HHSC: Value-Based Payment and Quality Improvement Advisory Committee, July 1st, 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The membership roster was not included as it appears to be out of date. Several new members were present.

Welcome and introductions. The meeting was convened by the Chair, Mary Pederson. A quorum was established

Review and approval of meeting minutes from March 9, 2020, meeting. The minutes were approved as written.

Review and approval of Bylaws. **MOTION**: *Approval of the bylaws - prevailed*.

Presentation: Joint Commission.

- Founded in 1951
- Private, non-governmental, non-profit
- Most well-known for accreditation of hospitals
- Accredit and certify nearly 23,000 health care organizations and programs
- Accreditation voluntary
- Recognized by most state agencies and Medicaid authorities

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Texas and Joint Commission (Texas programs and services that are Joint Commission Acc/Cert)

- Hospitals (787)
- Behavioral Health Care (905)
- Home Health (787)
- Primary Care Medical Home (260)
- Hospice (192)
- Ambulatory Surgery Centers (60)
- Palliative Care (2)
- Nursing Homes (12)

Texas use of accreditation in lieu of state surveys:

- Hospital
- Home Health
- Hospice
- Personal Assistance Services
- Home and Community Support Services Agencies
- Ambulatory Surgical Centers (initial surveys)
- Behavioral Health (chemical dependency, inpatient rehab center for children)
- Office-Based Anesthesia Services
- Nursing homes

Designation of Stroke Facility

- State reliance on accreditation does NOT reduce state authority
- The Joint Commission does not have authority to shut down an organization

Accreditation in a Value-Based Program

- Independent external review of organization's competency
- Contemporary standards – constantly updated by experts
- Managed care organizations and state agencies may direct limited resources toward other critical activities – instead of administration of value-based program operations and management
- Indicates organizations are willing to hold themselves to standards beyond state licensure requirements
- Accreditation standards focus on proactive assessment of risk through use of process improvement, safety and quality standards

Joint Commission Standards A Foundation for High Quality and Safety

- Developed from input from health care professionals, providers, subject matter experts, consumers, government agencies and employers

- Informed by scientific literature, expert consensus and best practices
    - Standards are Tools for Teaching Organizations Key Processes
        - Evidence Based Practice (EBP)
        - Root Cause Analysis (RCA)
        - Quality Assurance and Process Improvement (QAPI)

Joint Commission Surveyors:

- Joint Commission surveyors not contracted workers
- Masters degree minimum requirement
- Previous work experience in the field for which they survey
- Must achieve Yellow Belt status (robust process improvement training)
- Annual training conference targeting on new standards and organizational changes impacting survey process
- Survey experience is collaborative and educational

On-site and Virtual Survey Process. Joint Commission accreditation impacts all aspects of patient care process

- Infection Control
- Staff Competency Assessment
- Credentialing & Privileging
- Environment of Care
- Emergency Management
- Leadership Session

The Joint Commission uses a process-oriented survey methodology called the Tracer Method (individual and system)

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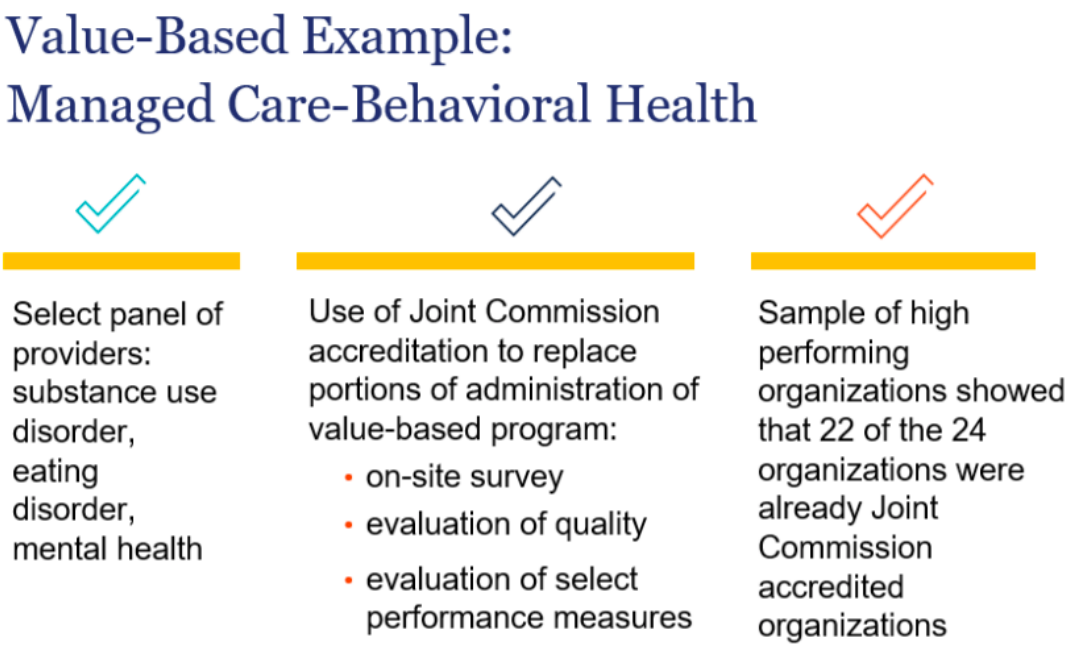
Value-based Example: Florida Medicaid Nursing Homes

