HHSC: Value-Based Payment and Quality Improvement Advisory Committee

November 9, 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 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
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 meeting was called to order by Dr. Carol Huber. A quorum was established.

2. Consideration of August 17, 2021, draft meeting minutes. The minutes were approved as drafted.

3. Presentation: Community Health Access and Rural Transformation (CHART) Model According to the U.S. Centers for Medicare and Medicaid Services (CMS), about 57 million Americans live in rural communities, and many use Medicare and/or Medicaid as their health insurance. Rural communities face unique challenges when providing health care services, including limited transportation, shortages of facilities and providers, and a lack of technological and delivery innovations.

To improve health care access and outcomes in rural communities, the Texas Legislature enacted Senate Bill 1621 during the regular session of the 86th Legislature in 2019, which required HHSC to create a strategic plan to ensure that Texans residing in rural areas have access to hospital services.

In the most recent Rural Hospital Services Strategic Plan Progress Report (PDF), HHSC identified three key strategies, outlined below, to further the goal of ensuring access to hospital services and reducing rural hospital closures:

1. Ensure that Medicaid reimbursements are adequate and appropriate.
2. Increase access to established revenue opportunities to maximize reimbursement for hospitals.
3. Identify challenges that hospitals experience in providing services to persons covered by Medicare and other payers.

In August 2020, CMS announced a new funding opportunity called the Community Health Access and Rural Transformation (CHART) Model specifically for rural hospitals.

The CHART Model will test whether aligned financial incentives, increased operational flexibility, and robust technical support can assist rural health care providers' capacity to implement an effective redesign of their health care delivery system. The CMS Center for Medicare and Medicaid Innovation will evaluate the impact of the CHART Model on Medicare and Medicaid expenditures, access to care, quality of care and health outcomes.

To assist rural communities overcome challenges and build on previous successes, HHSC partnered with a limited number of rural Texas hospitals to apply for the CHART Model funding opportunity for the Community Transformation Track.

On September 10, 2021, CMS announced HHSC is one of four Lead Organizations selected for the Community Transformation Track federal funding opportunity. As the Lead Organization, HHSC will be responsible for driving health care delivery system redesign by leading the development and implementation of Transformation Plans as well as convening and engaging the Advisory Council. Additional information about the Community Transformation Track, as it becomes available, will be included under the CHART Model Award section Rural Hospital Grant Facilitation | Texas Health and Human Services.

The CHART Model is a funding opportunity from the Centers for Medicare and Medicaid Services. The CHART Model is a voluntary opportunity for rural communities to test health care transformation supported by payment reform.
There are two tracks for which Lead Organizations can apply for funding:

- The Community Transformation Track – Provides award recipients with cooperative agreement funding and a programmatic framework to assess the needs of their community and implement health care delivery system redesign. This track builds on the lessons from the Maryland Total Cost of Care Model and Pennsylvania Rural Health Model.

807 BRAZOS ST, SUITE 607, AUSTIN, TX 78701 TEL: 512-708-8424, WWW.THBI.COM

- The Accountable Care Organization (ACO) Transformation Track – Provides upfront payments to rural ACOs that join the Medicare Shared Savings Program. This track builds on lessons learned from the ACO Investment Model. CMS will release the Request for Application in spring 2022. (Applications available spring of 2022)

The CHART Community Transformation Track will provide rural hospitals with three ways to transform their local health care system:

1. Regular lump sum payments based on a hospital's Medicare fee-for-service income (a.k.a. capitated payment amount)

CMS will replace Medicare fee-for-service claims reimbursement for Participant Hospitals with regular, lump sum payments also called a "capitated payment amount (CPA)" throughout the duration of the CHART Model. The CHART Model CPA will be calculated by CMS, not HHSC. The benefit of this payment change to hospitals is that the CPA payment provides stability and predictability, as well as the freedom to invest in new service lines and utilize regulatory flexibilities offered by the CHART Model initiative. For example, hospitals may have had to focus on providing higher-reimbursing specialty services over essential primary care and improving behavioral health capacity or maintaining inpatient beds to meet Medicare conditions of participation, even when it may not be what is needed in the community.

2. Cooperative Agreement Funding

As the CHART Model Lead Organization for Texas, HHSC will disperse up to $2.7 million in cooperative agreement funding to participant hospitals. Participating hospitals will use the funding to establish partnerships and technical support to address one or more health challenges in the Texas CHART application to establish a telemedicine project that fits the needs of the hospital's county, and to address health disparities and selected social determinants of health.

3. Operational Flexibilities

CMS will make available certain operational flexibilities to expand Lead Organizations' ability to implement health care delivery system redesign and promote participating hospitals' capacity to manage their patients' care. Lead Organizations, like HHSC, will be responsible for requesting operational flexibilities in their Transformation Plans in consultation with Participant Hospitals. These flexibilities will be provided through a combination of the Model Design Flexibilities listed in the notice of funding opportunity and through CMMI's authority under section 1115A(d)(1) of the Act to waive certain Medicare and Medicaid requirements, solely as may be necessary to test the Model. CMMI may waive such requirements of Titles XI and XVIII and of sections 1902(a)(1), 1902(a)(13), 1903(m)(2)(A)(iii), and provisions of section 1934 that were added to section 1115A(d)(1) by the PACE Innovation Act as may be necessary solely for purposes of carrying out section 1115A with respect to testing models described in section 1115A(b).

