HHSC: Value-Based Payment and Quality Improvement Advisory Committee, August 25th, 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

Welcome and introductions. Dr. Mary Peterson, Chair convened the meeting. A quorum was established.

Review and approval of meeting minutes from July 1, 2020, meeting. The minutes were approved as drafted.

Update: New member appointment process. The application process will open in the next few months with a one-month application deadline. Members with expired terms include Michael Stanley, Vincent Sowell, Joseph Ramon, Benjamin McNabb, Kathy Lee, Daverick Isaac, 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.

Presentation: California Maternal Care Collaborative. The California Maternal Quality Care Collaborative is a multi-stakeholder organization committed to ending preventable morbidity, mortality and racial disparities in California maternity care. CMQCC uses research, quality improvement toolkits, state-wide outreach collaboratives and its innovative Maternal Data Center to improve health outcomes for mothers and infants.

CMQCC was founded in 2006 at Stanford University School of Medicine together with the State of California in response to rising maternal mortality and morbidity rates. Since CMQCC's inception, California has seen maternal mortality decline by 55 percent between 2006 to 2013, while the national maternal mortality rate continued to rise.

- California's maternal mortality rate declined more than 55% from 2006 – 2013, saving 9.6 lives per 100,000
- 120,000 early births were prevented from 2009 – 2014, with an increase of 8% of births making it to full term
- Maternal morbidity was reduced by 20.8% between 2014 – 2016 among the 126 hospitals participating in our projects to reduce maternal hemorrhage and preeclampsia

One of the keys to CMQCC's success is its ability to provide hospitals with access to near real-time benchmarking data through its online Maternal Data Center. The MDC links state birth certificate data with each hospital's patient discharge data to generate a wide range of perinatal performance metrics and quality improvement insights. Currently there are more than 200 hospitals actively participating in the Maternal Data Center, representing approximately 95 percent of all births in California alone.

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CMQCC has developed evidence-based quality improvement toolkits for the leading causes of preventable death and complications for mothers and infants, including toolkits on: Cardiovascular Disease, Early Elective Delivery, Hemorrhage (1st and 2nd editions), Maternal Venous Thromboembolism, Preeclampsia, and Supporting Vaginal Birth and Reducing Primary Cesareans.

To help California hospitals implement the evidence-based care presented in our toolkits, CMQCC launched large-scale outreach collaboratives. State-wide collaboratives for hemorrhage and preeclampsia were launched individually and then a second time together in 2013 to help CA hospitals implement both obstetric hemorrhage and preeclampsia patient safety bundles. Maternal morbidity was reduced by 20.8% between 2014 – 2016 among the 126 hospitals participating in the California Partnership for Maternal Safety, the joint hemorrhage and preeclampsia collaborative.

A six-month pilot Collaborative to Support Vaginal Birth and Reduce Primary Cesareans was launched in 2014, and the first-birth cesarean rate decreased by greater than 20 percent between the three hospitals participating. Close to 100 hospitals are now participating in the current full-scale collaborative.

CMQCC collaborates with the state of California to publish the California Pregnancy-Associated Mortality Review. The first in-depth medical record review of pregnancy-related deaths occurring between 2002-2007 was published in 2011, which helped identify quality improvement opportunities in maternity care. A second in-depth medical record review focused on mental health is currently underway.

CMQCC has developed four quality measures endorsed by the National Quality Forum – Cesarean Rate for Low-Risk First Birth Women; Infants Under 1500g Delivered at Appropriate Site; Exclusive Breastfeeding at Hospital Discharge; and Unexpected Newborn Complications. We have also authored more than 60 publications in peer-reviewed journals focused on maternity care (complete list available here).

More than 200 hospitals are demonstrating their commitment towards quality improvement as active CMQCC members! CMQCC hospital members have priority access to all of our evidence-based best practice tools, including the Maternal Data Center and outreach collaboratives. Participation in both is designated on the member lists available to download below. Member lists are sorted alphabetically by county and hospital name.

Member Participant Lists:
Participation List by County
Participation List by Hospital

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CMQCC works together with more than 40 partner organizations to drive improvement in maternity care, including: state agencies, professional groups, consumer organizations, healthcare systems, purchasers and payers, hospitals and clinicians, policymakers and researchers. Relationships with key partners have been essential to our success establishing CMQCC's reputation as a state and national leader in maternal quality improvement.

We would like to recognize our founding organizations and current funders for their support.

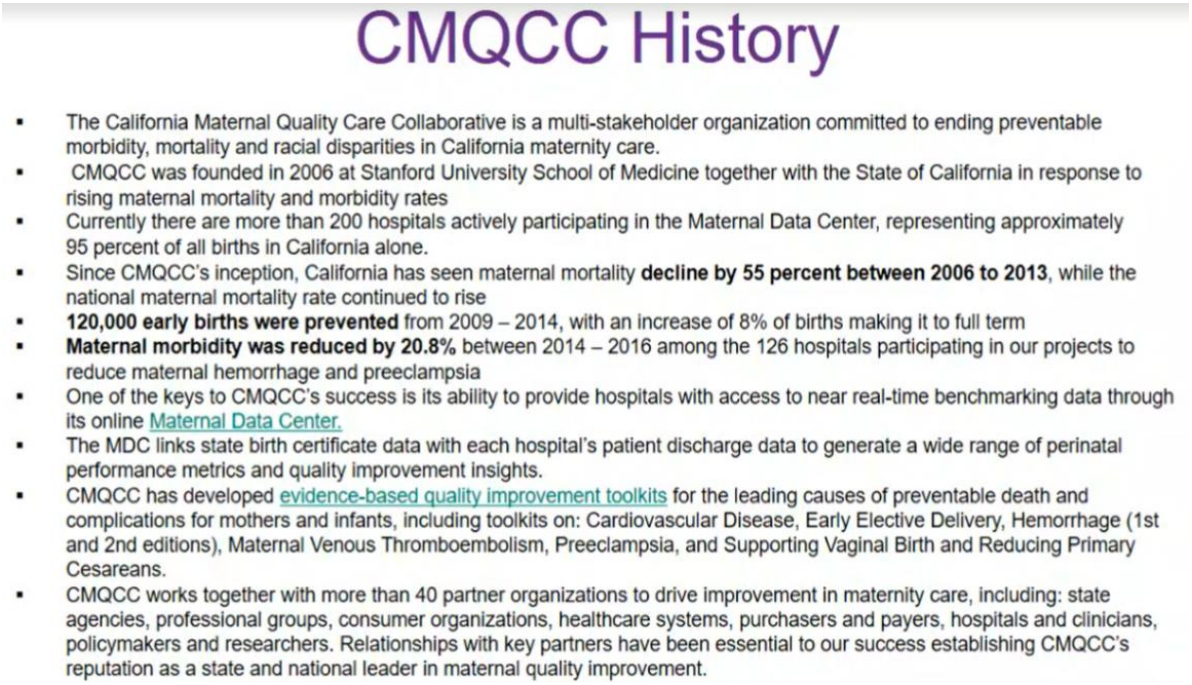
Founding Organizations

- California Department of Public Health, Maternal, Child and Adolescent Health Division (CDPH-MCAH)
  California Perinatal Quality Care Collaborative (CPQCC) and Stanford University

Current Funders

- California Department of Public Health, Maternal Child and Adolescent Health Division (CDPH-MCAH)
  California Health Care Foundation (CHCF)
  Centers for Disease Control and Prevention (CDC)
  Yellow Chair Foundation
  Participating hospitals

Presentation Materials Appear Below.



