Value-Based Payment and Quality Improvement Advisory Committee

February 15, 2022

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 Value-Based Payment and Quality Improvement Advisory Committee (Quality 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. It was established in accordance with Texas Government Code §531.012.
For more information on Health and Human Services Value-Based Payment Initiative, visit the Value Based Care page.

The Quality Committee studies and makes recommendations regarding:

- Value-based payment and quality improvement initiatives to promote better care, better outcomes, and lower costs for publicly funded health care services.
- Core metrics and a data analytics framework to support value-based purchasing and quality improvement in Medicaid/CHIP.
- HHSC and managed care organization incentive and disincentive programs based on value.
- The strategic direction for Medicaid/CHIP value-based programs.

The Quality Committee also pursues other deliverables consistent with its purpose to improve quality and efficiency in state health care services, as requested by the HHSC executive commissioner or adopted into its work plan or bylaws.
By December 1 of each even-numbered year, the committee submits a written report to the executive commissioner and Texas Legislature that:

- Describes current trends and identifies best practices in health care for value-based payment and quality improvement
- Provides recommendations consistent with the purposes of the Quality Committee

Members include:

- Dana Danaher, Austin
- Frank Dominguez, El Paso
- Cliff Fullerton MD, Dallas
- Adam M. Garrett, Lewisville
- Beverly Hardy-Decuir, DNP, Dallas
- Carol Huber, San Antonio
- Janet Hurley, Whitehouse
- Daverick Isaac, Austin
- Andy Keller, PhD, Dallas
- Kathy Lee, Gatesville
- Melissa Matlock, Canyon
- Mary Dale Peterson, MD, **Chair**, Corpus Christi
- Alejandro Posada, Houston
- Joseph Ramon III, R.Ph., McAllen
- Michael Stanley, MD, Dallas
- Vincent Sowell, Kenedy

Ex Officio Representatives

- Mark Chassay, Fort Worth
- Lisa C. Kirsch, Austin

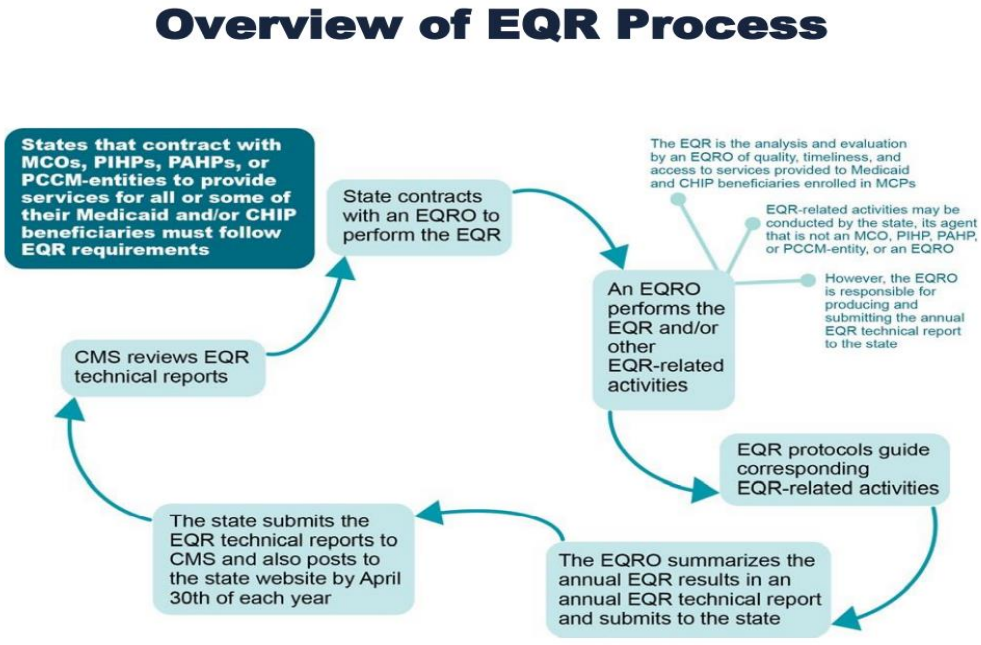
- Benjamin, McNabb, Pharm. D., Eastland
- Binita Patel, Houston
- Rachana Patwa, Missouri City
- Shayna Spurlin, College Station

Bylaws: Value-Based Payment Quality Improvement Advisory Committee (PDF)

1. Welcome and introductions
The meeting was convened by the Chair, Carol Huber. A quorum was established.

2. Consideration of November 9, 2021, draft meeting minutes
The minutes were approved as drafted.

3. Presentation: External Quality Review Organizations. External quality review (EQR) is one part of an interrelated set of quality requirements that apply to Medicaid managed care. The goal of EQR is to assess and monitor the quality of care provided to Medicaid and CHIP beneficiaries enrolled in MCPs and to identify opportunities for quality improvement. States contract with external quality review organizations (EQROs) for EQR. To qualify, EQROs must demonstrate capacity and expertise to do the work and satisfy conflict-of-interest protections. The Institute for Child Health Policy has been the EQRO for Texas Medicaid and CHIP since 2002.



Mandatory EQR Activities

- **Protocol 1** Validation of Performance Improvement Projects
- **Protocol 2** Validation of Performance Measures
- **Protocol 3** Review of Compliance with Medicaid and CHIP Managed Care Regulations
- **Protocol 4*** Validation of Network Adequacy

** CMS has not provided implementation guidelines for this protocol as of January 2022*

Optional EQR Activities

- **Protocol 5** Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plans
- **Protocol 6** Administration of Quality of Care Surveys
- **Protocol 7** Calculation of Additional Performance Measures
- **Protocol 8*** Implementation of Additional Performance Projects
- **Protocol 9** Conducting Focused Studies of Health Care Quality
- **Protocol 10**** Assist with Quality Rating of Medicaid and CHIP Managed Care Organizations

** HHSC does not contract with ICHP to conduct this activity.*

*** CMS has not provided implementation guidelines for this protocol as of January 2022*

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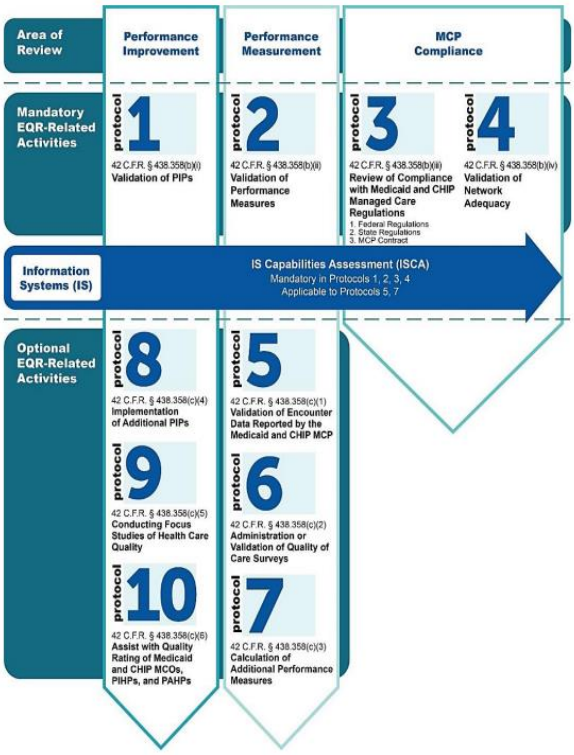
Overview of Relationship Between Protocols



Validation of Performance Improvement Projects (Protocol 1)

Overview -- States must require their Medicaid and CHIP MCOs and DMOs to conduct performance improvement projects (PIPs) that focus on both clinical and nonclinical areas each year as a part of the plan's quality assessment and performance improvement (QAPI) program.

Texas EQRO Activities

- Texas requires MCOs and DMOs to conduct PIPs over two years to provide sufficient time for project implementation and to increase the likelihood of reporting meaningful outcomes.
- Recent PIP topics include:
- prenatal and postnatal care, self-directed care, and potentially preventable emergency department visits for upper respiratory tract infection (2018),
- improving care for beneficiaries with complex needs (2019), and
- behavioral health, including integration of behavioral and physical health services (2020)

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Validation of Performance Measures (Protocol 2)
Overview

- This protocol guides the validation of the performance measures specified by states for inclusion in MCPs' QAPI programs.
- EQROs must assess whether the performance measures calculated by the MCOs/DMOs are accurate based on the measure specifications and state reporting requirements

Texas EQRO Activities

- Texas requires the MCOs and DMOs to (1) calculate quality measures determined by the state and submit the results, and (2) submit data allowing the state to calculate performance measures.
- The EQRO uses numerous strategies to assess information systems, processes, and data used in performance measure

Review of Compliance with Medicaid and CHIP Managed Care Regulations (Protocol 3)
Overview -- This protocol is used to determine the extent to which Medicaid and CHIP MCOs and DMOs are in compliance with federal standards.

Texas EQRO Activities

- The EQRO conducts two major review initiatives to fulfill protocol requirements:
- Administrative interviews for comprehensive assessment of MCO regulatory compliance
- QAPI evaluations to review quality improvement programs
- QAPI activities are an integral component linking the state managed care quality strategy with EQR activities

Relationship between EQR, the State Quality Strategy, and a QAPI program

Validation of Network Adequacy (Protocol 4)
Overview CMS has not released guidelines for this protocol as of January 2022.

EQRO Activities

The EQRO conducts several activities aimed at improving access to, and the timeliness of health services for Medicaid members:

- Assessing access and timeliness of MCO services as part of the compliance review process (AIs and QAPIs)
- Assessing MCO compliance with appointment wait time standards in behavioral health, prenatal care, primary care, and vision care through an annual study of appointment availability
- Assessing potential medical transportation needs through ongoing studies of non-emergency medical transportation services for Texas Medicaid me

Validation of Encounter Data Reported by MCOs/DMOs (Protocol 5)

Overview -- This protocol provides guidelines for assessing state requirements for encounter data submissions, reviewing MCO encounter data production capacity, analysis of encounter data accuracy and completeness, and review of medical/dental records for consistency with encounter data.

EQRO Activities

- Texas uses encounter data to determine capitation payment rates, assess and improve quality, and monitor program integrity. The state also can require corrective action plans for MCOs or DMOs not meeting minimum standards for data accuracy and completeness.
- EQRO activities related to encounter data validation include:
- An ongoing review of the encounter data submission system
- AI evaluation sections devoted to MCO encounter data production
- Annual certification of the quality of Texas Medicaid and CHIP based on guidance in Protocol 5
- Annual validation of encounter data for accuracy and completeness by comparing encounters to medical records

Administration of Quality of Care Surveys (Protocol 6)

Overview --This protocol provides broad guidance for administering and validating consumer or provider surveys.