807 BRAZOS ST, SUITE 607, AUSTIN, TX 78701 TEL: 512-708-8424, WWW.THBI.COM

As the lead organization, HHSC will receive up to $5 million in cooperative agreement funding. HHSC's goal is to use much of the cooperative agreement funding to:

- Provide technical assistance to hospitals related to transformation
- Allow hospitals to purchase telemedicine equipment, training, software and hire additional staff, if needed, to implement transformation goals

If successful, residents of participating rural communities should see improvement in access to health care services, financial stability of providers, and an alignment of payers and other stakeholders to address both the communities' needs and social support structures, such as food and housing, to ensure improved health. Ultimately, the CHART Model's purpose is to bring improved financial stability to participant rural hospitals through capitated arrangements and provide strategies to address health challenges through telemedicine. Through the CHART Model, health care providers, as well as public and private payers, can collectively invest in increasing access to care, promoting quality, and improving the health outcomes of residents within their community. The estimated project period is October 1, 2021 through December 31, 2028.
If you are interested in receiving additional information about HHSC's application for CHART Model program, sign up for email updates.

HHSC's CHART Model application and supplementary references are included below. It is recommended to view the CHART Model application requirements on pages 51 – 59 of the CHART Model Notice of Funding Opportunity before viewing HHSC's application. These pages show the information HHSC was required to include in its application.

- HHSC CHART Model Community Transformation Track Application (PDF)
- HHSC CHART Model Community Transformation Track References Attachment (PDF)
- CMS CHART Community Transformation Track Notice of Funding Opportunity (PDF)

CHART and Rural Health Care Resources

- CMS CHART Model Participation Quality Strategy Factsheet (PDF)
- HHSC CHART Model Project Abstract (PDF)
- HHSC CHART Model Letter of Intent Sent to CMS (PDF)
- CHART Model Fact Sheet (PDF)
- Centers for Medicare and Medicaid Services Center for Innovation
- Health Resources & Services Administration Federal Office of Rural Health Policy
- Texas Health Professional Shortage Area Map
- Health Professional Shortage Area Designation
- University of North Carolina Rural Health Research Program
- Rural Health Information Hub
- Texas State Office of Rural Health

Questions/Answers/Comments

Are there particular outcomes being targeted. HHSC stated that there are measures that CMS is requiring and the measures will be developed jointly with hospitals.

How many hospitals are considered rural? CMS stated that a hospital must be an acute care hospital or critical access hospitals. They must have 20% of Medicare services provided within the community as defined by HHSC. A process was followed that involved letters of intent from hospitals. There were 14 hospitals that initially sent a letter of intent.

Four community health challenges: Lack of coordinated care, transition needs, improvement of chronic conditions and improvement of access to primary and specialty care.

4. Presentation: Texas HealthCare Learning Collaborative Portal. The Texas HHSC is working to strengthen public reporting and to increase transparency and accountability of services and care being provided under the Texas Medicaid system. The goal is to encourage further discussion on the aspects of care being tracked by these quality measures and spur collaboration among internal and external stakeholders to improve the quality of care and cost effectiveness of the Texas Medicaid system. Please follow this link for access to the portal. Texas Healthcare Learning Collaborative (thlcportal.com). The portal screens were shared on a very high level and can be accessed by following the link.
Available links include:
HOME(CURRENT)
MEASURES
PPE
DASHBOARDS
RESOURCES(CURRENT)
HELP

807 BRAZOS ST, SUITE 607, AUSTIN, TX 78701 TEL: 512-708-8424, WWW.THBI.COM

Questions/Answers/Comments

The data available appear to be very old and don't reflect what is going on presently. Can the data be updated more frequently? HHSC stated because the portal is used for oversight and the only updated measures are PPE. Other measures are annual and with the dispute process, the delay is difficult to avoid . It is a full year process to get the data posted once after the data is finalized. HEDIS is done on a calendar year.

How many MCOs require corrective actions? HHSC stated they could pull that data and get it to the committee.

5. Staff update: Medicaid value-based activities

Medical Pay-for-Quality (P4Q) Program

- 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, CHIP) includes measures specific to the population. Lately the improvement has been so good that there was no money left in the bonus pool.

2020 the program was suspended and also in 2021. 2022 is in preparation for implementation.

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	

[1]

807 BRAZOS ST, SUITE 607, AUSTIN, TX 78701 TEL: 512-708-8424, WWW.THBI.COM

Measures	STAR+PLUS	STAR	STAR Kids	CHIP
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	
Assistance with Care Coordination			2022 2023	

[1]

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

807 BRAZOS ST, SUITE 607, AUSTIN, TX 78701 TEL: 512-708-8424, WWW.THBI.COM

Bonus Pool Measures	STAR+ PLUS	STAR	STAR Kids	CHIP
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	

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

807 BRAZOS ST, SUITE 607, AUSTIN, TX 78701 TEL: 512-708-8424, WWW.THBI.COM

[Texas Healthcare Learning Collaborative (thlcportal.com)]

Questions/Answers/Comments

QA can take a while and can be complicated. Moving to outcomes would make a better measure than process measures.

