HHSC: Value-Based Payment and Quality Improvement Advisory Committee, March 9th, 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. The members may be accessed by following the link above, but the list appears to be out of date.

1. Welcome and introductions. The meeting was convened by the Vice Chair, Lisa Kirsch on March 9th. A quorum was established.

2. Review and approval of meeting minutes from September 27, 2019. The minutes were approved with minor corrections.

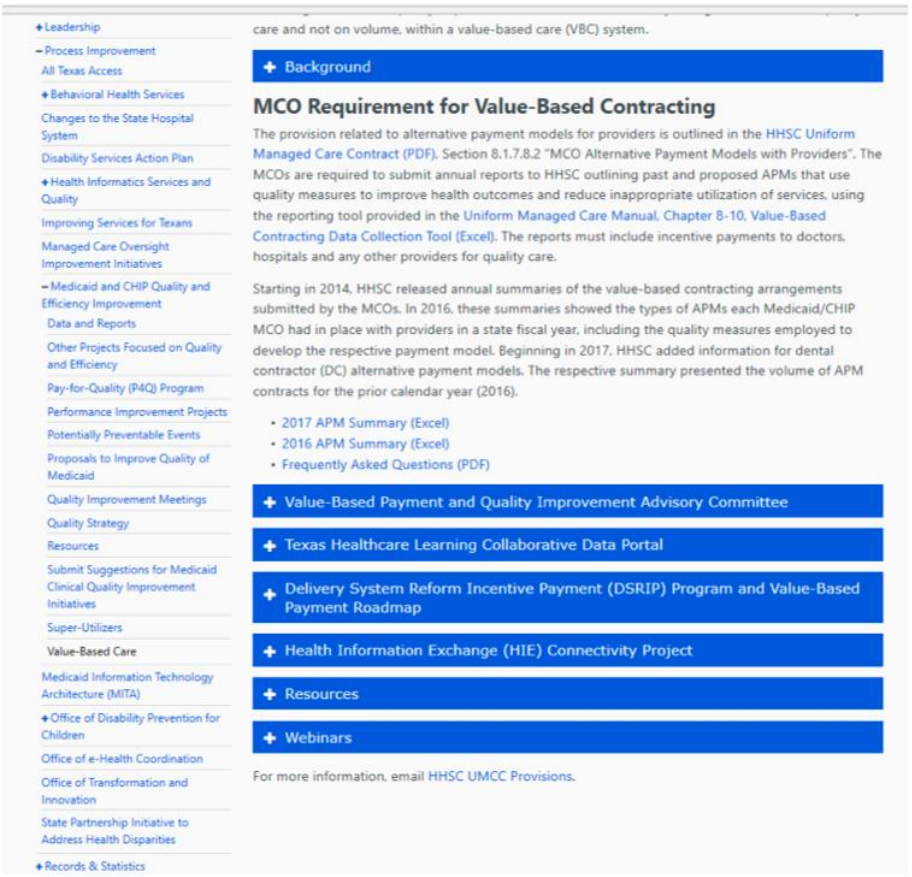
3. Update: Value-Based Care webpage. Navigation Link: https://hhs.texas.gov/about-hhs/process-improvement/improving-services-texans/medicaid-chip-quality-efficiency-improvement/value-based-care and (for the bigger picture) https://hhs.texas.gov/about-hhs/process-improvement/improving-services-texans/medicaid-chip-quality-efficiency-improvement

Mr. Blanton stated that there has been work on the webpage(s) to revamp it. The focus is to access value-based care efforts. A section of the webpage is included in the box below.

Projects underway:
- Pay-for-Quality (P4Q) Program
- Performance Improvement Projects
- Potentially Preventable Events
- Value-Based Care
- Super-Utilizers
- Quality Improvement Meetings
- Quality Strategy

Other quality resources:
- Other Projects Focused on Quality and Efficiency
- Submit Suggestions for Medicaid Clinical Quality Improvement Initiatives
- HHSC Advisory Committees
- Resources
- Data and Reports

For questions, comments and suggestions email HHSC Quality.



Dr. Stanley asked if there is a way to show the improvement in outcomes on any of the value-based programs. Mr. Blanton stated that there is language in the contract about evaluations by the MCOs. There were discussions about including additional codes in the claims data. We have to come up with a way to look at what the benefits have been. Perhaps this group, as well as data analytic partners, could help in this regard.

The Chair stated that there was an article related to the Camden Study, but the results were disappointing. If we looked at immunizations and immunization-related disease, we might be able to see some change. Cause and effect can be difficult to ascertain.

Staff stated that HHSC is preparing a legislative report on quality measures and payments. Until there is a robust tool for quality measures, this report could be used as a proxy.

Mr. Blanton stated that within the data analytics budget, there is space for evaluation of alternative payment models.

Mr. Blanton continued with his presentation. He stated that the website provides more information and he encouraged feedback to be included. He stated that there are many initiatives that are listed on the website. He stated that there are many initiatives on the page that this group might want to know more about, and they would be happy to provide a briefing.

4. Presentation: Pregnancy Related Outcome Measures

Senate Bill 750. The 85th Legislature passed S.B. 17 by Senator Kolkhorst, which directed the improvement of maternal health data, causes of death and morbidity, and the development of strategies to address the rates of maternal mortality and morbidity in Texas. The bill also reauthorized the Maternal Mortality and Morbidity Task Force until 2023. S.B. 750 builds upon the successes of S.B. 17 by seeking to maximize Texas' efforts to address maternal mortality as detailed by the Health and Human Services Commission's report, State Efforts to Address Maternal Mortality and Morbidity in Texas, address the findings and recommendations of the Maternal Mortality and Morbidity Task Force, and update Texas law to align with new federal legislation on maternal mortality review committees. (Original Author's/Sponsor's Statement of Intent)

S.B. 750 amends current law relating to maternal and newborn health care and the quality of services provided to women in this state under certain health care programs.

SB 750 requires HHSC to develop or enhance statewide initiatives to improve the quality of maternal health care services and outcomes for women in this state. The commission shall specify the initiatives that each managed care organization that contracts with the commission to provide health care services in this state must incorporate in the organization's managed care plans. The initiatives may address:

1. prenatal and postpartum care rates;
2. maternal health disparities that exist for minority women and other high-risk populations of women in this state;
3. social determinants of health; or
4. other priorities specified by the commission.