EQRO Activities

- The EQRO conducts annual and biennial consumer quality of care surveys to measure the experiences and satisfaction of adult members and caregivers of child and adolescent members in Texas Medicaid and CHIP.

- The EQRO utilizes the most recent NCQA version of the CAHPS Health Plan Survey, CAHPS 5.0H
- All results, including results by MCO and national benchmarks, are available on the THLC portal

Calculation of Additional Performance Measures (Protocol 7)

Overview

- This protocol provides guidance for EQROs that want to calculate additional performance measures beyond those specified by the state for inclusion in QAPI programs.
- The EQRO should calculate measures in accordance with state specifications, and report results compared to established benchmarks and standards

EQRO Activities

- Texas contracts with the EQRO to conduct comprehensive quality of care (QOC) evaluations across all Medicaid programs.
- The EQRO maintains a monthly updated data warehouse that includes medical, dental, and pharmacy encounter extracts; enrollment extracts; and provider data.
- Each year Texas selects QOC measures from nationally recognized quality assessment programs

Focused Studies of Health Care Quality (Protocol 9)

Overview--This protocol provides guidelines and suggestions for conducting studies on specific quality improvement, administrative, legislative topics.

EQRO Activities

- Two in-depth focus studies per year
- Four in-depth reports per year
- Two or three shorter issue briefs
- Additional ad hoc reports based on HHSC needs

Assistance with Quality Rating of Medicaid and CHIP MCOs (Protocol 10)

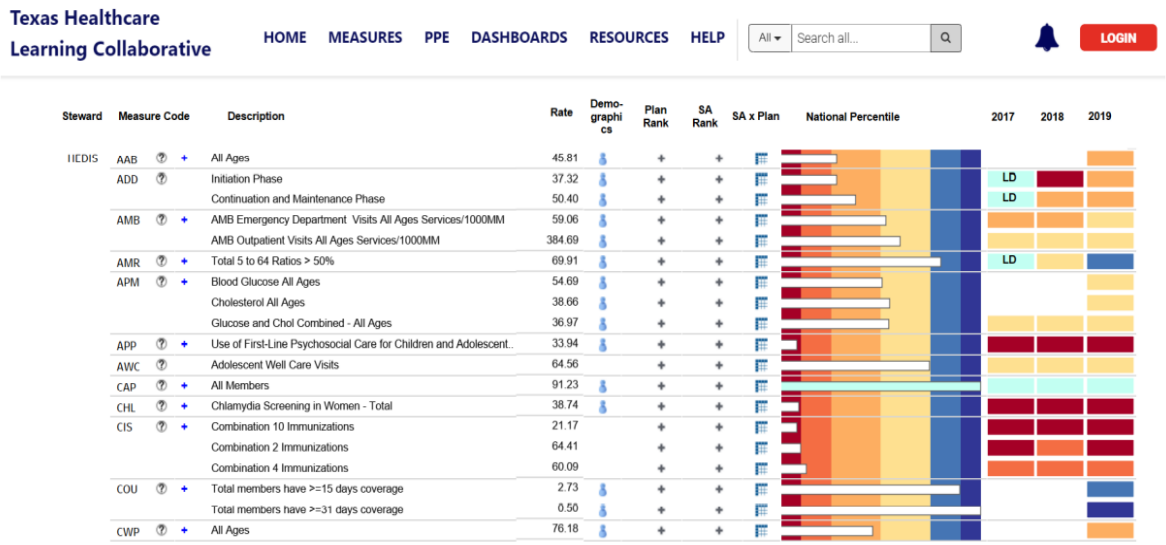
Overview-- CMS has not released guidance for this protocol as of January 2022

EQRO Activities

- Rankings and comparisons to benchmarks on the THLC portal,

- Performance Indicator Dashboard for Quality Measures
- Pay-For-Quality (P4Q) Performance Dashboard
- MCO Report Cards
- 62 unique report cards--one for each service area/program combination
- Produced in English and Spanish
- Available online and included in enrollment packets for new members

Texas Healthcare Learning Collaborative Portal



Steward	Measure Code	Description	Rate	Demographics	Plan Rank	SA Rank	SA x Plan	National Percentile	2017	2018	2019
HEDIS	AAB	All Ages	45.81								
	ADD	Initiation Phase	37.32						LD		
		Continuation and Maintenance Phase	50.40						LD		
	AMB	AMB Emergency Department Visits All Ages Services/1000MM	59.06								
		AMB Outpatient Visits All Ages Services/1000MM	384.69								
	AMR	Total 5 to 64 Ratios > 50%	69.91						LD		
	APM	Blood Glucose All Ages	54.69								
		Cholesterol All Ages	38.66								
		Glucose and Chol Combined - All Ages	36.97								
	APP	Use of First-Line Psychosocial Care for Children and Adolescent..	33.94								
	AWC	Adolescent Well Care Visits	64.56								
	CAP	All Members	91.23								
	CHL	Chlamydia Screening in Women - Total	38.74								
	CIS	Combination 10 Immunizations	21.17								
		Combination 2 Immunizations	64.41								
		Combination 4 Immunizations	60.09								
	COU	Total members have >=15 days coverage	2.73								
		Total members have >=31 days coverage	0.50								
	CWP	All Ages	76.18								

MCO Report Cards

HEALTH PLAN PERFORMANCE

Ratings are based on a scale of one to five stars. Fewer stars mean the health plan has lower performance than other health plans, but this does not always mean bad performance.

★★★★★ Highest Performance in STAR+PLUS
★★★★
★★★
★★
★ Lowest Performance in STAR+PLUS

	First MCO alphabetically	Second MCO alphabetically	Third MCO alphabetically
Overall Health Plan Quality	★★	★	★★★
Experience of Care	★★★	★	★★★
People get care, tests and treatment easily	★	★★★	★★★
Doctors listen carefully, explain clearly and spend enough time with people	★★★★★	★★★	★★★
People give high ratings to their personal doctor	★★★	★★★	★★★
People give high ratings to the health plan	★★	★	★★★
Staying healthy	★★	★	★★★
People get regular yearly checkups	★★★	★	★★★★
Women get regular screenings for breast and cervical cancer	★★	★	★★★
Common Chronic Conditions	★★★	★	★★★
People get care for depression and constant low mood	★★	★★	★★★
Doctors follow up after urgent treatment for alcohol, opioid or other drug use	★★★	★★★	★★★
Doctors follow up after urgent treatment for mental illness	★★★	★	★★★
People get tests and treatment for COPD (Chronic Obstructive Pulmonary Disease)	★★★	★	★★★
People get care for diabetes	★★★	★	★

[1] If a plan shows "No rating": this is not a bad rating.
At the time of the study, the plan either: (1) was new to the area or (2) did not have enough information to rate.

TEXAS

Key VBPQIAC Policy Issues in 2020

- Maternal and Newborn Care
- Leveraging Multi-Payer Data
- Social Drivers of Health
- Advancing Alternative Payment Models in Medicaid
- Lessons Learned from COVID-19

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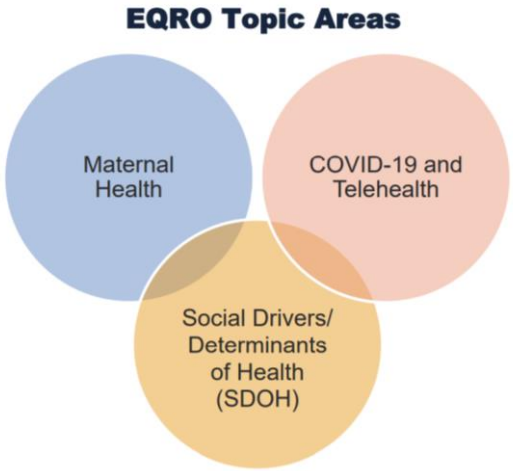


Maternal Health Focus areas

- Identifying measures for assessing and the quality of care that mothers receive under Medicaid and CHIP
- Continuity of care across the prenatal period, delivery, and postpartum period
- Identifying potential ways to reduce the cost of maternal care while also improving health care quality for members

Prior Work on Maternal Health

- Partnered with HHSC in a CMS Medicaid Innovation Accelerator Program addressing maternal mortality and severe maternal morbidity.
- Developed a C-section measure that aligned with national standards and could be calculated using only administrative data and categorize deliveries based on the presence or absence of complications.
- Produced several reports and issue briefs based on finding from maternal health studies:
- Using AIM measures to assess maternal morbidity among women in Medicaid
- Identifying and assessing the quality of care for women with high-risk pregnancies
- Developing a personalized quality of care index for maternal health
- Health teleservices for prenatal and postpartum care
- Trends in alternative payment models for increasing access to patient-centered maternal care

Maternal Health Work in SFY 2022

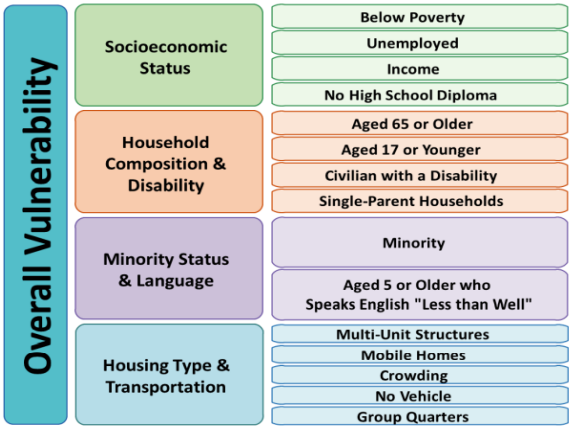
- Continuing to work with HHSC on identifying and refining measures for assessing maternal health and quality of care
- Upcoming studies:
- Midwife-assisted deliveries among women in Texas Medicaid
- Report on social determinants of health and postpartum care during the COVID public health emergency

- Webinar on maternal health

Social Drivers/Social Determinants of Health (SDoH)

Focus areas

- Identifying tools and measures for identifying social drivers and assessing their contribution to health disparities
- Identifying information that MCOs already collect which may also provide information on socioeconomic variables associated with health/healthcare disparities
- Identifying differences in the social drivers that affect quality, access, and timeliness of care across Texas Medicaid programs



Prior Work on SDOH -- Several reports on findings from SDoH studies:

- SDoH and Asthma, Type 2 Diabetes, and ADHD among children in Texas Medicaid (2019)
- Equity and SDoH of teleservices utilization and quality of care among Medicaid members before and during the onset of the COVID-19 pandemic (2021)
- How Texas MCOs are documenting and addressing SDoH (with UTHealth) (2020)
- SDoH impact on health care quality measures in CHIP and STAR/STAR Kids/STAR Health (with UTHealth) (2020)

SDOH Work in SFY 2022

- Continuing to work with HHSC on ways to assess SDoH and report health disparities among Medicaid and CHIP members
- Upcoming studies
- Health Disparities in Texas Medicaid Managed Care Programs in the context of SDoH
- SDoH and postpartum care utilization during the COVID public health emergency
- Webinar on SDoH

Concluding Points

- Effective implementation of the EQR-related activities helps facilitate state efforts to purchase high-value care (rather than volume) and to achieve higher performing health care delivery systems for their Medicaid and CHIP beneficiaries.
- ICHP has a long history of working with Texas, which has enabled the EQRO to build the capacity and infrastructure necessary to handle the complexities of ERQ for Texas Medicaid and CHIP.