Can measures show that we have reduced costs. HHSC stated it is difficult to tie cost changes back to specific measures.

How does evaluation of the measures work within the program. HHSC stated that they look at factors such as where is their room for improvement. There is a process for fixing obsolete measures.

Reducing provider administrative burden makes measures easier to track.

Value-Based Care Next Steps: Key Inputs.

- Value-Based Payment Roadmap
- CMS Letter on Advancing Value-Based Care
- Legislative Direction
- DSRIP Milestone Reports
- HCP-LAN Changes
- VBPQIAC Recommendation (August 2021):
- HHSC should adopt a more comprehensive contractual APM framework to assess MCO achievement
- INNOVATION CENTER STRATEGY REFRESH (cms.gov)

VBP Roadmap: Guiding Principles:

- Continuous Engagement of Stakeholders
- Coordinated Efforts
- Administrative Simplification
- Data Driven Decision-Making
- Movement through the APM Continuum
- Rewarding Success

See: Value-Based Payment Roadmap (texas.gov)

CMS Letter on Value-Based Care

- Critical Elements Identified by CMS for VBP Design and Operation 23
- Level and scope of financial risk
- Payment operations
- Multi-payer participation
- System readiness
- Health information exchange
- Stakeholder engagement
- Quality measure selection
- Sustainability

New Value-Based Legislation: MCO Benchmarks
87th Texas Legislature, General Appropriations Act (GAA), HHS

- Rider 20: HHSC shall develop quality of care and cost-efficiency benchmarks for MCOs participating in Medicaid and CHIP.
- Appropriations for fiscal year 2023 are contingent on HHSC developing benchmarks by 9/1/2022.
- Legislative report due 8/15/2022.

DSRIP Transition Milestone Update

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.

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.

Milestone 9 – Assessment of Texas Medicaid Rural Teleservices-- In June 2021, HHSC submitted the assessment of Texas Medicaid rural teleservices to CMS.

For additional information please see: [DSRIP Transition | Texas Health and Human Services]

Teleservices and The Digital Divide in Rural Texas

Number of Texas Counties by Level of Broadband Access* as of July 2020

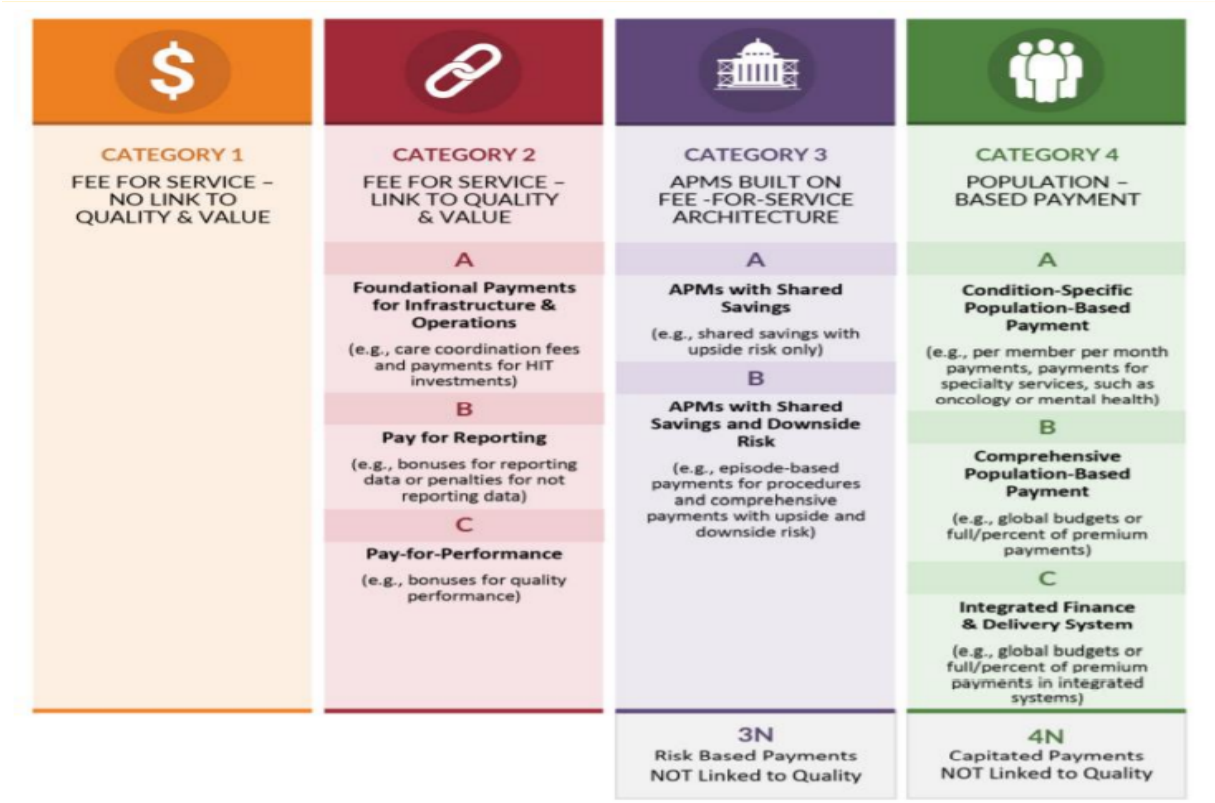
	Low	Medium	High	Total
Rural	36	36	100	172
Suburban	4	7	45	56
Urban	0	0	26	26
Total	40	43	171	254

*Broadband access categories are based on the distribution of percentages of households in each Texas county with 25x3 Mbps internet speeds. These percentages are estimated biannually by Connected Nation Texas. This table uses the July 31, 2020 update. For this report, low access is defined as less than 60% of county households having access to 25x3 Mbps internet speeds. Medium access is defined as 60%-79% with access. High access is defined as 80% or higher.