Senate Bill 17, 85th Legislature, First Called Session. The Maternal Mortality and Morbidity Task Force (task force) established by S.B. 495, 83rd Legislature, is a multidisciplinary group tasked to study maternal mortality and morbidity in Texas. The task force has produced two reports since its inception, providing critical information on maternal mortality trends and demographics in Texas. Considering the findings of the task force, much work still needs to be done to more directly address the causes of pregnancy-related deaths in Texas and severe maternal morbidity.

S.B. 17 as proposed extends the expiration date of the task force from September 1, 2019, to September 1, 2023. S.B. 17 also directs the Health and Human Services Commission

(HHSC) to evaluate options to address the most prevalent causes of maternal death as identified by the task force, including options for treating postpartum depression in low-income women.

S.B. 17 also directs the Department of State Health Services to implement a maternal health and safety initiative with healthcare providers to lower incidences of maternal mortality and morbidity. The bill also requires HHSC to determine the feasibility of adding maternal health and safety protocols and best practices as a measure of quality outcomes and for quality payment purposes in the Medicaid program. (Original Author's / Sponsor's Statement of Intent)

S.B. 17 amends current law relating to maternal health and safety, pregnancy-related deaths, and maternal morbidity, including postpartum depression.

Senate Bill 17, 85th Session, 2017 required the Health and Human Services Commission (HHSC), to evaluate options for reducing pregnancy-related deaths and for treating postpartum depression in economically disadvantaged women. This resulted in the 2018 Joint Biennial Report by DSHS and the Task Force reviewed the 2012 cohort of maternal deaths and analyzed maternal death trends for the years 2012-2015.

The bill further required Department of State Health Services (DSHS) and the Maternal Mortality and Morbidity Review Committee (MMMRC), to identify strategies to lower costs and to improve quality outcomes related to severe maternal morbidity (SMM) and chronic illness. (DSHS launched the maternal safety bundles initiative: Texas AIM in December 2017)

The bill required HHSC to study and determine feasibility of adding provider's use of procedures (AIM bundles) as an indicator of quality for quality-based payments.

SB17 Feasibility Study. HHSC studied the feasibility of adding the AIM maternal safety bundles as an indicator of quality. The limitations identified by the study were:

- MCOs' ability to influence hospital processes is limited.
- Hospitals contract with multiple MCOs.
- MCOs contract with multiple hospitals and the volume of members at each hospital may differ.

An MCO quality measure focused on member health outcomes would be better aligned with other MCO quality improvement activities than a measure focused on a hospital's adoption of AIM bundles. HHSC commissioned Texas's EQRO to explore applying the AIM maternal morbidity measures at the MCO level.

In 2018, the EQRO conducted a study (producing a report) to examine ways to leverage current data to evaluate maternal morbidity across Texas Medicaid/ and CHIP at the MCO-level. The study examined differences in maternal care utilization, pregnancy outcomes, and

the cost of maternal care for a cohort of women enrolled in the STAR Program, with the goal of better understanding how these outcomes vary with pregnancy risk status and service plan enrollment.

The EQRO found:

- Rates of hemorrhage and preeclampsia were lower in women that had timely prenatal care
- STAR+PLUS had highest Severe Maternal Morbidity (SMM) rates
- Black, non-Hispanic mothers had the highest rates of SMM despite only accounting for 18% of deliveries
- Mothers in rural areas had higher SMM rates than women in metropolitan or micropolitan areas

The EQRO collaborated with DSHS and discussed changing the data capture period from 15 days after delivery to 42 days after delivery. DSHS staff agreed HHSC should move forward with the SMM measures.

Based on the EQRO study findings and recommendations and collaboration with DSHS, HHSC developed three measures as indicators of quality

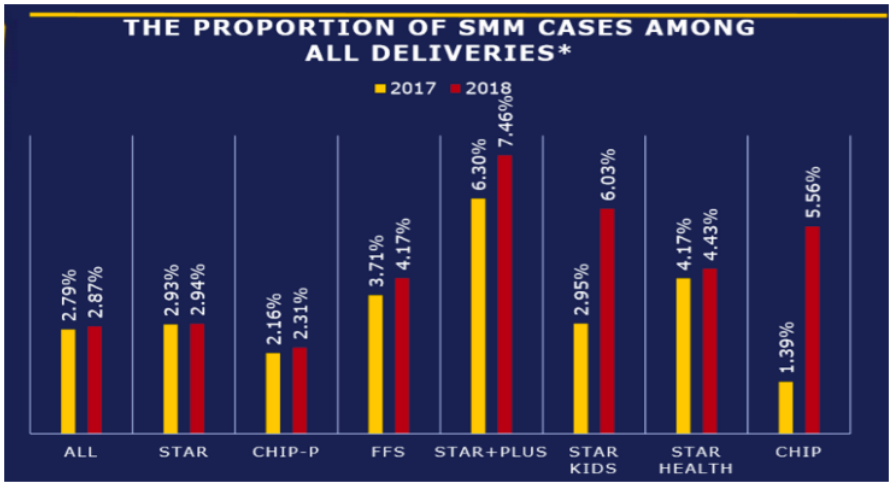
- **The proportion of SMM cases among all deliveries.**
- **The proportion of SMM cases among deliveries having hemorrhage.**
- **The proportion of SMM cases among deliveries with preeclampsia**

Data sources include

- Encounter and enrollment data
- AIM definitions for identifying Hemorrhage, Preeclampsia, and SMM

The data capture period is 7 days prior to through 15 days after the delivery. HHSC is planning to change the data capture period to 7 days prior to delivery encounter and 42 days after initial delivery admission. The following are base line data for use in developing measures.