CMQCC History

- The California Maternal Quality Care Collaborative is a multi-stakeholder organization committed to ending preventable morbidity, mortality and racial disparities in California maternity care.
- CMQCC was founded in 2006 at Stanford University School of Medicine together with the State of California in response to rising maternal mortality and morbidity rates
- Currently there are more than 200 hospitals actively participating in the Maternal Data Center, representing approximately 95 percent of all births in California alone.
- Since CMQCC's inception, California has seen maternal mortality **decline by 55 percent between 2006 to 2013**, while the national maternal mortality rate continued to rise
- **120,000 early births were prevented** from 2009 – 2014, with an increase of 8% of births making it to full term
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- One of the keys to CMQCC's success is its ability to provide hospitals with access to near real-time benchmarking data through its online Maternal Data Center.
- The MDC links state birth certificate data with each hospital's patient discharge data to generate a wide range of perinatal performance metrics and quality improvement insights.
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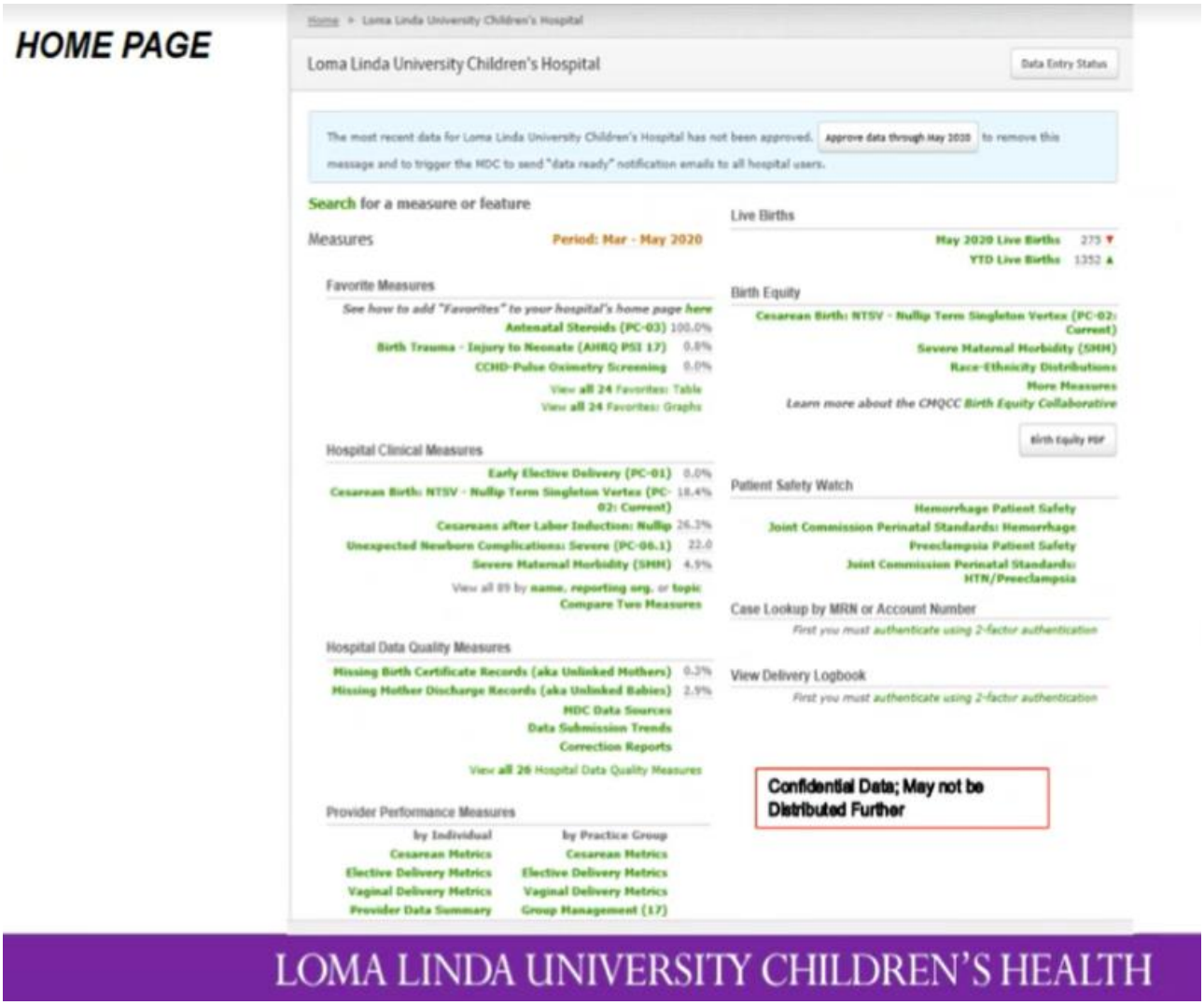
HOME PAGE


Home > Loma Linda University Children's Hospital
Loma Linda University Children's Hospital
Data Entry Status
The most recent data for Loma Linda University Children's Hospital has not been approved. Approve data through May 2020 to remove this message and to trigger the NDC to send "data ready" notification emails to all hospital users.
Search for a measure or feature
Measures
Period: Mar - May 2020
Favorite Measures
See how to add "Favorites" to your hospital's home page here
Antenatal Steroids (PC-03) 100.0%
Birth Trauma - Injury to Neonate (AHRQ PSI 17) 0.8%
CCHD-Pulse Oximetry Screening 0.0%
View all 24 Favorites: Table
View all 24 Favorites: Graphs
Hospital Clinical Measures
Early Elective Delivery (PC-01) 0.0%
Cesarean Birth: NTSV - Nullip Term Singleton Vertex (PC-02: Current) 18.4%
Cesareans after Labor Induction: Nullip 26.3%
Unexpected Newborn Complications: Severe (PC-06.1) 22.0
Severe Maternal Morbidity (SMM) 4.9%
View all 89 by name, reporting org, or topic
Compare Two Measures
Hospital Data Quality Measures
Missing Birth Certificate Records (aka Unlinked Mothers) 0.3%
Missing Mother Discharge Records (aka Unlinked Babies) 2.9%
NDC Data Sources
Data Submission Trends
Correction Reports
View all 26 Hospital Data Quality Measures
Provider Performance Measures
by Individual
Cesarean Metrics
Elective Delivery Metrics
Vaginal Delivery Metrics
Provider Data Summary
by Practice Group
Cesarean Metrics
Elective Delivery Metrics
Vaginal Delivery Metrics
Group Management (17)
Live Births
May 2020 Live Births 275
YTD Live Births 1352
Birth Equity
Cesarean Birth: NTSV - Nullip Term Singleton Vertex (PC-02: Current)
Severe Maternal Morbidity (SMM)
Race-Ethnicity Distributions
More Measures
Learn more about the CMQCC Birth Equity Collaborative
Birth Equity PDF
Patient Safety Watch
Hemorrhage Patient Safety
Joint Commission Perinatal Standards: Hemorrhage
Preeclampsia Patient Safety
Joint Commission Perinatal Standards: HTN/Preeclampsia
Case Lookup by MRN or Account Number
First you must authenticate using 2-factor authentication
View Delivery Logbook
First you must authenticate using 2-factor authentication
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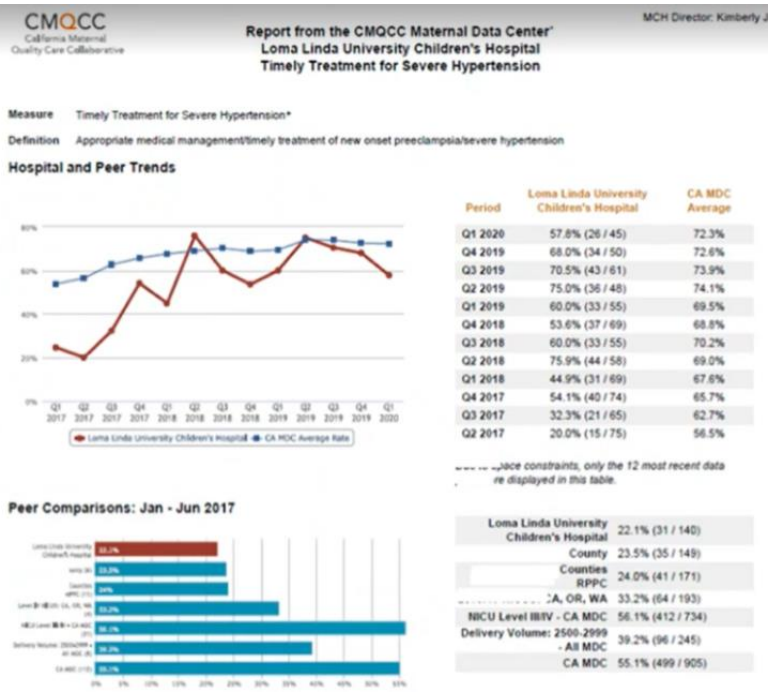
LOMA LINDA UNIVERSITY CHILDREN'S HEALTH

TIMELY TREATMENT DATA

Not all MDC hospitals submit the extra data needed to calculate this measure, thus the rates do not reflect "true" county or state rates, only the rates of facilities submitting the extra data.