- The EQRO is looking forwards to continued collaboration with HHSC and its stakeholders on efforts to improve the quality and efficiency of care for Texas Medicaid and CHIP members

Questions/Answers/Comments

How are the optional EQRO activities funded? A: The contract is a set contract, and all activities are covered in the contract. HHSC would be a good entity to answer this question.

Do we have any data that shows the protocols have reduced costs and improved outcomes? A: The dashboard with trends over time shows the improvement in care.

Do we have outcome data for inpatient care including newborn care? A: Looking at ED utilization and other similar measures will show inpatient care. There are focus studies that include NICU, but we do not have newborn care.

4. Presentation: Durable Medical Equipment Value Based Model for Home Medical Equipment Providers, Services and Supplies

How can we work effectively together to affect Clinical Outcomes?

- Payor, provider, and patient collaboration (as identified in the Texas Healthcare Learning Collaborative – THLC Learning Collaborative) in establishing benchmark data to understand how we determine clinical outcomes.
- Reducing the amount of time, a patient must spend in the hospital during an acute illness event or removing altogether the need to be admitted to the hospital.
- Facilitating prior authorization and incorporating patient discharge planning efficiencies.
- Collaboration between payor and DME provider involve in-flexibility in providing reimbursement for low-cost emergency backup supplies that could prevent an adverse event.

Cost and Impact - COPD Patients/Pulmonary Edema & Respiratory Failure

- Hospital Data shows readmission rates of 21% for Patients with COPD/pulmonary edema & respiratory failure as Primary Diagnosis
- Secondary Diagnosis readmission rates of 8%
- Tertiary Diagnosis readmission rates of 2%
- Other Respiratory Diagnosis showed readmission rates of 21%
- Average cost per Acute Admission - $17,410
- Average cost per Emergency Department Visit - $2,350
- Average cost per Observation Visit - $3,949

Cost and Impact - Enteral Patients Pediatric Costs of Hospitalization Stay

- Endocrine, Nutritional and Metabolic $9,000/case
- Digestive System $12,600/case Source: Costs of Pediatric Hospital Stays, Moore, Freemen & Jiang

Adult Costs – One Year of Feeding via PEG

- $31,832 (Median $12,227)
    - Percentage of Cost for Enteral Formula 24.9%
    - Percentage of Cost for PEG Procedure 29.4%
    - Percentage of Cost due to Complications 33.4%

Providing Services to Improve Patient Outcomes leads to Cost Savings

- Back-up G-Button for high acuity patients
    - Backup G-Button (HCPCS B9998 U2) reimbursement at 100% of Fee-for-Service = $138
    - Eliminates need for surgical reinsertion because of failed or damaged button
    - 35% of problematic G-Button issues are admitted - average cost feeding tube replacement National average (PEG) $3000 to $6000
    - Value to Texas Medicaid Program – cost of ER visit and Hospital Readmission Source: https://www.mdsave.com/procedures/feeding-tube-placement-peg/d784ffce and https://avanosmedicaldevices.com/wp-content/uploads/2021/07/2021-Reimbursement-Reference-Guide-G-J-Placement-Procedures-COPY-05432.pdf
- Emergency Back-up Bags for high acuity ventilator patient
    - Back-up Emergency Bags Cost = $335.27
    - Eliminates need for emergency service and extra risk associated with ER visits or possible hospital readmission
    - Value to Texas Medicaid Program – cost of ER visit and Hospital Readmission
- Backup battery power supplies as identified by the Governor's Texas Durable Medical Equipment Task Force

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Ventilator Emergency Backup Supplies Value

Ventilator Emergency Backup Bag
$335

-VS-

Emergency Room Visit
$2,350
and/or
Acute Hospital Admission
$17,410

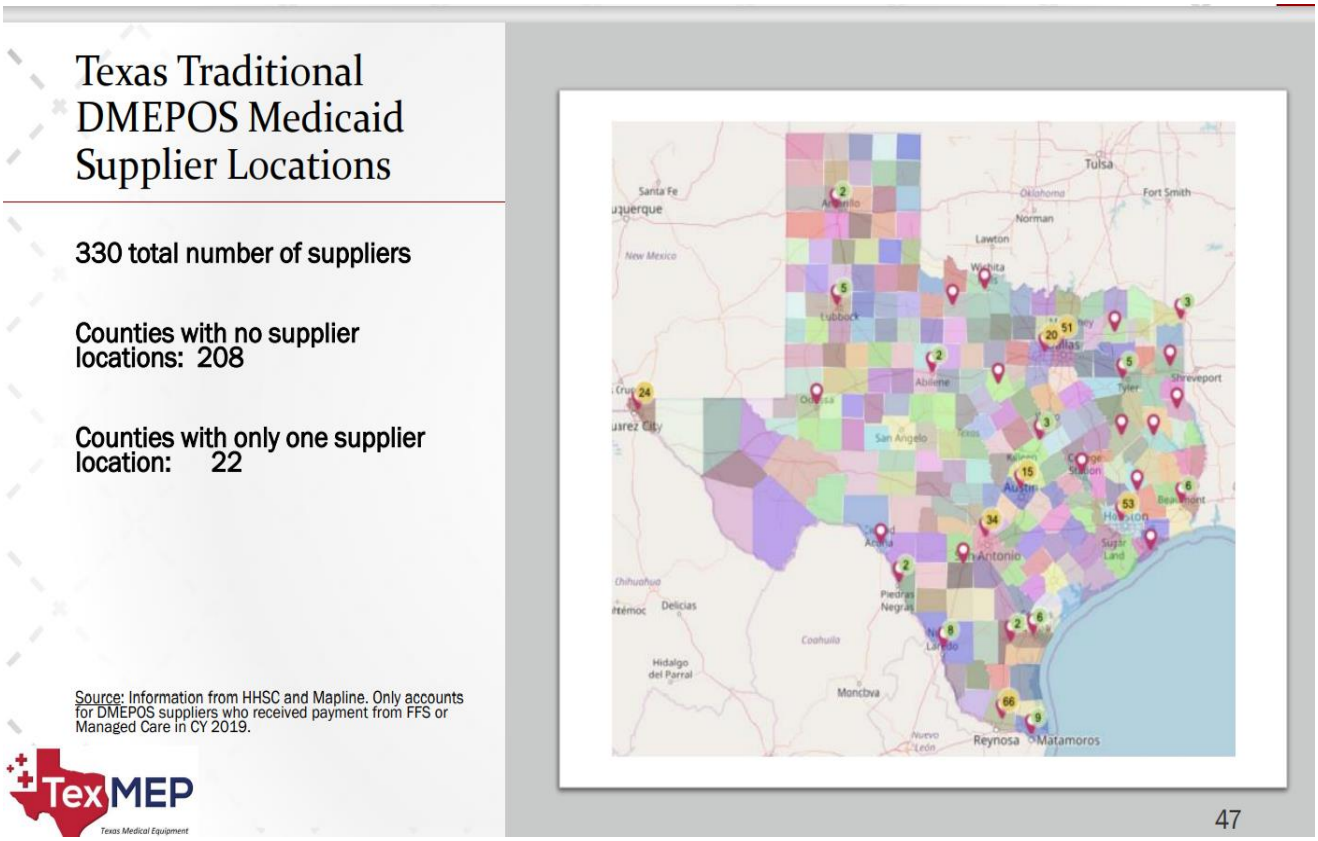
2022 Cost of Goods - Ventilator Patient Emergency Backup Bag	Cost per Item	Avg Cost
RHF605U TRACH BACTERIAL FILTER HUDSON RCI EA	$0.83	$83.00
3 most common Vent Circuits		
1073224 VENT TRILOGY CIRCUIT PEDI W/ H2O TRAP	$17.80	
1073225 VENT TRILOGY CIRCUIT PEDI PASS HEAT WIRE	$17.50	
1069443 VENT TRILOGY CIRCUIT ADULT PASS H2O TRAP	$9.00	
Total Avg by product used		$14.77
2 most common Omniflex		
3215 TRACH OMNI FLEX PEDI ISOTHERMAL CONN	$1.29	
3222 TRACH OMNI FLEX ADULT ISOTHERMAL CONN	$0.79	
Total Avg by Product Used		$1.04
1642 TRACH PRESSURE LINE ADAPTER EA	$0.51	
2329 OXIMETER MASIMO PROBE NEO FOOT/ADULT	$10.95	
2055 OXIMETER MASIMO 4' PATIENT CABLE LNC-04	$140.00	
Total by Product Used	$151.46	$151.46
2 most common Vent Probes		
$72.00 - 900MR569 VENT TEMP PROBE WIRE FOR HC500	$72.00	
$98.00 - 900MR869 VENT TEMP PROBE RT ANGLE FOR 550 & 850	$98.00	
Total Avg by Product Used		$85.00
Average Cost	**Total**	**$335.27**

TexMEP Texas Medical Equipment Providers Association

Source: *Average wholesale cost of Ventilator Supplies sourced by patient need, National DME Respiratory Providers, January 2022*