Testing the Methodology



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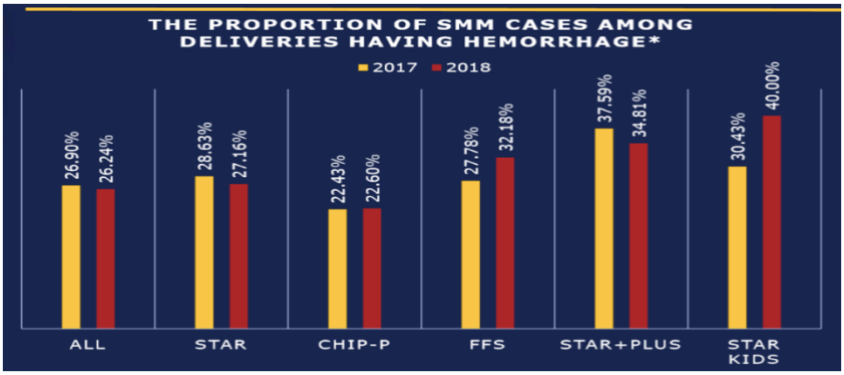
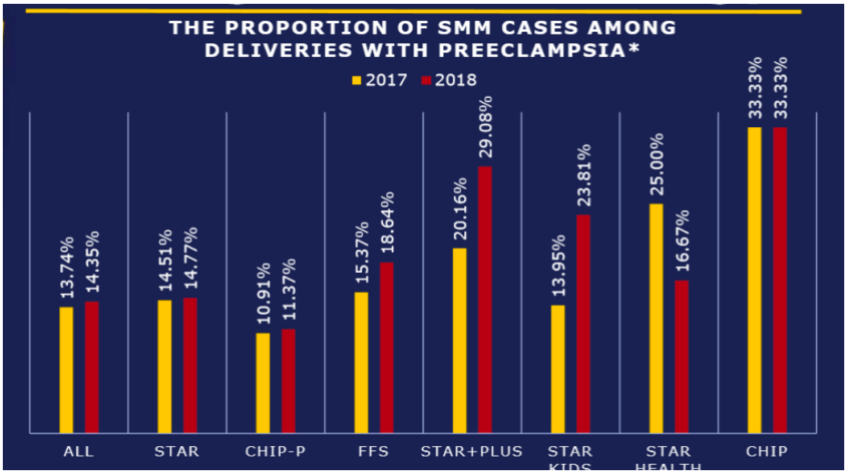




*These are results based on the data capture period 7 days prior to delivery and 15 days after. Data will be rerun using the new data capture period 7 days prior to delivery and 42 days after to establish a baseline

Next Steps include:

- Present pregnancy-associated outcome measures to stakeholders
- Modify the measurement timeframe (7 days prior through 42 days after delivery)
- Track measures and begin public reporting in 2020
- Incorporate measures into existing quality initiatives

The Chair asked about the definition of "hemorrhage." Staff stated that is the same definition in the AIM bundle and the one used by CDC. (Requiring transfusion.) The Chair stated that having actual numbers and percentages on the different systems would be helpful. She stated that she suspected the largest impact would be found in STAR. She stated that it would be good to track SMM by hospital. She stated that on Hemorrhage, you have to address how you respond to save the person's life (AIM Bundles). MCOs cannot usually directly affect hospital performance.

Dr. Stanley commented on the methodology and data provided on severe hemorrhage. He stated that the data looks off, and the Chair concurred that the numbers needed to be examined. Dr. Stanley stated that there is a need to include the definitions of terms.

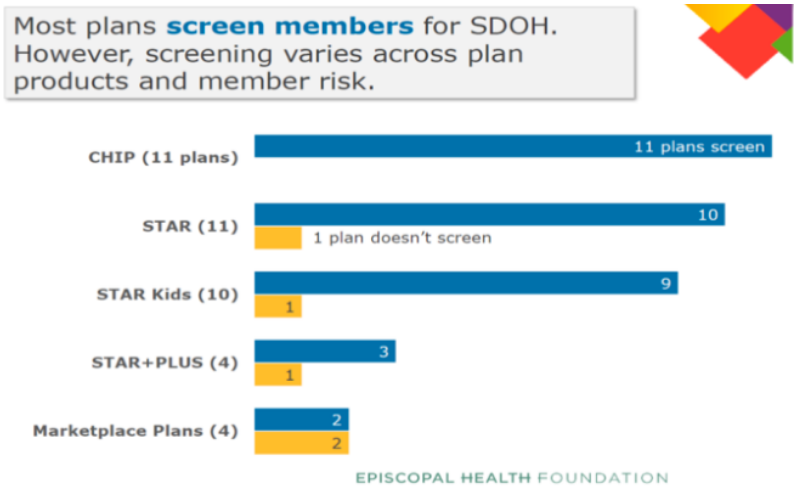
Ms. Kirsch stated that the *n* in STAR+PLUS would be very small.

The Chair stated that without transfusion, there is no hemorrhage.

Dr. Stanley stated that they went through reports on the Perinatal Period and asked if that data is being reviewed on the state level (beyond the perinatal period). The Chair (Dr. Pederson) stated that DSHS is tracking it.

The comment period runs through the end of April.

Social Determinants of Health (SDOH), Statewide Screening Tool.



There has been discussion about the need for a tool to measure SDH. Many HMOs have their own tool and that being the case, members get reevaluated every time they change plans. The Episcopal Health Foundation sponsored a pilot project in Harris county, and worked with three Texas health centers to test the SDOH tool. HHSC is awaiting the outcome of the effort and will leverage results of the pilot project as it considers approaches for an SDOH tool.

Please provide feedback to Quality Assurance Mailbox:
MCD_managed_care_quality@hhsc.state.tx.us

5. Presentation: Accountable Health Communities Model approach to Social Drivers (Determinants) of Health

Communities Model: Integrated Screening, Referral and Patient Navigation—Linda Highfield, PhD Associate Professor, UTHealth Houston. Linda.d.highfield@uth.tmc.edu

The Accountable Health Communities (AHC) model seeks to bridge the divide between the clinical health care delivery system and community service providers to address health-related social needs. This model promotes clinical-community collaboration through:

- Screening of community-dwelling beneficiaries to identify certain unmet health-related social needs;
- Referral of community-dwelling beneficiaries to increase awareness of community services;
- Provision of navigation services to assist high-risk community-dwelling beneficiaries with accessing community services; and
- Encouragement of alignment between clinical and community services to ensure that community services are available and responsive to the needs of community-dwelling beneficiaries (Alignment track only).
- 29 sites around the country are implementing the model
- Outcomes: utilization and cost from an evaluation.
- There are 30 organizations participating in the Accountable Health Communities Model. Three teams in Texas (Houston, San Antonio and Dallas)

The chart below describes the steps in the process and the associated benefits and considerations.

The assessment/screening tool can be used at no charge by those participating in the study, but others can also request use without participation required. There are differences in the domain that is covered across the tool. There are three Texas sites using the model and we should get a good instrument for Texas' use.

