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MCO Quality Meeting

October 19, 2021

Agenda

	Topic	Presenter
1	Welcome/Introductions	Andy Vasquez
2	Next Steps on the Road to Value-Based Care	Jimmy Blanton
3	SDOH VBP Models for Texas Medicaid	Joelle Jung Jennifer Quereau
4	Identifying Health Disparities	Andy Vasquez
5	Open Discussion	
6	Closing	



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Next Steps on the Road to Value-Based Care

Jimmy Blanton, *Director*, Value Based Initiatives

Texas Medicaid APM Targets*

Table 1 - The annual MCO targets established by HHSC by Calendar Year

HHSC will require that MCOs increase their total APM and risk based APM ratios according to the following schedule*

Period	Minimum Overall APM Ratio	Minimum Risk-Based APM Ratio
Calendar Year 1	>= 25%	>= 10%
Calendar Year 2	Year 1 Overall APM Ratio +25%	Year 1 Risk-Based APM Ratio +25%
Calendar Year 3	Year 2 Overall APM % + 25%	Year 2 Risk-Based APM % + 25%
Calendar Year 4	>= 50%	>= 25%

* An MCO entering a new program or a new service area, will begin on Calendar Year 1 of the targets as of the first day of its first calendar year in the program.

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



Value-Based Care Next Steps: Key Inputs

- Value-Based Payment Roadmap
- CMS Letter on Advancing Value-Based Care
- DSRIP Transition Milestone Reports
- Legislative Direction
- HCP-LAN Changes
- Stakeholder Input (e.g.; VBPQI Advisory Committee)



VBP Roadmap: Guiding Principles

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



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Link to 2021 Report:

<https://www.hhs.texas.gov/sites/default/files/documents/laws-regulations/policies-rules/Waivers/medicaid-1115-waiver/value-based-payment-roadmap.pdf>

CMS Letter on Value-Based Care

Critical Elements Identified by CMS for VBP Design and Operation

- Level and scope of financial risk
- Payment operations
- Multi-payer participation
- System readiness
- Health information exchange
- Stakeholder engagement
- Quality measure selection
- Sustainability



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DSRIP Transition Milestone Update (1 of 3)

DSRIP Transition Milestone Reports

Lay the groundwork for new value-based care innovations in Texas Medicaid.

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 Milestones: <https://www.hhs.texas.gov/laws-regulations/policies-rules/waivers/medicaid-1115-waiver/dsrp-transition>



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DSRIP Transition Milestone Update (2 of 3)

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.

DSRIP Transition Milestones: <https://www.hhs.texas.gov/laws-regulations/policies-rules/waivers/medicaid-1115-waiver/dsrip-transition>



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Accountable Health Communities

- The Accountable Health Communities Model (AHC) is a CMS/CMMI national grant to test whether systematically identifying and addressing the health-related social needs of Medicare and Medicaid beneficiaries through screening, referral, and community navigation services will impact health care costs and reduce health care utilization.
- HHSC works with three Texas AHC Bridge Organizations (BOs):
 - Dallas – Parkland Center for Clinical Innovation;
 - Houston – UT Health Science Center, School Public Health;
 - San Antonio – CHRISTUS Santa Rosa.



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MCO SDOH Learning Collaborative

- Funded by Episcopal Health Foundation (EHF) and Robert Wood Johnson Foundation; facilitated by the Center for Health Care Strategies.
- Partnership: TAHP, TACHP, HHSC, TMA, EHF.
- Year one:
 - Initial meeting (last October) on promising practices and key challenges.
 - Also convened re: improving maternal & child health; and responding to social needs during COVID-19.
- Year two:
 - Planning Webinars, Workgroup sessions, Case studies;
 - Topics: learning from DSRIP and AHC efforts; ROI; Quality Improvement cost reporting; and leveraging technology during COVID;
 - Strategies for Addressing Food Insecurity – October 1, 2021.



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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.