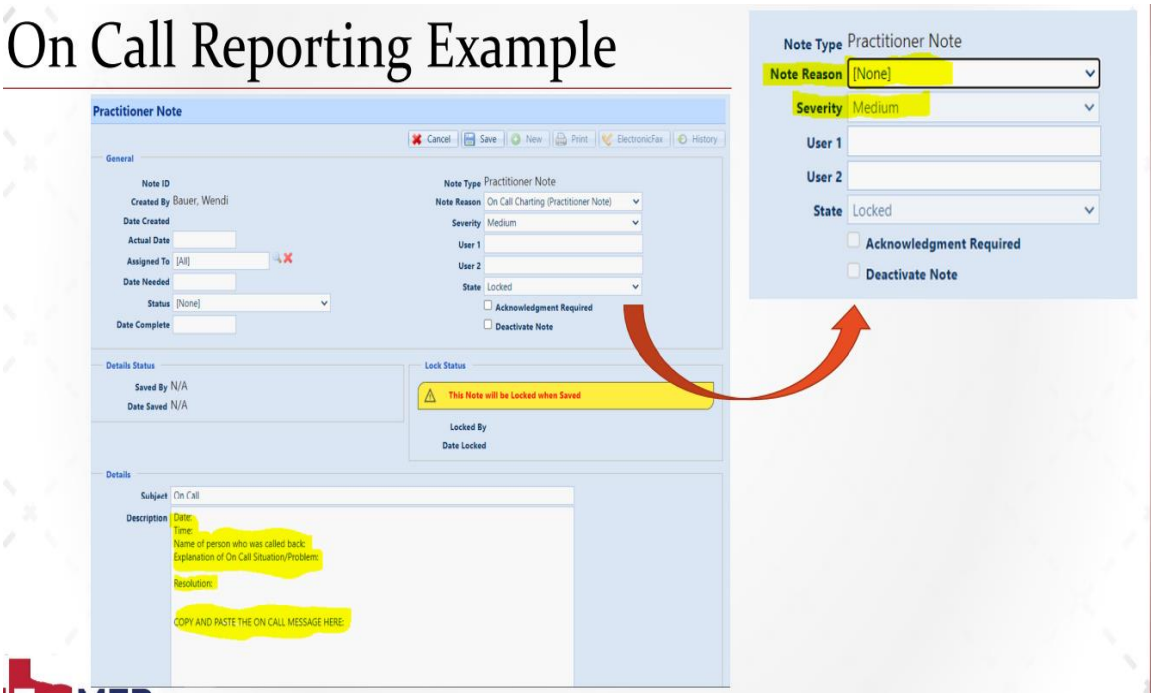
Solutions

- Increase reimbursement for Home Health equal to institutional care
- Collaborative Work
  - Reduce Administrative Burden
  - Improve Discharge Process
  - Improve Access
  - 24-hour medical reporting



On-Call Reporting Severity Definitions

- Critical Ventilator goes down and the patient has no back up ventilator. GButton becomes dislodged or mispositioning issue. Typically, a concern for Emergency Services Call and/or Hospitalization.
- High Ventilator issue (Circuit issues, alarm issues), Oxygen concentrator, suction machines, & feeding pumps. Dependent on the patient acuity level. Repair equipment at no charge or replace at no charge.
- Medium Pulse Oximeter issues, formula, IPV, Cough Assist, & heaters. Pulse Oximeter will depend on patient acuity level.
- Low Supply issues.



Questions/Answers/Comments

The paucity of providers in counties is important and a question is raised why Hidalgo County has more providers than Harris County. There is a need for duplication of life saving technology and equipment.

5. Staff update: Medicaid value-based activities

Projects covered in this report:

- Annual Report on Quality Measures and ValueBased Payments
- Alternative Payment Model: Revisions to contract and manual requirements
- STAR+PLUS Pilot Program

Annual Report on Quality Measures and ValueBased Payments Texas Government Code, Section 536.008, directs the Health and Human Services Commission to report annually on its efforts to develop quality measures and value-based payment initiatives. This annual report presents information on HHSC's healthcare quality improvement activities for the Texas Medicaid program and the Children's Health Insurance Program. It provides historical and current information on:

- Managed care value-based payment programs

- 1115 Healthcare Transformation Waiver
- Directed payment programs
- Trends in key quality measures

Content

- Managed Care Value-Based Payments Programs
- Pay-for-Quality Program • Alternative Payment Model Requirements for MCOs
- Hospital Quality-Based Payment Program
- Medicaid Value-Based Enrollment
- 1115 Healthcare Transformation Waiver
- Delivery System Reform Incentive Payment (DSRIP) Program
- Directed Payment Programs
- Nursing Home Quality Incentive Payment Program (QIPP)
- Uniform Hospital Rate Increase Program (UHRIP)
- Trends in Key Quality Measures
- Trends in Potentially Preventable Events, 2014-2010
- Performance Indicator Dashboard; HIV Viral Load Suppression; Relocation to a Community-Based Setting

Medical Pay-for-Quality (P4Q) Program

Background

- MCO Premiums at Risk (3% MCO)
- MCO performance is evaluated in three ways:
    1. Performance against self (comparison of an MCO's performance to its prior year performance)
    2. Performance against benchmarks (comparison of an MCO's performance against Texas and national peers)
    3. Bonus pool measures
- Each program (STAR, STAR+PLUS, STAR Kids, CHIP) includes measures specific to the population

Pay-for-Quality (P4Q) Program | Texas Health and Human Services

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At-Risk Measures for the Medical P4Q Program

Measures	STAR+PLUS	STAR	STAR Kids	CHIP
Potentially Preventable Emergency Room Visits (PPVs)	2018 2019 2022 2023	2018 2019 2022 2023	2022 2023	2018 2019 2022 2023
Potentially Preventable Admissions (PPAs)		2022 2023		
Potentially Preventable Readmissions (PPRs)	2022 2023			
Appropriate Treatment for Children with Upper Respiratory Infection (URI)		2018 2019		2018 2019 2022 2023
Prenatal and Postpartum Care (PPC)		2018 2022 2023		
Well Child Visits in the First 30 months of Life (W30), First 15 Months of Life		2018 2019		
Diabetes Control - HbA1c < 8% (CDC)	2018 2019 2022 2023			
Diabetes Screening for Members with Schizophrenia or Bipolar Disorder Who are Using Antipsychotics (SSD)	2018 2019			
Assistance with Care Coordination			2022 2023	
Cervical Cancer Screening (CCS)	2018 2019 2022 2023			
Child and Adolescent Well-Care Visits (WCV), 12-21 years of age				2018 2019
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (WCC)				2018 2019 2022 2023
Follow-up After Hospitalization for Mental Illness (FUH)	2022 2023		2022 2023	
Childhood Immunization Status (CIS) Combination 10		2022 2023		2022 2023
Follow-up Care for Children Prescribed ADHD Medication (ADD)		2022 2023		
Getting Specialized Services Composite			**2022 2023**	

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Bonus Pool Measures for the Medical P4Q Program

Bonus Pool Measures	STAR+ PLUS	STAR	STAR Kids	CHIP
Potentially Preventable Readmissions (PPR)	2018 2019			
Potentially Preventable Admissions (PPA)		2018 2019		
Prevention Quality Indicator (PQI) Composite	2018 2019 2022 2023			
Potentially Preventable Complications (PPC)	2018 2019 2022 2023			
Follow-up Care for Children Prescribed ADHD Medication (ADD) - Initiation Sub-measure			2022 2023	
Low Birth Weight		2018 2019 2022 2023		
Childhood Immunization Status (CIS) Combination 10				2018 2019
Immunizations for Adolescents (IMA) Combination 2				2022 2023
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM) - Glucose and Cholesterol Combined, All Ages		2022 2023		
Chlamydia Screening in Women (CHL)		2022 2023		
Cesarean Sections, uncomplicated deliveries		2022 2023		
Risk of Continued Opioid Use, Total members have >=15 days coverage	2022 2023			
Adherence to Antipsychotic Medications for Individuals with Schizophrenia, 80% Coverage	2022 2023			
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics			2022 2023	
Breast Cancer Screening, Non-Medicare Total	2022 2023			
Appropriate Treatment for Children with Upper Respiratory Infection (URI) – All Ages			2022 2023	

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Bonus Pool Measures	STAR+ PLUS	STAR	STAR Kids	CHIP
Pregnancy-Associated Outcomes		2022 2023		
Good Access to Urgent Care	2018 2019	2018 2019		2018 2019
Rating Health Plan a 9 or 10	2018 2019	2018 2019		2018 2019
Rating Their Child's Personal Doctor, a 9 or 10				2022 2023
Getting Care Quickly Composite				2022 2023
Transition to Care as an Adult			2022 2023	
Access to Routine Care, adult survey		2022 2023		
How well doctors communicate composite				2022 2023

Value-Based Enrollment (VBE)

Implemented September 1, 2020.

How it works

MCOs with better performance than others on the factors listed below receive a higher share of default enrollments (Medicaid recipients that do not choose a health plan) than under the previous methodology.

Criteria and Weighting

40% **Cost and Efficiency** *Risk-Adjusted Ratio of Actual to Expected Spending* X **20%** **Cost and Quality** *Risk-Adjusted Potentially Preventable Events (PPE) Ratios* X **40%** **Quality and Member Satisfaction** *Composite MCO Report Card Scores*

[Value-Based Enrollment Incentive Program Report - 2021 | Texas Health and Human Services]

After implementation, HHSC assessed the effect of the VBE process based on six months of enrollment data for STAR, STAR+PLUS, and STAR Kids. For 17 participating MCOs across the programs from December 2020 to May 2021:

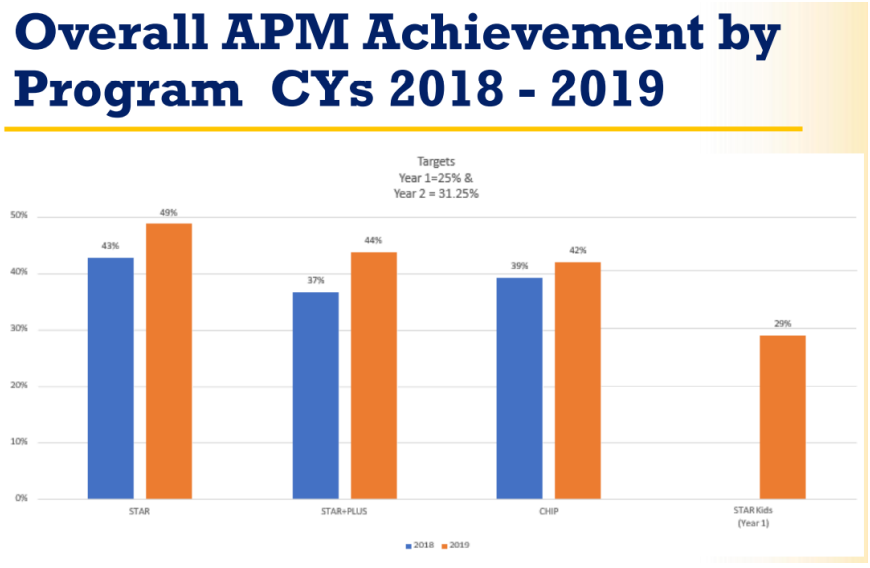
- Five plans gained greater than 2.5 percent in autoenrollments compared to the previous process
- Five plans lost at least 2.5 percent