After screening the referral occurs. Data used includes 211 data and other sources. Some create their own data base. The bridge organization is responsible for maintain the accuracy of the data. The standardized screening tool allows the determination if a person is positive in any of the domains. The referral summary is reviewed with the client. Services begin within 48 hours.

The purpose of navigation is to:

- Set some patient goals based on identified social needs
- Create an action plan
- Standardized follow up is established
- Provides regular positive contact

The alignment track adds a few levels of participation that requires a quality improvement plan and to link their work to broader community goals. Alignment or integration is an intentional process and there should be an underlying theory to guide the process.

Screening Overview
• Specific to Medicare & Medicaid Populations in a geographic target area
• Core and supplemental domains
• 7th grade reading level
• Testing delivery via phone, in-person, electronically
• Implementation linked to claims data for evaluation of impact on cost and utilization
	Screening Process
	• Occurs with all eligible beneficiaries at a clinical site including EDs, L&Ds, outpatient and mental health facilities.
	• Screening includes:
	  ○ Demographics
	  ○ Eligibility
	  ○ Standardized scoring for positives in each domain
	  ○ Definition of high-risk
	  ○ Standardized workflows through SOPs

Referral Approach
• Create or use community database of resources
  ○ Range of approaches from custom, 211, purchased
  ○ Maintained and updated a minimum of every six months
• Linked to positive domains on the screening
• Printed referral summary
  ○ Reviewed with patient immediately
  ○ Navigation begins within 48 hours
	Benefits and Considerations
	• Data quality
	  ○ Intensive to create & maintain an accurate database
	  ○ Quality of resource is not always apparent
	• Absorptive Capacity
	  ○ What is the capacity of the organizations to take these referrals?

Navigation Process • Begins immediately-48hrs post screening/referral • Sets patient goals • Creates patient-centered action plan • Standardized timing of follow up with patients • Phone, in-person and electronic approaches under testing • Beneficiary followed for 365 days	**Benefits and Considerations** • Regular contact with beneficiaries increases buy-in and trust • Built from evidence-base for patient navigation interventions • Action plan provides structure • 48-hour window rationale • 365-window

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Alignment Approach	Benefits and Considerations
• Assistance Track – coordination with healthcare providers, HHSC, local agencies, community within model areas • Alignment Track – adds engagement of advisory board, community gap analysis, quality improvement plan and link to broader community goals and implementation	• Alignment (integration) of providers is an intentional process • Use of theory and implementation design helpful • Takes time to build relationships and preconditions • New role for healthcare – linkage to public health

From CMS: The Accountable Health Communities Model addresses a critical gap between clinical care and community services in the current health care delivery system by testing whether systematically identifying and addressing the health-related social needs of Medicare and Medicaid beneficiaries' through screening, referral, and community navigation services will impact health care costs and reduce health care utilization.

Over a five-year period, the model will provide support to community bridge organizations to test promising service delivery approaches aimed at linking beneficiaries with community services that may address their health-related social needs (i.e., housing instability, food insecurity, utility needs, interpersonal violence, and transportation needs):
Assistance Track – Provide community service navigation services to ***assist*** high-risk beneficiaries with accessing services to address health-related social needs
Alignment Track – Encourage partner ***alignment*** to ensure that community services are available and responsive to the needs of the beneficiaries

To implement each approach, bridge organizations will serve as 'hubs' in their communities, forming and coordinating consortia that will:

- Identify and partner with clinical delivery sites (e.g., physician practices, behavioral health providers, clinics, hospitals) to conduct systematic health-related social needs screenings of all beneficiaries and make referrals to community services that may be able to address the identified health-related social needs;
- Coordinate and connect beneficiaries to community service providers through community service navigation; and
- Align model partners to optimize community capacity to address health-related social needs (Alignment Track only).

Funds for this model support the infrastructure and staffing needs of bridge organizations, and do not pay directly or indirectly for any community services (e.g., housing, food, violence intervention programs, utilities, or transportation).

Awareness Track Update—The Centers for Medicare & Medicaid Services (CMS) has withdrawn the Awareness Track Funding Opportunity for the Accountable Health Communities Model. The Funding Opportunity was withdrawn because CMS did not receive enough qualified applications to move forward with the Awareness Track. At this time, CMS does not intend to open a new funding opportunity for the model.

Questions about the model can be submitted to AccountableHealthCommunities@cms.hhs.gov.

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Additional Information:

- Fact Sheet
- Press Release
- Health Quality Innovators Case Study (PDF)
- Using Data for Quality Improvement Case Study (PDF)
- Funding Opportunity Announcement (FOA)
- Accountable Health Communities Health-Related Social Needs Screening Tool (PDF)
- National Academy of Medicine article about the AHC Screening Tool (PDF)
- New England Journal of Medicine article
- Press Release (HHS) – January 2016

They are moving into the 4th year of the model nationally and they are just now seeing the data they were hoping to look at.

The role of the School of Public Health is to build collaborations and their approach is to serve as a learning hub with health system partners. They do a two-level training with a teaching component and then the team integrates into the clinical setting, modeling the behavior, and then conduct structured de-briefing with the staff. We ensure that they are really ready to participate at a meaningful level. There are regular interactions with the team. Looking at screening, referral, and evaluation… they have implemented different steps and have seen some positive outcomes.

Comments, Questions and Answers

- **The Chair** asked if there will be some preliminary outcomes provided? The speaker stated that nationally, it will be a couple years past the model before the data becomes available. Locally, they are starting some initial publications of the data.
- How many grant dollars did the Texas groups receive from CMMI? The speaker stated that they received $2.6 million for the five years but for alignment, it was $4.9 million.
- **The Chair** stated that there were several CMMI initiatives that Texas has not participated in.
- How many people are you required to screen for that amount of money? The speaker stated that the milestone is not completed screening, but the offers to screen. The offers are set at 75,000 and services are for 248 unique beneficiaries a year.
- What about coordination with the other two Texas sites? The speaker stated that they have organized into a collaborative and they meet once a year. The accountable health communities project requirement was to have support from the state agency. Support from the agency comes in the form of claims data.
- Some written comment was provided regarding community pharmacies. They are trained in assessing the community drivers, especially in the rural communities.

