



TEXAS HEALTH AND HUMAN SERVICES COMMISSION

**Value-Based Payment and Quality Improvement
Advisory Committee
DRAFT Meeting Minutes
Monday, March 9, 2020
10:00 a.m.**

**Brown-Heatly Building
Public Hearing Room
4900 North Lamar Boulevard
Austin, Texas 78751**

Table 1: Value-Based Payment and Quality Improvement Advisory Committee member attendance at the Monday, March 9, 2020 meeting.

MEMBER NAME	YES	NO	MEMBER NAME	YES	NO
Bose, Sarojini, MD		X	McNabb, Benjamin, Pharm. D.	X	
Fullerton, Cliff, MD		X	Peterson, Mary Dale, MD	X	
Ganduglia Cazaban, Cecilia, MD, PhD	P		Sowell, Vincent	P	
Garrett, Adam M.	P		Stanley, Michael, MD	P	
Haney-Urrea, Angie		X	Vacant		
Hardy-Decuir, Beverly, DNP		X	Isaac, Daverick		X
Keller, Andy, PhD	P		Kirsch, Lisa C. (Ex-Officio)	X	
Lee, Kathy	X		Ramon, Joseph, III, R. Ph.	P	
Rose Taylor Calhoun		X			

Yes: Indicates attended the meeting. **No:** Indicates did not attend the meeting. **P:** Indicates member participated by phone.

Agenda Item 1: Welcome and Introductions

Ms. Lisa Kirsch, Vice Chair, convened the Value-Based Payment and Quality Improvement (VBPQI) Advisory Committee meeting at 10:02 a.m. Ms. Sallie Allen provided logistical announcement, conducted a roll and noted a quorum was present.

Agenda Item 2: Review and approval of meeting minutes from September 27, 2019

Dr. Mary Dale Peterson, Chair, called for a motion to approve the draft September 27, 2019, meeting minutes.

MOTION:

Ms. Kathy Lee moved to approve the September 27, 2019, meeting minutes with one correction. Dr. Benjamin McNabb seconded the motion. The September 27, 2019, meeting minutes with the noted correction were unanimously approved by voice vote with no nays nor abstentions.

Agenda Item 3: Update: Value-Based Care webpage

Mr. Jimmy Blanton provided an overview of the power point presentation handout. He stated the group is working on the Value-Based Care webpage. Their focus is to access value-based care efforts. The navigation link to the webpage was listed in the handout. Following are highlights of discussion:

- Possible to display/share improvement of outcomes within value-based programs
- Review MCO contracts for language related to evaluations
- Recommend addition of codes to certain claims data
- Research evidence to identify where most practices are used
- HHSC is preparing a legislative report on quality measures; could use it as a proxy towards quality improvement
- Enlist council and data analytics team to help with evaluation of benefits
- Want to create a good design tool for quality measures
- Within data analytics budget, there is room for an evaluation of alternative payment models

Mr. Blanton added that the webpage provided additional quality resource information, outline of various projects and strategies and current initiatives that are underway. If the group is interested in receiving more information on any of the initiatives, the team would be happy to provide them with an update.

Agenda Item 4: Presentation: Pregnancy Related Outcome Measures

Ms. Diana Forester, Quality Analyst, Medicaid/CHIP Quality Assurance, HHSC, provided an overview of the presentation related to this agenda topic. Highlights included:

- S.B. 750 amends current law relating to maternal and newborn health care and the quality of services provided to women in this state and it requires HHSC to:
 - Develop or enhance statewide initiatives to improve the quality of maternal health care services and outcomes for women in this state.
 - Each contracted MCO must incorporate in the plan and address prenatal and postpartum care rates, maternal health disparities that exist for minority women and other high-risk populations of women in this state, social determinants of health or other priorities specified by the commission
- S.B 17, 85th legislative session, 2017 required:
 - HHSC evaluate options for reducing pregnancy-related deaths and treatment of postpartum depression in economically disadvantaged women. This resulted in the 2018 Joint Biennial Report by DSHS and the Maternal Mortality and Morbidity Task Force.
 - HHSC initiated a feasibility study to determine the adding of provider's use of procedures (AIM bundles) as an indicator of quality for quality-based payments.
 - HHSC commissioned Texas' EQRO to conduct a study and generate a report to examine ways to leverage current data to evaluate maternal morbidity across Texas Medicaid/ and CHIP at the MCO-level.
- EQRO completed their study, reviewed their findings and recommendations with DSHS and agreed on the three SMM measures HHSC developed as indicators of quality:
 - The proportion of SMM cases among all deliveries.
 - The proportion of SMM cases among deliveries having hemorrhage.
 - The proportion of SMM cases among deliveries with preeclampsia.