- Seven plans saw changes of no greater than 2.5 percent
- Overall enrollment based on the new methodology varied between over 12 percent gains to almost 12 percent losses in cumulative proportions across the programs

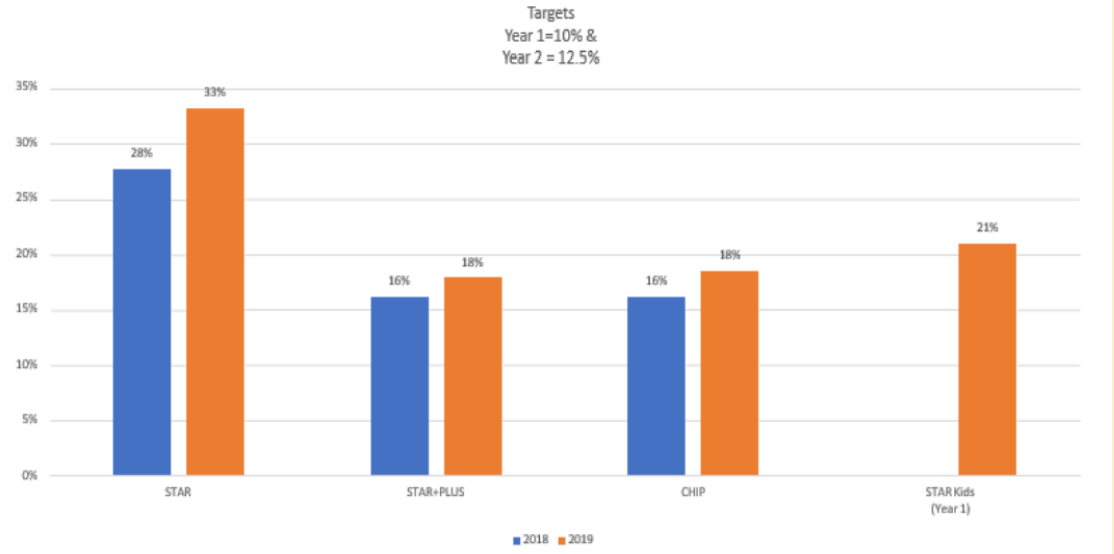
Alternative Payment Model Requirements for MCOs*

CATEGORY 1: FEE FOR SERVICE – NO LINK TO QUALITY & VALUE	CATEGORY 2: FEE FOR SERVICE – LINK TO QUALITY & VALUE	CATEGORY 3: APMs BUILT ON FEE-FOR-SERVICE ARCHITECTURE	CATEGORY 4: POPULATION- BASED PAYMENT
	CATEGORY 2A: Foundational Payments for Infrastructure & Operations (e.g. care coordination fees and payments for HIT investments)	**CATEGORY 3A: APMs with Shared Savings** (e.g. shared savings with upside risk only)	**CATEGORY 4A: Condition-Specific Population-Based Payment** (e.g. per member per month payments for specialty services, such as oncology or mental health)
	Category 2B: Pay for Reporting (e.g. bonuses for reporting data or penalties for not reporting data)	**Category 3B: APMs with Shared Savings and Downside Risk** (e.g. episode-based payments for procedures and comprehensive payments with upside and downside risk)	**Category 4B: Comprehensive Population-Based Payment** (e.g. global budgets or full/percent of premium payments)
	Category 2C: Pay for Performance (e.g. bonuses for quality performance)		**Category 4C: Integrated Finance & Delivery Systems** (e.g. global budgets or full/percent of premium payments in integrated systems)
		3N: Risk Based Payments NOT Linked to Quality	**4N: Capitated Payments NOT Linked to Quality**

* Healthcare Payment Learning and Action Network Alternative Payment Model Framework (available at: http://hcp-lan.org/workproducts/apm-framework- onepager.pdf)



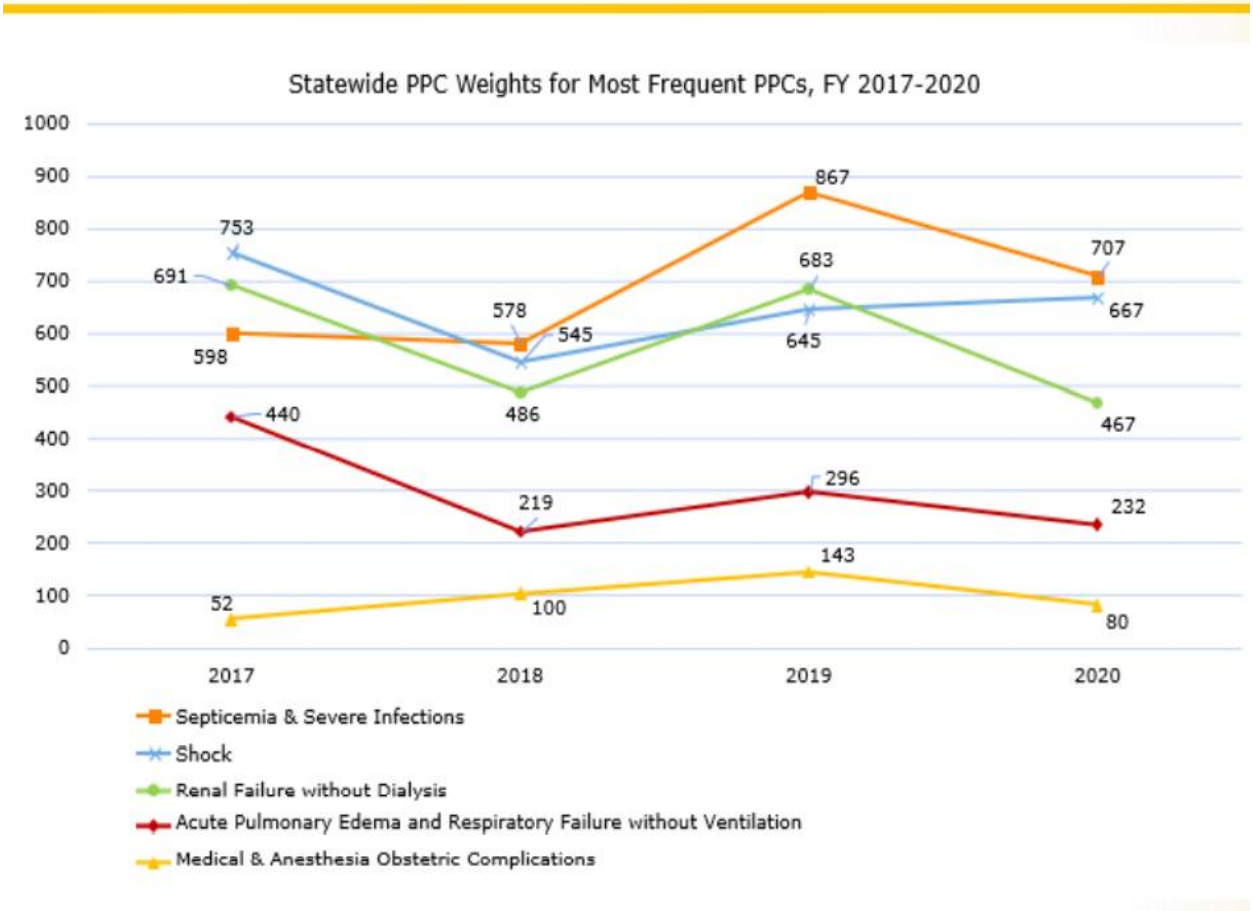
Risk-Based APM Achievement by Program CYs 2018 - 2019



Hospital Quality-Based Payment Program (HQBP)

- HHSC administers the HQBP Program for all hospitals in Medicaid and CHIP in the managed care and FFS delivery systems.
- Hospitals are measured on their performance for risk-adjusted rates of potentially preventable hospital readmissions within 15 days of discharge (PPR) and potentially preventable inpatient hospital complications (PPC) across all Medicaid Programs and CHIP, as these measures have been determined to be reasonably within hospitals' ability to improve.
- Hospitals can experience reductions to their payments for inpatient stays:
- up to 2 percent for high rates of PPRs
- 2.5 percent for PPCs
- Measurement, reporting and application of payment adjustments occur on an annual cycle.

