# HHSC: Value-Based Payment and Quality Improvement Advisory Committee
# August 17, 2021

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. Members:

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

Ex Officio Representatives

Mark Chassay, Fort Worth
Lisa C. Kirsch, Austin
Shayna Spurlin, College Station

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

**2. Consideration of meeting minutes from April 15, 2021 meeting**. The minutes were approved as written.

**3. Presentation: E-Health in Texas**. Nora Belcher Executive Director Texas eHealth Alliance

**1115 Waiver**

Special Terms and Conditions (STC) of the waiver renewal requires the Texas Health and Human Services Commission (HHSC) to develop a Health Information Technology (Health IT) Strategic Plan related to activities in the demonstration that will "link services and core providers across the continuum of care to the greatest extent possible" using Health IT initiatives and strategies.

As such a large purchaser of healthcare, Texas Medicaid has the unique opportunity to contribute to a global Health IT approach for the state. Texas Medicaid supports the Texas Health Services Authority, which is the Texas Health Information Exchange (HIE), five active community-based Health Information Exchanges (Local HIEs) and the health provider community by providing governance and infrastructure to ensure greater interoperability within the state. The Health IT Strategic Plan is designed to implement capabilities complementary to Texas Medicaid and the state's Health IT ecosystem.

**HIE IAPD**

The following three Health IT/HIE strategies detailed in the Texas Health Information Exchange Implementation Advance Planning Document (HIE IAPD) provide the foundation and building blocks for bringing this Health IT Strategic Plan to fruition:

Strategy 1: Medicaid Provider HIE Connectivity – This strategy is intended to assist Local HIEs with connecting the ambulatory providers and hospitals in their respective areas.

Strategy 2: Texas Health Information Exchange (HIE) Infrastructure – This strategy aids with building connectivity between the Texas Health Services Authority (THSA), which has a statutory charge to facilitate HIE statewide, and the state's Local HIEs.

Strategy 3: Emergency Department Encounter Notification (EDEN) system – Texas statewide Health Information Exchange Plan promotes Local HIEs connecting hospitals to their information technology systems and exchanging Admission, Discharge, Transfer (ADT) messages

**Telemedicine-Reimbursement Environment**

| Payor | Pre-COVID 19 | Post-COVID 19 |
|---|---|---|
| Medicare Fee for Service | Very restrictive- rural residents only and limited services | Rural restriction removed and large array of services added |
| Medicare Advantage | More flexibility than Medicare FFS but still a limited benefit | Expanded similarly to Medicare FFS |
| State Medicaid programs | Large variation on what can be covered | Services being expanded under 1135 waivers- check with state Medicaid office |
| State regulated insurance | Large variation on what can be covered | May be expanded- check with state insurance department |
| Self-funded insurers | Large variation on what can be covered | Varies per plan |

**Telemedicine Provider Utilization**

Pre COVID
• Physicians: adoption estimates ranged from 15% to 28%
• Hospitals already higher (76% reported by the AHA in 2017) than physicians

Post COVID
• Physicians: 80% surveyed by TMA say they offer or plan to offer telemedicine as of April 2020
• Hospitals: No survey data yet but probably close to 100

**Telemedicine Patient Utilization**

Pre COVID estimates range from 8% to 23%
Post COVID peak as high as 42% nationally
Estimates of as high as 4.5 million Texans
Long term probably falls to about 21% per Chilmark

**Telemedicine**
HB 4 (Price/Buckingham)- Makes the COVID flexibilities related to Medicaid and other public benefit programs permanent and adds technology to allowable ways to reach and assess clients:
– allows HHSC to implement telemedicine and telehealth in any program under the commission's jurisdiction as long as those services are cost-effective and clinically effective.
– makes audio-only benefits for behavioral health services a permanent benefit and allows HHSC to implement audio-only benefits in other programs.



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– clarifies that Medicaid managed care organizations may reimburse providers for home telemonitoring services that are not currently included in the program benefit.
– Directs HHSC to establish policies and procedures that allow managed care organizations to conduct assessment and service coordination activities for members receiving home and community-based services through telecommunication or information technology.
– Adds the availability of telemedicine and telehealth services to the list of criteria that must be considered by HHSC when setting provider access standards related to network adequacy for Medicaid managed care plans.
– Directs HHSC to create a consent form that will allow Medicaid and CHIP recipients to opt-in to receiving text messages from their health plan once they have enrolled

**Licensure and Compact Bills**

SB 40 (Zaffirini)- telehealth for practitioners licensed by the Texas Department of Licensing and Regulation, including audiologists and speech-language pathologists

HB 1616 (Bonnen)- Interstate Medical Licensure Compact

HB 2056 (Klick) - regulation of tele-dentistry

- Establishes a process for tele-dentistry regulation at the State Board of Dental Examiners using the same standard of care structure from SB 1107 (2017)
- Adds tele-dentistry to the list of covered services in various HHSC programs (Medicaid, Children with Special Health Care Needs)
- Adds tele-dentistry as a covered service in the Insurance Code
- Clarifies that dental hygienists can participate in tele-dentistry under supervision

**Telemedicine- Future Considerations**

What will the digital health landscape look like in 10 years, and how can an organization prepare for it?
– Reimbursement models are changing

- One significant limiter on the growth of telemedicine is the way fee for service methodologies count patient visits but not avoided costs
- Value based care and/or bundled purchasing models will allow for more flexibility in integrating telemedicine

– The broader evolution of the e-health landscape will support increased use of virtual care models

- Electronic medical records vendors are embedding telemedicine into EHRs and patient portals
- Artificial intelligence bots and other machine learning tools will become part of the patient interface

**Questions/Answers/Comments**

What is the timeline for HB4? HHSC has committed to continuity and the start date was immediate.



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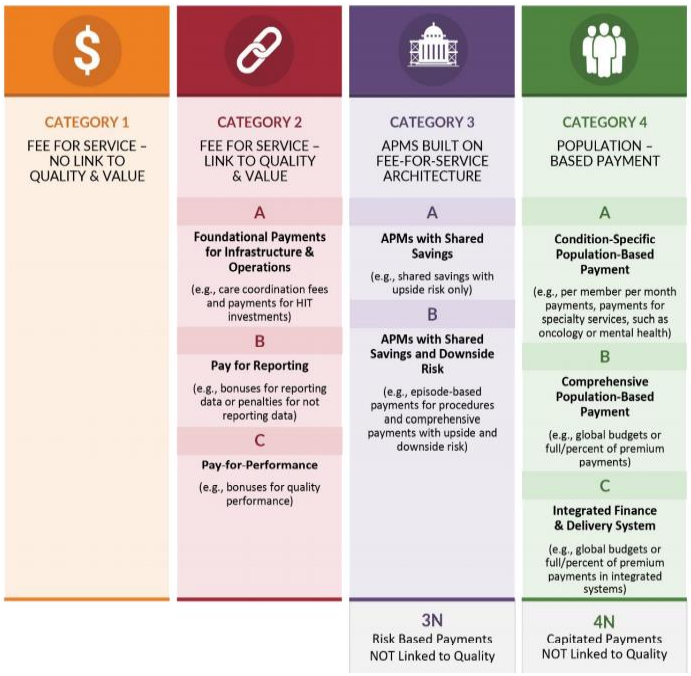
**4. Presentation: Overview of Value-Based Payment and tool** Andréa Caballero, MPA Program Director Catalyst for Payment Reform.

**Payment Reform Definition**
Payment reform: a range of health care payment models that use payment to promote or leverage greater value for patients, purchasers, payers, and providers. All models must include quality components to count as payment reform.

The unit of measurement when tracking payment reform is the total dollars that health plans (or managed care organizations) paid to providers through payment reform programs.