Next steps include, presenting pregnancy-associated outcome measures to stakeholders, modify the measurement timeframe, track measures and begin public reporting in 2020.

Dr. Peterson asked for the definition of hemorrhage. Staff stated that it was the same as the definition in the AIM bundle and the one used by CDC. With regards to hemorrhage, she stated you must be prepared and know how you respond to save the person's life; without a transfusion there is no evidence of hemorrhage. She also stated that it would be good to track SMM by hospitals.

Dr. Stanley expressed concern about the methodology data presented for severe hemorrhage. He also asked about the Perinatal Period information and questioned if that data was being reviewed on the state level. Dr. Peterson advised that DSHS is tracking that information, however HHSC does not, since participants are not part of Medicaid program. Dr. Stanley also recommended that a definition of terms be included in the report to have clear understanding of the coding being used.

The comment period related to severe maternal morbidity runs through the end of April.

- Statewide Screening Tool – Social Determinants of Health (SDOH)
 - Most plans screen members for SDOH, and screening varies across plan products and member risk
 - HMOs have their own screening tool and members get reevaluated whenever they change plans
 - Pilot project sponsored in Harris county worked with three health centers to test tool
 - Outcome from the pilot project will leverage HHSC approach towards the use of an SDOH tool

Feedback or comments may be sent to the Quality Assurance mailbox at: MCD_managed_care_quality@hhsc.state.tx.us

Agenda Item 5: Presentation: Accountable Health Communities (AHC) Model approach to Social Drivers (Determinants) of Health

Dr. Linda Highfield, PhD, Associate Professor, UT School of Public Health Houston, provided an overview of the presentation related to this agenda topic: Highlights included:

- The AHC model (5-year period) seeks to bridge the divide between the clinical health care delivery system and community service providers to address health-related social needs.
- Medicare and Medicaid beneficiaries are identified through screening, referral, and community navigation services
- Three Texas sites are using the model and there are 29 sites around the country implementing the model
- Purpose of the navigation tool is to:
 - Set some patient goals based on identified social needs
 - Create an action plan
 - Standardized follow up is established
 - Provides regular positive contact
- Role of the School of Public Health is to:
 - Build collaborations and serve as a learning hub with health system partners
 - Conduct a two-level training with a teaching component
 - Team integrates into a clinical setting modeling the behavior and finish with a structured de-briefing with the staff

- Regular interactions with the team ensure they are ready to participate at a meaningful level, and implements different steps and generates positive outcomes

Committee members asked the following questions and provided some general comments.

When will preliminary outcome measures be made available for public viewing?

Nationally, it will be a couple years past the model period before data will be available. Locally, they are starting some initial publication of the data. The participating Texas groups received grant dollars in the amount of \$2.6 million for the assistance track, and approximately \$4.9 million for the alignment track from CMMI for the five-year period.

How many people are you required to screen for the allotted funds?

The milestone is not “completed screening” but the “offers to screen”. The annual “offers to screen” are set at 75,000 and navigation services are for 248 unique beneficiaries a year.

What about coordination with the other two Texas sites?

They have organized into a collaborative and they meet once a year. The accountable health communities project requirements were to have support from the state agency. Support from the agency comes in the form of claims data.

What are the professional levels of the screeners and those providing the follow-up?

Nationally there are a variety of types of staff which include community health workers, nurses and others. In Houston it is done by the community health workers in the ER and nurses in the delivery department. In clinical sites graduate students provide the screening and follow-up.

Have you looked at Parkland’s model or the Philadelphia model integrating with the electronic health record (EHR)?

They considered looking at the integration with electronic health record to collect the data. At the national level, there are some sites doing it, but they face unique challenges. In general, the EHR is not structured properly for the data.

A committee member stated that he provided some written comment regarding community pharmacies and advised they are trained in assessing the community drivers, especially in the rural communities.

It was noted that Texas is the largest beneficiary of this project, nationwide. The Chair added that \$2.6 million was not a lot of funding given the scope of the project.

Agenda Item 6: Discuss Health and Human Services Commission Value Based Payment Strategies

Mr. Dan Culica, Medicaid and CHIP Services Department, HHSC and Mr. Jimmy Blanton, Director, Health Quality Institute, HHSC reviewed the presentation related to this agenda topic. Highlights included overview of:

- Value-Based Payment Reform Alternative Payment Models (APM) Framework Models
- Value Based Payment Roadmap
- Medicaid State Quality Strategy

The focus of the APM initiative is to increase performance by improving quality of care and efficiency in a member centered system of care. HHSC will work with MCOs and providers to evolve the program based on initial data, stakeholder input, and other developments in the field.