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DSRIP Transition Milestone Update (3 of 3)

Milestone 9 – Assessment of Texas Medicaid Rural Teleservices

- In June 2021, HHSC submitted the assessment of Texas Medicaid rural teleservices to CMS.



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DSRIP Transition Milestones: <https://www.hhs.texas.gov/laws-regulations/policies-rules/waivers/medicaid-1115-waiver/dsrip-transition>

Teleservices and The Digital Divide in Rural Texas (1 of 2)

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.



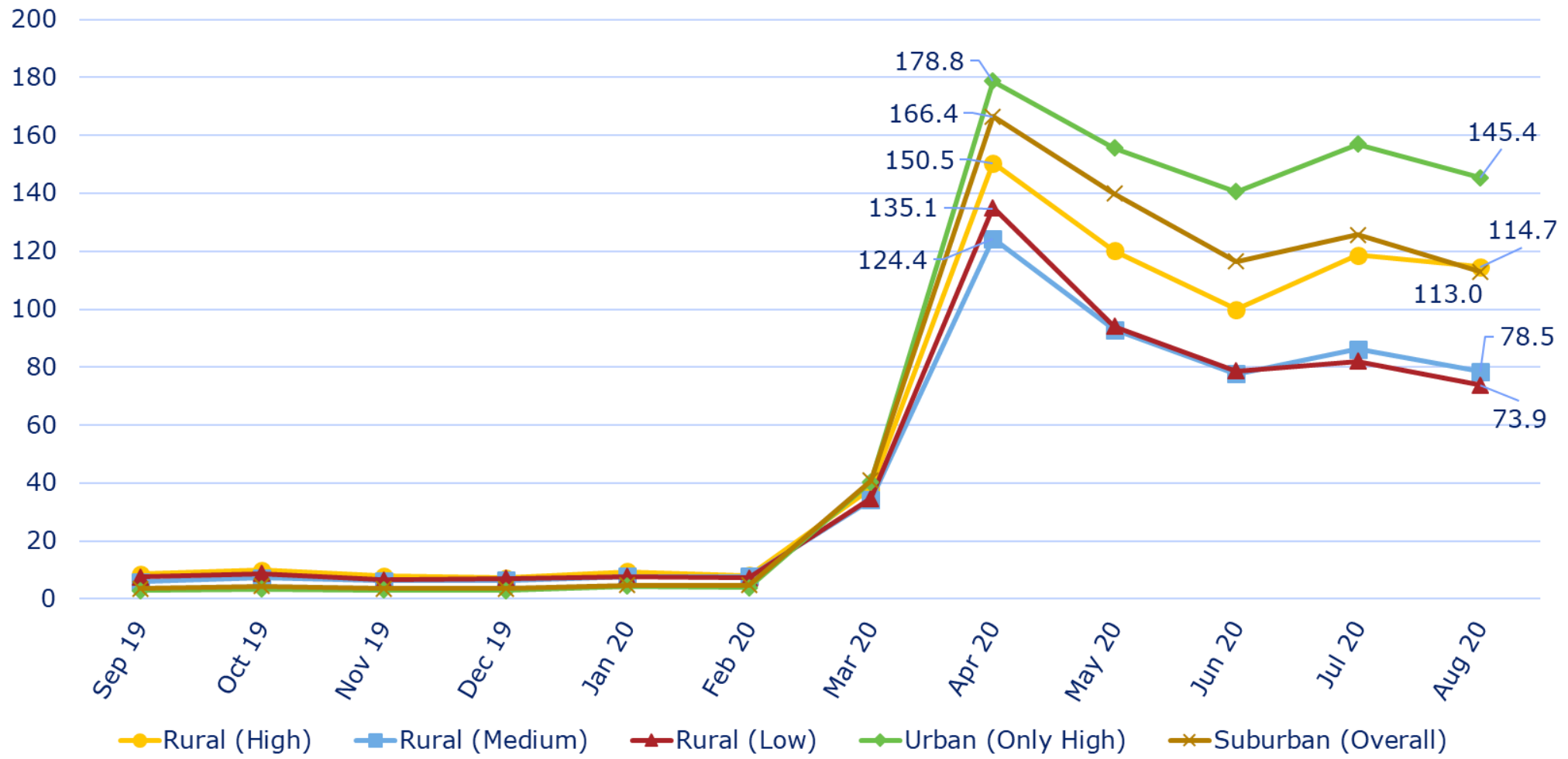
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Teleservices and The Digital Divide in Rural Texas (2 of 2)