# HCP-LAN APM Framework

- First published in 2016 and then refreshed in 2017, the APM Framework established a common vocabulary and pathway for measuring and sharing successful payment models
- The LAN will publish results for 2019 and 2020 in Q4 of 2021
- 4 Categories & 8 Subcategories
  - 3B and Category 4 all include "two-sided risk"



## The Pandemic Revealed Weaknesses in Fee-for-Service

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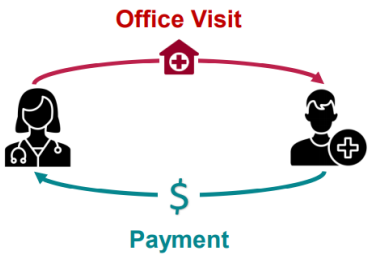
Fee for Service




- 1:1 relationship between patient office visit to provider revenue
- Medical group practices report 55% revenue loss due to COVID-19
- Lack flexibility, reserves, infrastructure to adjust

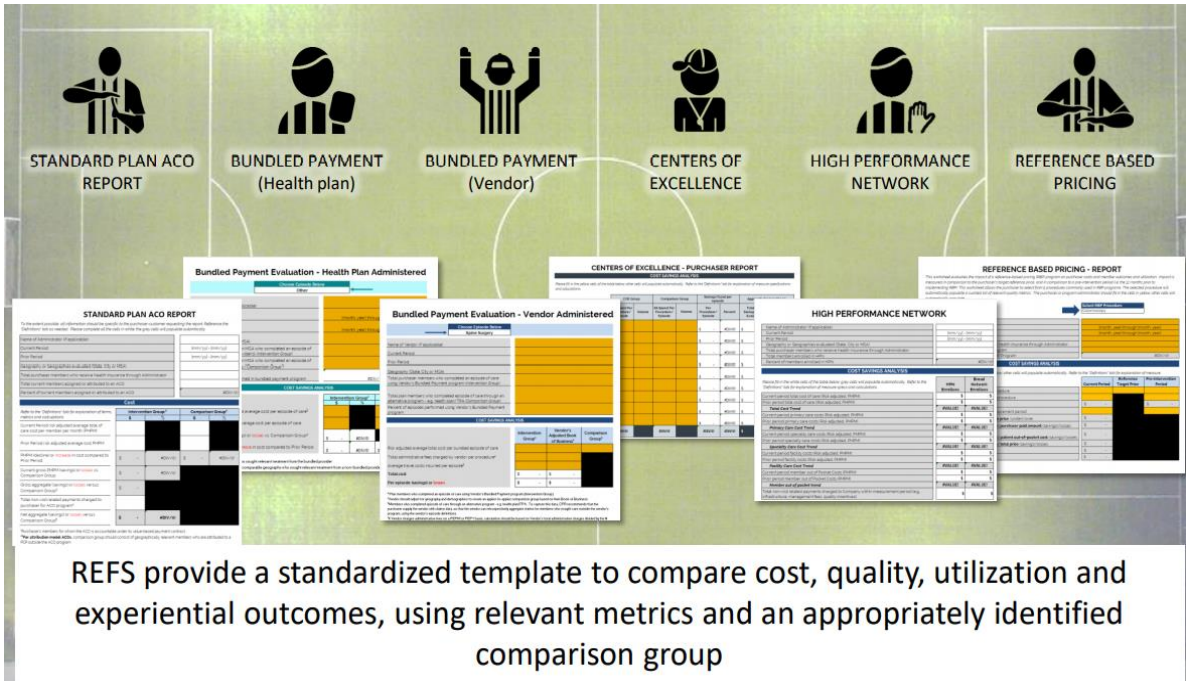
Capitation


- Revenue disconnected from utilization
- Opportunity for upfront infrastructure and population health management investment
- Indifferent between in-person and virtual care

**Looking Ahead**

- Could Hybrid Payment Models Provide a Happy Medium?
  - Example: CMS' Comprehensive Primary Care PLUS (Category 3A)
    - Combines FFS with % of expected evaluation and management (E&M) reimbursement paid upfront
- Future priorities for APM stakeholders
  - Tracking how patients are touched by payment reform
  - Scaling models proven to improve health equity

## CPR's Reform Evaluation Frameworks (REFs)




### What is in a REF?

Introduction
- Notes and caveats - sample size, risk adjustment, etc.
- Insights you will glean from the REF

Definitions
- General terms
- Operational definitions/instructions & calculations
- Quality & utilization measure specifications

Report – Purchaser
- Purchaser information - membership size, program administrator, etc.
- Cost savings analysis • Quality & utilization
- Program impact (RBP & Bundled Payment – Health Plan & Vendor) Report – Book of Business
- Same as purchaser but based on administrator's total population (Bundled Payment – Health Plan, Centers of Excellence, High Performance Network, ACO)

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- Same as purchaser but based on administrator's total population (Bundled Payment – Health Plan, Centers of Excellence, High Performance Network, ACO)



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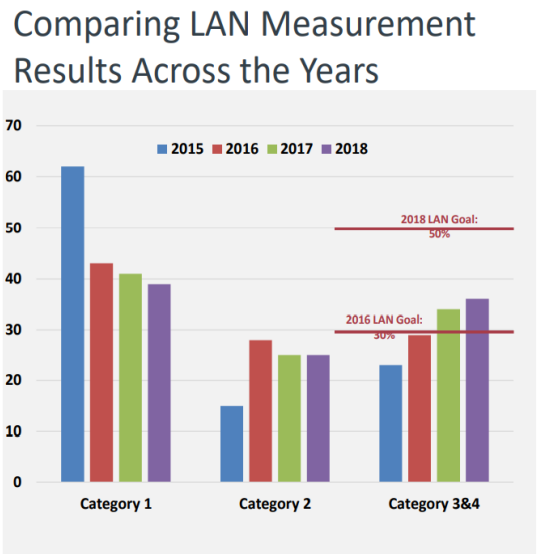
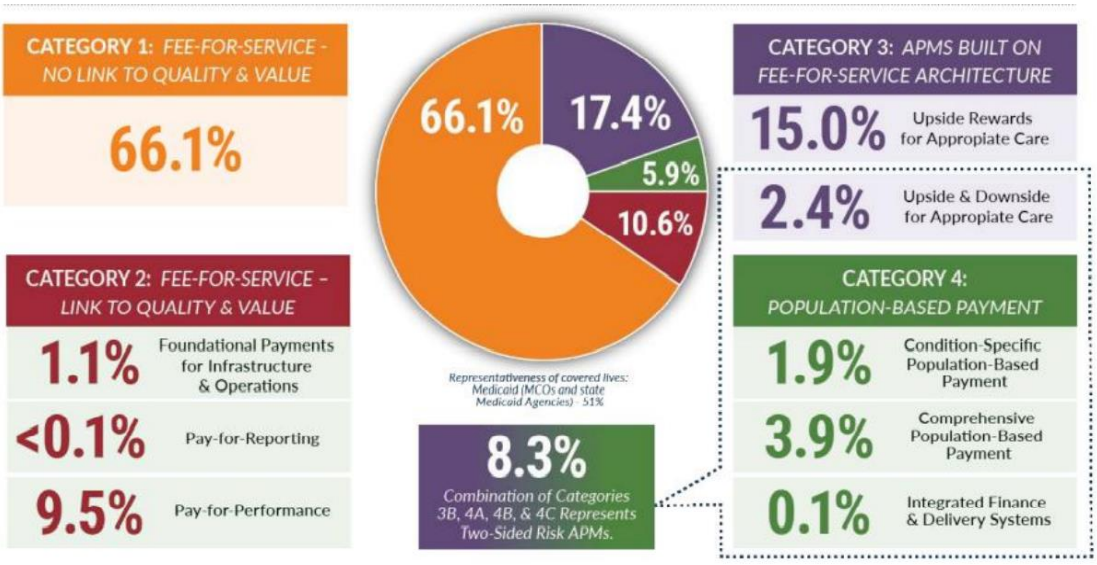
**Measuring Payment Reform Implementation**

- ✓ CPR's National and State-Level Scorecards - the first to track value-oriented payment implementation.
- ✓ The Health Care Payment – Learning Action Network (LAN) began tracking payment reform in 2016. Most recent results reflect 2018 data.




**HCP-LAN Medicaid Results (2019, reflecting 2018 data)**



## Introducing Scorecard "2.0"

**Scorecard 1.0**

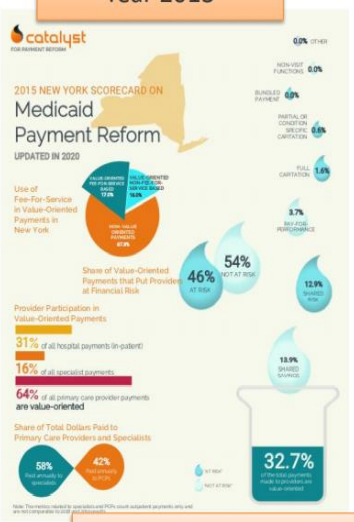
How many dollars flow through payment models by type and by payer (Medicare, Medicaid, Commercial)?

**Scorecard 2.0**

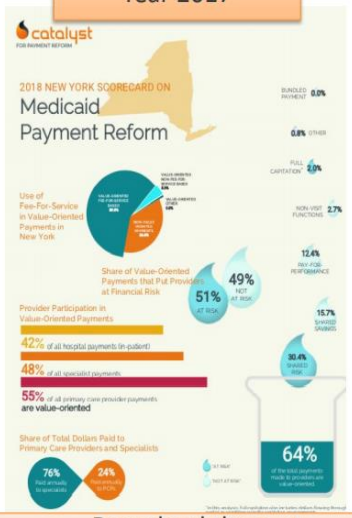
Are payment reform models having their intended impact on the quality, efficiency, and cost of health care?