Overall, the State has met or exceeded the first year APM targets, and the ultimate goal is to achieve high quality, efficient care. The STAR Kids APMs are not yet considered in the target achievement since they started in FY 2019. HHSC will continue to seek ways to advance the APM Initiative by:

- Revising the state's VBP Roadmap to reflect changes since the initiative started
- Obtaining stakeholder input on opportunities to strengthen the initiative
- Working with stakeholders to reduce administrative complexity

Mr. Blanton stated that the APM risked base target for STAR+PLUS is good but there is room for improvement. Ms. Kirsch stated that when you look at the percentages spend for inpatient hospital care, some of the patients are dual eligible and that could impact the number. Dr. Peterson stated that there are also less hospitalizations and maternity care in CHIP. There are also less MCOs participating in STAR+PLUS and CHIP.

Ms. Kirsch stated that there is also the small provider issue that overlaps with the rural. The smaller groups have a harder time engaging because of the administrative and technical work requirement. These groups may not have enough Medicaid volume for the Health Plans to focus on them. PPR and PPC (Potentially Preventable Readmissions- PPR and Potentially Preventable Complications -PPC) is a standardized model that HHSC has required be implemented and it is more standardized to enable smaller groups to participate. Dr. Peterson stated that this could be a carveout to incentivize health plans to work with the rural areas, smaller provider groups, however it depends on how much focus the state wants to have on the rural areas of the state.

Ms. Lee commented that many rural hospitals are not participating and MCOs may need to pay more attention and focus on these areas. It is important to see where the dollars are going, in relation to rural hospitals and clinics. Mr. Blanton stated they will go back and look at issues related to rural hospitals and rural service areas.

Dr. McNabb stated the pharmacy and lab services need to be separated so they are clearly defined in the provider type incentives report. Mr. Culica stated these could be separated.

APM 2020 Progress Timeline

The 2019 APM Reports will be received by July 1, 2020. Between July-October 2020 the data will be cleaned up (duplication of payments across APMs, data entry corrections, missing data) and individual analyses will be sent to each plan for review and feedback. By October we plan to have the analysis of the master data finalized; in November we will document the progress of APM adoption over the last three years, and we plan to post the document on the website in December.

Value-Based Payment Roadmap—The purpose of the road map is to support system transformation from volume to value. The roadmap deliverable is due in the beginning of September. Staff has been working in this area and it will eventually be shared with stakeholders.

The roadmap outlines seven areas of concern:

- Introduction and Roadmap purpose
- APM Initiative Description
- Alignment with Medicaid Goals
- Alignment with other Medicaid Value Initiatives
- Texas APM Initiative Progress
- National Context
- Lessons Learned

Dr. Peterson stated that trying to provide linkage and potential outcomes using quality metrics with the APM models would be useful to put in the report. We could ask MCOs how they have seen the needle move in relation to quantitative vs. qualitative manner to get more than just numbers in the report. Staff stated they are looking at how to collect more in-depth information, possibly through a survey, to determine the quality measures associated with each APM, i.e., successes, failures, what works, what doesn't work, etc.

Medicaid State Quality Strategy-- Texas is required to have a Texas Managed Care Quality Strategy approved by the Centers for Medicare & Medicaid Services (CMS). Every three years, Texas must review and update the quality strategy. Results of the review must be made available to the public, and the updated strategy must be submitted to CMS.

HHSC's goal is to use its Managed Care Quality Improvement Strategy to transition to a pay-for-performance model, improve member satisfaction with care and reduce payments for low quality care. This document is written at the level of the relationships with MCOs.

HHSC will achieve these goals through the following mechanisms:

- Program integrity monitoring through both internal and external processes
- Implementation of financial incentives for high performing managed care organizations and financial disincentives for poor performing managed care organizations; addressed through Pay-for-Quality (P4Q) programs
- Developing and implementing targeted initiatives that encourage the adoption by managed care organizations of evidence-based clinical and administrative practices

New ideas for the quality strategy include identifying measurement approaches for additional services and populations and improving alignment of APMs and outcome measures in Medicaid managed care. Intent is to focus less on complexity, more on simplification.

Dr. Peterson asked when the results of the 2019 P4Q will be published. Mr. Blanton stated that he would follow up with the program. Mr. Vasquez stated that they have compiled the 2018 results and anticipate a final report to be released within the next 3-6 weeks.