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Texas Medicaid Teleservices per 1,000 Clients by Month, Client County of Residence and Broadband Access Category



New Value-Based Legislation: MCO Benchmarks

Legislation

- **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.



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HCP-LAN Major Changes

- HCP-LAN emphasis is evolving to promote more advanced APM arrangements that place risk on providers.
- Fall of 2020, HCP-LAN launched its Healthcare Resiliency Collaborative 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.



VBPQI Advisory Committee

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

Adopted by unanimous vote by Value-Based Payment and Quality Improvement Advisory Committee, 8-17-2021.



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Potential APM Menu Options Identified by VBPOIAC (1 of 3)

Example Menu	Points
<ul style="list-style-type: none">Maintaining or improving on current APM benchmarks (total dollars involved in APMs)	
<ul style="list-style-type: none">Meeting APM targets for challenging circumstances, e.g., APMs in rural areas (challenges can change over time)	
<ul style="list-style-type: none">Improving APM rates for priority sectors with low APM participation, e.g., home-health or behavioral health (priority sectors can change over time).	
<ul style="list-style-type: none">Increasing the amount of dollars providers earn or can earn through APMs	



Potential APM Menu Options Identified by VBPOIAC (2 of 3)

Example Menu	Points
<ul style="list-style-type: none">Monitoring provider satisfaction or establishing other formal provider outreach mechanisms related to APMs OR processes for provider engagement	
<ul style="list-style-type: none">Sharing data with providers through HIE (e.g., ADT data) or claims	
<ul style="list-style-type: none">Sharing performance reports and best practices with providers	
<ul style="list-style-type: none">Improving on quality measures or documenting processes that describe outcomes achieved and improvements that can be made in future years	



Potential APM Menu Options Identified by VBPOIAC (3 of 3)

Example Menu	Points
<ul style="list-style-type: none">Developing innovative approaches to address SDOH:<ol style="list-style-type: none">Leveraging VBP to incent the reduction of health disparitiesAddressing SDOH as part of an APM?	
<ul style="list-style-type: none">Developing a formal strategic plan for advancing APMs	
<ul style="list-style-type: none">Collaborating with other MCOs within a service area (region) on standard measures and APM models	
<ul style="list-style-type: none">Establishing formal APM evaluation criteria and reporting on evaluation results for key APMs	





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Thank You

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Social Determinants of Health (SDOH) Value-Based Payment (VBP) Models for Texas Medicaid Managed Care

**Joelle Jung and Jennifer Quereau, *Senior Analyst,*
Healthcare Transformation Waiver Team**

Background

As part of the Delivery System Reform Incentive Payment (DSRIP) transition work,

- HHSC received stakeholder feedback that value-based payment (VBP) models could help standardize performance measures and reduce administrative burden for providers and MCOs.
- HHSC also submitted the *Assessment of Social Factors impacting Health Care Quality in Texas Medicaid* to CMS in March 2021, which found associations between SDOH variables, including food insecurity, and quality measure outcomes for Texas Medicaid beneficiaries.



Background (2)

- DSRIP providers with the highest quality performance rates for Medicaid and CHIP beneficiaries were more likely to have implemented screenings for food insecurity and housing needs.
- According to the DSRIP Transition Best Practices Workgroup, the second most impactful DSRIP key practice was the inclusion of community health workers (CHWs) or promotor(a)s in a care coordination role on care teams.