## CPR's New York Medicaid Scorecards on Payment Reform

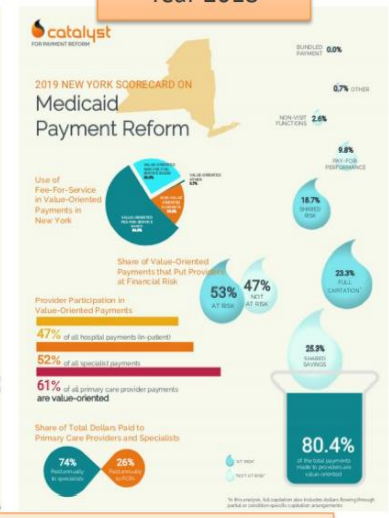
2015 Scorecard Data from Fiscal Year 2013




2018 Scorecard Data from Fiscal Year 2017




2019 Scorecard Data from Fiscal Year 2018




Download these at
Catalyze.org > Research & Analysis > Scorecards on Payment Reform

## CPR's New York Medicaid Scorecards on Payment Reform (2 of 2)

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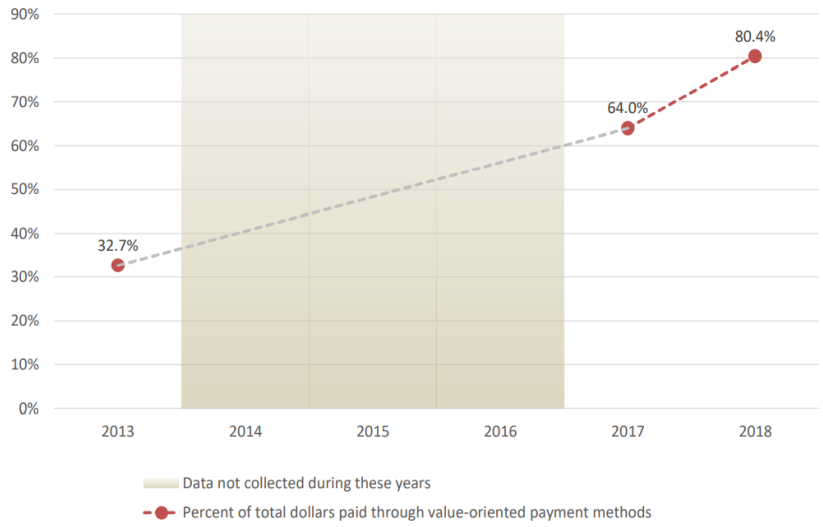


## Quality Results for NY Medicaid During the Same Time Period (1 of 2)

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### HbA1c testing

| '13 | '17 | '18 |
|---|---|---|
| 88% | 90% | 92% |

(Higher is better)

### HbA1c poor control

| '13 | '17 | '18 |
|---|---|---|
| 35% | 30% | 31% |

(Lower is better)

### Childhood Immunizations

| '13 | '17 | '18 |
|---|---|---|
| 73% | 75% | 76% |

(Higher is better)

## Quality Results for NY Medicaid During the Same Time Period (2 of2)

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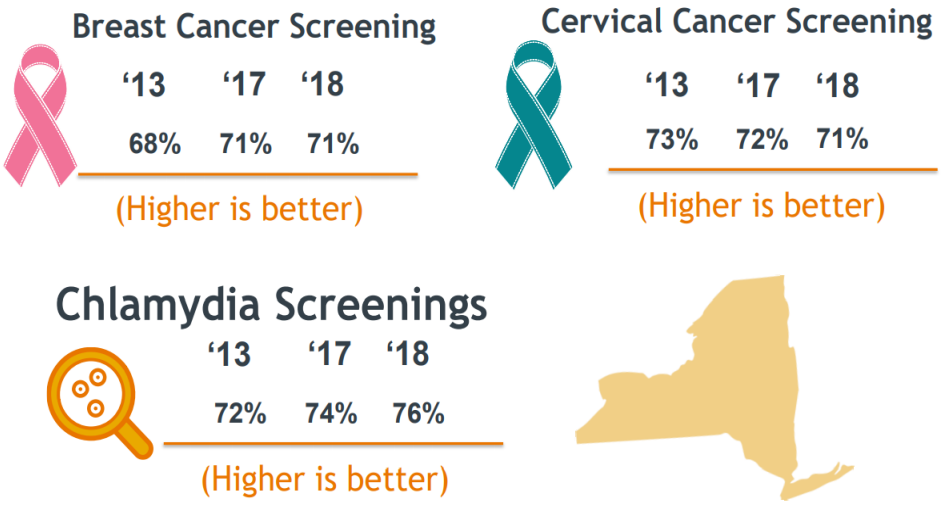



*Source: New York State Department of Health's Quality Assurance Reporting Requirements*

**Developing a Scorecard 2.0 for Texas Medicaid**

- Texas already collects Medicaid APM data and has quality metric data available.
- There's an opportunity for Texas Medicaid to use the Scorecard on Payment Reform 2.0 Methodology to obtain a statewide baseline.
- By showcasing payment reform implementation alongside quality performance, Scorecard 2.0 can help stakeholders evaluate the impact of a state's payment reform strategy.

**Questions/Answers/Comments**

An issue that providers have is the different MCOs have different sets of metrics. Are there any states that have a uniform set of metrics? The speaker stated it is a difficult situation for providers to be in. The lack of standardization across health plans wreaks havoc. California has uniform measures.

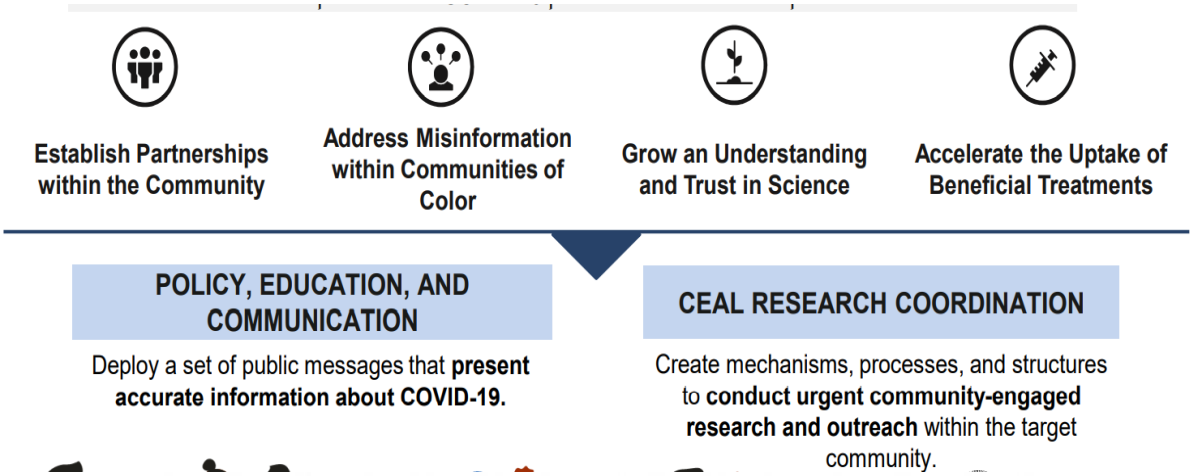
When you go by HEDIS criteria it delays payment. We have the data on APMs and the quality data and about 42 percent are hybrid models and we are seeing pediatric and obstetric measures.

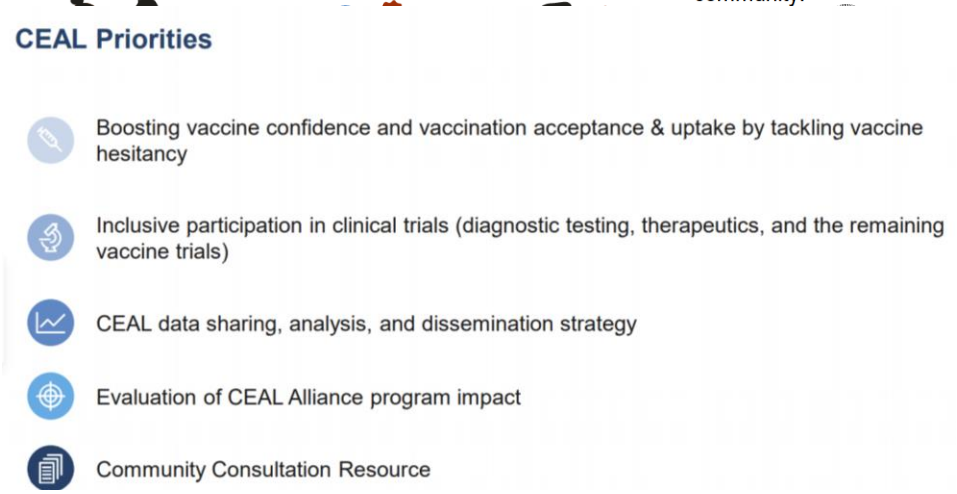
The evaluation tool can be downloaded but is there support that can be offered to health plans. The speakers answered in the affirmative. They will do more research on this issue.

## 5. Presentation: Texas Center for Health Disparities

NIH Community Engagement Alliance (CEAL) Against COVID-19 Disparities was established to lead outreach and engagement efforts in underserved ethnic and racial minority communities disproportionately affected by the COVID-19 pandemic and in overall vaccine and therapeutic trials in the future.