- Voluntary incentive option for all nursing centers in Florida
- Select quality measures; structural incentive to achieve accreditation
- Each measure is worth a point value; points have a specific monetary value; rates set annually based on performance
- Accreditation has been widely adopted by nursing homes –75%
    - (56% accredited by The Joint Commission)
- Use of psychotropic drugs dropped 10%
- Florida ranks 7th in the nation in top 4 CMS quality star ratings.
- Average star rating; Florida nursing homes 3.8; national average 3.4

Value-based Example: Alabama Primary Care Medical Home (PCMH)

- Payments to Primary Care Physicians
- Quarterly bonus payment if meet or exceed benchmark
- Performance payouts 50% for quality, 45% for cost effectiveness, and 5% for Patient Centered Medical Home (PCMH) accreditation
- Incentivize providers to attain PCMH certification from a nationally recognized medical home model
- Signed into law Q4 2019 no available data.



Value-Based Example: Managed Care-Orthopedic Joint Replacement

- Total Knee/Hip Replacement Surgery

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- Setting: Ambulatory Surgery Center
- Drive delivery of care to lowest cost/highest quality provider
- Enhance quality by requiring ASC to be certified (by an accrediting organization)
- Additional quality outcome measures must be met in order to participate in the value-based panel
- According to the MCO: patients who choose these ASCs have: better outcomes, fewer complications and fewer readmissions

***Questions*/Answers/Comments**

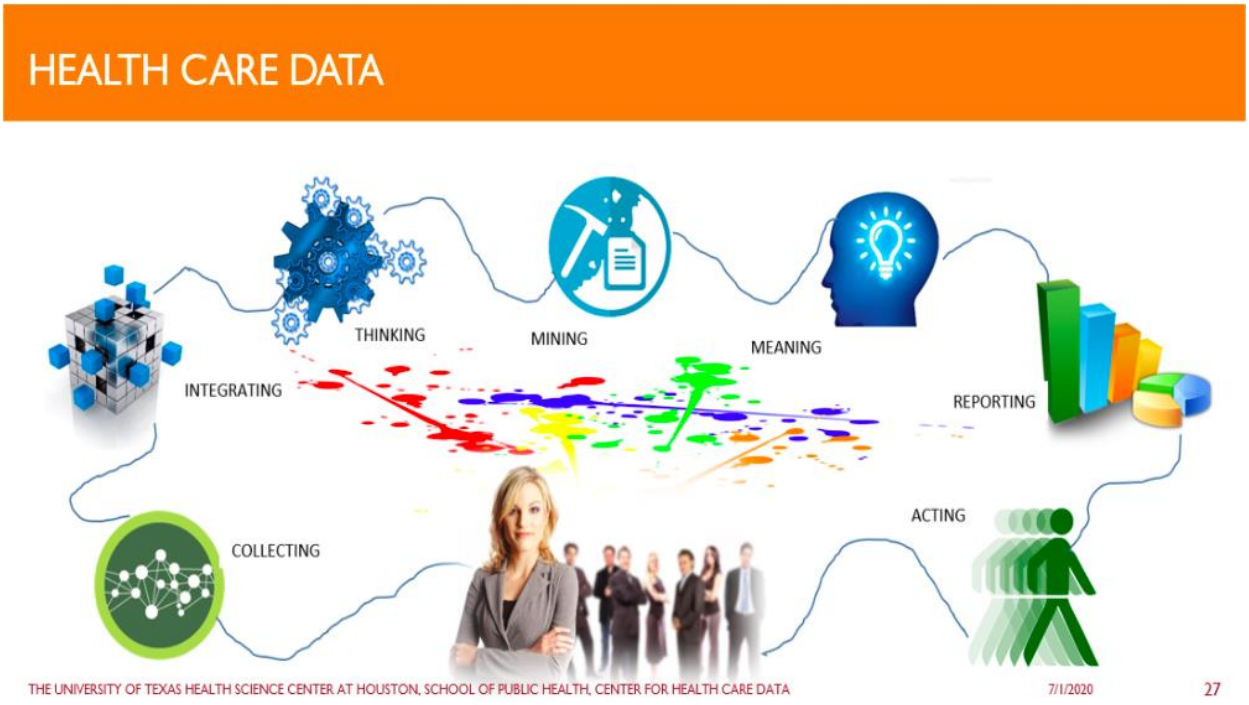
Does the joint commission look at quality outcomes for perinatal units and maternal care? The speaker stated that an advance look is coming. *Is comparison data available?* There is some shared information; some is not shared, but given to the hospital as a benchmark.

How does the JC work with new health plans for data sharing? The approach is individualized for each health plan. We also work with registries and that data is available. Providers can make their own results available to the health plan.

What barriers have been encountered in getting some providers to participate? There has to be a driver to incentivize participation.

There are tradeoffs. For behavioral health providers, routine symptom and management measures are not always useful.

<u>Presentation: Leveraging Multi-Payer Data</u>. School of Public Health, University of Texas.