HCP-LAN Major Changes

The Health Care Payment Learning & Action Network (HCP-LAN) emphasis is evolving to promote more advanced alternative payment model (APM) arrangements that place risk on providers. In the fall of 2020, HCP-LAN launched its [LAN Healthcare Resiliency Collaborative - Health Care Payment Learning & Action Network (hcp-lan.org)](). and framework following the challenges presented by COVID-19. This framework promotes collaboration between payers, providers, and other stakeholders to shift payments into population-based APMs.

HCP-LAN APM Framework



See: [APM_onepager_v1 (hcp-lan.org)]()

CMS Innovation Center

"The purpose of the [Center] is to test innovative payment and service delivery models to reduce program expenditures…while preserving or enhancing the quality of care furnished to individuals under such titles" The Center for Medicare and Medicaid Innovation (CMMI) relooked at their

models of which six out of over 50 models have generated statistically significant savings to Medicare and to taxpayers, and four have met the requirements to be expanded in duration and scope. Looking Back: Issues and Barriers identified in the Models:

1. Health Equity isn't embedded in models
2. Portfolio of models are not streamlined
3. Lack of support for Care Delivery Transformation
4. Model Design has not ensured broad transformation
5. Complex financial Benchmarks have undermined effectiveness
6. Models haven't encouraged lasting transformation

CMMI is launching a new strategy with the goal of achieving equitable outcomes through high quality, affordable, person-centered care. To achieve this vision, the Innovation Center is launching a strategic refresh organized around five objectives provided in white paper.

White Paper: Overview

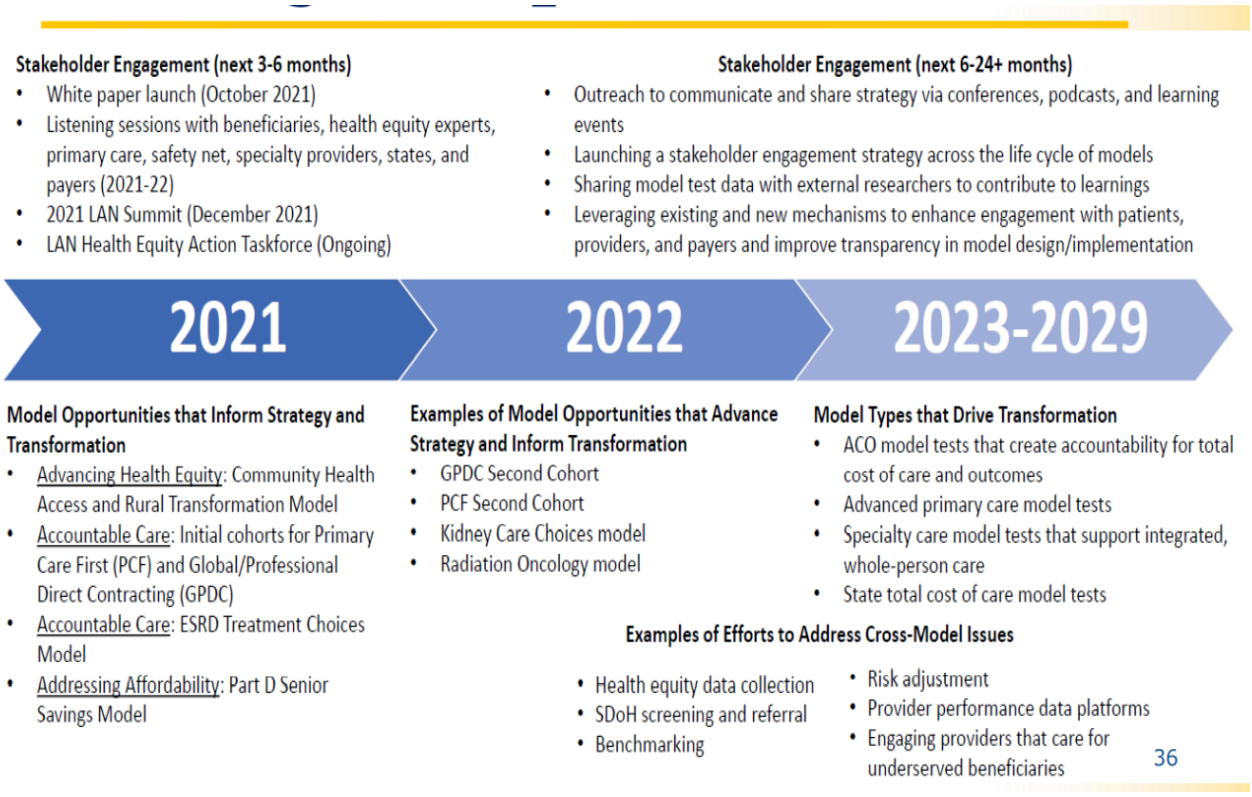
- White Paper: Describes the Innovation Center's refreshed vision and strategy and provides examples of approaches and efforts underway.
- CMMI Goal: Move every Medicare beneficiary and a majority of Medicaid members into an accountable care arrangement within the next 10 years.
- Concerns that brought change: Providers showed concerns about current models being too burdensome and benchmarks too complex.