VISION: To become the most trusted partner in community engagement efforts addressing the scientific response to the COVID-19 pandemic and related disparities

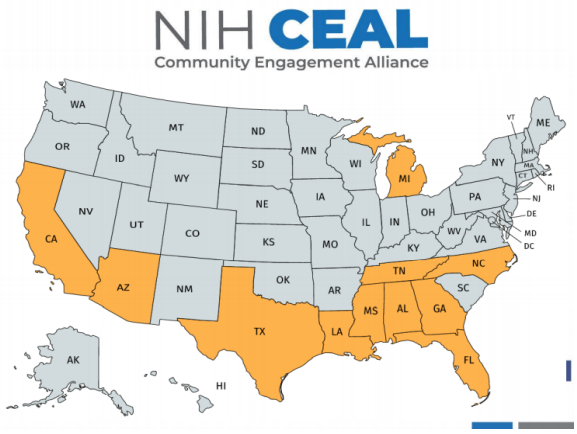


## Communities of Concentrated Focus

*CEAL is currently supporting research teams in 11 states to focus on urgent community-engaged research and outreach focused on COVID-19 awareness and education among communities hardest hit by the pandemic.*

- Focus on **assessing** and **addressing** community knowledge, **misinformation and mistrust** about COVID-19
- **Strong partnerships** across academic, faith- and community-based organizations as well as federally qualified health centers and historically Black colleges and universities
- **Integrated projects** focused on the most affected communities
- Innovative strategies to facilitate **inclusion in COVID-19 trials**
- Variety of **communication channels,** including website, eNewsletter, social media, partnerships and news media




**Texas CEAL Consortium: Program Goals**

To use community -engaged strategies to reduce the burden of Coronavirus Disease 2019 (COVID -19) among disproportionately affected communities across Texas .

• Objective 1 : Conduct community -engaged research to promote awareness and enhance knowledge to overcome COVID -19 misinformation in diverse racial and ethnic populations across Texas.

• Objective 2: Leverage existing community -partnerships and proven local strategies to increase uptake and active participation of diverse racial and ethnic groups in evidenced - based COVID -19 prevention practices and therapeutic trials (example: ongoing vaccine and future trials) .

• Objective 3 : Disseminate science -based and targeted educational campaigns in diverse racial and ethnic communities and evaluate their impact on beliefs, attitudes, knowledge, and practices of COVID -19 prevention and treatment .

• Objective 4 : Develop sustainable community -engaged organizational capacity in Texas by creating a repository of local community -centric, evidence -based COVID -19 knowledge products (i.e., best practices) targeted towards populations experiencing disproportionate burden of COVID -19 .

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## Texas CEAL Consortium Projects

| | Texas CEAL Consortium Projects | | | |
|---|---|---|---|---|
| Project | Project Title | County | Research Objective | Project Lead |
| 1 | Deliberative and Participatory Approaches to Addressing COVID-19 in African American and Hispanic Communities in Texas | Harris | 1 | Bettina Beech |
| 2 | Unidos Contra COVID/United Against COVID | Bexar | 1,3,4 | Robert Ferrer |
| 3 | Promoting knowledge to action in COVID-19 prevention and engagement among underserved communities | Tarrant | 1,2,3 | Emily Spence |
| 4 | Community Engagement Strategies for COVID-19 Prevention and Response in Underserved Communities in Hidalgo County | Hidalgo | 1,3 | Luis Torres-Hostos |
| 5 | COVID Communications Resource Hub to Promote Health Equity for Texans | Dallas | 1,2,3,4 | Rebecca Seguin-Fowler |
| 6 | Engaging Black and Hispanics in COVID-19 clinical trials, vaccine uptake and educational campaigns. | Harris | 1,2,3 | Lorna McNeill |
| 7 | Identifying Community Impacts and Attitudes of COVID-19 on Health Inequity | Harris | 1,2,3,4 | Jasmine Opusunju |
| 8 | Community health education advocacy to increase COVID-19 vaccine uptake | Tarrant | 2,3 | Harlan Jones |
| 9 | Deliberative Democracy: A Novel Strategy for Engaging Houston's Underserved Communities to Address COVID-19 Vaccine Hesitancy and Improve Uptake | Harris | 2,3 | Hoda Badr |
| 10 | Assessing media approaches to increasing COVID-19 vaccination and trial participation in Vietnamese Americans | Harris | 1,2,3 | Bich-May Nguyen |
| 11 | Increasing COVID-19 vaccine uptake among high-risk Hispanic Communities | Hidalgo | 2,3 | Candace Robledo |
| 12 | COVID-19 vaccination experience SWOT analysis and intervention plan | Statewide | 2,3 | Venus Ginés |

## Dallas County- CEAL Program

### ACADEMIC & COMMUNITY PARTNERS

- Texas A&M AgriLife Extension (statewide network serving all 254 Texas counties)
- University of Texas Southwestern

- ❑ Día de la Mujer Latina (CBO partner for CTCN trainings with COVID 19 module)
- ❑ 28 total community partners (includes CBOs, CFOs, HBCUs, FQHCs)

### Project Reach

African American, Latino, LGBTQ, low literacy, older, rural and disabled populations

### PROJECT ACTIVITIES

1. Conduct Clinical Trial Community Navigation (CTCN) trainings with development of a tailored COVID-19 module
   a) Increase recruitment and retention for racial/ethnic minority participants in COVID-19 related trials
   b) Recruitment for trainings within of counties of focus (Bexar, Dallas, Harris, Hidalgo, Tarrant) and offered statewide
   c) Includes clinical trials referral tracking system and survey dissemination (Milestone 2 and 3)
2. Create resource hub website with curated, web-based repository of COVID-19 products
   a) Provides a communications infrastructure and serves as the statewide visibility platform for the CEAL team's work
   b) Conduct document analysis and evaluation (focus groups) of COVID-19 related materials and related adaptations and best practices (will be used to populate the web-based repository)
3. Convene Community Advisory Board (CAB) for Dallas county
   a) Stakeholder engagement (includes members from existing CBO/CFO partnerships); survey dissemination among CAB networks (Milestone 3)
   b) CAB to assess suitability of repository products for various groups experiencing disparities



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## Tarrant County- CEAL Program

### ACADEMIC & COMMUNITY PARTNERS

- University of North Texas Health Science Center at Fort Worth
- Texas Center for Health Disparities
- ❑ United Way of Tarrant County
- ❑ Tarrant County Public Health
- ❑ YMCA of Metropolitan Fort Worth
- ❑ DFW CHW Association

### Project Reach

Twelve target zip codes identified as primarily non-white and non-Hispanic, disproportionately impacted by COVID-19 (high case and death rates, testing deserts)

Population= 368,653; 61.5% Hispanic, 19% Black/African American, 14% White

### PROJECT ACTIVITIES

- Use rapid assessments to understand: a) community level misinformation and myths of COVID-19 and trust in sources of information, b) knowledge, beliefs, attitudes, and fears about COVID-19 including vaccine hesitancy, vaccine acceptance and willingness to participate in COVID-19 vaccine, therapeutic, and prevention trials
- Utilize focus groups and interviews to develop depth of understanding around mistrust, misinformation, and willingness to participate in clinical trials and engage in prevention behaviors
- Establish a multiple modality educational campaign using Lay Health Workers and Community Health Workers, and social media reach of partner organizations to address mistrust and misinformation, willingness to consider clinical trial participation, vaccine acceptance, COVID-19 prevention and mitigation behaviors.

## Hidalgo County- CEAL Program

### ACADEMIC & COMMUNITY PARTNERS

Univ. of Texas Rio Grande Valley

- School of Social Work
- School of Medicine, Population Health & Biostatistics
- School of Medicine, Immunology and Microbiology

Area Health Education Center (AHEC) Program

Operation COVID Shield

### RIO GRANDE VALLEY

1,401,299 Persons (5% of Texas' Population)
17% of COVID Deaths Across State
94% Hispanic/Latino
56% between 0-34 years of age
3.5 persons per household

### PROJECT ACTIVITIES (OBJ. 1, 3)

1. Deliver brief COVID prevention intervention to individuals seeking COVID testing at community testing sites and to AHEC patients
   - Factual COVID-19 related information
   - Case-management, COVID testing and post-testing guidance, risk-reduction
   - Vaccine information, including clinical trials information
2. Conduct baseline and follow-up assessments at 30, 60, 90, and 180 days
   - Demographics, services needed/received, health status
   - Increases in COVID prevention skills and knowledge
   - Change in COVID prevention behaviors
   - COVID positivity rate and household seroconversion rate
   - Level of satisfaction with intervention



