraduate students who 'volunteered'. We paid them a stipend after the fact
Connection Load: Each caller had a panel of 6-8 people.
Caller training, support, quality control and escalation carefully designed & implemented.

Sunshine Calls – Assessment through a randomized controlled trial.



Protocol delivered over 4 Weeks

- Week 1, Calls 5X a week
- Weeks 2-4 Choose 2-5X a week
- ~15 callers, ~6-8 recipients in each panel
- Calls targeted to <10 mins long, but many in first week went longer

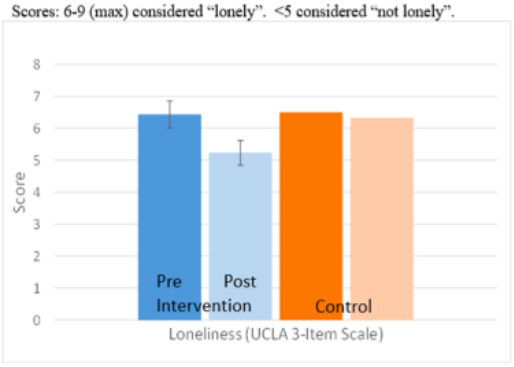
Factor Health
Real. Life. Health.

2

Sunshine Calls – Prelim Results (pre-publication)

1. First, how often do you feel that you lack companionship?
2. How often do you feel left out?
3. How often do you feel isolated from others?

Scores: 6-9 (max) considered "lonely". <5 considered "not lonely".

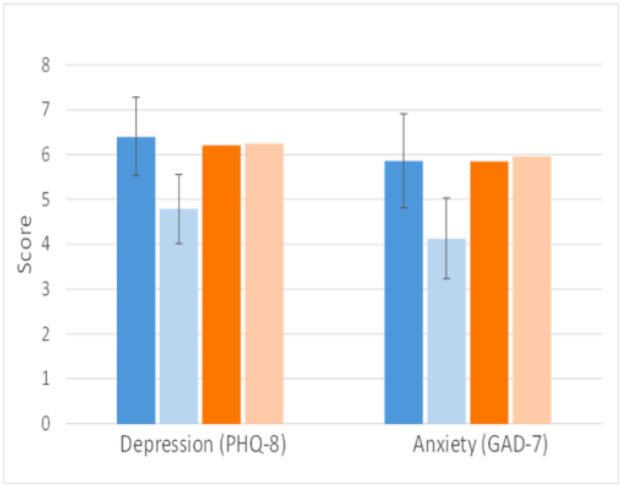


Error Bars: 95% Confidence Interval

1. On average the population is lonely.
2. The program significantly reduced loneliness ($p<0.01$) in 4 weeks.
3. Loneliness is a new enough concept in health that minimum clinically important difference (MCID) hasn't been defined.

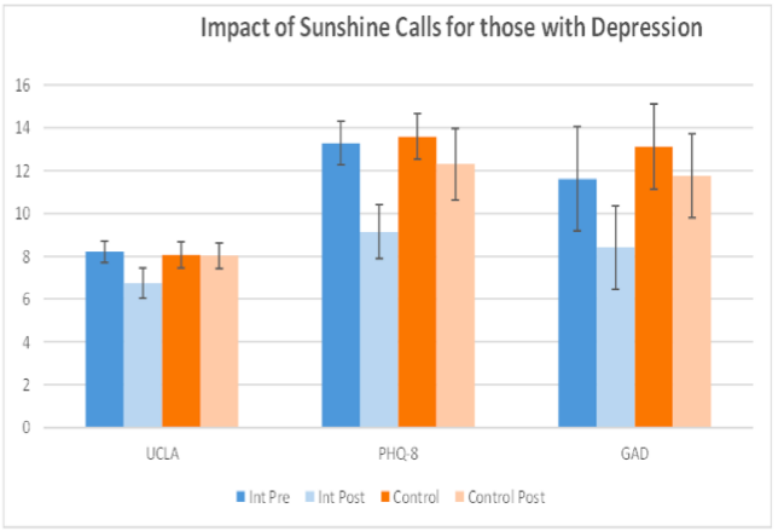
Factor Health
Real. Life. Health.

22



Error Bars: 95% Confidence Interval

1. On average the population wasn't depressed or anxious, but with considerable variability in baseline scores.
2. The program significantly reduced depression ($p<0.01$) in 4 weeks.
3. The program significantly reduced anxiety ($p<0.01$) in 4 weeks.
4. We only tested after the intervention, so these results do not tell us about how these results sustain.