CMQCC
California Maternal Quality Care Collaborative

MCH Director: Kimberly J

Report from the CMQCC Maternal Data Center
Loma Linda University Children's Hospital
Timely Treatment for Severe Hypertension

Measure Timely Treatment for Severe Hypertension*

Definition Appropriate medical management/timely treatment of new onset preeclampsia/severe hypertension

Hospital and Peer Trends

Period	Loma Linda University Children's Hospital	CA MDC Average
Q1 2020	57.8% (26 / 45)	72.3%
Q4 2019	68.0% (34 / 50)	72.6%
Q3 2019	70.5% (43 / 61)	73.9%
Q2 2019	75.0% (36 / 48)	74.1%
Q1 2019	60.0% (33 / 55)	69.5%
Q4 2018	53.6% (37 / 69)	68.8%
Q3 2018	60.0% (33 / 55)	70.2%
Q2 2018	75.9% (44 / 58)	69.0%
Q1 2018	44.9% (31 / 69)	67.6%
Q4 2017	54.1% (40 / 74)	65.7%
Q3 2017	32.3% (21 / 65)	62.7%
Q2 2017	20.0% (15 / 75)	56.5%

...lace constraints, only the 12 most recent data re displayed in this table.

Peer Comparisons: Jan - Jun 2017

Loma Linda University Children's Hospital	22.1% (31 / 140)
County	23.5% (35 / 149)
Counties RPPC	24.0% (41 / 171)
...A, OR, WA	33.2% (64 / 193)
NICU Level IIIIV - CA MDC	56.1% (412 / 734)
Delivery Volume: 2500-2999 - All MDC	39.2% (96 / 245)
CA MDC	55.1% (499 / 905)

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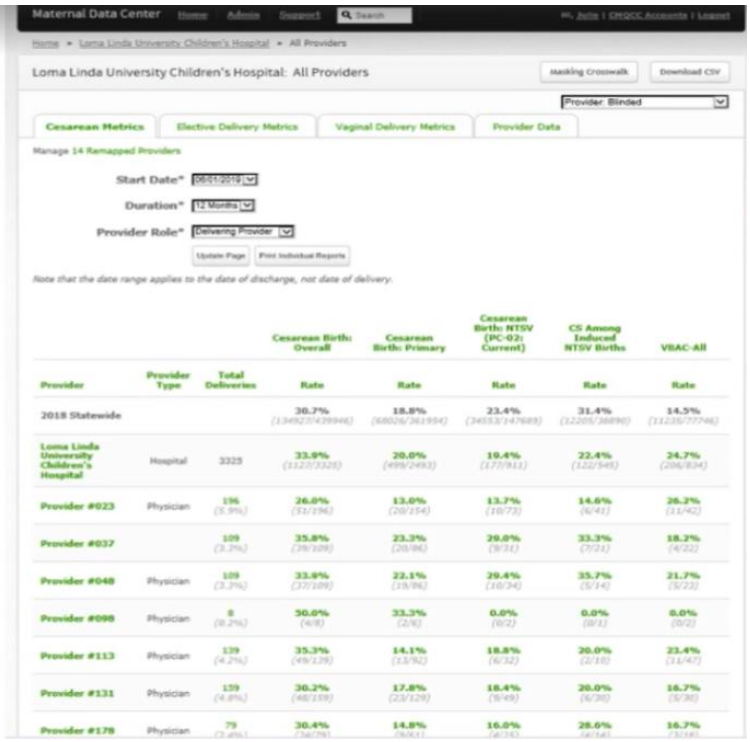
PROVIDER PERFORMANCE MEASURES



Maternal Data Center

Loma Linda University Children's Hospital: All Providers

Cesarean Metrics | Elective Delivery Metrics | Vaginal Delivery Metrics | Provider Data

Start Date* 06/01/2019
Duration* 12 Months
Provider Role* Delivering Provider

Note that the date range applies to the date of discharge, not date of delivery.

Provider	Provider Type	Total Deliveries	Cesarean Birth: Overall Rate	Cesarean Birth: Primary Rate	Cesarean Birth: NTSV (PC-02: Current) Rate	CS Among Induced NTSV Births Rate	VBAC-All Rate
2018 Statewide			30.7% (134927/439946)	18.8% (68026/361954)	23.4% (34553/147689)	31.4% (12205/38890)	14.5% (11216/77746)
Loma Linda University Children's Hospital	Hospital	3325	33.9% (1127/3325)	20.0% (498/2493)	19.4% (177/911)	22.4% (122/545)	24.7% (206/834)
Provider #023	Physician	196 (5.9%)	26.0% (51/196)	13.0% (20/154)	13.7% (10/73)	14.6% (6/41)	26.2% (11/42)
Provider #037		109 (3.3%)	35.8% (39/109)	23.3% (20/86)	29.0% (9/31)	33.3% (7/21)	18.2% (4/22)
Provider #048	Physician	109 (3.3%)	33.9% (37/109)	22.1% (19/86)	29.4% (10/34)	35.7% (5/14)	21.7% (5/23)
Provider #098	Physician	8 (0.2%)	50.0% (4/8)	33.3% (2/6)	0.0% (0/2)	0.0% (0/1)	0.0% (0/2)
Provider #113	Physician	139 (4.2%)	35.3% (49/139)	14.1% (13/92)	18.8% (6/32)	20.0% (2/10)	23.4% (11/47)
Provider #131	Physician	159 (4.8%)	30.2% (48/159)	17.8% (23/129)	18.4% (9/49)	20.0% (6/30)	16.7% (5/30)
Provider #178	Physician	79 (2.4%)	30.4% (24/79)	14.8% (9/61)	16.0% (4/25)	28.6% (4/14)	16.7% (3/18)

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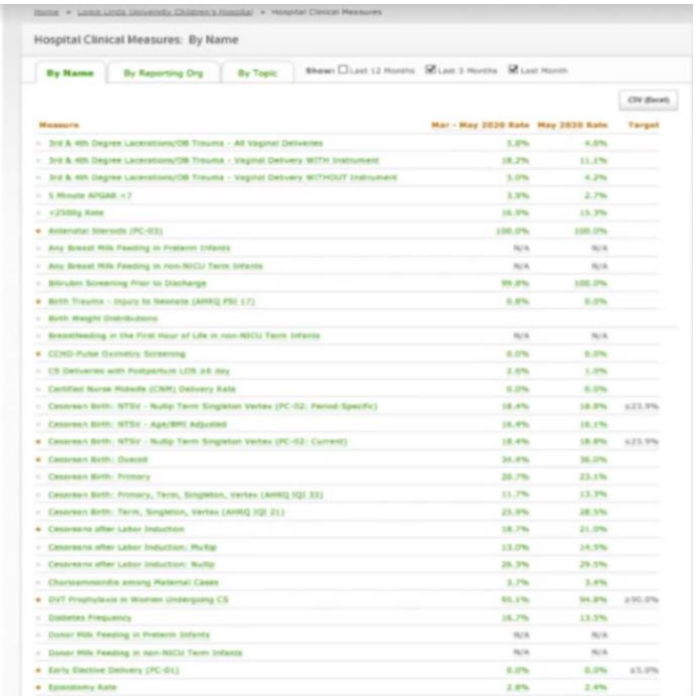
OVER 86 MEASURES AVAILABLE AND CONSTANTLY ADDING NEW ONES
Can be viewed by name or by Topic



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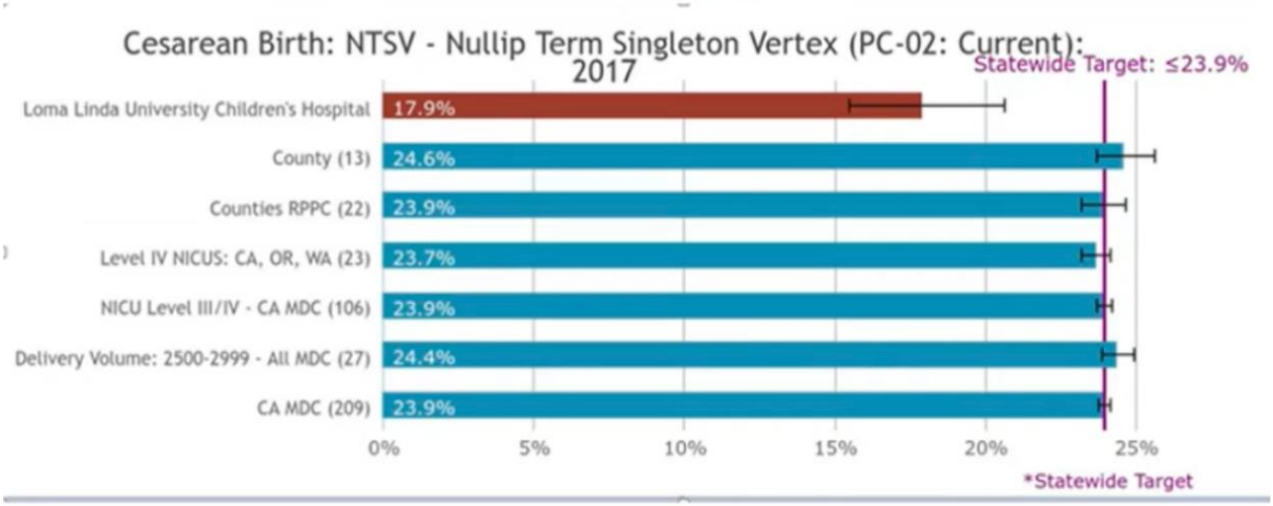
WE ARE ABLE TO COMPARE OUR DATA TO OUR PEERS