INNOVATION CENTER STRATEGY REFRESH (cms.gov)

Five Strategic Objectives in Advancing System Transformation

Figure 1. CMS Innovation Center Vision and 5 **Strategic Objectives** for Advancing System Transformation.

Moving to Implementation.



Resources

The first of the Listening Session Series will focus on the Strategy Refresh overall and it will be scheduled for November. Additional topic-focused listening sessions will be scheduled for November and December. For additional resources: visit the CMS Innovation Strategic Direction webpage and read the white paper (link above).

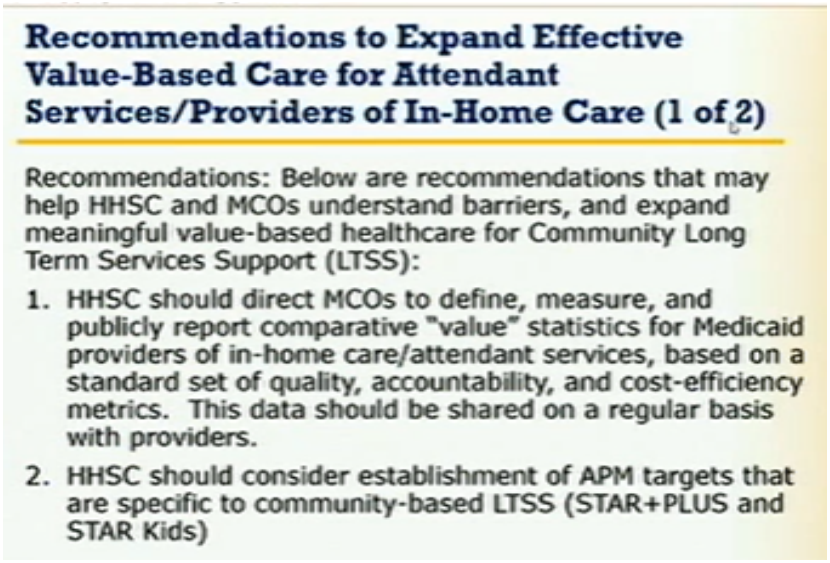
6. Workgroup reports:

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

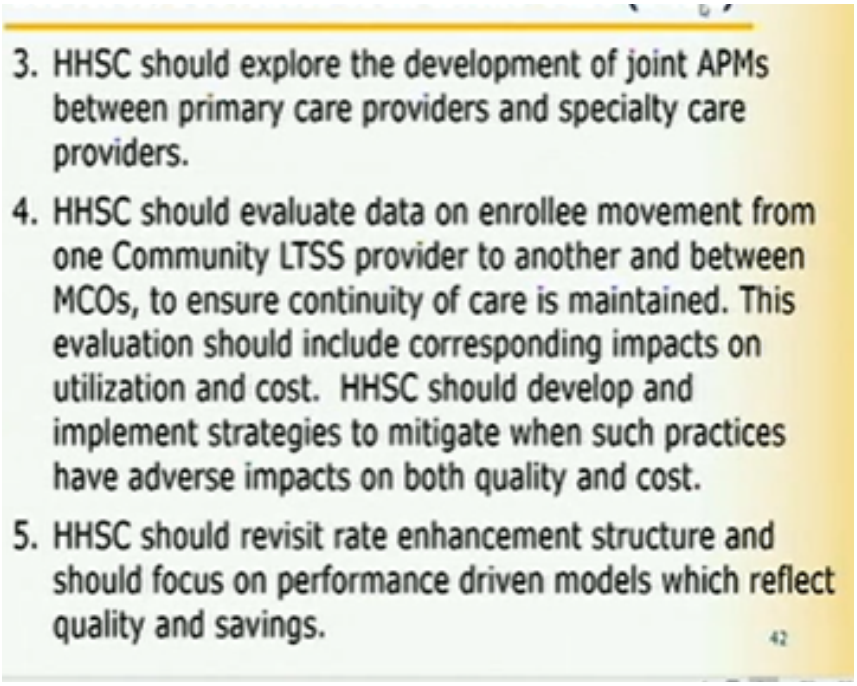
Possible directions for Pharmacy work:

- Establish standards and a working definition for an Accountable Pharmacy Organization (APO).
- Consider the positive impact of paying pharmacists as providers under the medical benefit in Texas Medicaid.
- 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.

Attendant Services



807 BRAZOS ST, SUITE 607, AUSTIN, TX 78701 TEL: 512-708-8424, WWW.THBI.COM



Overview of Joint Commission Accreditation and Value Based Payment

CHAP and ACAC or other Accrediting entities that could be used to enhance quality.