Under the Qualified Entity Certification Program (QECP), CMS certifies QEs to receive Medicare Parts A and B claims data and Part D prescription drug event data for use in evaluating provider performance. CMS monitors certified QEs annually.

A QE is required to complete a rigorous application process including the following elements:

- Financial Resources
- Professional Resources and Experience
- Policies and Procedures regarding Data Privacy and Security
- Process Evaluation for Measure Development and Measure Analytics
- Provider Review, Corrections and Appeals Processes

QEs are required to use the Medicare data to produce and publicly disseminate CMS-approved reports on provider performance. QEs are also permitted to create non-public analyses and provide or sell such analyses to authorized users. In addition, QEs may provide or sell combined data, or provide Medicare claims data to certain authorized users.

UT Health Reporting Site.
Many QE's are also all payer claims databases – APCD. Texas has a voluntary claims data collection effort through the University of Texas Center for Healthcare Data. They collect medical and pharmacy claims that account for 80% of the Texas population. The Center for health Care Data has obtained a variety of Commercial, Medicaid and Medicare claims and electronic Medical Records data sets.

Texas has also attempted mandating an APCD for the state. In 2011, the Texas Legislature passed SB 7 in the first special session of the 82nd Legislature. Article 3 of the bill created the Texas Institute of Health Care Quality and Efficiency at the Health and Human Services Commission (HHSC). The Institute was required to create a state plan to improve the quality and efficiency of health care delivery, and study and make recommendations on various issues. One of these issues is the feasibility and desirability of establishing an APCD. The Institute was dissolved in 2015 and, as of 2017, no new efforts to establish an APCD in Texas are in process.

The Center is an active member of national groups that support and advocate for transparency in health care.

The following are two of the most notable organizations.

- APCD Council: a learning collaborative that:
    - Shares experience amongst APCD stakeholders
    - Provides early stage technical assistance to states
    - Catalyzes states to achieve mutual goals
- NAHDO: a national non-profit membership and educational association dedicated to improving health care data collection and use. NAHDO's members include state and private health data organizations that maintain statewide health care databases and stakeholders of these databases.
- NRHI: The Network for Regional Healthcare Improvement: a national organization representing Regional Health Improvement Collaboratives working to transform the healthcare delivery system and improve the health of populations – locally and nationally

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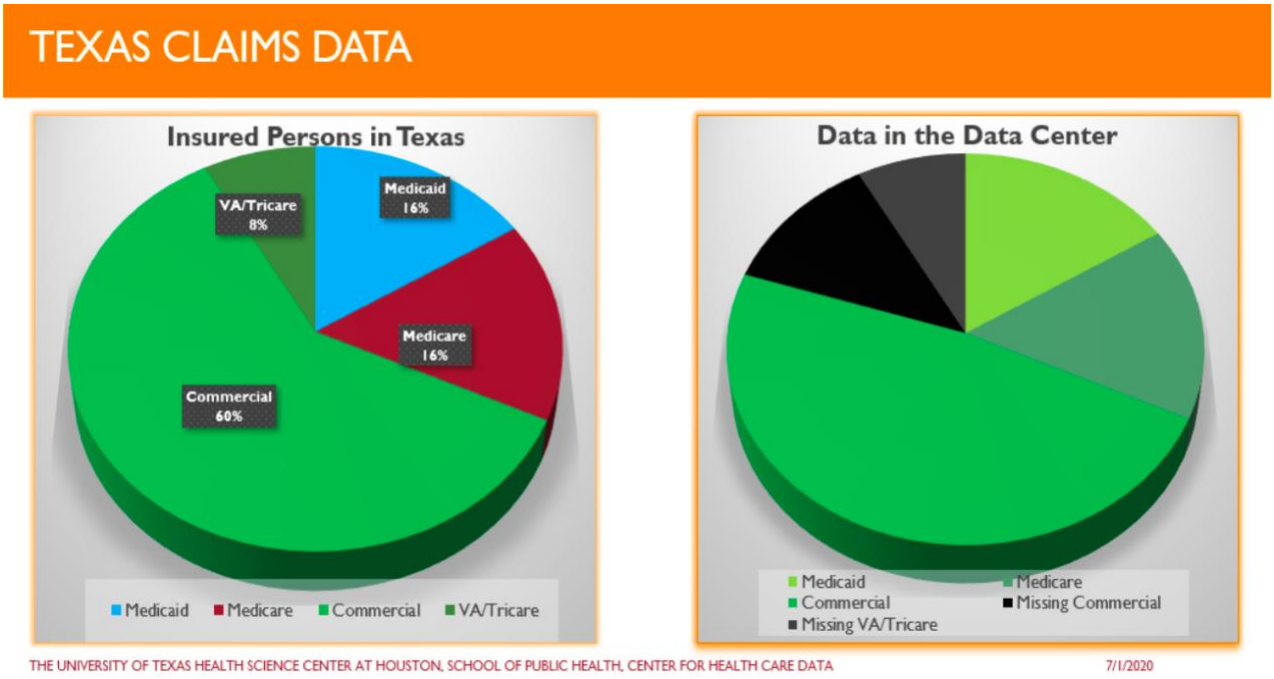
APCD States