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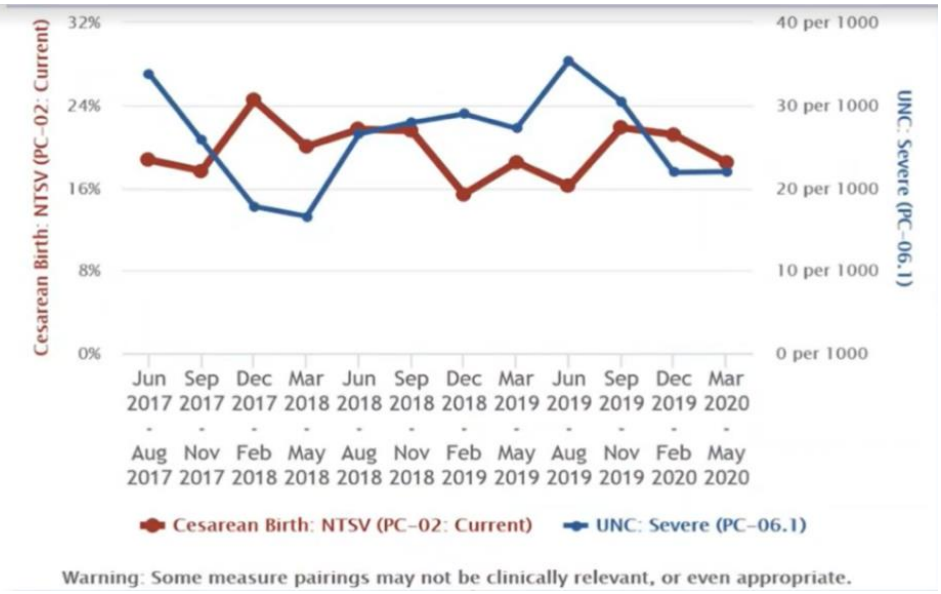
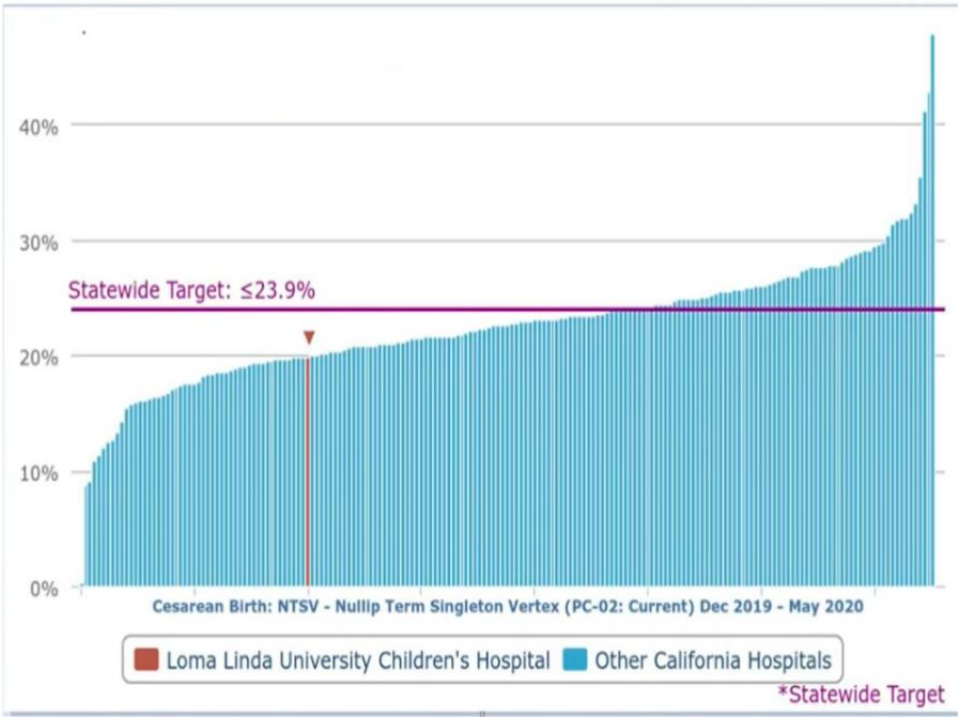
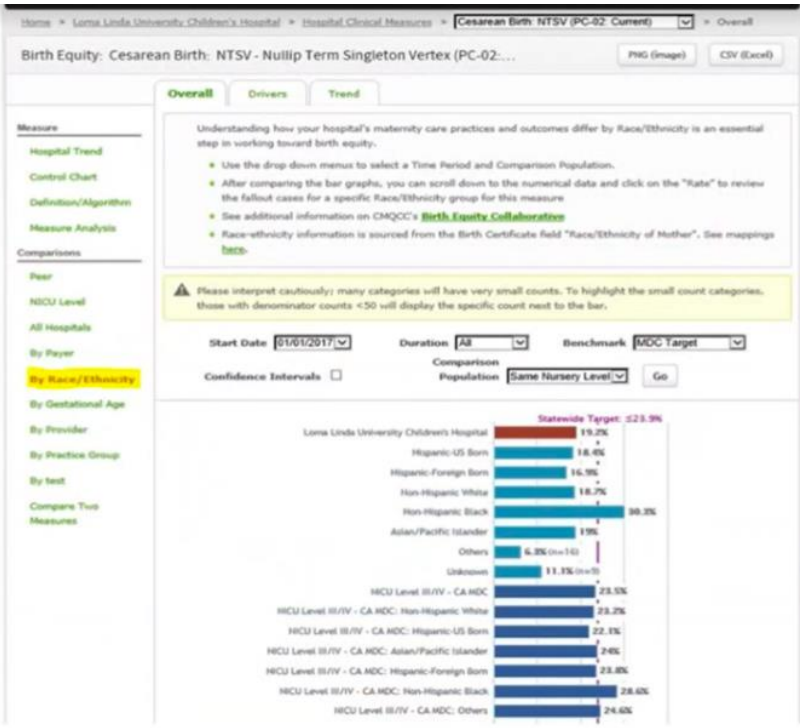
WE ARE ABLE TO COMPARE 2 MEASURES SUCH AS NTSV AND UNEXPECTED NEWBORN COMPLICATIONS



NTSV RATE COMPARED TO ALL HOSPITALS IN CMQCC WHICH ACCOUNTS FOR 95% OF BIRTHS IN CALIF.