- What about the professional levels of the screeners and providing the follow-up? Nationally, there are myriad types of staff. They include community health workers, nurses, and others. In Houston it is done by the community health workers in the ER and nurses in the delivery department. In clinical sites, graduate students provide the screening and follow-up.
- Have you looked at Parkland's model or the Philadelphia model integrating with the electronic health record (EHR)? The speaker stated that they considered looking at the integration with the EHR to collect the data. Nationally, there are sites doing this, but they face unique challenges. "It is a bubble gum and duct tape approach." Generally speaking, the EHR is not structured properly for the data. The Assistance track is outside the EHR.
- Texas is the largest beneficiary of this project, nationwide. The Chair added that $2.6 million not a lot of funding given the scope of the project.

6. Discuss Health and Human Services Commission Value Based Payment Strategies

Alternative Payment Model (APM) Initiatives.
The focus of the APM initiative is to increase performance by improving quality of care and efficiency in a member centered system of care. (STAR Kids APMs are not yet considered in the target achievement since they started in FY 2019). HHSC will work with MCOs and providers to evolve the program based on initial data, stakeholder input, and other developments in the field.

The State overall met or exceeded first year APM targets, however, meeting APM targets is not the ultimate goal. The goal is to achieve high quality, efficient care. MCOs appear to be leveraging the initiative to provide incentive dollars to providers and HHSC will continue to seek ways to advance the APM Initiative, including by:

- Revising the state's VBP Roadmap to reflect changes since the initiative started
- Obtaining stakeholder input on opportunities to strengthen the initiative
- Working with stakeholders to reduce administrative complexity

MCO APMs with Providers: Targets had been established over the past 4 years.

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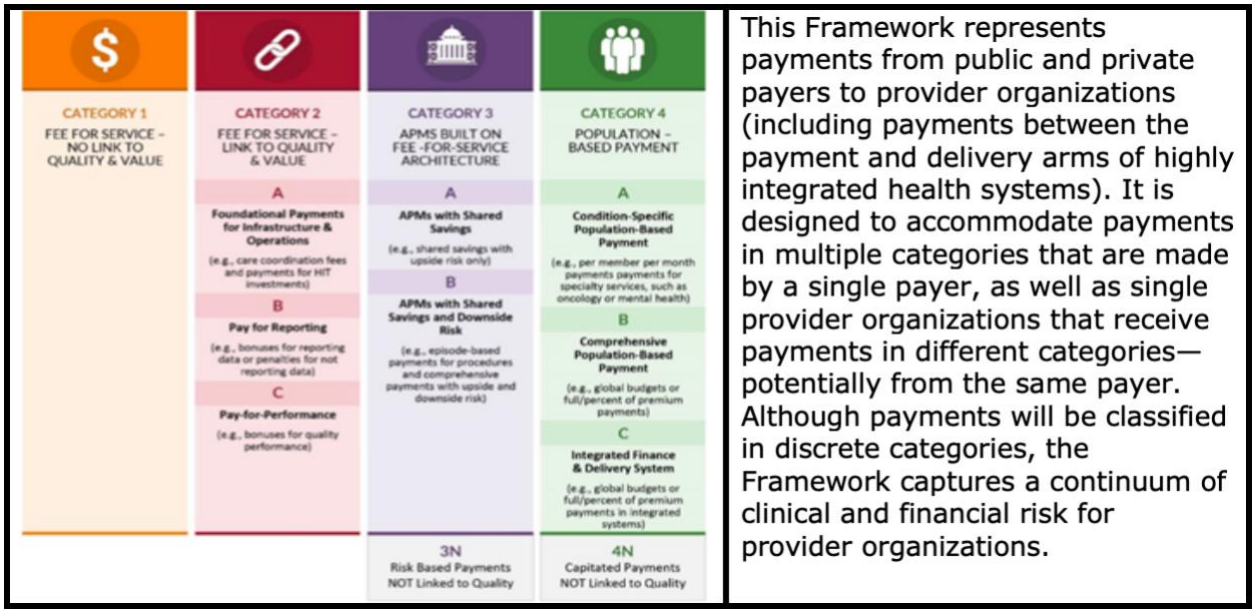
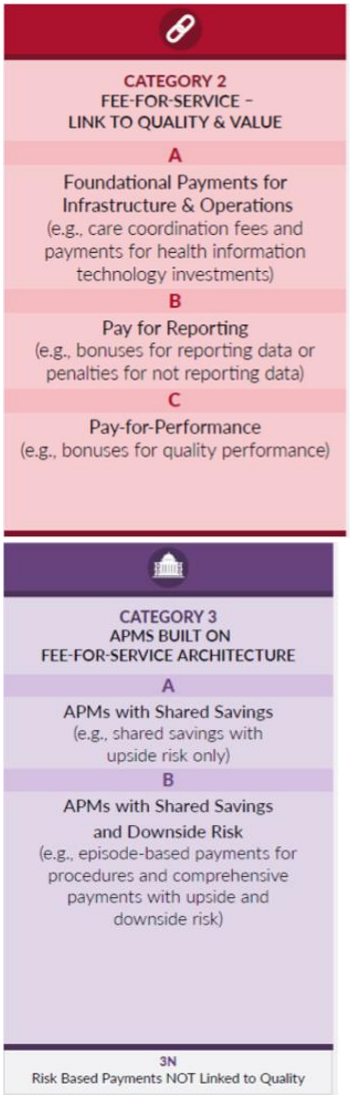
Year	Overall VBP target	Risk Based VBP Target
2018	**25%** of medical expense in a VBP model for MCOs and Dental Contractors (DCs)	▪ **10%** of medical expense in a risk based VBP model for MCOs; ▪ **2%** for DCs
2021	**50%** of medical expense in a VBP model for MCOs and Dental Contractors (DCs)	▪ **25%** of medical expense in a risk based VBP model for MCOs; ▪ **10%** for DCs

HCP LAN Framework for Alternative Payment Models (https://hcp-lan.org/)

Mr. Blanton stated that the STAR+PLUS is good but there is room for improvement. Ms. Kirsch stated that when you look at the spend for inpatient hospital care, some of the patients are dual-eligible. That could impact the number. The Chair stated that there are fewer hospitalizations and maternity care in CHIP. There are also fewer MCOs participating in STAR+PLUS and CHIP.



Distribution of APMs by HCP LAN Type. There is a shift from the category 2 models to category 3 models, as depicted below.