For those with depression (PHQ>=10)

Significant, and large improvements in Depression (and loneliness & anxiety)

Summary:

- Lay person delivered telephonic program can significantly reduce validated measures of loneliness, depression & anxiety over 4 weeks.
- More work needed to assess just how much more improvement can be gained over time (instead of 1 month, 2-3 months) especially when focused on those with depression.
- Can the callers add additional support to build on individual agency to for example, tackle their diabetes? This will improve the cost-effectiveness of the program.

Factor Health Portfolio & Status

1. Currently in Austin, Houston, Dallas
2. Programming for populations served by-

807 BRAZOS ST, SUITE 607, AUSTIN, TX 78701 TEL: 512-708-8424, WWW.THBI.COM

   i. Medicaid STAR PLUS & STAR
   ii. Hospital Districts
   iii. Medicare Advantage.
3. Populations & conditions at various stages of planning & implementation:
   i. Diabetes – Elderly; Families.
   ii. BMI/Youth Health trajectories
   iii. Depression & comorbidities
   iv. Loneliness, social connection & depression
   v. Chronic Kidney Disease.

Summary:

1. Programs delivered outside the clinic with social components can rapidly deliver clinically meaningful results, with savings < 2 years.
   - For e.g. Medically tailored meals and social connection for older adults with diabetes
2. Programs offer novel solutions to otherwise hard to solve problems, in clinically meaningful ways, for example, loneliness, depression & anxiety in home bound older adults.
3. Creativity required to align policy and payment to paying for results that matter.

Opportunities:

1. How can we make it easier to pay for meaningful results of programs whose components are not standard healthcare services?
2. For Medicaid, how can we incent MCO's to invest in social needs-targeted care without negatively impacting future cap rates for successful outcomes (premium slide).
3. What opportunities exist to partner with primary care delivery organizations to maximize value to patient and payer.
4. More broadly, what opportunities exist to incentivize competing on results of health programs, and the value they deliver.

Questions/Answers/Comments

Where are the next opportunities in this area? Dr. Peterson stated that we need studies that show what works. We have to incentivize MCOs to work with research partners. Doing controlled trials is still necessary. Mr. Blanton stated that we have opportunities when it comes to analytics if in Medicaid. The difficult part is paying for the interventions and partnerships might be necessary.

The pilot studies got help from other grant foundations. The speaker stated that the funding from foundations is critical but does not last forever.

What should the commitment be before investment produces a return? What are realistic expectations? The speaker stated that the big improvements are from long-term interventions. There is a need to accelerate the activities around social determinants of health.

Community pharmacies can become diabetes self-management entities. It has been difficult to secure a contract with the health plans. There is a need to look at pharmacies differently.

Given multiple MCOs and the frequency of changing MCOs, is the MCO model the most appropriate one? There are not a lot of other models out there. Perhaps community-based pharmacies or clinical systems could assume the risk for some of the services. The policy pieces have to be reviewed to ensure that they have the mechanisms to participate.

4. Update: New member appointment process

- Application process will open in the next few months
- One-month application deadline

Members with expired terms:

- Michael Stanley, Vincent Sowell, Joseph Ramon, Benjamin McNabb, Kathy Lee, Isaac Daverick, Beverly Hardy-Decuir, Adam Garrett, Cliff Fullerton
- All members continue on the VBPQIAC until an appointment is made
- Outgoing members are eligible to apply for another term

5. 2020 Legislative Report update. Please follow the link to access the report.

2020 Legislative Report Topics

- **Workgroup 1:** Maternal and Newborn Care Measures
- **Workgroup 2:** Leveraging Multi-Payer Data
- **Workgroup 3:** Managed Care Organizations' Activities to Address Social Drivers (Determinants) of Health
- **Workgroup 4:** Advancing Alternative Payment Models in Medicaid
- **Workgroup 5:** Impact of COVID-19 on Value-Based Care

Next Steps.

- Report distributed by Chair to the standing committees of the Texas senate and house with primary jurisdiction over health matters
- Report posted to the VBPQIAC website
- Committee educational activities
- The report will be presented at a future Executive Council Meeting.

Summary:
As health care costs in the US continue to increase with mixed outcomes, there is momentum nationwide to promote higher value care by changing how we pay for care. Throughout this report, the terms "value-based care", "value-based payment" (VBP), and

"alternative payment model" (APM) are used interchangeably to describe Texas' efforts to improve outcomes for patients while reducing the cost of achieving these outcomes.