Introduction

Based on these best practices from the DSRIP program, HHSC has outlined three potential SDOH VBP arrangements for which HHSC is seeking MCO input:

- 1. Integrating Community Health Workers (CHW)/Promotor(as) into Care Teams**
- 2. Standardized SDOH Screening Initiative**
- 3. Targeting Food Insecurity**



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Introduction (2)

The three SDOH VBP arrangements:

- Use evidence-based interventions or standardized models to address SDOH
- Encourage the advancement of alternative payment models (APMs) between MCOs and providers
- Advance a goal and objective from the [Texas Managed Care Quality Strategy](#)



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Introduction (3)

Alternative Payment Models

- The APM recommendations use the Health Care Payment Learning & Action Network (HCP LAN) Framework to outline stepwise advancement over a projected time horizon.
- For these VBPs, APMs would progress over time from a Category 2, to Category 3, to Category 4.



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Introduction (4)

HCP-LAN APM Categories

- Category 2: FFS – Link to Quality & Value
 - 2A:** Foundational Payments for Infrastructure and Operations
 - 2B:** Pay-For-Reporting (P4R)
 - 2C:** Pay-For-Performance (P4P)
- Category 3: APMs built on FFS Architecture
 - 3A:** APMs with Shared Savings
 - 3B:** APMs with Shared Savings and Downside Risk
- Category 4: Population-based Payment
 - 4A:** Condition-Specific Pop-based Payment
 - 4B:** Comprehensive Pop-based Payment
 - 4C:** Integrated Finance & Delivery System



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Integrating CHWs/Promotor(as) into Care Teams (1 of 5)

Aim

- This VBP arrangement aims to leverage the effective use of Community Health Workers/Promotoras by integrating them into care teams through a structured, evidenced-based intervention, known as Individualized Management for Patient Centered Targets (IMPACT).



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Integrating CHWs/Promotor(as) into Care Teams (2 of 5)

Evidence-Based Intervention

- IMPaCT is a “theory-based intervention, in which specially hired and trained CHWs provide tailored social support for high-risk patients”.
- This intervention has been evaluated using a randomized control trial and an economic analysis to determine its cost effectiveness to a Medicaid payer.
- The intervention is highly structured and includes recommended caseloads, supervision ratios, hiring algorithms, training courses, and software for documentation, reporting, and quality control. The intervention lasts six months.



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Integrating CHWs/Promotor(as) into Care Teams (3 of 5)

Evidence-Based Intervention (2)

- MCO would hire and manage the CHW/Promotor(a) staff operating the evidence-based intervention.
- CHWs are trained to use interviewing techniques to understand patients' social needs and preferences to inform tailored, patient-driven action plans.
- CHWs communicate weekly with patients and support the execution of action plans. CHWs also convene weekly support groups to foster social support networks among high-risk patients with shared experiences.
- CHWs are closely integrated with outpatient primary care practices, including having workspace in the practice and access to the electronic medical records of their patients and the ability to communicate with clinical staff regularly.



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Integrating CHWs/Promotor(as) into Care Teams (4 of 5)

Recommended Alternative Payment Model

- 2A: MCO would pay a “care coordination” fee to Provider to integrate the intervention staff with Provider’s care team, including access to Provider’s medical records, physical space in the clinical setting as needed, and communication and collaboration with clinical staff.
- 2B-2C: MCO would pay a P4R or P4P bonus to Provider based on reporting of or performance on quality measure data such as SDOH screening process measures, SDOH appropriate action/referral completion rates, and/or SDOH incidence rates.



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Integrating CHWs/Promotor(as) into Care Teams (5 of 5)

Recommended Alternative Payment Model (2)

- 3A: Provider and MCO would share any realized savings based on reduced ED and/or inpatient hospitalization or other quality performance such as SDOH screening process measures, SDOH appropriate action/referrals completion rates, and/or SDOH incidence rates.
- 4A-4B: MCO would pay a capitated payment (PMPM or global) or percentage/full premium to Provider to manage care for eligible clients using the evidence-based intervention.