What Makes are Standards Unique

The Joint Commission

Go beyond many state and CMS regulations, provides specific guidance on areas of risk such as medication management and performance improvement.

Only accreditor to require organizations meet National Patient Safety Guidelines. Home Care 2021 NPSGs are:

- Patient Identification
- Safe Use of Medicine
- Infection Prevention
- Fall Prevention
- Identification of Patient Safety Risks

Accreditation Standards and Survey Process

Expert Advice, Collaborative Process, Actionable Insights

The Joint Commission

Joint Commission Accreditation Standards

- Developed with input from health care professionals, providers, subject matter experts, consumers, and government agencies (including CMS).
- Informed by scientific literature and expert consensus and reviewed by the Board of Commissioners.
- Subject to technical advisory panel and field review.

Surveyors Are Experienced Industry Professionals

- Employed by The Joint Commission, not independent contractors
- Working or previously employed in home care; understand day-to-day issues facing providers
- Continuous training and education to provide consistent, current and relevant insights

The On-Site Survey Process

- Uses the *tracer methodology* - the cornerstone of on-site survey - "tracing" the process of care and communication hand-offs
- Provides thorough, written evaluation with practical, evidence-based strategies for improvement

DASH (Data Analytics for Safe Healthcare)

The Joint Commission

DASH is a set of proprietary business intelligence tools developed to support Joint Commission customers and empower them to make more informed decisions to drive quality improvement and reduce harm.

- Compare organization to national and state peers on Medicare Condition of Participation [CoPs] performance.
- Compare organizational performance against other Joint Commission accredited organizations.
- Aggregated dashboard display of survey findings at the organization and multiorganization level.
- Management tool to identify trends and patterns.

Joint Commission Survey Cycle and Costs

The Joint Commission

Survey Cycle

- On-site survey every 3 years
- Survey typically 1 surveyor for 2-4 days depending on size of organization

Survey Structure

- Survey fee structured to fit all organizations – cost based on average daily census
- Two types of surveys: Deemed and Non-Deemed
- Deemed surveys allow for Joint Commission accreditation to be used for Medicare certification. Deemed surveys have slight cost differential for on-site survey fee only.

Survey Costs (Two Components-pricing commensurate for pharmacy])

1. Annual Fee: Medium Size Home Health Agency (51-300 average daily census] =$1925.00
2. On-Site Survey Fee: Every 3-years = $5,660.00 [deemed) $3580.00 (non-deemed]

Licensure & Recognitions (Home Health Agencies)

Added Value of Accreditation

The Joint Commission

State licensure

Joint Commission accreditation has been approved by some states (including Texas) for home health agencies seeking initial licensure and re-licensure. Texas home health agencies are also exempt from additional DADS surveys if they maintain accreditation.

Liability Insurers

There are liability insurers who are inclined to provide preferred rates/discounts and will account for it in their underwriting, if they are aware that your organization is accredited.

Medicare Certification

The Joint Commission is designated by the Centers for Medicare & Medicaid Services (CMS) as an approved accreditor for home care providers seeking Medicare certification.

Most Home Health Organizations are Not Accredited

The Joint Commission

- Most home health agencies in the United States (nearly 60%) are not accredited by any accrediting organization (including The Joint Commission).
- Most home health agencies choose to meet licensure and Medicare certification requirements through (minimum requirements) of the state licensure survey process.
- Accreditation may be used in value-based payment models as a structural or process measure; with bonus payments or quality incentives for those organizations who choose to meet standards above (minimum) state/federal licensure requirements.

Home Health Accreditation by Accrediting Organization

The Joint Commission

Main Home Health Accrediting Organizations:
ACHC, CHAP and The Joint Commission

Accredited HHA* in the United States		Accredited HHA* in Texas	
Joint Commission:	16%	Joint Commission:	3.5%
CHAP:	16%	CHAP:	10%
ACHC:	12%	ACHC:	2.5%
Unaccredited:	56%	Unaccredited:	84%
Total U.S. HHA:	10,681	Total Texas HHA:	2092

*Medicare Certified HHA; source CMS 10, 2021

Accreditation Can Impact CMS Quality Ratings

Home Health Care Management & Practice

Joint Commission accredited HHAs:

-higher star ratings for all measures

-more likely to score 4 – 5 stars (5 is highest)

-high star ratings sustained over time

- A study published in HHCMP in 2017 showed Joint Commission accredited home health agencies perform better than non-accredited agencies in nearly every CMS star rating category.
- A study completed in 2021 [currently under develop for publication] reviewed the same information and found that there were no significant changes from the findings in 2017.
- These studies demonstrate strong evidence that Joint Commission home health accreditation supports sustained quality over time.