These value-based approaches incentivize high-quality and cost-efficient care by linking healthcare payments to measures of value. In 2016, the Executive Commissioner of the Health and Human Services (HHS) system established the Value-Based Payment and Quality Improvement Advisory Committee (VBPQIAC or Committee) to evaluate the evidence on emerging value-based approaches and make recommendations to both HHS and the Legislature aimed at optimizing how health care dollars are spent in Texas.

The Committee released its first biennial report in 2018. The 2018 recommendations included implementing a comprehensive informatics strategy, making data more readily available to support value-based initiatives, addressing patients' non-clinical health related needs, prioritizing maternal and child health, sustaining innovative behavioral health models, expanding VBP for substance use disorders, and reducing administrative complexity to promote provider participation in VBP models.

These recommendations informed discussion and legislation when the Texas Legislature met in 2019. Building on its 2018 report, the Committee's second biennial report includes 14 recommendations in five policy areas: maternal and newborn health, leveraging multi-payer data, social drivers of health, advancing alternative payment models in Medicaid, and lessons learned from COVID-19.

The Committee adopted these recommendations without a dissenting vote to offer good faith solutions to help Texas continue to advance high quality, efficient care in its state health care programs, and particularly Medicaid and the Children's Health Insurance Program (CHIP).

The Committee's 2020 recommendations reflect the themes that have informed its work since 2016. Successful VBP initiatives require broad stakeholder engagement, timely data, and aligned incentives for managed care organizations and providers to improve care delivery and health outcomes. Many of this year's recommendations relate to information gathering, such as conducting landscape assessments of current programs, barriers, and tools for VBP and addressing social drivers of health.

In addition, the recommendations underscore the importance of convening stakeholders to review and identify standardized performance measures and best practice models. Finally, this year's report again stresses the importance of data, and, in particular, aggregating and integrating data sources to analyze trends and opportunities for improvement across populations.

Recommendations:

Maternal and Newborn Care

1. HHSC should establish a consensus endorsement of a set of standardized performance measures, measure specifications, and reporting periods for maternal and newborn care through a two-stage process:

- Regional stakeholders in diverse pilot regions establish consensus measures and measurement approaches that address local needs, priorities, and barriers to provider participation.
- Convene stakeholders from the Department of State Health Services (DSHS), Health and Human Services Commission (HHSC), and other relevant advisory committees and collaboratives to establish a statewide endorsement informed by regional needs.

2. Texas should establish a statewide de-identified database linking mothers and babies that enables providers to explore and improve on their performance on key measures in near real-time.

Leveraging Multi-Payer Data

3. The Legislature should build on the multiple legislative sessions of direction to encourage collaboration in the use of health care data by:

- Extending the term of the 10.06 rider for cross-agency collaboration for another five years, maintaining the services of the Center for Healthcare Data at The University of Texas Health Science Center at Houston School of Public Health (UT Data Center).
- Directing remaining state funded health plans and health services to participate in the rider 10.06 cross-agency collaboration, specifically the state run hospitals (including psychiatric hospitals) and state supported living centers, juvenile justice health system, and employer sponsored health plans for state colleges and universities.
- Requiring the agencies involved in the 10.06 rider to permit their data to be included in aggregated multi-payer analyses and reporting activities conducted by the UT Data Center.
- Exploring how to strategically partner with additional commercial payers, including self-insured payers and county indigent care programs, so that their data could be included in the UT Data Center as well.
- Directing that data aggregated by the UT Data Center, including state agency data and data from other payers who have provided authorization, be shared at a de-identifiable level through a Public Use Data File (PUDF). An application programming interface (API) should be developed and made available as one way of accessing the PUDF, in addition to a streamlined request process similar to that used for the Texas Health Care Information Collection (THCIC).
- Exploring price and utilization variation among providers for similar services, both within metro areas and across the state, to identify instances and programs where savings can be achieved without sacrificing quality.

807 BRAZOS ST, SUITE 607, AUSTIN, TX 78701 TEL: 512-708-8424, WWW.THBI.COM

- Directing UT Data Center to aggregate all available clinical, claims, pharmacy, cost, and quality data regarding specific high cost/high prevalence conditions, such as diabetes, to develop additional web features and de-identified data files for public and research use.
- Exploring federal funding opportunities, such as those offered by the Center for Medicare & Medicaid Innovation, that advance value-based payment and that are enabled by access to multipayer data.

4. Texas should identify new and expanded use cases for the Texas Healthcare Learning Collaborative (THLC) Portal as well as analyze potential use cases for aggregating data from the THLC, the UT Data Center, the Texas Health Care Information Collection, and any other data sources that could prove beneficial. Texas should develop an implementation strategy for the most valuable use cases that leverages the strengths of these existing data sources while minimizing duplication of state resources.