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Standardized SDOH Screening Initiative (1 of 6)

Aim

- Through mutual engagement between MCOs and providers, this VBP arrangement aims to standardize the identification of four health-related social needs associated with health care quality in Texas Medicaid such that future steps towards capitation may include social risk adjustments:
 - Food Insecurity
 - Transportation Need
 - Housing
 - Interpersonal Violence



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Standardized SDOH Screening Initiative (2 of 6)

Standardized Model

- Provider would implement standardized SDOH screening(s) using a recommended question or tool.
- The following table provides MCOs and providers with recommended screening questions, tools, and resources for the four health-related social needs based on existing research and the user guide released by CMMI (Center for Medicare and Medicaid Innovation) in June 2021.



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Standardized SDOH Screening Initiative (3 of 6)



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Health-Related Social Needs	Health-Related Social Needs	Screening Tool	Screening Question(s)
Food Insecurity	Food Insecurity	<u>Hunger Vital Sign™</u>	<p>“Within the past 12 months we worried whether our food would run out before we got money to buy more.” Was that often true, sometimes true, or never true for (you/your household) in the last 12 months?</p> <p>“Within the past 12 months the food we bought just didn’t last and we didn’t have money to get more.” Was that often true, sometimes true, or never true for (you/your household) in the last 12 months?</p>
	Food Insecurity	<u>U.S. Household Food Security Survey Module</u>	<p>Three stage design with screeners, in addition to the two questions above asks questions such as: “(I/we) couldn’t afford to eat balanced meals.” Was that often, sometimes, or never true for (you/your household) in the last 12 months?</p>

Standardized SDOH Screening Initiative (4 of 6)



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Health-Related Social Needs	Screening Tool	Screening Question(s)
Transportation	<u>PRAPARE</u> ; <u>AHC-HRSN</u> ; <u>EveryONE Project Tool</u>	In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?
Housing Instability	<u>Housing Stability Vital Sign</u>	Over the past year, were you homeless or living in a shelter at any time? Yes or no?
Interpersonal Violence	<u>HARK</u> ; <u>HITS</u> ; <u>E-HITS</u> ; <u>PVS</u> ; <u>WAST</u>	Screenings include 3-8 questions such as: Has your partner ever physically hurt you in the past 12 months?
Interpersonal Violence	Tool developed by HHSC drawing from combination of validated tools	Similar to what <u>other states</u> have done, HHSC could develop a tool drawing from a combination of validated tools such as those above.

Standardized SDOH Screening Initiative (5 of 6)

Recommended Alternative Payment Model

- 2A: MCO would pay a “data infrastructure or other foundational” fee to Provider to implement the SDOH screening initiative infrastructure and operations.
- 2B-2C: As the SDOH screening(s) becomes more integrated, MCO payments to Provider would shift to P4R or P4P on quality measure data such as SDOH screening process measures, SDOH appropriate action/referrals completion rates, and/or SDOH incidence rates.



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Standardized SDOH Screening Initiative (6 of 6)

Recommended Alternative Payment Model (2)

- 3A: Provider and MCO would share any realized savings based on reduced ED and/or inpatient hospitalization and quality performance such as SDOH screening process measures, SDOH appropriate action/referrals completion rates, and/or SDOH incidence rates.
- 4A-4B: MCO would pay a capitated payment (PMPM or global) or percentage/full premium to Provider to manage care for eligible clients incorporating social-risk adjustments using the standardized model.



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Targeting Food Insecurity (1 of 4)

Aim

- This VBP arrangement aims to use a “screen and intervene” framework to identify clients facing food insecurity during a clinical encounter and actively refer eligible clients into an appropriate intervention to address food insecurity and improve health outcomes.



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Targeting Food Insecurity (2 of 4)

Standardized Model

- **Screen** - Use a validated, standardized screening question to identify food insecurity among clients seen in the clinical setting
- **Intervene** - Refer eligible clients identified with food insecurity to an appropriate intervention such as:
 - SNAP assistance program
 - Medically tailored meal (MTM) program
 - Food prescription (Rx) program
- Provider would implement the “screen and intervene” model, and MCO would hire and manage the staff operating an appropriate intervention.