NTSV PULLED BY RACE AND ETHNICITY



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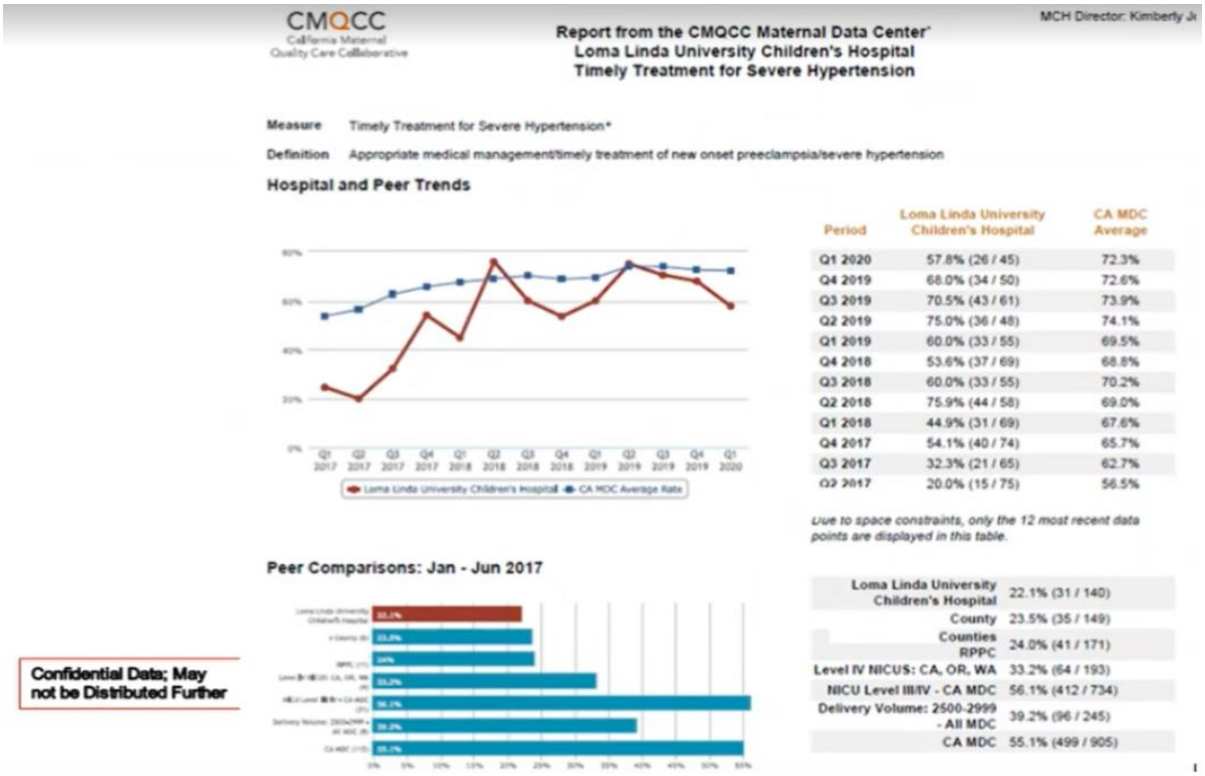

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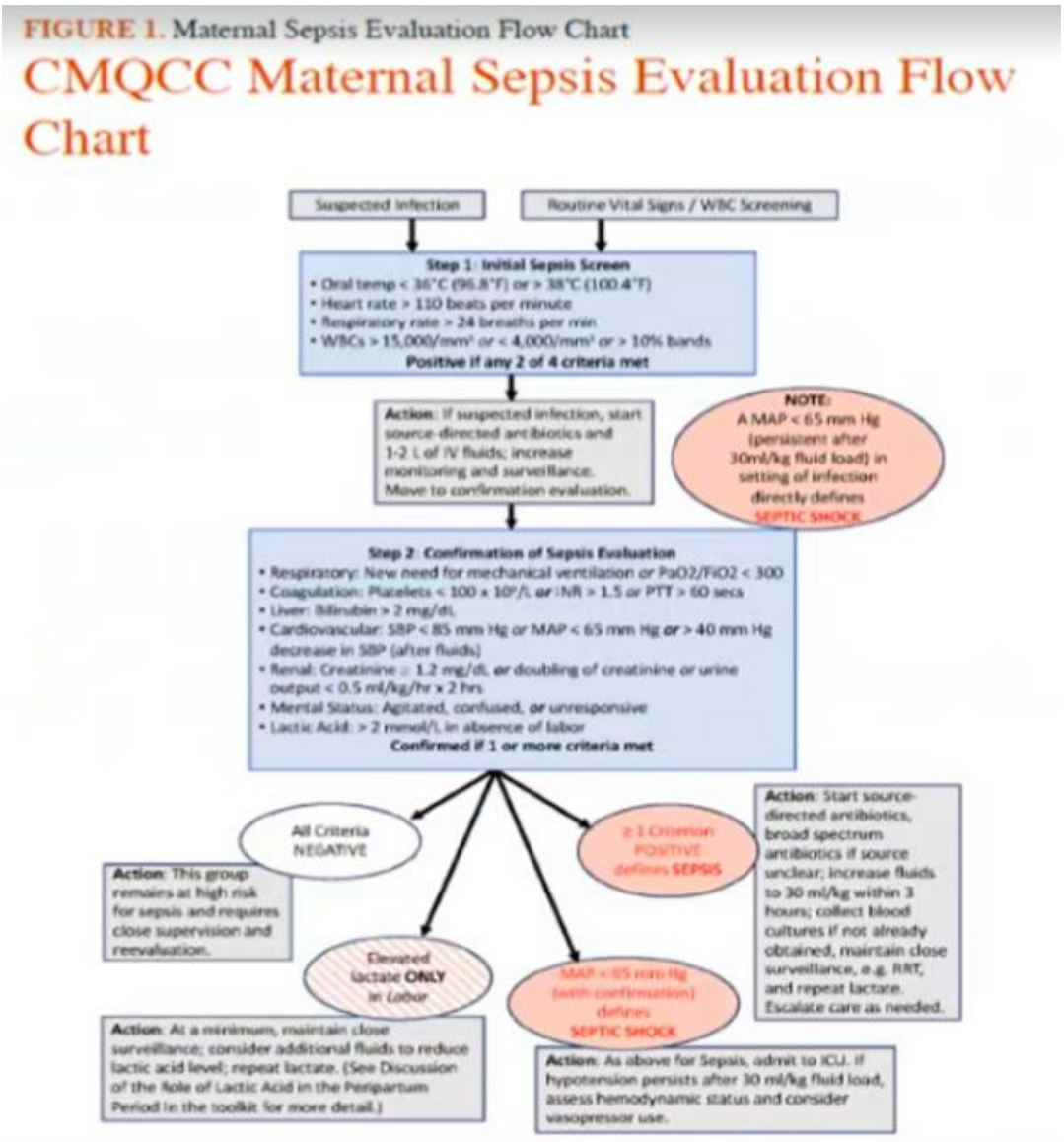
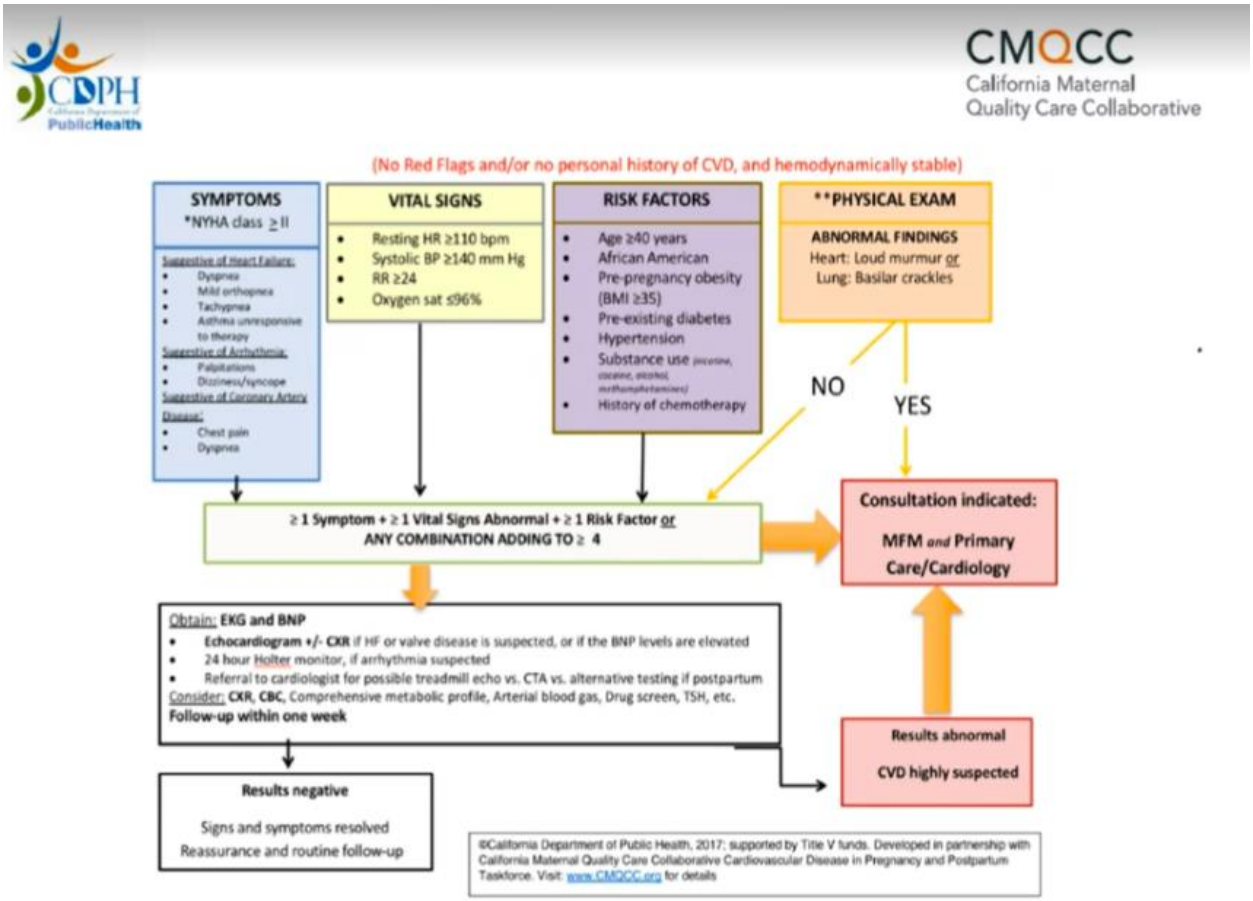
Goals & Interventions (Action Plans)