Changes in Hospital PPC Performance for 2017- 2020



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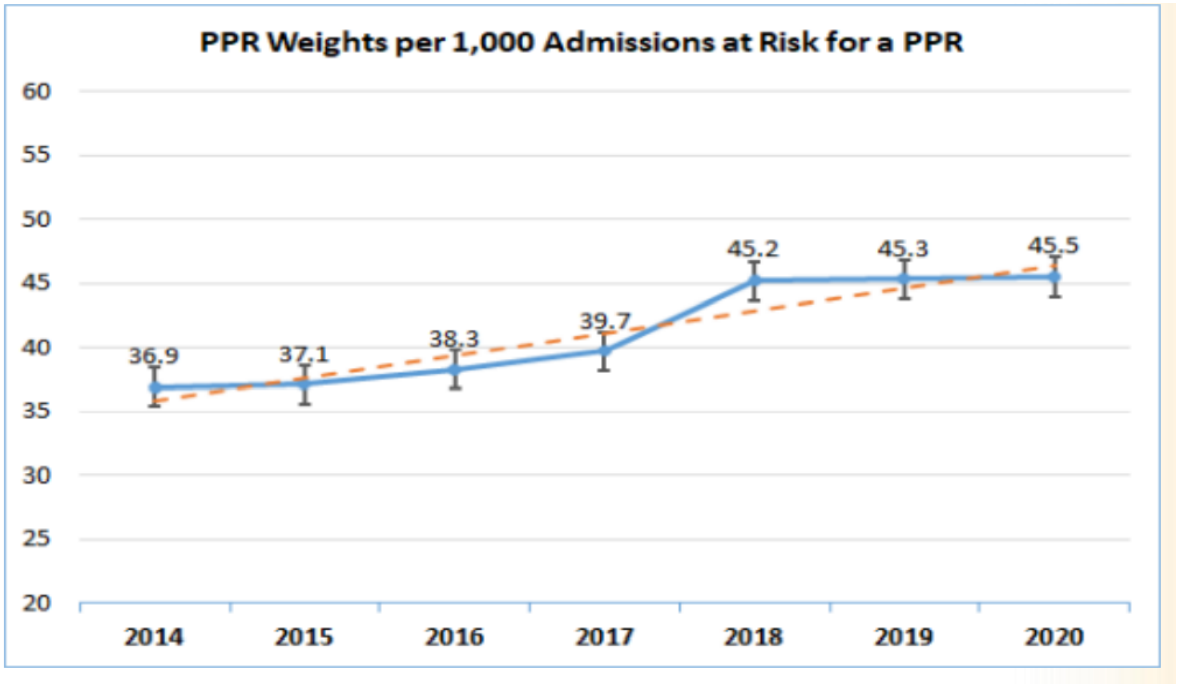
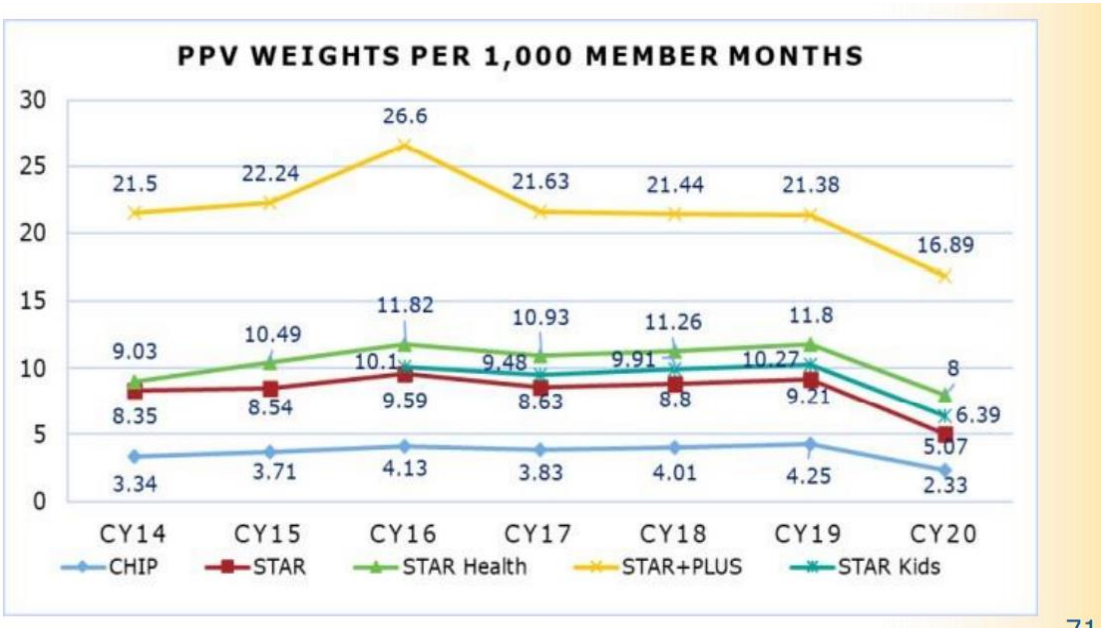
Changes in hospital PPR performance for 2014-2020



Seven Year Trends of PPV Weights per 1,000 Member Months- All Programs, 2014-2020



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HHSC Performance Indicator Dashboard. HHSC expects Medicaid and CHIP MCOs to meet or surpass the HHSC-defined minimum standard on more than two- thirds of the measures on the Performance Indicator Dashboard. The minimum standard is the program rate or the national average, whichever is lower, from two years prior to the measurement year.

Resources-- Annual Report on Quality Measures and ValueBased Payments
Quality Measures and Value-Based Payments December 2021 (texas.gov)

Alternative Payment Model Contract Requirements: Revisions to contract and manual requirements

Current APM Targets

Table 1 - The annual MCO targets established by HHSC by Calendar Year		
HHSC will require that MCOs increase their total APM and risk based APM ratios according to the following schedule*		
Period	**Minimum Overall APM Ratio**	**Minimum Risk-Based APM Ratio**
Calendar Year 1	>= 25%	>= 10%
Calendar Year 2	Year 1 Overall APM Ratio +25%	Year 1 Risk-Based APM Ratio +25%
Calendar Year 3	Year 2 Overall APM % + 25%	Year 2 Risk-Based APM % + 25%
Calendar Year 4	>= 50%	>= 25%
* An MCO entering a new program or a new service area, will begin on Calendar Year 1 of the targets as of the first day of its first calendar year in the program.		

Targets started in CY 2018. HHSC will extend CY 2021 target through CY 2022

VBPQIAC Recommendation
Recommendation: HHSC should adopt a more comprehensive contractual APM framework to assess MCO achievement

- Move away from a specific focus on meeting APM targets
- Provide a menu of approaches to give MCOs credit for a broader range of work promoting value-based care
- Revise the current APM reporting tool to collect only needed data in as streamlined a format as possible

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Timeline for Submitting Contract & Manual Changes

MCO/DMO Contract Amendment Process:

- Concept Phase: submitted concept Oct. 30, 2021: Complete
- Initiation Phase: Change Request Form (CRF) for Managed Care contract changes: Nov – Dec 21
- Submit CRF to MCCO – Jan 1, 2022
- Refinement Phase: Feb – Jun 22
- Finalization Phase: Jun – Jul 22
- Routing & Execution: Jul – Aug 22

MCO/DMO Manual Amendment Process:

- Opportunity exists to update current APM tool for 01/01/2023.

HHSC Resources to Support VBP

Value-Based Care | Texas Health and Human Services (Web Resources)

- MCO Requirements for Value-Based Contracting
- Reporting template for health plans Alternative Payment Models (APMs) with their providers
- Summaries of APMs volumes 2017 – 2019
- Set of outside resources related to VBPs, APMs
- Webinars on HHSC's approach to VBP and APM
- Frequently Asked Questions on APMs

Update: STAR+PLUS Pilot Program

Statutory Innovative Payment Requirements Section 534.104(c) requires the pilot program be designed to test innovative payment rates and methodologies for the provision of LTSS to achieve the goals of the pilot program by using payment methodologies that include:

- The payment of a bundled amount without downside risk to a comprehensive LTSS provider, for some or all services delivered as part of a comprehensive array of LTSS;
- Enhanced incentive payments to comprehensive LTSS providers based on the completion of predetermined outcomes or quality metrics; and
- Any other payment models approved by HHSC.

In developing an alternative payment rate or methodology, HHSC, MCOs and comprehensive LTSS providers shall consider:

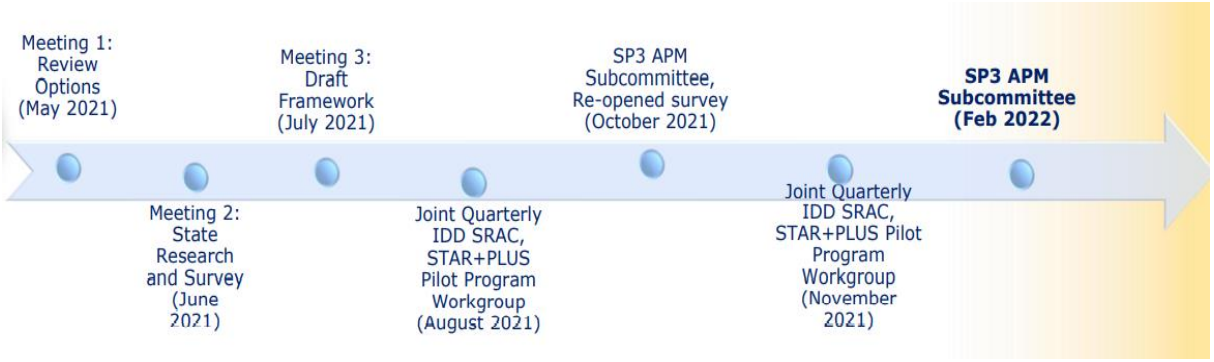
- Historical costs of LTSS, including Medicaid FFS rates;
- Reasonable cost estimates for new services under the pilot program; and
- Whether an alternative payment rate or methodology is sufficient to promote quality outcomes and ensure the provider's continued participation in the pilot.

An alternative payment rate or methodology may not reduce the minimum payment rate received by a provider for delivery of LTSS under the pilot program below the fee-for-service reimbursement rate received by the provider for the delivery of those services before participating in the pilot program.

Overarching Principles

- Start simple (phased approach of long-term vision with short-term goals for the 2-year pilot phase).
- Maintain administrative simplicity.
- Permit flexibility to incorporate innovative approaches
- Tailor APMs to this specific population's needs.
- **APMs should promote the goals of the pilot program (**GOVERNMENT CODE CHAPTER 534. SYSTEM REDESIGN FOR DELIVERY OF MEDICAID ACUTE CARE SERVICES AND LONG-TERM SERVICES AND SUPPORTS TO PERSONS WITH AN INTELLECTUAL OR DEVELOPMENTAL DISABILITY (texas.gov)**)**

STAR+PLUS Pilot Program HHSC facilitated three stakeholder meetings and conducted a survey to explore options to test innovative payments in the STAR+PLUS Pilot Program through the Summer of 2021. Stakeholders from IDD SRAC, STAR+PLUS Program Workgroup and STAR+PLUS MCOs provided valuable input in this process.



Questions/Answers/Comments were postponed until the workgroup projects are discussed

6. Update: Center for HealthCare Strategies Technical Assistance Call

CHCS Approach to Work. They partner with Medicaid stakeholders — including state and federal agencies, managed care plans, providers, communitybased organizations and consumers — to promote innovations in health care delivery where they are needed most. They:

- Identify and advance best practices
- Drive policy improvements with evidence and insights
- Develop the capacity and expertise of health care leaders
- Provide practical training, technical assistance, and tools
- Spread success by connecting peers and experts across sectors

This Project and Exploration

Key Audience
→ Health and Human Services Commission
→ The Value-Based Payment and Quality Improvement Advisory Committee ("Quality Committee") •

Timeline → December 1, 2021 – June 30, 2022

CHCS Support
→ Presentations & facilitated Discussions
→ Tailored technical assistance
→ Connections with other states and subject matter experts

Funded by the Episcopal Health Foundation

Project Goals

- Learn about other states' approaches to in lieu of services (ILOS)
- Apply these learnings to a Texas context
- Discuss potential ILOS candidates, with a focus on services that address health-related social needs
- Develop recommendations for the legislature (Summer 2022) →Quality Committee Report, Summer 2022

What are in lieu of services?