▪ Arkansas All-Payer Claims Database ▪ California Health Care Cost Transparency Database ▪ Colorado All-Payer Health Claims Database ▪ Connecticut All-Payer Claims Database ▪ Delaware Health Care Claims Database ▪ Florida Agency for Health Care Administration ▪ Hawaii Health Data Center ▪ Maine Health Data Organization ▪ Maryland Health Care Commission Medical Care Data Base	▪ Massachusetts Division of Health Care Policy and Finance ▪ Minnesota Department of Health ▪ New Hampshire State Law on Commercial Claims Data Collection ▪ New York All Payer Database ▪ Oregon Health Policy and Research ▪ Rhode Island APCD (RI-APCD) ▪ Vermont Healthcare Claims Uniform Reporting and Evaluation System ▪ Virginia All-Payer Claims Database ▪ Washington State All-Payer Claims Database (WA-APCD) ▪ West Virginia Health Care Authority Database



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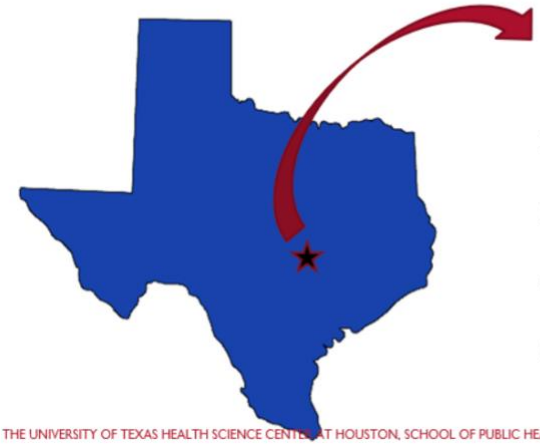
DATA ETL AND REPORTING PROCESSES

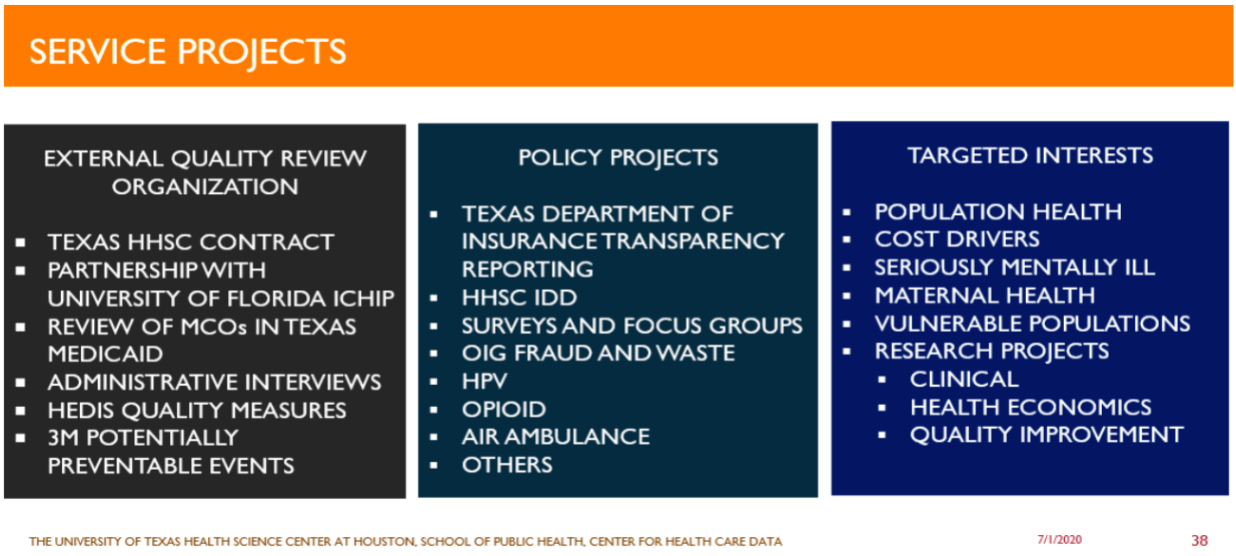
CROSS AGENCY COORDINATION 10.06

The Texas Legislature requested information from the analysis of data from 5 key state agencies to assess ways to reduce costs and improve the quality of health care provided to Texans



1. Department of State Health Services (DSHS)
2. Employees Retirement System (ERS)
3. Health and Human Services Commission (HHSC)
4. Texas Department of Criminal Justice (TDCJ)
5. Teachers Retirement System (TRS)

THE UNIVERSITY OF TEXAS HEALTH SCIENCE CENTER AT HOUSTON, SCHOOL OF PUBLIC HEALTH, CENTER FOR HEALTH CARE DATA 7/1/2020 37



Update on 10.06: Sec. 10.06. Cross-Agency Coordination on Healthcare Strategies and Measures 86th Texas Legislature, Regular Session, 2019.
(a) Out of funds appropriated elsewhere in this Act, the Health and Human Services Commission shall coordinate with the Department of State Health Services, the Employees Retirement System of Texas, the Texas Department of Criminal Justice, and the Teacher Retirement System to compare healthcare data, including outcome measures, to identify outliers and improvements for efficiency and quality that can be implemented within each healthcare system. To administer the data comparison, HHSC shall expend $2.5 million per year with the Center for Healthcare Data at the University of Texas Health Science Center at Houston (UT Data Center) for data analysis, including individual benchmark and progress data for each agency. As applicable, agencies shall collaborate on the development and implementation of potential value-based payment strategies, including opportunities for episode-based bundling and pay for quality initiatives.