- **Maternal Sepsis and Timely Antibiotic Administration**
  - Issue with identifying sepsis, standardized treatment protocols, lack of safety infrastructure
  - CMQCC Toolkit identifies protocol and planning
  - Sepsis Care Pathway development initiation
    - Improve diagnosis, treatment, decrease length of stay, reduce neonatal complications and length of stay





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Questions/Answers/Comments

On the data center, does the state pay for the data collection? The speaker stated that there is payment to the hospitals, but they were not sure about the state funding.

Can you discuss the way the data is used for a value-based payment model? The speaker stated that the metrics are used for a pay-for-performance with the county insurance. There is a requirement to submit data that includes the post-partum follow-up visits.

How much investment do hospitals have to make upfront? A fair amount of data is transferred in one data platform file with the help of a dedicated data person that verifies the coding.

How do you decide on the questions, metrics, and targets? The speaker stated that is done by pulling from the peer review literature.

In hospitals with perinatal care units, how do you transfer directly into the VON database? The speaker stated that the data is automatically uploaded.

In response to a comment on the synergy between CPQCC and CMQCC, the speaker stated that the CPQCC is looking at neonatal management where CMQCC looks at the maternal care received.

Presentation: Home health initiatives. Advancing Value in Community Based LTSS. Home care is a lynchpin for the care of frail and elderly patients. In the health care system, improving the quality of care improves the quality of life for patients, improves health outcomes and saves money. "A dollar saved is more valuable than a dollar earned."

Improving Texas Medicaid Long Term Services and Support (LTSS)/Personal Attendant Services (PAS) Depends On…

- Improving the performance of the attendants
- Improving the performance of the agencies that employ them
- Development of performance measures that could be utilized for an industry rating system
- Updating the reimbursement system to incentivize improved outcomes
- Strengthening industry requirements and responsibilities of all the participants in the Texas LTSS/PAS programs (patients, attendants, agencies, MCOs, OIG & HHSC Medicaid)-paving the way for continuous improvement
- Cut administrative burdens, bring more value to the patients
- Bring in all industry representatives to the table

Research indicates "that (members served by) Personal Care Attendants (PCAs) who have completed a comprehensive, evidence-based PCA training program…report higher satisfaction and better health outcomes."

- Improve EVV performance
- Current minimum training requirements do not serve members effectively
- Require on-going training for all attendants
- Active Fraud, Waste & Abuse (FWA) education and response
- Ratings system for attendants

Elements of An Attendant Training Program:

- Program can be implemented over a 1-2-year period
- Training to be done through a credentialed program, internally or externally
- Curriculum can include:
    - Recognizing potential patient health care issues
    - Trip and fall avoidance
    - Bed transfers
    - Bathing
    - PCP visits

  - Basic nutrition and cooking.
  - Medication prompting.
  - Mobility and activity
  - Telemedicine and telemonitoring
  - Other critical knowledge and certified competencies

Improving Agency Performance

- Star ratings system for agencies based on HHSC-reported performance metrics and external agency surveys
- Agency performance metrics to include:
  - Improved EVV – auto link, preferred codes, % ratings
  - Decrease ER and hospitalization rates when data available
  - Verified Complaints – survey to be done by an outside, independent group
  - Improved care management of enrollee
  - Competencies for attendants and other staff
  - One or more specialty programs (PCP follow up visits, medication management, falls, Call Me First, etc.)
  - Active Compliance (solicitation, OIG initiatives, audits, employee training)
  - Improved PCP engagement…improved care coordination, improvement in key metrics related to chronic conditions

Enrollee Experience—Customer Surveys may include questions such as:

- Is the attendant showing up?
- How often do supervisors make a home visit?
- Does the attendant help you arrange MD visits and/or help with refilling prescriptions?
- Are they attentive to your needs?
- Have you been to the ER or admitted to the hospital?
- Which entity conducts? MCO or HHSC/EQRO?
- Should some of these be Medicaid MCO report card measures?

Update Agency Reimbursement Structure to Incentivize Improved Outcomes

- Agencies to be reimbursed based on their Star Ratings and outcomes
- Top agencies get 100+% reimbursement
- Second tier agencies get 100% reimbursement
- The other agencies get less than 100% reimbursement (prorated)
- HHSC and MCOs may decide to drop those at the bottom tier

Incentivizing the Program is Critical

- In the private sector, what gets incentivized gets improved
- Aligning of goals and incentivizing of value to outcomes is critical
- The 90% attendant reimbursement rule does not incentivize attendants to improve service

- The 90% attendant reimbursement system does not provide for the administrative investment needed to improve health outcomes
- If all agencies are paid the same, regardless of the quality of care, there is no incentive to improve quality of life or health outcomes for members
- If there are no repercussions for poor or negative health outcomes or agency performance, there is no incentive for either improved health outcomes or financial savings to the system
- There are financial incentives in the program for MCOs and others to improve services and cut costs. No such incentives are available to the agencies

Strengthen Responsibilities in Home Care

- Enrollees must commit to their responsibilities to report FWA
- Attendants must meet training requirements, adhere to FWA requirements
- Agencies must meet Star Ratings requirements
- The MCOs must improve their compliance efforts, coordination of care, timely data analysis, oversight of agencies, staff training, etc.
- HHSC must take an active role in developing and policing the agency star ratings system, coordination of care and agency oversight
- The OIG must increase its enforcement activities against solicitation, poaching of clients, fraudulent attendants, patient abuses and onsite visits at agencies
- All industry partners must be at the table

Alternative Payment Models Involving Community Based Attendant Services in Texas Medicaid

Service Costs for Community-Based Attendants

In STAR+PLUS: MCO costs for community-based services involving attendants** totalled about $2.5 billion in Fiscal Year 2019, as reported by MCOs on financial reports. As a point of comparison, the MCOs reported they spent $70 million on primary care services for the same period. Reported costs for services involving attendants was 36 times the reported costs for primary care. Costs for services involving attendants equaled ~27% of the total medical and prescription expenses across all STAR +PLUS MCOs (includes outpatient, emergency services, inpatient hospital, nursing facility, lab, prescription)

** Reported categories include personal attendant services (non HCBS STAR+PLUS Waiver, DAHS - Adult Day Care Services, and HCBS STAR+PLUS Waiver Long-Term Care Services (Part 5 of STAR+PLUS MCO Financial Statistical Reports)

Attendant Services Present a Significant Value Proposition. In addition to being a high proportion of overall MCO costs, attendant services represent a disproportionately high volume of face to face service time across all providers types. Attendants are in the home every day, often for many hours a day. Data provided by a provider indicated that over 50%

of enrollees receiving attendant services get over 20 hours a week, with a significant proportion getting >30 hours a week. If agencies/attendants are properly trained and incentivized, this could translate into a significant return on investment. There could be less focus on volume of attendant services and more focus on efficient accountable and effective attendant services. Attendants can identify issues early, which leads to early and more effective primary care; which leads to avoidance of high cost care.

APMs Involving Attendant Services. For calendar year 2018, there were only 9 APMs reported by STAR+PLUS MCOs involving provider types Health Home, Nursing Facilities, and Home Care (Overall APM totals across all programs= 351) (note: community based attendant care is a subset of the aforementioned provider types). For provider types Health Home, Nursing Facilities, and Home Care, the amount of APM incentives relative to overall claims paid was 0.4% ($4,245,475 in incentives / $1,026,391,034 in claims). Data source here.