State Medicaid Levers to Address Health-Related Social Needs

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Benefit Design

- Medicaid state plan amendments
-1915(c) waivers
-1115 demonstration projects
-1915(b)(3) waivers
-CHIP Health Services Initiatives

Delivery System

-Medicaid managed care organizations
-Medicaid accountable care organizations
-Value-based payment (VBP) initiatives

Program Partnerships

-Fast Track Enrollment
-Targeted Enrollment Outreach
-Braiding Medicaid funding with other program funds

In lieu of Services (ILOS): Federal Rule & Example

An MCO may cover, for enrollees, services or settings that are in lieu of services or settings covered under the State plan as follows:

- The State determines that the alternative service or setting is a medically appropriate and cost-effective substitute for the covered service or setting under the State plan
- The enrollee is not required by the MCO, PIHP, or PAHP to use the alternative service or setting
- The approved in lieu of services are authorized and identified in the MCO, PIHP, or PAHP contract, and will be offered to enrollees at the option of the MCO, PIHP, or PAHP

Example: "in-home prenatal visits for at-risk pregnant beneficiaries as an alternative to a traditional office visit"

Cost & Utilization of Services: Developing MCO Capitation Rates

Projected Benefit Costs (a.k.a., "Benefit Load")
→State plan services
→In lieu of services (some exceptions) ✓

Projected Non-Benefit Costs (a.k.a., "Non-Benefit Load")
→Care coordination and care management
→Other material non-benefit costs (e.g., other quality improvement costs)
→Administrative costs ⌋

The cost of value-added services cannot be included when determining payment rates.

Pre-approved ILOS: Texas(Behavioral Health)

Current – settings in lieu of an acute care inpatient hospital setting
→ Freestanding psychiatric hospital
→ Substance use disorder treatment services in a chemical dependency treatment facility

Phase one – services in lieu of inpatient services (2021)
→ Coordinated specialty care
→ Crisis respite
→ Crisis stabilization units
→ Extended observation units
→ Partial hospitalization
→ Intensive outpatient program

Phase two – services in lieu of outpatient services (2022)
→ Cognitive rehabilitation
→ Multisystemic therapy
→ Functional family therapy

State Decision Points: Startup

- Should the state pre-approve ILOS? •Should the state create a process for MCOs to submit ILOS for approval?
- How will the state or MCOs engage communities to determine appropriate ILOS? Who will be consulted?
- Which services should be approved? →Is the service a "cost-effective and medically appropriate substitute," and what evidence will be considered?
- How will approval of the services be formalized in contracts?

State Decision Points: Implementation

- Developing MCO reporting requirements
- Using data to develop rates
- Supporting partnerships between MCOs & CBOs
  →Credentialing

  →Rate guidance

  →Model contracts

- Member protections & continuity of care (length of ILOS elections) •Capacity building
- Technical assistance

Consider existing Texas programs and research

Within Medicaid:
→Many HCBS waivers and programs! (E.g., Home and Community-Based Services – Adult Mental Health (HCBS-AMH), with a potential upcoming evaluation)
→Many existing and emerging MCO programs and pilots (e.g., asthma, housing, food)!

Outside Medicaid
→Supportive housing models (for individuals experiencing homelessness)
→Food prescriptions
→Home-delivered meals
→Social isolation interventions

Technical Assistance Updates

Roadmap for These Sessions

- Kickoff →December 3, 2021
- Session #1: Exploring Asthma Remediation →Tuesday, January 25th
- Session #2: Exploring Medically Supportive Food and Meals →Friday, February 25th
- Session #3: Exploring Housing Supports →Tuesday, March 29th
- Develop recommendations/takeaways for legislative report →April & May 2022

December 2021: Recap
Nominated five services of interest
→Housing tenancy & sustaining services
→Medical respite
→Medically supportive food & meals
→Asthma Remediation
→Community health workers

Met with California DHCS Team to discuss their in lieu of services approach
→Discussed policy development, and importance of provider, plan, & community engagement
→Update: California received approval of their two waivers (1915(b) & 1115) in late December. All 14 community supports received CMS approval, but only 12 were approved as official in lieu of services.

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January 2021: Recap
Reviewed levers available to Medicaid agencies and MCOs to address health-related social needs, including the role of in lieu of services

Heard from three organizations doing asthma remediation work about the design and effectiveness of their programs
→Green & Healthy Homes Initiative
→UnitedHealthcare
→San Antonio Kids BREATHE

Reviewed evidence on clinical efficacy and cost effectiveness of asthma remediation programs

Questions/Answers/Comments

No comments or questions were offered

7. Workgroup reports:

Workgroup 1.Value-based payment in home health, pharmacy, and other areas

Home Health
Recommendations to Expand Effective Value-Based Care for Attendant Services/Providers of In-Home Care Recommendations: Below are recommendations that may help HHSC and MCOs understand barriers, and expand meaningful value-based healthcare for Community Long Term Services Support (LTSS):

1. HHSC should direct MCOs to define, measure, and publicly report comparative “value” statistics for Medicaid providers of in-home care/attendant services, based on a standard set of quality, accountability, and cost-efficiency metrics. This data should be shared on a regular basis with providers.

2. HHSC should consider establishment of APM targets that are specific to community-based LTSS (STAR+PLUS and STAR Kids)

3. HHSC should explore the development of joint APMs between primary care providers and specialty care providers.

4. HHSC should evaluate data on enrollee movement from one Community LTSS provider to another and between MCOs, to ensure continuity of care is maintained. This evaluation should

include corresponding impacts on utilization and cost. HHSC should develop and implement strategies to mitigate when such practices have adverse impacts on both quality and cost.

5. HHSC should revisit rate enhancement structure and should focus on performance driven models which reflect quality and savings.

Recommendations to Expand Effective ValueBased Care for Attendant Services/Providers of In-Home Care

Addressing Behavioral Health Issues

- A significant number of members suffer from severe behavior health issues (e.g., paranoia, hallucinations, etc.).
- This results in verbal and physical abuse of attendants who do not have the necessary training or skills to appropriately deal with these members.
- This severely limits the number of attendants who are willing to staff these cases.
- Attendants require specialized training and monetary incentives to deal with these members.
- The agencies need more resources from the MCO to properly serve and staff these cases (better coordination with PCP & MCO staff, detailed diagnosis, specialized programs, medication management, etc.).

Pharmacy

Increasing Value-Based Payment in Home Health, Pharmacy, and other areas. Possible directions for Pharmacy work:

1.HHSC should establish standards and a working definition for an Accountable Pharmacy Organization (APO).

2.HHSC should work with stakeholders to increase engagement with Accountable Pharmacy Organizations (APOs).

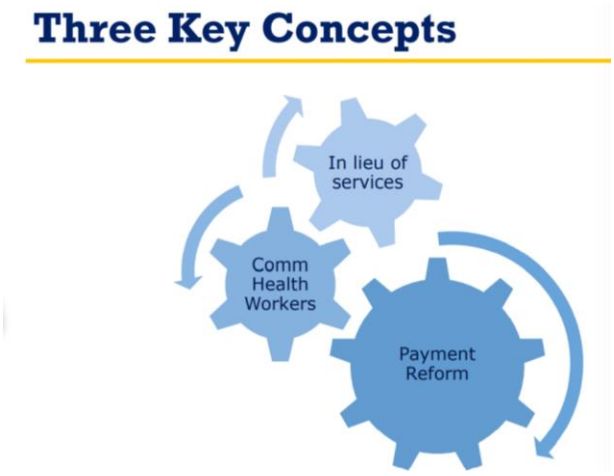
3.Pharmacy Product Reimbursement Should not be Included in Value-Based Payment Models.

4. Pharmacy Value-Based Payment Models Are Not a Tool to Enforce Limited Provider Networks.

5.HHSC should develop guidance for MCOs to reimburse pharmacists as providers for services within a pharmacist's scope of practice.

6.HHSC should evaluate an expedited Community Health Worker (CHW) training and certification program for healthcare professionals.

Work Group 2: Social drivers of health



California In-lieu of Services

- Housing transition and navigation services
- Housing deposits
- Housing tenancy and sustaining services
- Short-term post-hospitalization housing
- Recuperative care
- Respite services
- Day habilitation programs
- Nursing facility transition to lower-level assisted living facilities
- Nursing home transition services, to a home
- Personal care and homemaker services
- Home modifications
- Medically tailored meals
- Sobering centers
- Asthma remediation

Asthma Remediation

Key components

- Home visit
- Environmental supports
- Mattress and pillow covers
- Pest management
- Mold remediation

- Carpet removal/replacement
- Filter changes
- Ensure proper venting of appliances
- High-efficiency particulate air (HEPA) filtered vacuums
- Connection to other social resources
- Monitoring and follow-up

Green & Healthy Homes Initiative®

- Cost per enrollee: $700-$2500, with environmental remediation $3500-$5500
- Return on investment:
- Confirmed when followed for 1 year, 2.3 years, and 5 years
- $5.3 - $14 for each $1 invested
- -0.57 avg decrease in median number of acute care visits per year
- -21 avg. decrease in symptom days per year
- -12.3 avg. decrease in school absences per year

United Healthcare Community Plans of Texas

United Healthcare Community Plan of Texas

- Similar as prior (Green Healthy Homes Initiative)
- Also used an electronic device which monitors adherence to inhaler use (Airwaze)

San Antonio Kids B.R.E.A.T.H.E

- Clear, defined eligibility criteria:
- 2 or more ER visits
- 1 hospitalization
- Missed 10% or more days of school
- Two or more unscheduled school nurse visits per week
- Measured success based on Average Asthma Control Test (ACT) scores, with clear improvement seen
- Grant-funded

How Do We Fund It?

- Missouri and North Carolina defined additional benefits within Medicaid
- Wisconsin and Maryland: Used a state plan amendment to implement a health services initiative within CHIP using administrative funding
- New York: Used value-based payment initiatives to fund interventions
- California: In lieu of services (Community Support)

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In-Lieu-Of Services

- In-lieu-of service expenditures qualify as covered services for rate-setting unless a statue or regulation explicitly requires otherwise, thus these claims would count toward the capitation rate.
- The SDOH Workgroup may need to collaborate actively with the APM Workgroup to develop formal recommendations.