Social Drivers of Health (SDOH)

5. HHSC should conduct a landscape analysis of which SDOH assessment tools and electronic referral platforms are currently being utilized in Texas Medicaid, and also review strong models throughout the US. Working with Medicaid managed care organizations (MCOs), providers, and other stakeholders, HHSC could assess whether a state-level or regional tool(s) and/or platform(s) would better enable Texas Medicaid to address SDOH.

- Based on the landscape analysis, HHSC should work with Medicaid MCOs to implement an assessment tool and electronic referral platform strategy that can be used to better facilitate the ability to address SDOH needs.

6. HHSC should work with stakeholders to explore how initiatives to address SDOH that drive healthcare costs and poor health outcomes are/could be supported through APMs, including:

- Promoting better reporting of ICD-10 Z codes for social needs. The information could be useful for eventually identifying areas for improvement or intervention.
- Developing accountability metrics in the Medicaid program related to SDOH/health equity.
- Looking at pilot/study/proof of concept opportunities with MCOs to develop evidence to inform future HHSC policy.
- Reviewing opportunities in 1115 waivers, such as the DSRIP transition.

Advancing Alternative Payment Models in Medicaid

7. HHSC should conduct a landscape assessment to determine the barriers and opportunities to advancing APMs. The landscape assessment should include:

- Considerations and opportunities specific to rural and small providers and provider types not significantly represented in current APMs, including emerging models for these provider types

807 BRAZOS ST, SUITE 607, AUSTIN, TX 78701 TEL: 512-708-8424, WWW.THBI.COM

- An assessment of the current Texas Medicaid APM requirements and targets for any modifications that could incentivize implementation of the highest impact models
- Identification of opportunities for measure standardization to reduce provider administrative burden to participate in Medicaid APMs, while acknowledging flexibilities may be required to address specific regional or sub-population needs
- Review of strong models related to maternal and newborn health, behavioral health, and opioid and other substance use identification and treatment

8. HHSC should convene Medicaid MCOs and provider stakeholders to share the results of the landscape assessment as well as discuss best and promising APM models in Texas and other states.

9. HHSC should leverage findings from the DSRIP Best Practices Workgroup and the Delivery System Reform Incentive Payment (DSRIP) Transition Plan milestone analysis of DY 7-8 DSRIP quality data to identify key outcomes and effective interventions to inform HHSC strategies to advance alternative payment models.

10.HHSC should encourage MCOs to work with providers to make adjustments to APMs, including adjusting risk-based requirements, that acknowledge the barriers COVID-19 has posed to achieving metrics agreed upon prior to COVID-19 and engaging patients in certain preventive health care practices.

Lessons Learned from COVID-19

11. HHSC should work with stakeholders to evaluate the Medicaid waivers used in telehealth during the pandemic including access to care, patient experience, health outcomes and cost effectiveness to share best practices and determine policy changes that should continue post-pandemic.

- Consider how telehealth can count toward network adequacy.

12. HHSC should work with stakeholders to reward and incentivize creative practices that improve health based on the experience during COVID-19, such as prospective payments for primary care providers.

13. Texas should review the experience of social drivers of health (SDOH) Medicaid members experienced during the COVID-19 pandemic for waivers that could be instituted in an expedited approval process in future emergencies/disasters. Areas of focus could include:

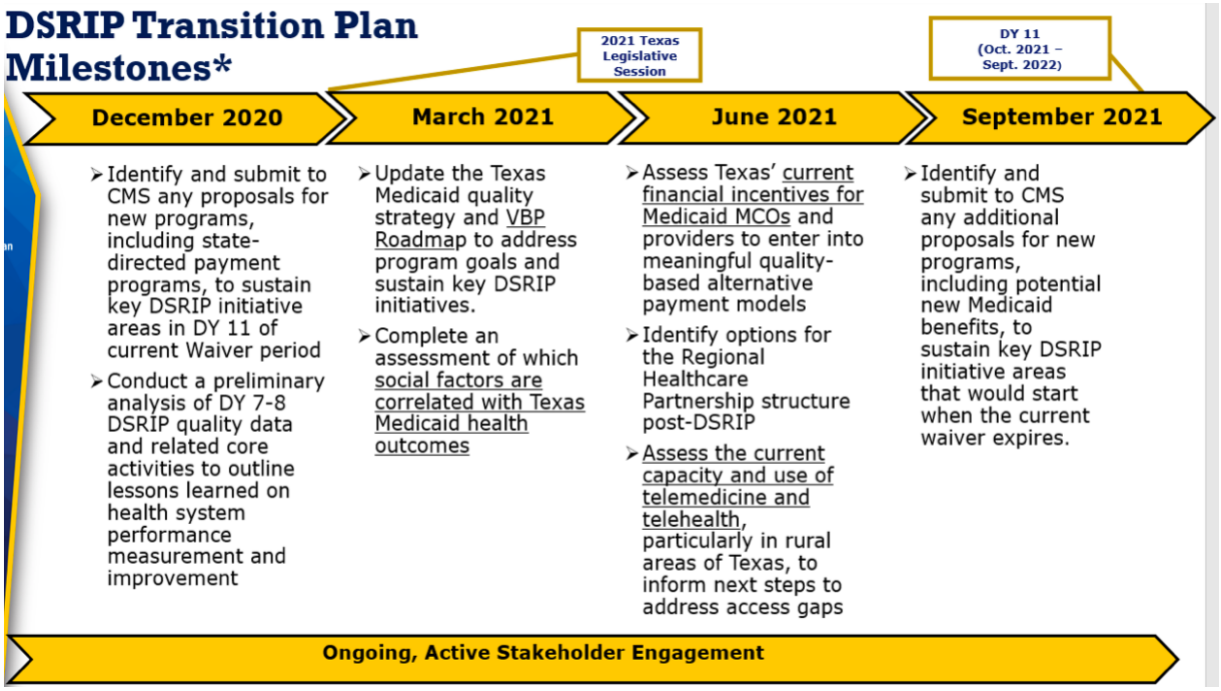
- Establishing enhanced rates for disaster-related services, such as used by Medicare for COVID-19.
- Flexibility for additional administrative costs required during a disaster, such as purchase of pre-paid smart phones for beneficiaries to use for telehealth during a disaster.

14. HHSC should work with stakeholders to align value-based payment measures and incentives as much as possible within each region of Texas to reduce provider administrative burden.

6. Staff update: Medicaid value-based activities

Key Projects/Milestones planned for SFY 2021:

- Annual Report on Quality Measures and Value-Based Payments
- Implementation of Value-Based Enrollment Method (Rider 43)
- FY 2019 Update on Alternative Payment Models
- Accountable Health Communities
- Continued Assessment of COVID-19 Impacts on Value-Based Initiatives
  - Hospital Pay for Quality
- Multi-agency collaboration on value-based and quality improvement initiatives (General Provision 10.06)
- Ongoing quality and value-based research projects
- Projects to support VBP&QI Advisory Committee Recommendations
- HHS Quality Webpages
- MCO Report Cards, Pay for Quality, and Performance Improvement Projects
- Texas Healthcare Learning Collaborative Portal
- DSRIP Milestone Work Continues



807 BRAZOS ST, SUITE 607, AUSTIN, TX 78701 TEL: 512-708-8424, WWW.THBI.COM

Questions/Answers/Comments
One of the problems we have is getting providers to accept Medicaid. Will the transition impact this in some way? Can we simply pay more per episode? Mr. Blanton stated that the dollar decisions are still under discussion in the DSRIP programs. Improving access to care is a priority. The funding strategy is still being developed.

Some of the fee schedules are not different from a decade or two ago. FQHCs are built on a more reasonable cost structure. The legislature will have to be involved in the funding decisions.

There will also be an actuarial process involved in bonus payments.

There have been pauses in the pay for quality because of COVID. It will be a year before vaccine is distributed enough into the population to go back to normal. Are extensions being considered? Yes, the extensions will be reviewed in pay for quality and other programs.

Is there any preliminary information on assessment of social factors and behavioral outcomes? Mr. Blanton stated he would take that and discuss with staff. There are some efforts going on with COVID and DSRIP. Overall admissions are less but behavioral health admissions are higher.

Any thoughts about how pharmacy will follow the road map? Mr. Blanton stated that there are high-level targets. There are some areas that are not up to the same level as primary care. We would like to see other areas relate better to quality-based payment, and pharmacy falls into that area.

There is a UHRIP redesign occurring and they are looking at options on how to connect to quality. There will be a rule comment opportunity. This could also be discussed at the February meeting.

On rural telehealth, we should look at audio only. Data from rural areas should be compared to urban areas.

7. Planning 2021. See above discussion.

8. Public comment. No public comment was offered.

9. Action items for staff and/or member follow-up.

- Staff will reach out to members about reapplying for the committee
- EQRO data will be sought
- There were potential workgroups related to COVID and other services not covered by quality payments

- Next meeting Wednesday February 3rd

10. Adjourn. There being no further business, the meeting was adjourned.

***