Social drivers of health (SDOH)

Looking Backward: Recommendation from 2020 legislative Report

VBPQIAC Recommendations

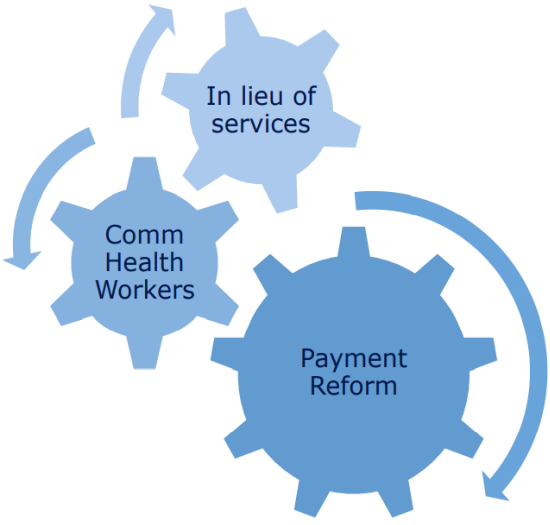
- VBPQIAC Recommendation #5: Landscape Assessment; Use the CMS letter as a potential framework for the SDOH landscape assessment (VBPQIAC recommendation #5)
- VBPQIAC Recommendation #6: Explore how initiatives to address SDOH can be supported through APMs; Explore opportunities under federal authorities, including 1115 Waivers; Explore opportunities to address SDOH through MCO quality improvement efforts, Value-added services, and In-Lieu of Services

Issues identified in addressing SDOH

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.

Looking Forward: Three Key Concepts



2022 Legislative Report should explore ways addressing SDOH

1. Alternate Payment models and MCO contract workgroup: The workgroup approved recommendations for year 2022 and beyond. The direction recommended by council include providing a menu of approaches to give MCOs credit for a broader range of work promoting value-based care including in SDOH area. A brainstorming survey was conducted to identify top priority approaches to which points will be attached: Developing innovative approaches to address SDOH:
    a. Leveraging VBP to incentivize the reduction of health disparities
    b. Addressing SDOH as part of an APM

2. Ways which in-lieu of services can cover social drivers of health for Texas.

3. Looking at opportunity in enhancing role of community health workers.

Example: 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

Resources:

Social Determinants of Health (SDOH) State Health Official (SHO) Letter (medicaid.gov)
Assessment of Social Factors Impacting Health Care Quality in Texas Medicaid
Assessment of Financial Incentives for Alternative Payment Models (texas.gov)
Five States Break Down Interagency Silos to Strengthen their Health and Housing Initiatives – The National Academy for State Health Policy (nashp.org)

Next steps for Alternate Payment Models and contract language

807 BRAZOS ST, SUITE 607, AUSTIN, TX 78701 TEL: 512-708-8424, WWW.THBI.COM

Current APM Targets~(Targets started in CY 2018. HHSC considering extending targets past CY 2021)

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.		

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
Attachment A - Medicaid and CHIP Managed Care Services RFP, Uniform Managed Care Contract Terms and Conditions (texas.gov)

STAR Health Contract Terms and Conditions (texas.gov)

STAR Kids Contract Terms and Conditions (texas.gov)

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

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

- Extending the 4th year target (2021) for one additional year
- Identifying a more comprehensive set of milestones to show achievement, rather than just APM targets
- Enhancing APM evaluations and best practice sharing
- Identifying opportunities for aligning metrics and models
- Recognizing innovative APM approaches, such as for addressing health related social needs, i.e., social determinants or drivers of health (SDOH)

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	

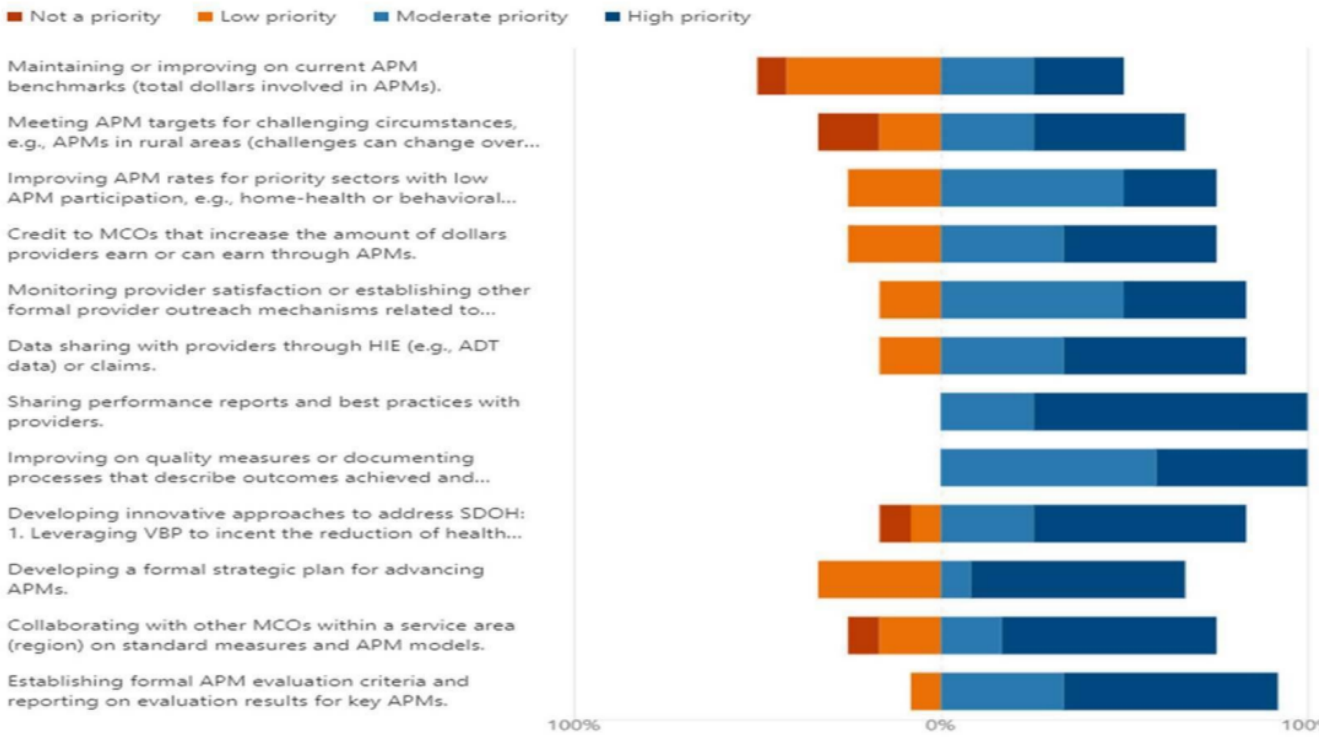
• Monitoring provider satisfaction or establishing other formal provider outreach mechanisms related to APMs **OR** processes for provider engagement	
• Data sharing with providers through HIE (e.g., ADT data) or claims	
• Sharing performance reports and best practices with providers	
• Improving on 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	