Social Determinants of Health Medicaid Managed Care (commonwealthfund.org)

Next Steps

- 2/25/2022, Explore Medically Supportive Food
- 3/29/2022, Explore Housing Supports
- April & May, develop recommendations for the legislative report

Workgroup 3: Alternative Payment Models and Value-based Payment Contract Language

Timeline for Contract & Manual Changes 128 MCO/DMO Contract Amendment Process:

- Concept Phase: submitted concept Oct. 30, 2021: Complete
- Initiation Phase: Change Request Form (CRF) for Managed Care contract changes: Nov – Dec 21
- Submit CRF to MCCO – Jan 1, 2022
- Refinement Phase: Feb – Jun 22
- Finalization Phase: Jun – Jul 22
- Routing & Execution: Jul – Aug 22 MCO/DMO Manual Amendment Process:
- Opportunity exists to update current APM tool for 01/01/2023.

Recommendations VBP Contract and APMs Workgroup

Recommendation 1: HHSC should adopt a more comprehensive contractual APM framework to assess MCO achievement • Move away from a specific focus on meeting APM targets • Provide a menu of approaches to give MCOs credit for a broader range of work promoting value-based care • Revise the current APM reporting tool to collect only needed data in as streamlined a format as possible

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APM Menu Options Discussed by Workgroup

Example Menu	Points
• Maintaining or improving on current APM benchmarks (total dollars involved in APMs)	
• Meeting APM targets for challenging circumstances, e.g., APMs in rural areas (challenges can change over time)	
• Improving APM rates for priority sectors with low APM participation, e.g., home-health or behavioral health (priority sectors can change over time).	
• Credit to MCOs that increase the amount of dollars providers earn or can earn through APMs	
• Monitoring provider satisfaction or establishing other formal provider outreach mechanisms related to APMs **OR** processes for provider engagement	
• Data sharing with providers through HIE (e.g., ADT data) or claims	
• Sharing performance reports and best practices with providers	
• Improving on quality measures **or** documenting processes that describe outcomes achieved and improvements that can be made in future years	
• Developing innovative approaches to address SDOH: 1. Leveraging VBP to incentivize the reduction of health disparities 2. Addressing SDOH as part of an APM	
• Developing a formal strategic plan for advancing APMs	
• Collaborating with other MCOs within a service area (region) on standard measures and APM models	
• Establishing formal APM evaluation criteria and reporting on evaluation results for key APMs	

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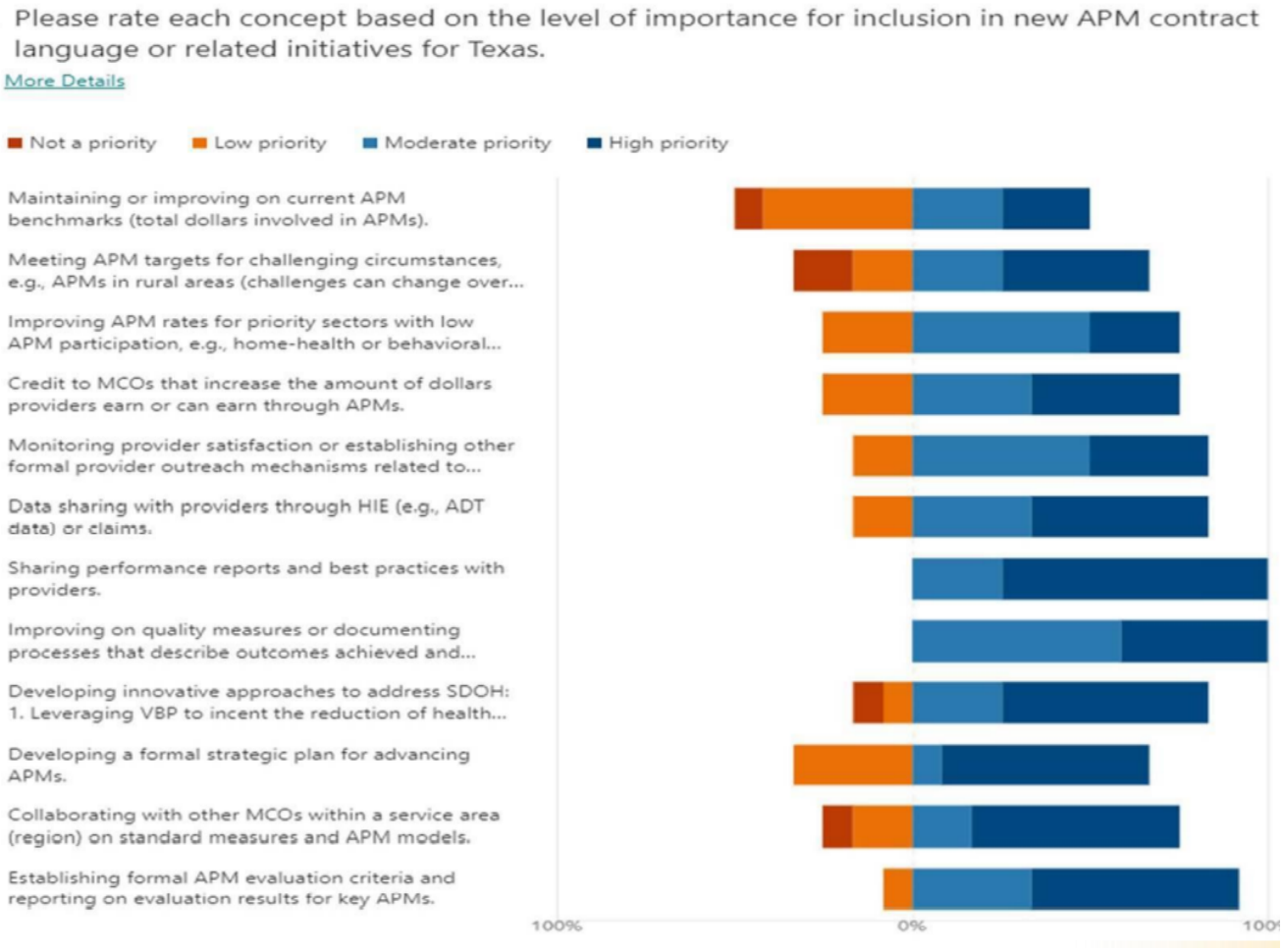
VBPQIAC Proposed APM Contract Language/Initiatives Survey Results



<u>NEW WORKGROUP:</u> Timely Data for provider and Managed Care Plans

This is a new workgroup. HHSC has a stream of some data from EDEN and THSA. The questions are how to use the date to address health plan issues. Behavioral health data must also be included. There will be more coming from this new group in the future.

All Workgroup Questions/Answers/Comments

Does In Lieu of Services require legislative action. A: There was explicit language in SB1177 for outpatient mental health services. Having legislative direction is important for the agency to move forward.

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8. 2021 Planning meeting:

Recommendations: 2018 Legislative Report

1. Implement a comprehensive informatics strategy
2. Make data available to support value-based initiatives
3. Address patients' non-clinical health related needs
4. Prioritize maternal and child health
5. Sustain innovative behavioral health models
6. Expand treatment for substance use disorders
7. Reduce administrative complexity

Recommendations: 2020 Legislative Report

1. Promote alternative payment models for maternal and newborn care in Medicaid managed care by standardizing outcome measures and creating a mother-baby registry.
2. Leverage multi-payer data to advance the alignment of value-based payment and quality improvement efforts across major payers of health care.
3. Support addressing social drivers of health (SDOH) as part of value-based improvement in Medicaid managed care.
4. Develop strategies to increase adoption of the most effective alternative payment models (APMs) by Medicaid managed care organizations (MCOs) and providers.
5. Use lessons learned from the COVID-19 public health emergency to strengthen care delivery and value-based care in Medicaid.

2022 Planning: Brainstorming Recommendation on potential policy issues for the 2022 legislative report

The goal is to vote on recommendations at the May meeting. A recommendation around APMs has already been approved by the group. Mr. Blanton stated that there are recommendations from the workgroups and the purpose of this brainstorming is to identify any ideas not yet covered by the workgroups.

Timeline and next steps

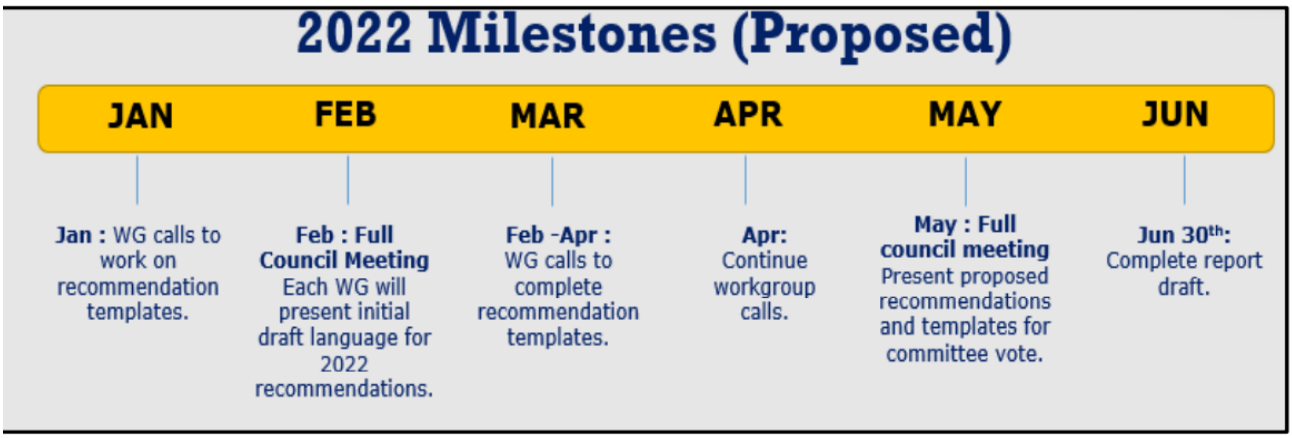
New Member Appointment Process

Applications submitted are under review.

Members with expired terms: 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

VBPQIAC Legislative Report Timeline



9. Public comment No public comment was offered.

10. Action items for staff and member follow-up No specific items were identified.

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

***