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## Harris County – CEAL Program

| ACADEMIC & COMMUNITY PARTNERS | PROJECT ACTIVITIES |
|---|---|
| • Baylor University Medical Center<br>• MD Anderson Cancer Center<br>• Univ. of Houston<br><br>❑ CANDO Houston<br>❑ Federally Qualified Health Centers<br>❑ Houston area Churches<br>❑ Housing Developments (Acres Homes)<br>❑ Service Organizations in Harris County | • Use deliberative methods with African American and Hispanic/Latino community opinion leaders to identify feasibility and acceptability of home-based testing and barriers (e.g. vaccine hesitancy) and facilitators (e.g. vaccine education) to uptake of COVID-19 vaccines trials and/or an approved vaccine<br>• Design, evaluate and disseminate educational messages designed to increase knowledge, attitudes, and beliefs about COVID-19 clinical trials and vaccines.<br>• Evaluate the effectiveness of the COVID-19 messages in various settings including FQHCs, churches, neighborhoods, and entire cities.<br>• Survey vulnerable communities and communities with highly concentrated COVID-19 exposure rates. The survey will be disseminated by the FARO Community Health Workers (CHWs) and by telephone.<br>• Quantitative spatial analytics of social determinants of health and physical community factors of vulnerable communities. |

## Bexar County – CEAL Program

| ACADEMIC & COMMUNITY PARTNERS | PROJECT ACTIVITIES |
|---|---|
| • Univ. of Texas Health Center at San Antonio<br><br>❑ Bexar County Health Collaborative<br>❑ San Antonio Metropolitan Health District<br>❑ Grass roots groups<br>❑ Places of worship | • Community-engaged strategy to increase affected communities' access to timely, accurate guidance on reducing risk of SARS-CoV-2 infection.<br><br>• Develop tailored engagement and outreach strategies designed to reduce risk among their communities.<br><br>• Using social media, develop, diffuse, and evaluate community-relevant messaging. |

Vaccine Uptake & Trials

- Trained over 800 community health workers (CHWs) in conducting community engagement activities through the creation of a training program hosted on the state's Department of Health website
- Designed and disseminated COVID-19 Clinical Trials 101 Training – educated CHWs working with diverse populations to increase participation
- Launched TexasCEAL.org – increased information availability through links and information on local, state, and national COVID-19 clinical and treatment trials . Included vaccine information and links to reliable state and national websites
- Emphasized state and local public health will travel to neighborhoods with poor transportation to vaccinate in response to hotline requests
- Over 200 people received information through tip sheets promoting vaccine confidence after the Mexican Consulate opened its new offices



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- CHWs attended a webinar, which provided information on COVID-19 vaccination and children in terms of vaccine safety and requirements for the new school year
- Resource fair with 300 attendees was held – COVID/vaccine information was distributed, and J&J vaccine was available

Diversity & Inclusion

- Designed and disseminated COVID-19 Vaccine 101 Communication Training – ensured meaningful and productive conversations with diverse populations to decrease hesitancy
- Recommended resources to community leaders that would be the most useful for the community through creating a Community Advisory Board and designing the statewide CEAL website

Information Sharing

- Spoke at state CHW meetings and national webinars – shared information pertinent to CHW community engagement and uptake by programs and researchers
- Addressed misinformation and community concerns through the organization of symposiums and town hall sessions involving leaders. Leaders included legislative members and the Mayor of Houston
- Participated in media interviews to educate the public and inform about CEAL work to reach underserved communities
- Texas Conference on Health Disparities – 2 day event-- Nearly 600 people tuned in and engaged with our speakers during the Q&A sessions over the course of the 2 day event
- CHWs interacted with participants through phone calls, emails, and text messages – provided valuable COVID-19 education and addressed rumors and frequently asked questions

**Questions/Answers/Comments**

There are HIPPA concerns with text messages. Please comment. It takes a while to get through the IRB. Approval came because the data was de-identified.

How long is the timeline? Originally it was one year and there are still COVID challenges, so it is being extended for another year.

## 6. Staff update: Medicaid value-based activities

**Annual Report on Quality Measures and Value-Based Payments**

- Texas Government Code, Section 536.008, directs the Health and Human Services Commission (HHSC) to report annually on its efforts to develop quality measures and quality-based (or value based) payment initiatives.
- 2021 Annual Report is in development
- 2020 Annual Report available online here: Annual Report on Quality Measures and Value Based Payments 2020 (texas.gov)
- This annual report presents information on HHSC's healthcare quality improvement activities for the Texas Medicaid Program and the Children's Health Insurance Program (CHIP).
- 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
- 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)
- HHS Quality Webpage and THLC Portal
    - HHS Quality Webpage
    - Texas Healthcare Learning Collaborative (THLC) Portal
- Trends in Key Quality Measures
    - Trends in Potentially Preventable Events
    - HHSC Performance Indicator Dashboard
    - HIV Viral Load Suppression
    - Relocation to a Community-Based Setting

Key Project Updates

- Accountable Health Communities convening
- Continued Assessment of COVID-19 Impacts on Value-Based Initiatives
- Multi-agency collaboration on value-based and quality improvement initiatives (Five Agencies Project, General Provision 10.06)
- Value-based and quality improvement analytic/research projects
- Quality website refresh

STAR+PLUS Pilot Program Innovative Payments

- Texas Government Code Section 534.104(c) requires the pilot program to test innovative payment rates and methodologies for the provision of long-term services and supports.
- Value-Based Initiatives Office has hosted three stakeholder meetings to explore options.
- Results from this focused collaboration were presented at the Joint Quarterly IDD SRAC and STAR+PLUS Pilot Program Workgroup on August 12 and HHSC is incorporating feedback.

STAR Kids Transition Services Collaborative

- The STAR Kids Managed Care Advisory Committee provided HHSC with recommendations on ways to improve the transition process from the pediatric system to adult system for members in its December 2020 Annual Report and subcommittee meetings.
- In 2021, HHSC has benefited from technical assistance from the National Alliance to Advance Adolescent Health and is exploring potential programmatic changes through this collaboration.

- Discussion has focused on:
    - Opportunities for better coordination between STAR Kids/STAR Health MCOs and STAR+PLUS MCOs
    - Potential contractual changes to improve transitions
    - Alternative payment methods to incentivize coordinated transfers from pediatric to adult providers • Related quality measures
    - Transition-related questions to potentially add in member surveys.

DSRIP Transition Milestone Update

Milestone 1 – VBP Roadmap and APM in Texas Medicaid Report

- In March 2021, HHSC submitted the updated Value-Based Payment Roadmap and the Alternative Payment Models in Texas Medicaid reports to CMS as required by the DSRIP Transition Plan. DSRIP Transition | Texas Health and Human Services

Milestone 3 – DY11 Program Options

- In January 2021, HHSC submitted the Support Further Delivery System Reform report with the four directed payment programs to begin September 1, 2021. All programs are subject to CMS approval.
    - Texas Incentives for Physician and Professional Services (TIPPS)
    - Comprehensive Hospital Increased Reimbursement Program (CHIRP)
    - Directed Payment Program for Behavioral Health Services • Rural Access to Primary and Preventive Services

Milestone 4 – DSRIP DYs 7-8 Quality Data Analysis

- In December 2020, HHSC submitted to CMS the analysis of DY 7-8 DSRIP quality data required by the DSRIP Transition Plan.

Milestone 7 – Assessment of Financial Incentives for Alternative Payment Models (APMs)

- In June 2021, HHSC submitted the assessment of Financial Incentives for APMs and Quality Improvement Cost Guidance to CMS, as required by the DSRIP Transition Plan."

Milestone 8 – Assessment of Social Factors Impacting Health Care Quality in Texas Medicaid

- In March 2021, HHSC submitted the assessment of social factors to CMS, as required by the DSRIP Transition Plan.

Milestone 9 – Assessment of Texas Medicaid Rural Teleservices

- In June 2021, HHSC submitted the assessment of Texas Medicaid rural teleservices to CMS, as required by the DSRIP Transition Plan.

Milestone 10 - Regional Healthcare Partnership (RHP) Structure Post DSRIP

- In February 2020, DSRIP Anchors and providers submitted feedback on the existing Regional Healthcare Partnership (RHP) structure as part of the transition to post-DSRIP programs.
- HHSC will consider all responses as the agency develops post-DSRIP programs and operations framework.

References for Milestones:
Value-Based Payment Roadmap (texas.gov)
Alternative Payment Models in Texas Medicaid

Texas Incentives for Physicians and Professional Services (TIPPS) Program | Texas Health and Human Services
Comprehensive Hospital Increased Reimbursement Program (CHIRP) | Texas Health and Human Services
Directed Payment Program for Behavioral Health Services (DPP BHS) | Texas Health and Human Services
Rider 38 DSRIP (texas.gov)
Assessment of Financial Incentives for Alternative Payment Models (texas.gov)
Quality Improvement Cost Guidance (texas.gov)
Assessment of Social Factors Impacting Health Care Quality in Texas Medicaid
Texas Medicaid Managed Care Focus Study
Texas Medicaid Managed Care Focus Study Addendum
Assessment of Texas Medicaid Rural Teleservices
Milestone 10 - Provider Responses (texas.gov)
Milestone 10 Survey - Anchor Responses (texas.gov)
Regional Healthcare Partnership Structure Post-DSRIP (texas.gov)

**Questions/Answers/Comments**.

Are there numbers based on savings from these efforts. HHSC stated that they would look at metrics on savings.