(b) The agencies shall meet quarterly to carry out coordination activities as described above.

(c) The agencies shall submit a report to the Legislative Budget Board and the Governor no later than September 1, 2020 describing coordination activities, efficiencies identified, individual agency policies and practices that have been improved due to the application of the data, and recommendations on future ways to reduce cost and improve quality of care in each healthcare system

Our future goals:

- Designation by State as APCD, Voluntary or Regulated
- Contributions by More Commercial Carriers and Employer Sponsored Groups
- VA and Tricare Participation

- Collaboration with TDI
- Continuation of 10.06 Efforts
- Support State Efforts for Timely Data Analytics and Reporting, i.e.: COVID-19 Impact

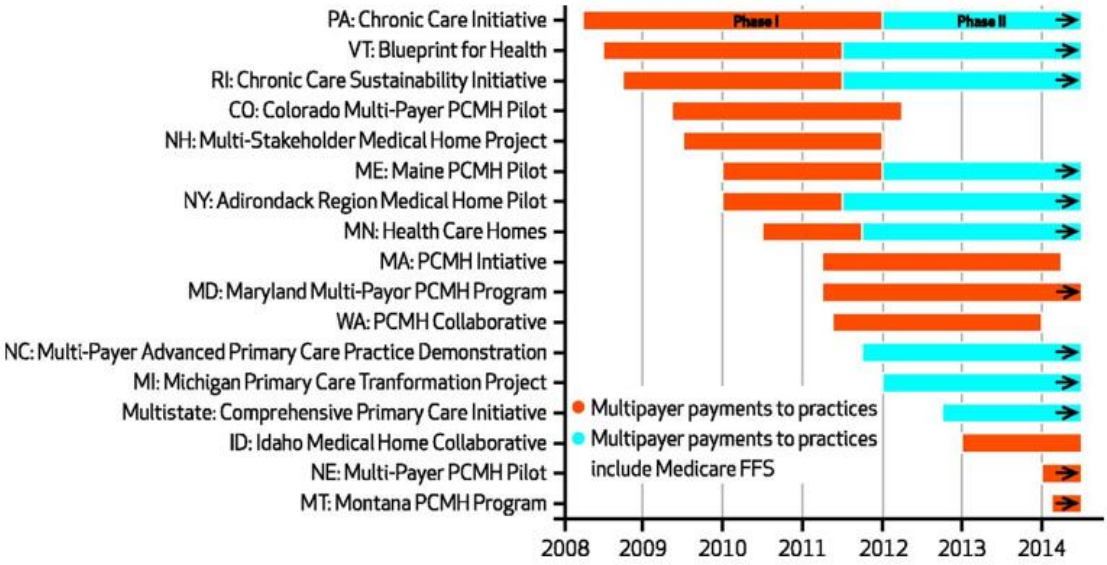
***Questions*/Answers/Comment**

Codes are available, but they can clutter the payment practice. Can you comment? The codes are being brought in when they are available. We want to bring in everything.

How recently are the data sets updated? It varies by data submitter, but most data are updated quarterly. Facility-specific information is not presently reported, but is available.

Presentation: Texas Medical Home Initiative. Dr. Sue Bornstein, Texas Medical Home Initiative

Timeline for Multi-payer Medical Home Initiative Payments



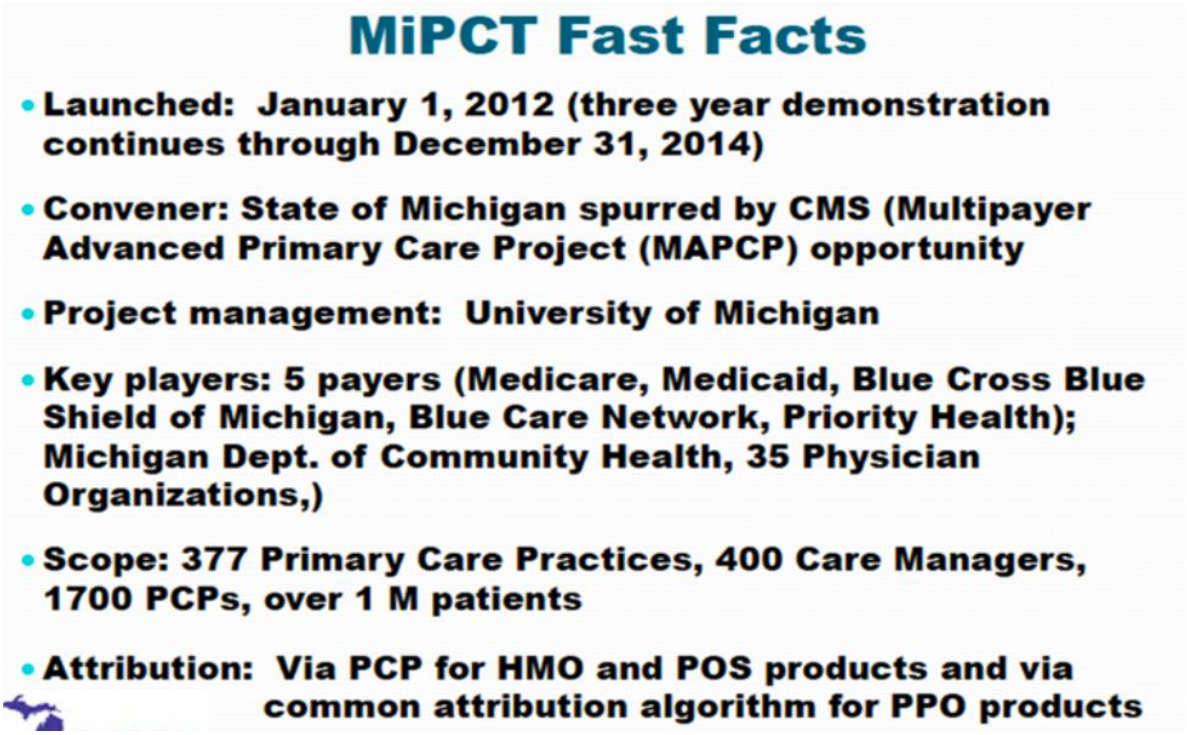
Colorado Multi-Payer Patient Centered Medical Home (PCMH) Pilot:

- Began in 2009; 15 practices; 98,000 patients; 7 payers including Medicaid
- No net overall cost savings in study period but 2 years after initial pilot practices showed decrease in ED costs of $4.11 PMPM; $3.50 PMPM after 3 years
- Improvement across all measures of diabetes care
- 15% fewer ED visits and 18% fewer inpatient admissions
- Rosenthal M et al. A difference in difference analysis of changes in quality, utilization and cost in a PCMH pilot. Journal of General Internal Medicine Oct. 2015

Pennsylvania Chronic Care Initiative

- Began in 2008; 171 small and medium size practices; 640 providers; 17 payers
- By year 3, pilot participants associated with:
  - Lower rates of all case hospitalization;
  - Lower rate for all case ED visits;
  - Lower rate for ambulatory care sensitive ED visits;
  - Lower rate of ambulatory visits for specialists.
- Statistically significant higher performance in all 4 examined measures of DM quality
- Total costs of care were significantly lower in PCMH practices during all 3 follow up years
- Neal J et al. American Journal of Managed Care June 2015.

Michigan Primary Care Transformation



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- **Infrastructure: Data Warehouse, Central Care Manager Training, Leadership Oversight, Medical Director Team, Learning Collaboratives, Website (www.mipctdemo.org)**
- **Payment Model: Population funding model; POs receive 7.50 PMPM for NonMedicare and 9.50 PMPM for Medicare attributed lives**
- **Payment Flow: Practice Transformation paid directly to practices; Care Coordination and Incentives paid to POs and distributed to practices as appropriate**
- **Contractual Relationships:**
  - **Payers contract with MDCH**
  - **POs and Practices contract with MDCH**
  - **MDCH contracts with UMHS for Program Administration**
  - **UMHS contracts with external and internal vendors**
- **Data Flow via Data Warehouse (common measure set)**
  - **Receives monthly member list and claims feeds from payers**
  - **Provides POs monthly member lists, bimonthly dashboards, and semiannual incentive results**

MiPCT

2

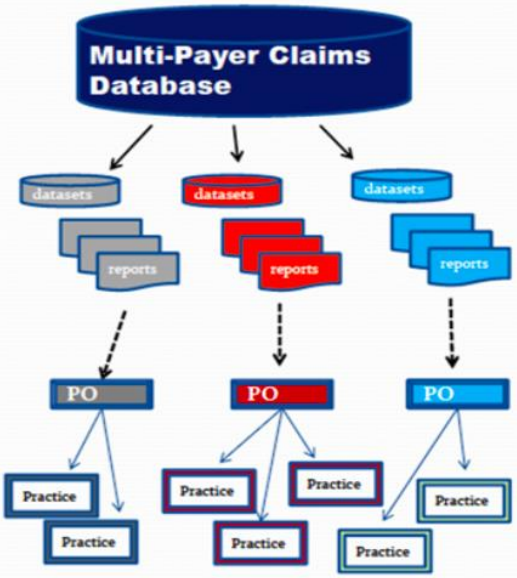
MiPCT Data Warehouse

- Summary level and PO-specific
- Delivered to POs
  - POs will distribute to Practices

Retrospective Reports
- Quality and Utilization performance metrics chosen for the project
- Only claims-based metrics for Year 1
  - Requires 2-3 month run-out to ensure availability of complete data

Prospective Reports
- Timely feedback about attributed population for use in care management
  - Providers are not being measured/scored