807 BRAZOS ST, SUITE 607, AUSTIN, TX 78701 TEL: 512-708-8424, WWW.THBI.COM

VBPQIAC Proposed APM Contract Language/Initiatives Survey Results

Please rate each concept based on the level of importance for inclusion in new APM contract language or related initiatives for Texas.

More Details



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.**

Resources

smd20004.pdf (medicaid.gov) CMS Medicaid letter

{a7b8bcb8-0b4c-4c46-b453-2fc58cefb9ba}_Change_Healthcare_Value-Based_Care_in_America_State-by-State_Report.pdf (pcpcc.org)

SHVS_APM-Tracking_Brief_Final.pdf (State Tracking)

Final Report on State Strategies to Promote Value-Based Payment through Medicaid Managed Care (macpac.gov)

Questions/Answers/Comments

There are 135 items on the quality of care websites and that is an untenable number. HHSC stated that the rider 20 work may look at that issue. There has been some work on EVV and other issues. Medicaid put out 25-30 measures on disease management. HHSC is working to report the LTSS measures and that is coming soon.

The P4Q is an attempt to focus on a few important measures that can be standardized with the help of the health plans

7. 2021 Planning meeting:

Texas Value-Based Payment and Quality Improvement Advisory Committee Recommendations to the 87th Texas Legislature

The workbook tracker is available to track the recommendations and actions that are in response.
Recommendations: 2018 Legislative Report

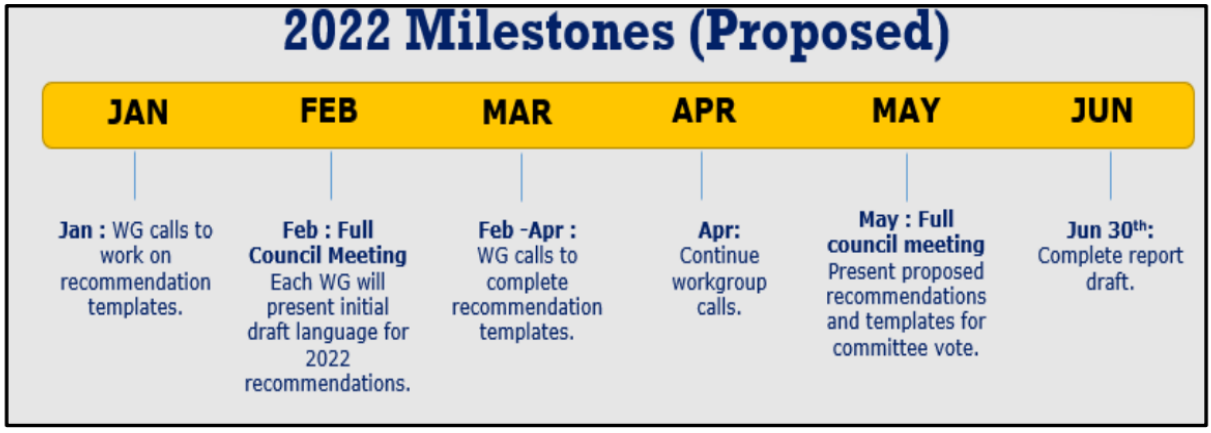
1. Implement a comprehensive informatics strategy
2. Make data available to support value-based initiatives
3. Address patients' non-clinical health related needs
4. Prioritize maternal and child health
5. Sustain innovative behavioral health models
6. Expand treatment for substance use disorders
7.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

Mr. Blanton stated that the outline for the report will have to be decided in February. There are already some recommendations developed.



The committee discussed potential areas for the report to address.

- Accreditation and quality
- Improving access to strong health homes
- Add graphics
- Health equity
- Scope of practice in specialties is an evolving issue

8. Public comment. No public comment was offered.

9. Action items for staff and member follow-up. Two items for staff were mentioned as well as health home discussion.

10. Adjourn. Next meeting February 4th, 2022.

***