## 7. Update: 87th Legislature, Regular Session (2021) Lisa Kirsch

Provisions in SB 1 Related to VBPQI Committee Work

- Article II, HHSC Rider 20 requires HHSC to develop quality of care and cost efficiency benchmarks for managed care organizations participating in Medicaid and CHIP by September 1, 2022.
- Continues Article IX Special Provision (10.06) related to cross-agency (HHSC, DSHS, ERS, TRS, and TDCJ) coordination on healthcare strategies and measures supported by the UT Data Center in Houston.

American Rescue Plan Federal Aid Money

- $1.9 trillion aid package approved by Congress in early March, with the following estimates for Texas:
  - State to receive just under $17 billion in direct aid
  - $10 billion going directly to local municipalities
  - $12.2 for education spending.
- Spending of federal relief and economic stabilization funds from the American Rescue Plan Act is included in the call for the 2nd Called Special Session that began August 8th.

**Telemedicine/Telehealth**

HB 4

• As permitted by federal law and if cost effective and clinically effective, expands access to Medicaid/CHIP telemedicine/telehealth services in many ways.
• HHSC is to consider the availability of telemedicine and telehealth services within the provider network of an MCO when assessing network adequacy.

HB 5

• Establishes the Broadband Development Office within the Office of the Comptroller of Public Accounts and tasks the office with preparing, updating, and publishing a state broadband plan

SB 40

• Allows the health professions programs administered by the Texas Department of Licensing and Regulation (i.e., Behavior Analysts, Dietitians, Dyslexia Therapists, Hearing Instrument Fitters and Dispensers, Midwives, Orthotists

and Prosthetists, Podiatry, and Speech Language Pathologists and Audiologists) to provide telehealth services within the scope of their practice as direct patient observation or care.

**Data**
HB 2090

- Establishes a statewide all payor claims database with information useful for improving health care quality and outcomes, lowering health care costs, and increasing consumer price transparency.
- The Center for Healthcare Data (CHD) at The University of Texas Health Science Center at Houston is to serve as the administrator of the database and manage the information submitted for inclusion in the database.

**Maternal Health**
HB 133
• Extends Medicaid coverage for new mothers from two months to six months after birth
• Improves continuity of care and care transitions by moving under the purview of Medicaid health plans case management for pregnant women and children and the Healthy Texas Women's program

## 8. Workgroup reports:

**Value-based payment in home health, pharmacy, and other areas**

Why Did CMS Move to APMs?

- Priority #1: The need for improved patient health outcomes
- Priority #2: The need for high quality care.
- Priority #3: The need for cost efficient care.
- The need for improved patient outcomes.
- The need to use proven approaches
- The need to eliminate what has NOT worked

What the VBPQI Advisory Committee Has Already Achieved

- Committed to APMs
- Identified Value Proposition of APMs
- The need for critical measure/metrics
- Promotes innovative approaches, collaborations between different partners
- Moving to implement APMs
- Moving to find common ground among different stakeholder

What RGVSG Proposes

- Focus on proven approaches
- Focus on data and metrics
- Pay for improved patient health outcomes
- Reduction in Potentially Preventable Events
- Cost reductions for HHSC, MCOs
- Greater patient education
- Better attendant training • Willing to partner with any group who can provide better patient outcomes

We Know What Hasn't Worked for Patients

- Rate enhancements not tied to performance improvement
- Fee for Service
- Tokens are abused by some attendants
- Attendants jumping agencies and taking the patients
- Hospitalizations, re-admits stress & clog the healthcare system

What Else Has Not Worked for Patients: Patient Choice

- Patient Choice is pointless if it is uninformed
- Patients can look up information/ratings on doctors and other medical providers
- No source for patients to look up information on health plans, provider agencies or attendants
- Patients are selecting health plans, provider agencies and attendants with minimal information
- Patients are making healthcare decisions with minimal information
- Patients may not be familiar with the health plan or prover agency they select

Patient Choice Has Become Attendant Choice

- Too many attendants switch patients from provider agency to provider agency with impunity
- Frequent patients switching is a burden for MCOs
- This is a problem everyone in the healthcare system
- This causes repeated interruptions in the continuum of care
- CMS has allowed other states to limit patient switching agencies
- RGVSG, OIG developed positive awareness program for attendants

Patient Choice Has Become Patient Abuse

- Attendants switch agencies when they are being properly supervised
- Attendants switch agencies when they are required to meet EVV minimums
- Attendants switch agencies when they are required to meet their daily duties
- Attendants switch agencies when they are being properly supervised
- Attendants switch agencies when they are required to meet EVV minimums
- Attendants switch agencies when they are required to meet their daily duties

Patient Choice Has Become A Serious Health Risk

- Substandard provider agencies are not policing attendants
- The industry is not policing itself
- Hospitalizations, ER visits, falls and other Potentially Preventable Events are likely tied to repeated attendant switching patients from agency to agency
- This is costing HHSC, health plans, hospitals, provider agencies and PATIENTS
- Some attendants are NOT ACCOUNTABLE to provider agencies that employ them or the patients

Substandard Agencies Are the Scourge of The Medicaid Program

- Substandard agencies provide no meaningful supervision of attendants
- They poach members from other agencies



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- They have NO anti-fraud protocols
- They have lower EVV rates
- Even when an agency gets de-barred, the owners just start another one under a new name.
- The industry does not police itself

GPS-Based App for EVV is Proven Technology

- Once attendants have been trained to use it effectively, they like it
- Attendants currently using it show increased auto linking rate
- Reduces cost by decreasing EVV maintenance for agencies, HHSC
- Provides manageable, more accurate data
- EVV app is easily scalable, adjustable to provide more services (daily patient checks)
- Software constantly improving
- Security can be built into the app
- Tracking is blocked except when checking in and out
- Provides innovative solution
- Most attendants have access to smart phones
- Flip phones are virtually unavailable
- Eliminates extra cost to agency by not having to install the token in the home.
- Tokens hard to upgrade
- Tokens easy to take out of the home

Attendant Training Is Validated in Numerous Studies

- Produces a better informed and educated attendant to prevent ER visits, hospitalizations, special diet to meet disease management
- Increased PCP visits
- Improved medication usage
- Reduced falls
- Increased use of nurse hotlines

Hospital Release Care Coordination Is A Proven Approach

- Provides clean hand-off on care
- Provides, improves coordination of care between MCOs & provider agencies
- Reduces readmissions
- Provides patients with continuity of care
- Links hospital instructions with PCP care and home care
- Early intervention is critical
- Requires close coordination between MCOs and home health agencies
- IDTs essential to full patient recover at home
- Behavioral health issues require more focused attention & support

Movement towards APMs Are Here to Stay

- CMS & states are moving to this approach



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- States moving away from fee-for service
- States moving away from volume approach
- Texas is behind in moving to APMs but working to improve

Cost Containment Is Growing Issue
- Hospitalizations costs are not decreasing significantly
- Readmissions, ER visits are not decreasing significantly
- Potentially Preventable Events are a major cost driver

Metrics & Data Are Critical
- Need to know primary and secondary diagnoses; PCP and specialty names/contact info; other healthcare providers i.e. DME, DAHS, Therapists, etc.
- PCP visits • Hospitalizations
- ER readmissions
- Medication adherence
- Fall prevention
- Data needs to be accessible to make metrics worthwhile

Strengthening the Industry
- Increased standards and quality for agencies improve the industry
- Builds greater respect for the industry
- Drastically decreases fraud
- Strengthens industry standing in legislative, administrative sectors
- Improves health outcomes for patients
- Reduces costs for HHSC, MCOs and agencies

What's Coming
- More pressure for cost-containment
- More pressure for improved patient health outcomes
- More pressure to strengthen data collection & tied to health outcomes
- Models working to improve care through innovation
- More outcomes tied to metrics

**Still workgroup one: Increasing Value-Based Payment in Home Health, Pharmacy and other areas**
KEY CONSIDERATIONS:
1. Meaningful Quality/Efficiency Metrics
- Training and Compliance Related Metrics accountable care
- Clinical Quality Metrics-good care • Efficiency Metrics-cost effective care

2. Medicaid-Specific Quality Rating System for Providers
- Abundance of providers, but a need to understand which providers demonstrate high value
- Preferred providers, tiered reimbursement tied to rating
- Ratings based on improved member health outcomes •

- There is no existing mechanism for eliminating poorly performing providers

3. HHSC Contractual Levers to Advance Meaningful APMs
- MCO Targets should be amended to stimulate growth in APMs in targeted areas
- Collaborative APMs
- e.g., In Home Care-Primary Care