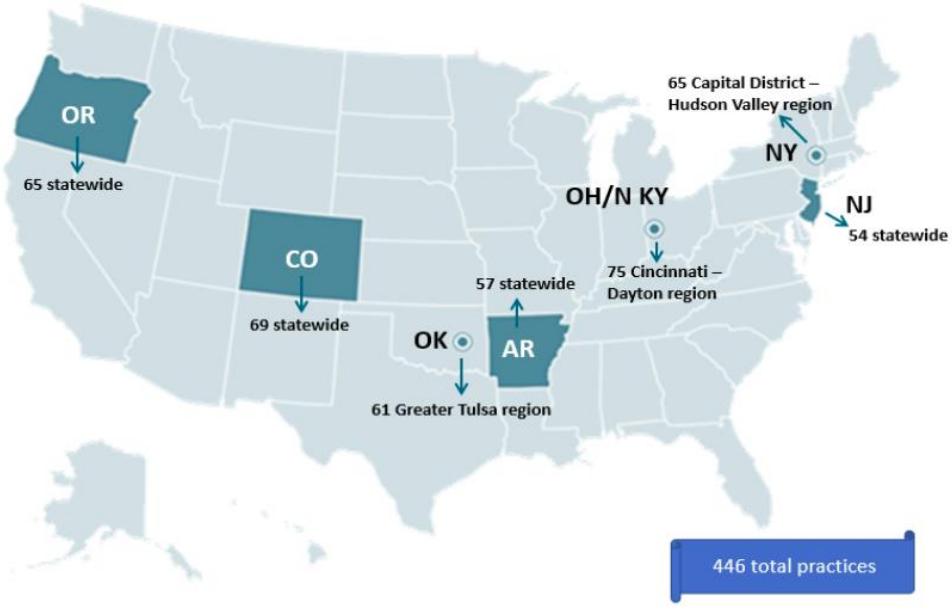
Incentive Payments Reports
- Incentive scores and payments



Comprehensive Primary Care Initiative

- A healthcare delivery model developed by CMS that ran from 2012-2016 to test whether multi-payer support of primary care practices would improve care delivery
- CMS leveraged the support of 39 other public and private payers to target the transformation of primary care delivery in 500 practices in seven regions across the US
- These practices included more than 2,000 clinicians and served around 3 million patients
- Medicare FFS paid 58% of total care management fees
- In 2016 (final year), this translated to a median of $179,519 per practice ($50,189 per clinician.)

CPC Regions and Participating Practices



Practice count as of March 1, 2016. Abbreviations in report include NY = New York: Capital District – Hudson Valley Region; OH/N KY = Ohio & Northern Kentucky: Cincinnati – Dayton Region, OK = Oklahoma – Greater Tulsa Region.

CPCI Elements:

CPC required practices to transform across 5 key care delivery functions:

1. Access and continuity
2. Planned care for chronic conditions and preventive care
3. Risk-stratified care management
4. Patient and caregiver engagement
5. Coordination of care across the medical neighborhood.

Practices were not required to have/obtain PCMH recognition though 40% did when they applied to CPC

CPCI Support
CPC supported practices with:

1. Prospective care management fees and the opportunity for shared savings in addition to their usual payments
2. Data feedback on cost, utilization and quality performance measures
3. Learning support: participating practices found in-person learning activities and opportunities for peer-to-peer learning to be the most valuable.

Comprehensive Primary Care Plus
Public-private partnership in which practices are supported by 52 aligned payers in 18 regions that began in 2017 to run for five years. CPC+ seeks to improve quality, access and efficiency of primary care.

Key primary care functions:

1. Access and continuity
2. Care management
3. Comprehensiveness and coordination
4. Patient and caregiver engagement and
5. Planned care and population health

CPC+ Program Elements
There are 2 tracks with increasingly advanced care delivery requirements and payment options.

3 payment elements:

1. Care management fee for non-visit based – risk adjusted for practice characteristics
2. Performance based incentive payments: patient experience of care, quality measures, utilization
3. Payment under Medicare fee schedule

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Findings

- **CPC+ provided practices with significant supports in the first year.** These include payments over and above what they already receive for providing care, data feedback, individualized and group learning supports, and health IT vendor support. Most significantly, the median practice received CPC+ care management fees of over $88,000 per Track 1 and $195,000 per Track 2 practice, on top of traditional payments.

- **CPC+ practices started changing care delivery in 2017.** Many CPC+ practices focused on risk stratifying patients, hiring and deploying care managers, and integrating behavioral health into primary care in 2017. Prior transformation experience (e.g., a Patient-Centered Medical Home model), and access to resources and supports from a larger health care organization facilitated implementation.

- **Practices thought their work was making a difference, but found aspects challenging.** Nearly all practices (93 percent) reported that CPC+ improved quality of care. However, many practices found meeting the care delivery, financial reporting, and health IT requirements to be burdensome.

- **Primary care transformation takes time to implement.** As expected, CPC+ had minimal effects on Medicare fee-for-service (FFS) beneficiaries served by practices that began CPC+ in 2017. There were few, very small differences in service use and quality-of-care outcomes or total Medicare expenditures without enhanced CPC+ payments. When including enhanced payments CMS made to practices for participating in CPC+, expenditures for Medicare FFS beneficiaries were 2 to 3 percent higher for CPC+ practices than for comparison practices.

TAKEAWAYS

In the first year, CPC+ provided primary care practices with substantial supports and the practices began the hard work of transforming care delivery. However, as expected, there were few effects on cost, service use, and quality for Medicare FFS beneficiaries in the first year. Effects on patient outcomes may emerge with more time as CPC+ practices deepen and expand care delivery changes.