Cat.	APM Type	Number	Percent
2A	**Foundational Payments for Infrastructure & Operations** (e.g. care coordination fees and payments for HIT investments)	30	8.5%
2B	**Pay for Reporting** (e.g. bonuses for reporting data or penalties for not reporting data)	13	3.7%
2C	**Pay for Performance** (e.g. bonuses for quality performance)	141	40.2%
	TOTAL	184	52.4%

Cat.	APM Type	Number	Percent
3A	**APMs with Shared Savings** (e.g. shared savings with upside risk only)	47	13.4%
3B	**APMs with Shared Savings and Downside Risk** (e.g. episode-based payments for procedures and comprehensive payments with upside and downside risk)	79	22.5%
	Total	126	35.9%

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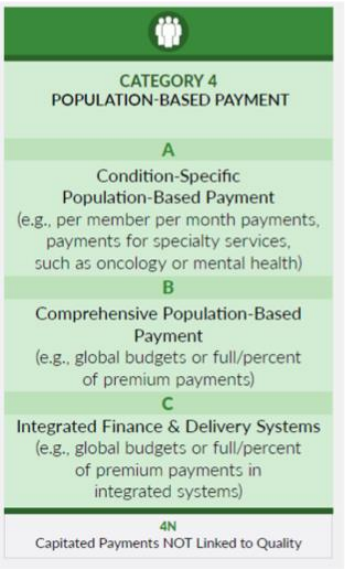

Cat.	APM Type	Number	Percent
4A	**Condition-Specific Population-Based Payment** (e.g. per member per month payments for specialty services, such as oncology or mental heath)	21	6.0%
4B	**Comprehensive Population-Based Payment** (e.g. global budgets or full/percent of premium payments)	3	0.9%
4C	**Integrated Finance and delivery Systems** (e.g. global budgets or full/percent of premium payments)	0	0%
4N	Capitated Payments NOT Linked to Quality	17	4.8%
	Total	41	11.7%

Financial Risk.

Financial Risk	Number	Percent
Provider has no downside risk	249	71%
Provider has upside incentives and downside risk	102	29%
TOTAL	351	100%

APM Distribution by Program Type and Financial Risk

PROGRAM	Level of Financial Risk for Providers			
	Provider has no downside risk		Provider has upside incentives and downside risk	
	Number	Percentage	Number	Percentage
STAR	85	24.2%	38	10.8%
CHIP	66	18.8%	33	9.4%
STAR_Kids	50	14.3%	17	4.8%
STAR+PLUS	42	12.0%	10	2.9%
STAR Health	6	1.7%	4	1.1%
Total	249	71%	102	29%

The Chair asked what the 85 (STAR number) means. Staff stated that it is the number of initiatives but not the number of providers. That information is not collected. The Chair stated that it might be good to look at types of providers.

APM Distribution by Program Type and Payment Amounts

PROGRAM	Level of Financial Risk for Providers (risk group %)							
	Provider has no downside risk				Provider has upside incentives and downside risk			
	Payments		Incentives		Payments		Incentives	
	$	Percentage	$	Percentage	$	Percentage	$	Percentage
STAR	$1,207,936,564	15.0%	$34,076,302	43.2%	$2,300,368,186	28.6%	$ 22,077,502	28.0%
STAR_PLUS	$1,856,881,092	23.1%	$6,470,869	8.2%	$1,542,452,839	19.2%	$ (6,901,617)	-8.8%
CHIP	$148,498,670	1.9%	$3,718,072	4.7%	$137,257,270	1.7%	$ 1,603,934	2.0%
STAR Kids	$134,972,151	1.7%	$1,580,600	2.0%	$574,917,472	7.2%	$ 15,478,685	19.6%
STAR Health	$45,040,988	0.6%	$62,406	0.1%	$96,491,490	1.2%	$ 699,680	0.9%
Total	$3,393,329,465	42%	$45,908,249	58%	$4,651,487,256	58%	$ 32,958,184	42%
Denominator	$ 3,439,237,713				$ 4,684,445,440			

PROGRAM	Level of Financial Risk for Providers (column %)							
	Provider has no downside risk				Provider has upside incentives and downside risk			
	Payments		Incentives		Payments		Incentives	
	$	Percentage	$	Percentage	$	Percentage	$	Percentage
STAR	$1,207,936,564	35.6%	$34,076,302	74.2%	$2,300,368,186	49.5%	$ 22,077,502	67.0%
STAR_PLUS	$1,856,881,092	54.7%	$6,470,869	14.1%	$1,542,452,839	33.2%	$ (6,901,617)	-20.9%
CHIP	$148,498,670	4.4%	$3,718,072	8.1%	$137,257,270	3.0%	$ 1,603,934	4.9%
STAR Kids	$134,972,151	4.0%	$1,580,600	3.4%	$574,917,472	12.4%	$ 15,478,685	47.0%
STAR Health	$45,040,988	1.3%	$62,406	0.1%	$96,491,490	2.1%	$ 699,680	2.1%
Total	$ 3,393,329,465		$45,908,249		$ 4,651,487,256		$ 32,958,184	
TOTAL	No Downside Risk APM: $ 3,439,237,713 (42%				With Downside Risk APM: $ 4,684,445,440 (58%)			

Provider Type.

Provider Type	Number	Percent
Primary Care	143	40.7%
Hospitals	62	17.7%
Specialist, Behavioral, Mental	50	14.3%
ACO	36	10.3%
Ob/Gyn	27	7.7%
Pharmacy and Lab	17	4.8%
Health Home, Nursing Facilities and Home Care	9	2.6%
Emergency Services and Urgent Care	7	2.0%
Total	351	100%

The specialist/Behavioral health models doubled as depicted in the chart above.

Distribution of Total Payments, Claims and (Dis)Incentives by Provider Type.