4. HHSC Monitoring/Enforcement of Provider Compliance
- Unethical Provider Marketing/Solicitation
- Requirement for Active Compliance Plans and Reports for all providers

5. MCO Support for Meaningful APMs that Transform Care
- More collaboration/communication between MCOs and providers "along the way"
- Provide critical member medical information to providers so that they are better able to serve the member
- Provide real time data on member status for actionable responses in the home

6. Piloting/Testing Innovative Models
- Incubators to test new approaches
- New approaches not based on the old playbook
- Require process and performance measures for providers and attendants
- Require benchmarks on which to base measures

Possible directions for Pharmacy work:
- Establish standards and a working definition for an Accountable Pharmacy Organization (APO).
- Consider the positive impact of recognizing pharmacists as providers and allowing pharmacist fee-for-service billing in Texas Medicaid.
- Consider a workgroup tasked to recommend suggested enhanced pharmacy services and quality measures that align with other stakeholders (i.e. National Committee for Quality Assurance (NCQA), Healthcare Effectiveness Data and Information Set (HEDIS))
- Innovative pharmacy: APMs should be encouraged by performing outcome-based pilot studies that bring increased awareness and visibility to interested stakeholders.
- H.B. No. 2658, Sec. 533.00515., MEDICATION THERAPY MANAGEMENT. The executive commissioner shall collaborate with Medicaid managed care organizations to implement medication therapy management services to lower costs and improve quality outcomes for recipients by reducing adverse drug events.

**Social drivers of health** (A much more detailed report will be available at the next meeting)

Resources and collaborative efforts to inform opportunities for Texas to address Social Determinants of Health (SDOH)
• CMS letter to State Health Officials re: "Opportunities in Medicaid and CHIP to Address Social Determinants of Health" (1/7/2021) https://www.medicaid.gov/federal-policyguidance/downloads/sho21001.pdf
• National Academy for State Health Policy: "Five States Break Down Interagency Silos to Strengthen their Health and Housing Initiatives" (December 2020)

• Five States Break Down Interagency Silos to Strengthen their Health and Housing Initiatives – The National Academy for State Health Policy (nashp.org)
• Texas MCO SDOH Learning Collaborative (ongoing)
• DSRIP Milestone 8 – Assessment of Social Factors Impacting Health Care Quality in Texas Medicaid (March 2021)
• DSRIP Milestone 7 – Assessment of Financial Incentives for Alternative Payment Models (APMs) (June 2021)

VBPQIAC Recommendations

- VBPQIAC Recommendation #5: Landscape Assessment
- Use the CMS letter as a potential framework for the SDOH landscape assessment (VBPQIAC recommendation #5)
- VBPQIAC Recommendation #6: Explore how initiatives to address SDOH can be supported through APMs
- Explore opportunities under federal authorities, including 1115 Waivers
- Example: North Carolina - authorizes the provision of the Enhanced Case Management and Other Support Services Pilot Program, to improve health outcomes and lower healthcare costs. The state is piloting evidence-based interventions, such as those for housing, transportation and food.
- Explore opportunities to address SDOH through MCO quality improvement efforts, Value-added services, and In-Lieu of Services
- Example: screening and referral of patients to services such as food, shelter and transportation
- Example: Pittsburgh's healthcare strategies to address SDOH, with a focus on winter housing

Identified issues for continued exploration:

- Identify evidence-based approaches to screening and referral
- Review Geo Mapping in referral tools, which identify available resources near patient.
- Identify different referral tools tailored to specific practice types.
- Role and funding for social workers, community health workers and others, who can refer patient to appropriate resources.
- Need to establish clear priorities for SDOH work.

SDOH Action Plan

HHSC is designing an SDOH action plan informed by recent and current developments, including:

- DSRIP Assessment of Social Factors Milestone report
- Texas experience with CMS Accountable Health Communities Model grants
- MCO SDOH Learning Collaborative
- CMS letter to State Health Officials re: "Opportunities in Medicaid and CHIP to Address Social Determinants of Health"

The action plan will establish HHSC priorities and SMART goals/milestones for advancing SDOH initiatives through Medicaid managed care.

**Next steps for Alternate Payment Models and contract language**

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 considering extending targets past CY 2021.

Other Current Requirements

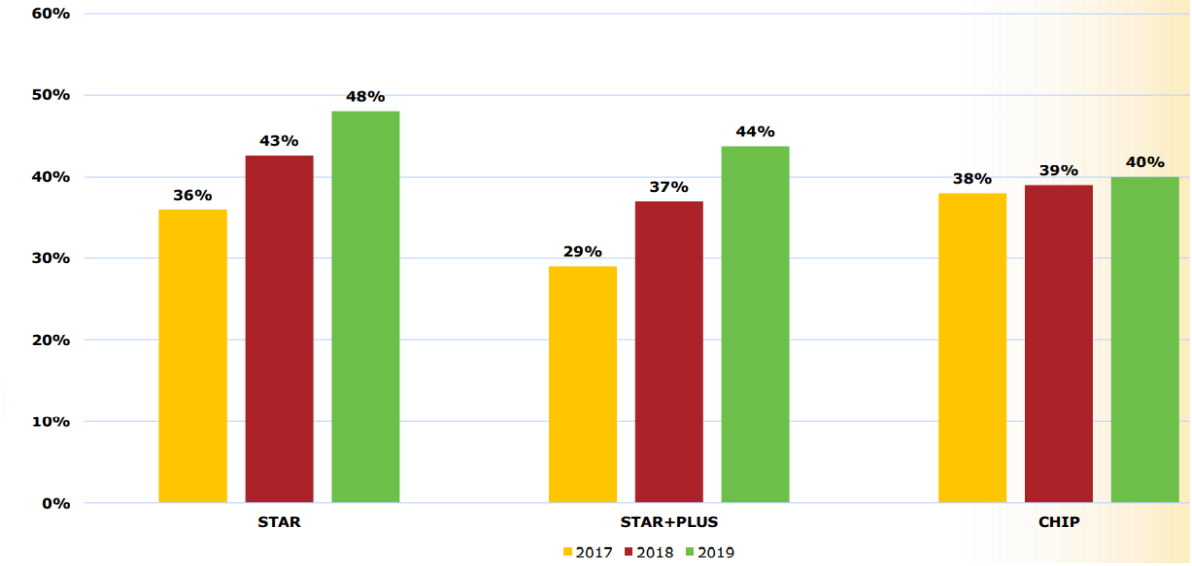
Current APM Contract Requirements:

- Submit to HHSC its inventories of APMs with Providers by July 1st of each year using the data collection tool in UMCM Chapter 8.10.
- Implement processes to share data and performance reports with Providers on a regular basis.
- Dedicate resources to evaluate the impact of APMs on utilization, quality and cost, as well as return on investment.

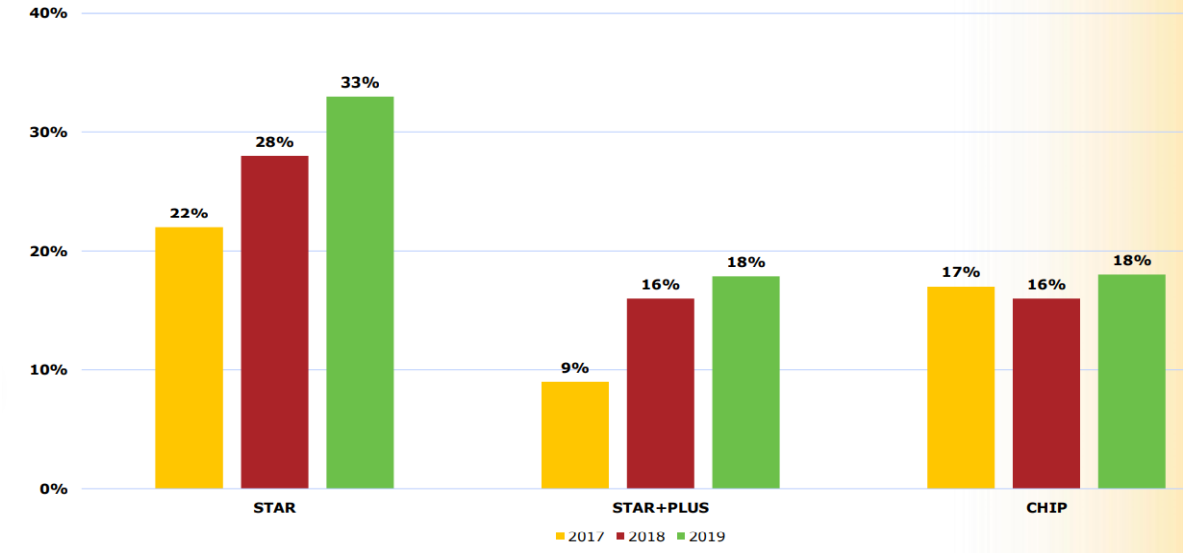
Contract Language: Alternative Payment Models with Providers

- Uniform Managed Care Contract (UMCC) – 8.1.7.8.2 (STAR, STAR+PLUS and CHIP).
- STAR Health Managed Care Contract - 8.1.7.9.2.
- STAR Kids Managed Care Contract – 8.1.7.9.2.