… Compared to APMs for Primary Care: For calendar year 2018, there were 143 APMs reported by MCOs involving Primary Care (across all programs). The amount of incentives relative to overall claims paid was 2% ($45,004,524 in incentives / $2,228,567,050 in claims. Primary Care APMs are crucial, but likely not sufficient for enrollees with complex/chronic conditions. Other providers must be involved.

To summarize, there is a high volume of face to face service hours in which community-based attendants interact with enrollees and a high percentage of overall costs associated with attendant services, BUT the number of APMs involving attendant services (9) and magnitude of incentives (0.4%) is not nearly enough to drive value

Key Issues:

- Budget shortfalls in upcoming legislative session should stimulate additional, proactive strategies by HHSC to support population health management through effective APMs, rather than the alternative of often ineffective and potentially deep rate cuts
- APM targets are not the goal. Based on how APM dollars are calculated, APM targets can be achieved or exceeded but that does not necessarily translate to impactful APMs, particularly for enrollees with complex needs and high service costs.
- The drive toward a value-based healthcare system is evolutionary and HHSC has many contractual, policy and financial levers to continue to stimulate and advance value-based care for enrollees with complex needs and chronic conditions

Recommendations Going Forward

- HHSC should adapt its contractual requirements to stimulate APMs for populations that are more complex and higher cost. This could also include specific targets for more collaborative care models like Behavioral Health and Primary Care, or Primary Care and Community based LTSS, Pharmacy and Primary Care, etc.).

- HHSC should strengthen the "softer" APM provisions contract. These include data/report sharing, common APMs across MCOs in service areas, standardized measures for LTSS, etc.
- HHSC should implement a Star rating system for Medicaid Community–based LTSS, so that value can be better understood and recognized
- HHSC should examine additional ways to support preferred, high value and accessible provider networks. This is an important tool for effective value-based healthcare.
- HHSC should develop more effective strategies to monitor/enforce unethical marketing /solicitation by attendants. Attendants migrate to those agencies that reimburse at a higher rate and have few demands placed upon them relative to qualifications or accountability. Because of the churn in personal attendants and as a result, MCO members, there is reduced opportunity to improve member health outcomes by the MCO.
- HHSC examine innovative rate setting processes for MCOs, to ensure that MCOs are properly incentivized to continue the emphasis on pay for performance/maximizing value
- HHSC should more adequately resource data analytics/sharing of data in ways to support APMs. HHSC is the custodian of all the Medicaid data, and should be utilizing in ways to better support APMs
- HHSC should support a more robust stakeholder learning environment in which best practices are being shared with the MCO and provider community
- HHSC should support and incentivize pilot programs to expand telemonitoring for community based LTSS

Summary

- MCOs are focused on value-based healthcare and have responded to, and have exceeded HHSC 's contractual requirements for more APMs
- HHSC has historically maintained a "laissez-faire" approach to MCO's relationships with providers, including the movement toward value-based healthcare and APMs
- The movement toward APMs and a value-based healthcare system requires is evolutionary. HHSC should examine its historic role and its approach in supporting this transition an ensure its success
- In supporting this effort, HHSC should utilize all its policy, contractual and financial levers to support this movement and keep MCO and provider administrative burden low
- Collaborative relationships between HHSC, MCOs and providers is essential. HHSC success depends on MCO success, and MCO success depends on provider success

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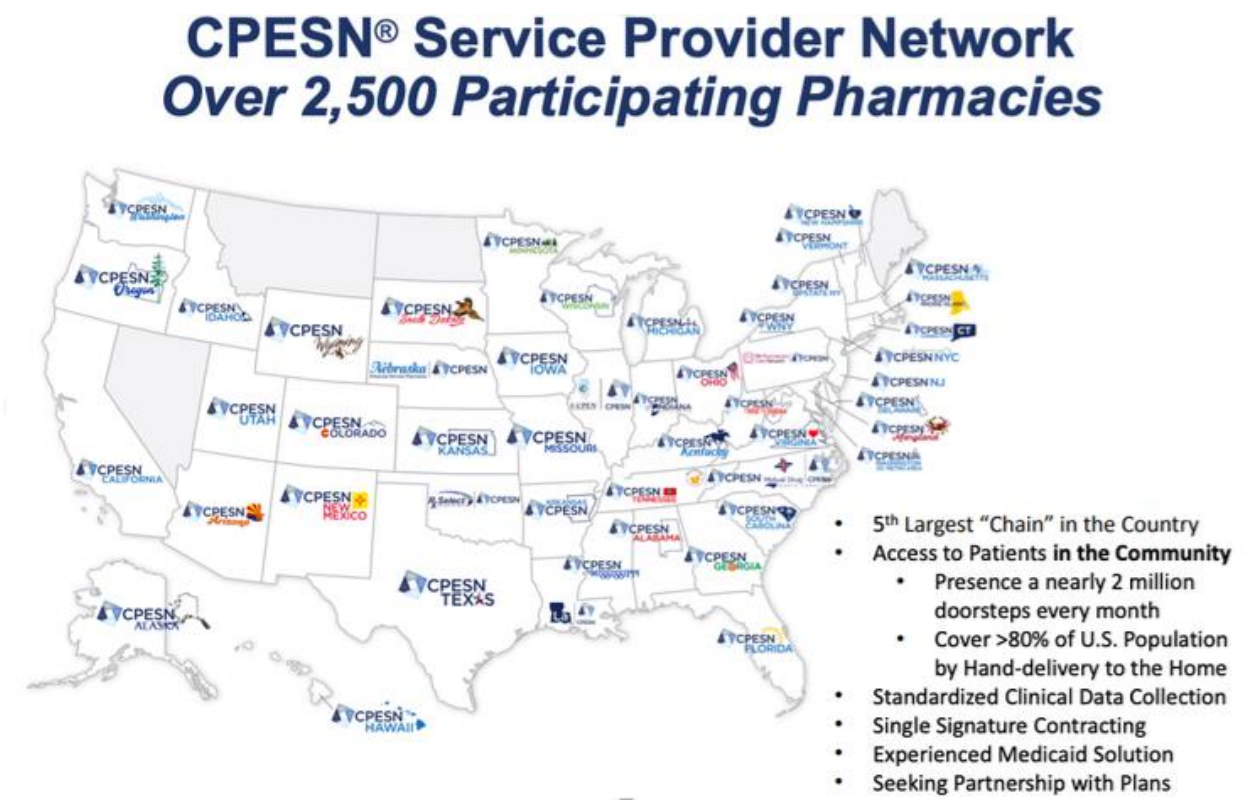
Presentation: Community pharmacy enhanced services network.

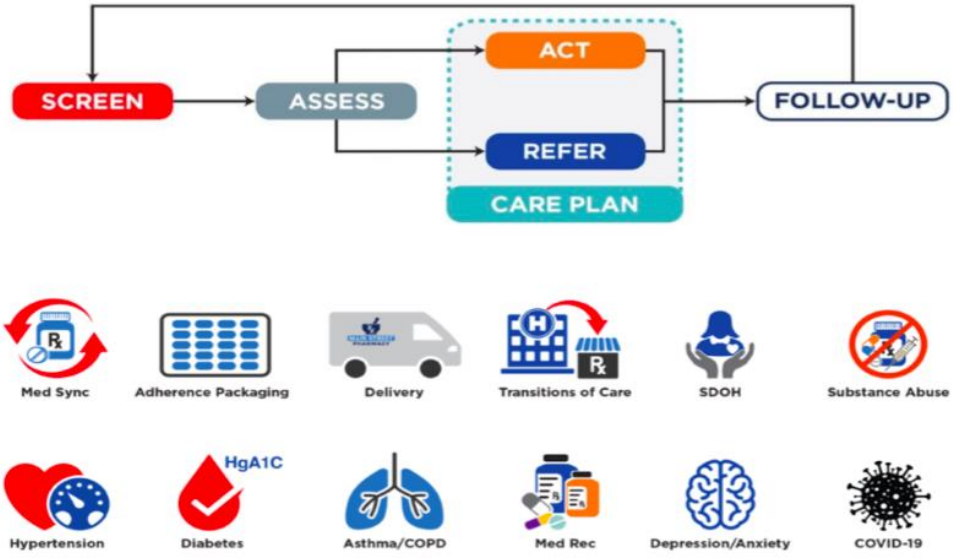


The pharmacies aggregated as community pharmacies because they are very different, and have different local impacts in their communities. They act as an accountable pharmacy organization.