Provider Type	Total Payments	Percentage of Total Payments	Claims Paid	Percentage of Claims Paid	(Dis)Incentives	Percentage of (Dis)Incentives
Hospitals (Inpatient and Outpatient)	$3,557,412,089	43.8%	$3,579,011,096.00	44.5%	($21,599,007)	-27.4%
Primary Care	$2,273,571,575	28.0%	$2,228,567,050.70	27.7%	$45,004,524	57.1%
Health Home, Nursing Facilities, and Home Care	$1,030,636,509	12.7%	$1,026,391,034.00	12.8%	$4,245,475	5.4%
ACO	$747,481,553	9.2%	$739,403,054.54	9.2%	$8,078,498	10.2%
Pharmacy and Lab	$250,474,188	3.1%	$250,426,565.42	3.1%	$47,623	0.1%
Obstetrics & Gynecology	$172,254,774	2.1%	$169,413,560.89	2.1%	$2,841,213	3.6%
Specialist, Behavioral & Mental Health	$87,333,702	1.1%	$47,311,311.01	0.6%	$40,022,391	50.8%
Emergency Services and Urgent Care	$4,518,763	0.1%	$4,293,048.45	0.1%	$225,715	0.3%
Total	$8,123,683,154	100%	$8,044,816,721.01	100%	$78,866,433	100%

Again, in summary— The State overall met or exceeded first year APM targets, however, meeting APM targets is not the ultimate goal. There are more dollars going out in incentive payments. There has always been good participation in primary care and the specialty care and behavioral health has grown significantly. The goal is to achieve high quality, efficient care. MCOs appear to be leveraging the initiative to provide incentive dollars to providers and HHSC will continue to seek ways to advance the APM Initiative, including by:

- Revising the state's VBP Roadmap to reflect changes since the initiative started
- Obtaining stakeholder input on opportunities to strengthen the initiative
- Working with stakeholders to reduce administrative complexity

The focus of the APM initiative is to increase performance by improving quality of care and efficiency in a member centered system of care. STAR Kids APMs are not yet considered in the target achievement since they started in FY 2019 and HHSC will work with MCOs and providers to evolve the program based on initial data, stakeholder input, and other developments in the field.

Regarding provider engagement,

- Meeting will be scheduled (in-person or by webinar) in the Summer and Fall 2020 to go over Alternative Payment Models initiative (including what other states are doing)
- Report data and information regarding the APMs developed by the MCOs with providers in 2017, 2018, and 2019 (reports submitted in July 2020)
- Make available educational materials regarding the above
- Obtain input from providers through the state's Value-Based Payment and Quality Improvement Advisory Committee, other stakeholder forums, and direct meetings
- Emphasize importance of the MCO-Provider relationship for the success of the initiative

C: many rural hospitals are not participating and MCOs may need to pay more attention to this. Mr. Blanton stated that they will be going back to look at this issue related to rural hospitals. Ms. Kirsch stated that there is also the small provider issue that overlaps with the rural. We have heard that the smaller groups have a harder time playing because of administrative work required. They may not have enough Medicaid volume for the Health Plans to focus on them. PPRPPC (Potentially Preventable Readmissions: PPR; Potentially Preventable Complications: PPC) is a standardized model that HHSC is requiring, and something like this that is more standardized to allow the smaller players to participate. The Chair stated that this could be a carve-out to incentivize health plans to work with them. It depends on how much focus the state wants to have on the rural issues.

Dr. McNabb stated that it gets confusing seeing pharmacy and lab combined together.

APM 2020 Progress Timeline

- **July 1st, 2020** – 2019 APM Reports will be received.
- **July** – data cleaning.

- **August** – individual plan analysis for target achievement and master data assembly – still some aspects in the data need to be addressed (duplication of payments across APMs, data entry corrections, missing data).
- **September** – begin sending the individual analyses to each plan for review and feedback.
- **October** – analysis of master data.
- **November** – document the progress of APM adoption over the last three years.
- **December** – post the document on the website.

Value-Based Payment Roadmap. The purpose of the roadmap is to support system transformation from volume to value. This is due in the beginning of September. Staff has been working in this area and this will eventually be shared with stakeholders. This, below, is a high-level outline.

The Map Includes:

Introduction and Roadmap purpose – To ensure it is clear what is happening.

APM Initiative History:

Alignment with Medicaid Goals—
- Texas Managed Care Quality Strategy (in development concurrently)
- HHSC Quality Plan
- Blueprint for a Healthy Texas
- DSRIP Transition Plan

Alignment with other Medicaid Value Initiatives
- Medical Pay-for-Quality Program (P4Q)
- Dental P4Q
- Hospital Quality Based Payment Program
- Quality Incentive Payment Program (QIPP)
- Performance Improvement Projects (PIPs)
- Analytics and public reporting
- DSRIP

The map should show Texas APM Initiative Progress
- APM Trends
- Successful APM Models (Focus on primary care)
- Gaps in performance

And the National Context
- HCP-LAN Principles
- National Performance
- Other CMS Initiatives

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The lessons learned should include

- Successful APMs link payment to delivery system transformation
- Oversight in a value-based program is different from a traditional model
- Data analytics and sharing are fundamental
- APMs should foster a positive MCO-Provider relationship
- The payment model needs flexibility
- Reducing administrative complexity begins by aligning performance metrics
- Other lessons suggested by the committee

The Chair stated that trying to provide linkage and potential outcomes using quality metrics with the APM models would be useful in the report. Additionally, we could ask MCOs how they have seen the needle move to get more than just numbers in the report.

Staff stated that there are two columns in the chart about the quality measures associated with each APM. They go into more detail. They are looking at how to collect more granular information.

The Chair stated that we can look at what works and what doesn't work.

Mr. Blanton stated that he is reluctant to over-survey, but would like to get the MCO information.

The Chair stated that financial oversight for the APMs could be discussed.

Medicaid State Quality Strategy. Texas is required to have a Texas Managed Care Quality Strategy approved by the Centers for Medicare & Medicaid Services (CMS). Every three years, Texas must review and update the quality strategy. Results of the review must be made available to the public, and the updated strategy must be submitted to CMS.

It is the goal of HHSC to use its Managed Care Quality Improvement Strategy to:

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

HHSC will achieve these goals through following mechanisms:

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

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

New ideas for the Quality Strategy include:

- Identifying measurement approaches for additional services and populations
- Improving alignment of APMs and outcome measures in Medicaid managed care

The Chair asked when the results of the P4Q will be out. Mr. Blanton stated that he would follow up. Mr. Vasquez stated that they have compiled the 2018 results and the report should go out very soon (next 3-6 weeks).

The Chair stated that there are stakeholder groups that are looking at measures as part of the DSRIP transition. This group may want to go through some of those. This group could be a filter for what could be recommended for an APM.

7. 2020 Legislative Report: Breakout Session

A framework was put together for consideration. Soon there will be new members and there will be topic calls made. The four topics include:

- Workgroup 1: Maternal and Newborn Care
- Workgroup 2: Leveraging Multi-Payer Data
- Workgroup 3: Managed Care Organizations' Activities to address Social Driver (Determinants) of Health
- Workgroup 4: Advancing Alternative Payment Models in Medicaid

Topic 1: Maternal and Newborn Care.