# Overall APM Achievement CYs 2017 - 2019




# Risk-based APM Achievement CYs 2017 - 2019



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# Distribution of Total Payments, Claims and (Dis)Incentives by Provider Type CY 2018

| Provider Type | Total Payments | Percentage of Total Payments | Claims Paid | Percentage of Claims Paid | Incentives | Percentage of Incentives |
|---|---|---|---|---|---|---|
| Primary Care + Ob/Gyn + Urgent Care | $2,450,345,112 | 53.7% | $2,402,273,660 | 53.8% | $48,071,452 | 47.8% |
| Health Home, Nursing Facilities, and Home Care | $1,030,636,509 | 22.6% | $1,026,391,034 | 23.0% | $4,245,475 | 4.2% |
| Specialist, Behavioral & Mental Health | $87,333,702 | 1.9% | $47,311,311 | 1.1% | $40,022,391 | 39.8% |
| ACO | $747,481,553 | 16.4% | $739,403,055 | 16.6% | $8,078,498 | 8.04% |
| Pharmacy and Lab | $250,474,188 | 5.5% | $250,426,565 | 5.6% | $47,623 | 0.05% |
| Total | $4,566,271,065 | 100% | $4,465,805,625 | 100% | $100,465,440 | 100% |

Options under consideration to advance HHSC's Medicaid managed care APM initiative include:

- Extending the 4th year target (2021) for one additional year.
- Revisiting MCO APM requirements for the future
- Enhancing APM evaluations and best practice sharing
- Identifying opportunities for aligning or standardizing metrics and models
- Recognizing innovative APM approaches, such as for addressing health related social needs, i.e., social determinants or drivers of health (SDOH)

**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

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 | |

| Example Menu | Points |
|---|---|
| • 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 | |

| Example Menu | Points |
|---|---|
| • Developing innovative approaches to address SDOH:<br>1. Leveraging VBP to incent the reduction of health disparities<br>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 | |

**Questions to Brainstorm**

Possible questions:

- What additional APM related elements should be incorporated into a more comprehensive framework?
- What are the options for MCOs to communicate needed information to HHSC?
    - Expand current APM tool
    - Survey
    - Require new evaluation tool (If using a new tool, consider using Catalyst Payment Reform Evaluation Tool as a potential template?)
- The challenge: How can the new elements be efficiently collected, measured and combined to establish quantifiable contractual standards?

**Recommendation 2**: HHSC should maintain current APM targets for overall and risk-based APMs or incrementally align them with updated targets suggested by HCPLAN, CMS, or planned by other states. (Targets should be only one of many criteria used to assess MCO achievement with APMs).

Consider including 3A HCPLAN category as part of risk-based targets.

Timeline for Submitting Contract/Manual Changes

MCO/DMO Manual Amendment Process:

- Opportunity exists to update current APM tool for 01/01/2022.

MCO/DMO Contract Amendment Process:

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

**Questions/Answers/Comments**

Population segmentation was mentioned. Hospitals are in different evolutionary phases and so maybe the measures could be done in a tiered approach.

We are a way away from full capitation where the SDOH happen automatically. It will be a balancing act moving in that direction. The Primary Care Marshal Plan was mentioned as a resource. primary_care_marshall_plan.pdf (tafp.org)

There seems to be a slight disconnect between the two recommendations related to targets. Ms. Kirsch stated that they could possibly be combined.

**Public Comment**

**Subject Matter Experts Comments**

**Rachel Hammond, TAHCH** stated that quality in the homecare space has been conducted mostly on the Medicare side of the business. There are standardized metrics on a standardized platform. CMS implemented demonstration projects in nine other states. Value-based expansion will occur on the Medicare side nationwide in 2022. CMS had released an RFI in 2020 and results are still pending. There are challenges providers have because of the lack of uniformity and this will be an issue in home health as well. There has been work on the measures side through NCQA and CMS. Eight measures for Medicaid have been developed. They are recommending measures on the macro level for home care.

**Other Public Comment**

**Marjorie Costello, provider** stated LTSS agencies appreciate the opportunity to work together on quality measurement. She had some concerns:

- So many MCOs with their own value-based programs creates an administrative burden on agencies… there is a need for uniformity

- Promote accreditation and reward such

**MOTION**: Approve recommendation one prevailed

## 9. 2021 Planning meeting

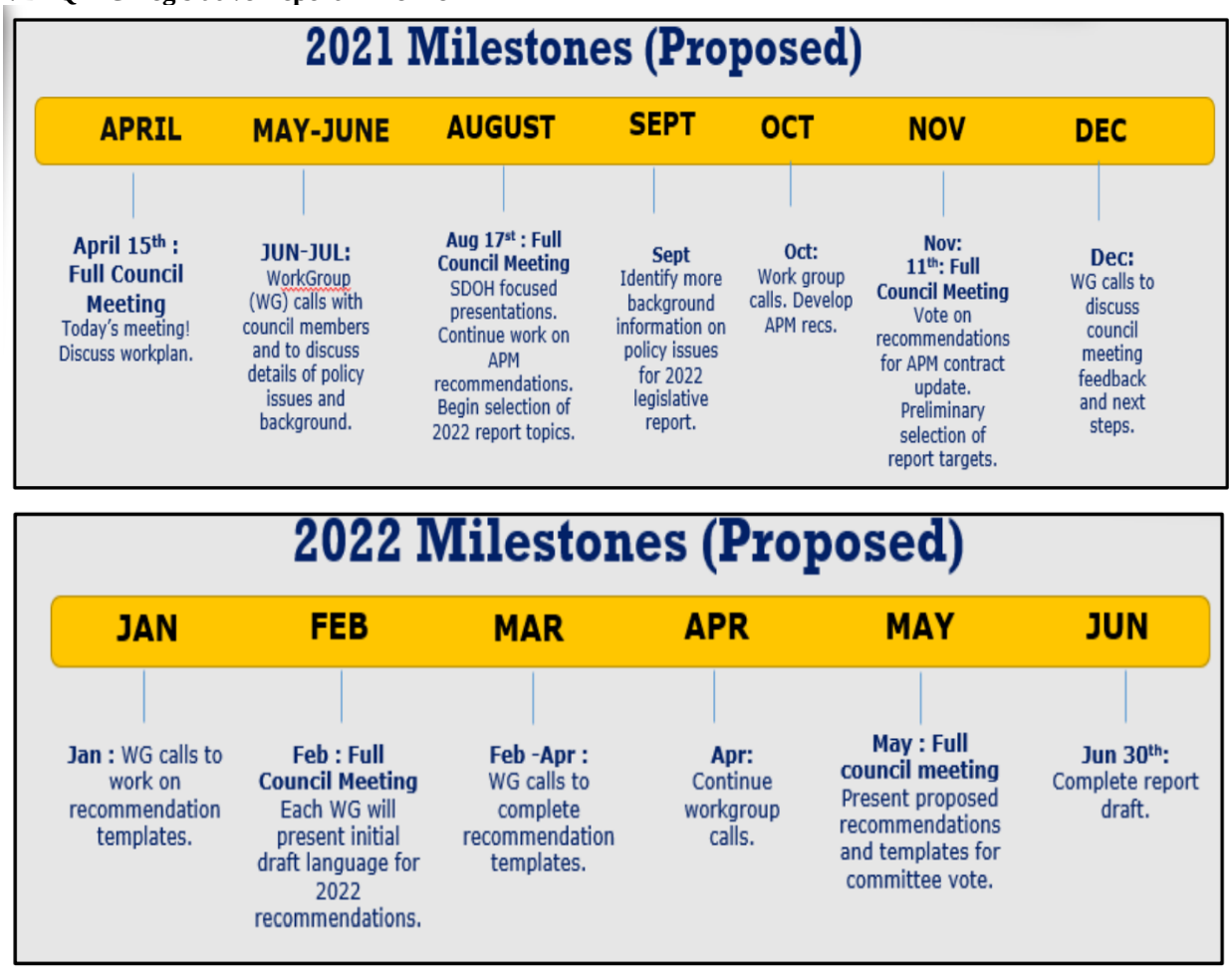
Update: Work-plan tracker--- is being used to address priorities from the committee and the tracker will be made into a live document across all the issues being investigated by the committee. The 2020 report recommendations and implementation are being tracked. This is designed to be a planning tool for actionable items.

New Member Appointment Process: Application process will open in the next few months with a one-month application deadline

Members with expired terms:

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

**VBPQIAC Legislative Report Timeline**




**10. Public comment**. No additional public comment was offered

**11. Action items for staff and/or member follow-up**. Three items were proposed by staff.

**12. Adjourn**. November 9th is the next meeting. There being no further business, the meeting was adjourned.

***