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Targeting Food Insecurity (3 of 4)

Recommended Alternative Payment Model

- 2A: MCO would pay a “care coordination” fee to Provider to integrate the appropriate intervention staff with Provider’s care team, including access to Provider’s electronic medical records, physical space in the clinical setting as needed, and communication and collaboration with clinical staff.
- 2B-2C: MCO would provide a P4R or P4P bonus to providers based on reporting of or performance on quality measure data such as food insecurity screening process measures, appropriate action/referrals completion rates, and/or food insecurity incidence rates, ED rates, inpatient hospitalization rates, and/or disease-specific clinical outcomes and intermediate outcomes.



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Targeting Food Insecurity (4 of 4)

Recommended Alternative Payment Model (2)

- 3A: Provider and MCO would share any realized savings based on reduced ED and/or inpatient hospitalization and quality performance such as food insecurity screening process measures, food insecurity-related appropriate action/referrals completion rates, food insecurity incidence rates, and/or disease-specific clinical outcomes and intermediate outcomes.
- 4A-4B: MCO would pay a capitated payment (PMPM or global) or percentage/full premium to Provider to manage care for eligible clients incorporating food insecurity-risk adjustments using the standardized model.



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Feedback or Questions

- Are MCOs currently implementing similar activities regarding VBP models that address SDOH? If so, what benefits have they seen? If not, what are the main reasons?
- What barriers might there be to adopt or implement the proposed SDOH VBP models?
- How feasible are the recommended APMs for the proposed SDOH VBP models?
- Do the aims of the proposed SDOH VBP models align with MCO priorities?
- Any other feedback?



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Identifying Health Disparities

Andy Vasquez, *Deputy Associate Commissioner*
Quality & Program Improvement

Identifying Health Disparities (1 of 3)

CMS offered to extend DSRIP for one year with the “collective goal of advancing equity in the safety net”

1. Extension is contingent on Texas reporting on 5 to 10 metrics related to health disparities and health equity, to be agreed upon by CMS and the state.
 - a. Metrics would establish a baseline for measuring health disparities in the safety net for the purposes of making future improvements around equity.
 - b. The metrics would include reasonable requirements for providers, managed care plans, and/or the state to track race, ethnicity, and other information about beneficiaries served, for the purposes of measuring health disparities.
2. Reporting of metrics required within the demonstration year.
3. Twenty percent of the aggregate annual DSRIP payments (\$2.49 billion) will be contingent on the timely and complete reporting of these metrics.



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Identifying Health Disparities (2 of 3)

Selecting Health Equity Measures

- Centers for Disease Control and Prevention (CDC) says health equity occurs when all individuals have opportunity to attain their full health potential and no one is disadvantaged from achieving this potential because of social position or other socially determined circumstance.¹
- Per the National Quality Forum (NQF), disparities-sensitive measures detect differences in quality across institutions or in relation to certain benchmarks, but also differences in quality between populations or social groups.²

¹ <https://www.cdc.gov/chronicdisease/healthequity/index.htm>.

² A Roadmap for Promoting Health Equity and Eliminating Disparities: The Four I's for Health Equity. November 2017. Available at: https://www.qualityforum.org/NQFs_Roadmap_to_Health_Equity.aspx



Identifying Health Disparities (3 of 3)

Selecting Health Equity Measures

- HHSC will propose measures for which health equity data is already collected.
- Measures will be stratified by sub-populations: e.g. race/ethnicity, metro/non-metro member residence, gender, and in some cases, disability
- HHSC will work with CMS to finalize the set of measures and stratification
- Future: identify health disparities evidenced by the data and develop initiatives to close the gaps.

Reference. CMS Report, *Paving the Way to Equity: A Progress Report (February 2021)*: <https://www.cms.gov/files/document/paving-way-equity-cms-omh-progress-report.pdf>



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Questions

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Open Discussion



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Thank You!