Dr. Peterson stated that there are stakeholder groups that are looking at measures as part of the DSRIP transition. This group may want to go through and review some of those measures and possibly make recommendations for an APM.

Agenda Item 7: 2020 Legislative Report: Breakout Session

The staff put together a framework for the committee's consideration. As soon as the new members are on-board, staff will conduct calls to determine where their interests fall. Four workgroups will concentrate on the following topics:

- Workgroup 1: Maternal and Newborn Care
 - Recommendation Goal: to help align APMs and performance metrics for maternal and newborn care in Medicaid Managed Care
- Workgroup 2: Leveraging Multi-Payer Data
 - Recommendation Goal: advance alignment of value-based payment and quality improvement efforts across major payers of healthcare

- Workgroup 3: Managed Care Organizations' Activities to address Social Driver (Determinants) of Health
 - Recommendation Goals:
 - Support alignment of SDOH activities with quality/value-based improvement goals
 - Promote learning and identification of best practices within Medicaid Managed Care

- Workgroup 4: Advancing Alternative Payment Models in Medicaid
 - Recommendation Goals:
 - Support alignment of SDOH activities with quality/value-based improvement goals
 - Promote learning and identification of best practices within Medicaid Managed Care

Following discussions are focused on the recommendation goals of the workgroups

Workgroup 1:

Dr. Peterson commented the maternal newborn arena included expert consensus measures and not evidence-based measures. There are some unintended consequences of some proposed measures. Programs have been complaining about metric fatigue. The state could create a newborn registry that would be a critical piece to determine what interventions produce better birth outcomes.

Workgroup 2:

Ms. Kirsch stated that with the different data sets developed, they have 80 percent of covered lives. Dr. Peterson stated that maybe the CMMI people could give a presentation on the CPC PLUS model where they have taken all the payors in Medicare and give data that is more actionable and real time. She stated that they could use those resources for free. Ms. Kirsch stated that there are some state websites that can be accessed (Colorado) that shows their data. Getting the data out there would be a huge step in moving us forward. A comment was made that the only real time data they we get is pharmacy data.

Workgroup 3:

Mr. Blanton stated that there is a learning collaborative of some MCOs, and we hope information can be gathered through the collaboration which could generate a survey. There has been discussion about setting up a learning hub. Ms. Kirsch stated there will be surveys coming out related to DSRIP. Providers will be getting asks for data from HHSC.

Workgroup 4:

This looks at areas with smaller providers, pharmacy providers, etc. to involve them more in value-based payments. Dr. McNabb stated that it has been difficult to convey the payor concept and we should standardize what an accountable pharmacy organization is. A comment was made related to RHP16 and they are sharing specialists for rural areas. Maybe instead of looking at a rural RHC, we could pull together multiple facilities in an ACO model. Dr. McNabb stated that he has discussed medical savings, but there could be value based payment models in drug benefit. Financial interest is not aligned with HHSC goals. We should propose some performance metrics in the drug benefit apart from the enhance benefits.

Agenda Item 8: Legislative Report Planning and Timeline

March-May:

Adopt specific recommendation language and start on draft report. Present draft outline and recommendation letters at May 19th meeting.

June-August:

Share draft report, obtain stakeholder comments, and finalize report

September:

Members review and adopt report at September 4th meeting. Dr. Peterson, Chair submits final report to legislative and other offices.

October/November:

Share report follow-up, briefings, and presentations

December 31, 2020: Deadline for submission of report to legislature

Agenda Item 9: Public Comment

Ms. Helen Kent Davis, Texas Medical Association commented there is a disconnect between doctors and the plans. Rural area physicians have not been contacted about the APMs and they are not familiar with the model information. Ms. Rachell Hammond, Texas Association of Home Care and Hospice commented there is a disconnect in the home and community-based (HCB) setting. The HCB agencies and HMOs need to discuss payment methodology and put a structure in place, especially in the Medicaid environment.

Agenda Item 10: Action items for staff and/or member follow-up

Ms. Viral Khakkar, Program Specialist, Health Quality Institute, HHSC, noted the following action items:

- Look at rural providers and the numbers and percentages on SMM cases
- Break down the pharmacy and lab section
- Workgroup III look at the 48-hour window for navigation systems
- Housing wait list number
- STAR PLUS and CHIP numbers for 2018 overall achievement
- See if CMMI will make a presentation on CPC+ models

Agenda Item 11: Adjourn

Ms. Kirsch adjourned the meeting at 2:23pm.

Please click on the link to the archived HHSC webcast to view, and listen to, the entirety of the March 9, 2020, VBPQI AC meeting:

<https://Texashhsc.swagit.com/play/03092020-1194>