Recommendation goal: to help align APMs and performance metrics for maternal and newborn care in Medicaid Managed Care

Possible approaches include:

- Collaboration with DSHS and invited SMEs to identify models and measures
- Review work related to SB 750
- Research potential funding opportunities to support technical assistance or pilots
- Identify resources or policy actions needed to support the states maternal/newborn quality improvement collaborative

Topic 2: Leveraging Multi-Payer Data

Recommendation goal: advance alignment of value-based payment and quality improvement efforts across major payers of healthcare

House Bill 1, Article IX, Section 10.06, 86th Texas Legislature

- Funds development of cross-agency data analytics capacity for HHSC, ERS, TRS, TDCH, and DSHS
- Purpose: support coordination in quality improvement and value-based strategies for major state healthcare payers

Possible approaches include:

- Identify resources or policy actions needed to maintain/support the initiative
- Research potential funding or technical assistance opportunities
- Provide input on multi-payer opportunities for quality improvement and value-based payment, including to promote administrative simplification

Topic 3: Managed Care Organization Activities to address Social Drivers of Health (SDOH)

Recommendation goals:

- Support alignment of SDOH activities with quality/value-based improvement goals
- Promote learning and identification of best practices within Medicaid Managed Care

Possible approaches include:

- Compile information on current MCO and community-based organization activities
- Assess policy options to promote effective implementation of SDOH screening/assessment tools and electronic referral platforms
- Identify flexibilities needed to support efforts to address SDOH in value-based models

Topic 4: Advancing Alternative Payment Models (APMs) in Medicaid

Recommendation goals:

- Support alignment of SDOH activities with quality/value-based improvement goals
- Promote learning and identification of best practices within Medicaid Managed Care

Possible approaches include:

- Compile information on current MCO and community-based organization activities
- Assess policy options to promote effective implementation of SDOH screening/assessment tools and electronic referral platforms
- Identify flexibilities needed to support efforts to address SDOH in value-based models

Discussion.

Topic I

The Chair stated she was concerned that maternal newborn arena included expert consensus measures and not evidence-based measures. There are some unintended consequences of some proposed measures.

Ms. Kirsch stated that the bridges to excellence were included because they were transparent. Fewer are better and they should go with the measures that are strong.

Ms. Kirsch stated that the last report used maternity newborn care where standardization of effort was included. There could be some consensus this time about some certain core measures. She stated it will be important to include the key clinicians from Healthy Texas Mothers and Texas Babies. The maternity home health pilots will need measures that this group could align with.

The Chair stated that programs have been complaining about metric fatigue. The state could create a newborn registry that would be a critical piece to determine what interventions produce better birth outcomes.

Ms. Kirsch stated that Dr. Stanley stated that the RACs wanted the maternal baby registry to be de-identified.

Topic II.

Ms. Kirsch stated that with the different data sets, they have they have 80 percent of covered lives.

The Chair stated that maybe the CMMI people could give a presentation on the CPC PLUS model where they have taken all the payors in Medicare and give data that is more actionable and real time. She stated that they could use those resources for free.

Ms. Kirsch stated that there are some state websites that can be accessed (Colorado) that show their data. Getting the data out there would be a huge step in moving us forward.

A comment was made that the only real-time data they we get is pharmacy data.

Topic III.

Mr. Blanton stated that there is a learning collaborative of MCOs, and the hope is the information can be gathered through the collaborative. It could also be a survey through the collaborative. There has been discussion about setting up a learning hub.

Ms. Kirsch stated there will be surveys coming out related to DSRIP. Providers will be getting asks for data from HHSC.

Topic IV.

This looks at areas with smaller providers, pharmacy providers, etc., to involve them more in value-based payments.

Dr. McNabb stated that it has been difficult to convey the payor concept and we should standardize what an accountable pharmacy organization is.

A comment was made related to RHP16 and they are sharing specialists for rural areas. Maybe instead of looking at a rural RHC, we could pull together multiple facilities in an ACO model.

Dr. McNabb stated that he has discussed medical savings, but there could be value-based payment models in drug benefit. Financial interest is not aligned with HHSC goals. We should propose some performance metrics in the drug benefit apart from the enhanced benefits.

8. Legislative Report Planning and Timeline.

February/March: Finalize recommendation topics.

March-May: Create workgroup calls. Adopt specific recommendation language and begin drafting the report. Next meeting is May 19th and we hope to have recommendation language at that time.

June-August: Finalize report draft, seek additional stakeholder comment, and adopt report.

September: Chair submits final report to legislative and other offices (Meeting September 4th when the recommendations will be adopted). Dr. Peterson would send the report to the legislative offices.

October/November: Report follow-up, briefings, and presentations.

December 31st: Final report due to legislature by rule.

9. Public comment.

Helen Kent Davis, TMA, stated that they feel there is a disconnect between the doctors and the plans. Having input from service providers would be important. OB/GYN does not talk much about alternative payment models since the preventive care seems to be on the decline. The language used seems to also be a barrier as there are differing definitions. The rural doctors state that there is confusion out there because rural doctors have not been approached about APMs.

Rachel Hammon, Texas Association for Home Care & Hospice stated that she wanted to dovetail off of the disconnect issues, which also affect home- and community-based settings. As you look at your plans, and what it means to develop alternative payment models (APMs) in the home and community-based space—home care and hospice agencies in particular—we need to get the MCOs involved in the conversation. HHSC put forth some initiatives in their contracts in terms of the amount of money that must be paid out in the APM methodology, but did not necessarily put sufficient infrastructure in place first. "Quality" does not have uniform metrics across the board. In the Medicaid space specifically, there is some inconsistency in assessment tools for the community. In home care and hospice agencies in particular, they operate in many different areas, and may see beneficiaries that belong to many different MCO networks. With MCOs each developing their own standards for quality, and agencies seeing beneficiaries from different kinds of MCOs, it's very difficult for agencies to be efficient, and to consistently apply the operations and changes they need within their organization to meet these varying quality thresholds.

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

- Look at rural providers and the numbers on SMM cases
- Break down the pharmacy and lab section
- Workgroup III look at the 48-hour window
- Housing wait list number
- STAR+PLUS and CHIP numbers for 2018 achievement
- See if CMMI will make a presentation

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

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