They aggregate around service delivery. They found the standard community pharmacy addresses the needs of high-risk patients 35 times a year.

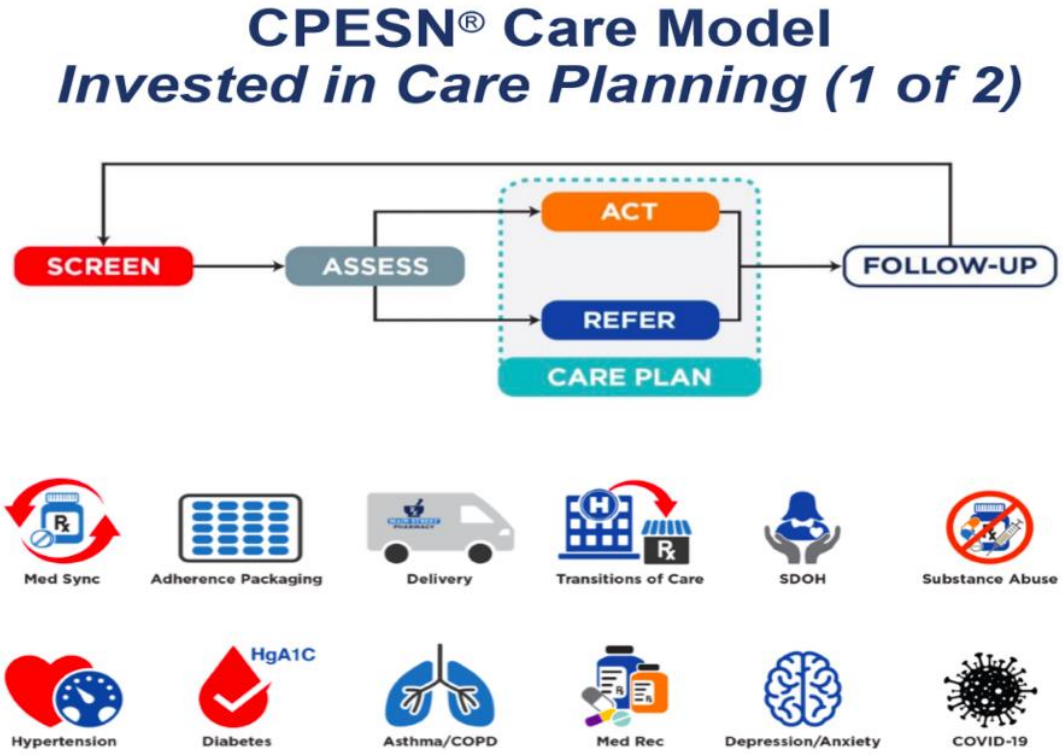
CPESN® Service Provider Network
Excels in Maximizing Regular Touchpoints

CPESN® Care Model
Invested in Care Planning

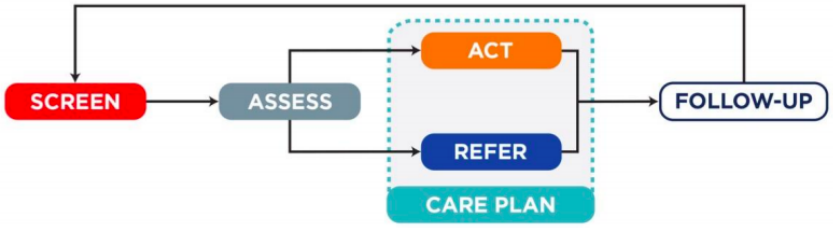


Many deliverables have been standardized. They are doing COVID-19 testing, COPD treatments and more. The care model is built around care planning involving chronic

conditions. They pride themselves on follow-up, including food insecurity issues and medications compliance issues.



CPESN® Care Model
Invested in Care Planning (2 of 2)



Asthma Screenings
Cancer Screenings & Referrals
Community Health Workers
Community Resource Tables
Depression Screenings
Food Insecurity Screenings
Home Assessments
Immunization Screenings/Referrals
LOCAL Care Coordination
LOCAL Support Group Referrals
Medicaid Eligibility Support
Medication Optimization
OOP Cost Reduction Services
Pediatric Asthma Supports
SDoH Screenings
Self Monitoring Blood Pressure
Transportation Support (transit)
WIC Screenings & Referrals

Questions/Answers/Comments

It's hard for MCOs to address a circumstance where there are only a few patients going to a pharmacy. The speaker stated that there is a health plan handing off the high-risk patients to these community pharmacies. The attribution that is given to a pharmacy is where the prescription is filled. These pharmacies engage the patients with the necessary services. Coverage in a rural area can be an issue.

This could require a pilot in Texas.

This is advanced community paramedicine conducted by pharmacies. Do you partner with other paramedicine programs? The speaker stated that they do. All members are imbedded in their individual communities.

Are you worried about mail order options? The speaker stated that there has been a push towards mail order on the product side, but on the service side there is a local need.

Can you compete on price because of the pharmacies coming together? The speaker stated that there is a lot of effort around cost to employer, but pricing is done at the individual pharmacy.

There are 115 Texas pharmacies participating in the local network. They service about 70 percent of the geography.

2020 Legislative Report. For detail on each item click on the link below. The detail provides background as well as edited information.

Workgroup 1: Maternal and newborn care measures

The following recommendations would enable better informed maternal and newborn health interventions as well as enable more uniform and meaningful performance measurement:

1.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 DSHS, HHSC, and other relevant advisory committees and collaboratives to establish a statewide endorsement informed by regional needs

2. 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.

Comments.

Collaborative models improve care; this should be included in the background information.

Anchor role in transitioning DSRIP should be added in background.

Workgroup 2: Leveraging multi-payer data

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

a) Extending the term of the 10.06 rider for cross-agency collaboration for another five years, maintaining the services of the UT Data Center.

b) 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.

c) 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.

d) Adding additional sources of data to the UT Data Center – State leadership should explore 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.

e) 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).
f) 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.
g) 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.
h) Exploring federal funding opportunities, such as those offered by the Center for Medicare & Medicaid Innovation, that advance value-based payment (VBP) and that are enabled by access to multi-payer data.

2. 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.
Comments.

Should we have one main data source? That would be worthy of exploration.

We need a clinical component as part of data interpretation.

The costs of collecting the data remain an issue, and the focus should be on how it improves care.

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

The VBPQI Committee supports alignment of SDOH activities with quality and value-based improvement goals, including promoting learning and identification of best practices within Medicaid managed care through the following:

The Committee recommends 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 should assess whether a state-level or regional tool(s) and/or platform(s) would better enable Texas Medicaid to address SDOH.

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- Based on the landscape analysis, the Committee recommends that HHSC 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.

The Committee recommends that HHSC 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 or waiver applications.
- Reviewing opportunities in 1115 waivers, such as the DSRIP transition.

Comments: None offered.

Workgroup 4: Advancing alternative payment models in Medicaid

1.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
- 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

2. 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. 3. Leverage findings from the DSRIP Best Practices Workgroup and 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 alternative payment models. 4. 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.

Comments.
There is administrative burden created by the required metrics. Standardization would simplify things.

CMS is setting up an ACO program in which local rural providers can participate for the background information.

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

- HHSC 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.
- HHSC 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.
- Texas 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.
- HHSC 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.

Comments.
COVID-19 crossed all the workgroups.

Long-term, the independent provider (small group) will not exist in the future and COVID-19 has sped this up. We have to look at how to keep providers in Texas.

Public Comment.

Matt Ferrara, Private Healthcare Consultant, made the following points:

- Focus should be on the strategies that tie money to value
- APM contracts are the starting point and the recommendations in the Workgroup #4 document are consistent with his thinking
- There is opportunity to improve quality and save money
- For populations with complex needs, there should be a more global approach

- There is a need to define metrics that define value

Written Comment was submitted from 3M and is summarized below

- Texas uses the 3M as an alternative payment model
- Providers and health pans commented that there is a lack of understanding about the methodology
- Because of APMs that do leverage PPRs and PPMs, there might be less incentive to change models
- 3M indicated a willingness to engage with Texas stakeholders

MOTION: *Grant the authority to the chair and vice chair to submit the recommendations in a letter on behalf of the committee - prevailed*.

Legislative Report planning and timeline

- 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

Action items for staff and/or member follow-up

- Include more background information as mentioned above
- Finalize the report
- Schedule a 3M meeting with the Council

Adjourn. The next meeting Tuesday November 10th. There being no further business, the meeting was adjourned.

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