Primary Care First Model (New model not yet launched).

- Starting in January 2021, this model is designed for primary care practices with advanced primary care capabilities that are prepared to accept increased financial risk in exchange for flexibility and potential rewards based on performance
- 125 attributed Medicare beneficiaries
- Primary care accounts for >70% of collective billing
- Experience with value-based payment arrangements
- CMS will attribute Seriously Ill Population (SIP) patients lacking a primary care practitioner to Primary Care First practices that opt to participate in this model.

Observations

- Collaboration and cooperation among payors is possible and necessary to realize transformation on a large scale but generally requires a mandate.
- The ability to share timely, accurate and actionable data is critical to success.
- Practices must be adequately incentivized to transform.
- "Moving the needle" in terms of cost and outcomes takes time – in most cases, 3-5 years.
- The greatest "delta" will be seen when the efforts are focused on the highest need patients.
- We CAN do this in Texas!

***Questions*/Answers and Comments**

I would like to learn more about Michigan and maybe we can explore this further.

It takes a long time to get financial benefit.

It's important that we weigh administrative burden with the need for data collection. Getting data directly from EHR would be beneficial.

Discuss HHSC value-based payment strategies

- Alternative payment model initiatives—MCO contractual requirements that focus on value; payment is tied to quality.
- Value-based payment roadmap… 2.0 is about to be released as well as future updates.
- Medicaid state quality strategy? DSRIP Milestones. There are many projects focusing on quality.

2020 Legislative Report: Breakout Session

Workgroup 1: Maternal and Newborn care measures

Policy Issues:

- Complex data collection & reporting of performance measures is barrier to participation in VBP for providers.
- Providers need data that is timely and actionable to enhance maternal health and improve birth outcomes.

Possible Recommendations:

- Establish a set of standardized performance measures, measure specifications, and reporting periods for maternal and newborn care. Use a two-stage process: regional and then state-level consensus.
- Establish a statewide de-identified registry linking mothers and babies that enables providers to explore their performance on key measures in near real-time.
- Creation of a de-identifed data base that is real time to compare to like units

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Workgroup 2: Leveraging multi-payer data
Policy Issues:

- Advance alignment of value-based payment and quality improvement efforts across major payers of healthcare
- Improve access and availability of robust multi-payer data that can inform next steps to improve quality and outcomes and reduce the cost of care

Possible Recommendations:

- Direct the Legislature to require HHS to further utilize multi-payer data in a de-identified way and provide recommendations from data analyses for an increased understanding of cost drivers, outcome measures and other variables that affect the Texas population
- Building on the multiple legislative sessions of direction to encourage cross-agency collaboration in the use of healthcare data, generate a public use data file using state payer claims data aggregated by the UT Data Center
- Reiterate the committee's 2018 recommendation to further leverage the Texas Healthcare Learning Collaborative Portal, including analyzing potential use cases for aggregating data from the Texas Health Care Learning Collaborative Portal with claims data in the UT Data Center

Workgroup 3: Managed care organization activities to address social drivers (determinants) of health
Policy Issues:

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

Possible Recommendations:

- 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

Workgroup 4: Advancing alternative payment models in Medicaid
Policy Issues:

- Need for multi-stakeholder input on the direction of the state's Medicaid APM initiative
- Need for strategies to increase adoption of effective APMs by Medicaid MCOs and providers
- Need for mechanisms to incorporate effective Medicaid-focused DSRIP work into Medicaid APMs

Possible Recommendations:

- Endorse standardized outcome measures to reduce provider administrative burden to participate in Medicaid APMs
- Conduct a landscape assessment to determine the barriers/opportunities to advancing APMs

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- Leverage the 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 APMs

Workgroup 5: Impact of COVID-19 on value-based initiatives
Policy Issues:

- COVID-19 accelerated some policy changes, such as expansion of telemedicine/telehealth, that have been enabled by 1135 Medicaid waivers.
- The pandemic has required health plans and providers to innovate quickly to meet patient needs (e.g., more home-based care; uptick in prospective, capitated payments to primary care providers)

Possible Recommendations:

- Evaluate the Medicaid waivers used in telehealth during the pandemic to assess impact on access to care, patient experience, health outcomes and cost effectiveness. Use this information to share best practices and consider potential policy changes post-pandemic.
- Continue to explore how to reward and incentivize through Medicaid managed care innovative practices that improve health, including many strategies used during the pandemic.
- Member engagement
- Audio only telehealth should be considered
- We need to be thoughtful about provider feedback
- Credentialing issue with pharmacies and MCOs present barriers

Legislative Report planning and timeline. Because of the delay in getting members, the timeline is really compressed.

- **June-August:** Finalize report draft, seek additional stakeholder comment, and adopt report
- **September:** Chair submits final report to legislative and other offices
- **October/November:** Report follow-up, briefings, and presentations
- **December 31st:** Final report due to legislature by rule

Public comment. No public comment was offered.

Action items for staff and/or member follow-up. Send approved bylaws to members for signature.

Adjourn. Next meeting Tuesday August 25th. There being no further business the meeting was adjourned.

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