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Value-Based Payment and Quality Improvement Advisory Committee (VBPQIAC)

July 26, 2022

Full Committee Meeting

9:00 AM

REVISED
12:09 pm, Jul 26, 2022

Meeting Overview (1 of 2)

Main Objectives

1. Welcome and roll call
2. Consideration of May 10, 2022 draft meeting minutes
3. Tabled - Texas Medicaid Directed Payment Programs & Quality Improvement
4. Staff update: Medicaid value-based activities

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Meeting Overview (2 of 2)

5. Workgroup reports:
   a. Home Health and Pharmacy
   b. Social Drivers of Health (SDOH)
   c. Alternative Payment Models (APM) and Value-based Payment Contract Language
   d. Timely and Actionable Data
   e. Voting on recommendations
6. Public comment
7. Action items for staff and member follow-up
8. Adjourn

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Welcome and Roll Call

Staff and Council Member Introductions

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Consideration of May 10, 2022 draft meeting minutes

Review and approval of meeting minutes from May 10, 2022

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Staff Update: Medicaid Value-Based Activities

Jimmy Blanton
Director, Office of Value-Based Initiatives
HHSC

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Workgroup 1: Home Health and Pharmacy

Home Health:

Mr. Joe Ramon (Lead)

Pharmacy:

Dr. Benjamin McNabb (Lead)

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Workgroup 1: Home Health

Mr. Joe Ramon (Lead)

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Proposed Recommendations: Home Health (1 of 2)

HHSC should work with Managed Care Organizations, home health agencies, and stakeholders to:

1. Define, measure, and publicly report quality, experience, and cost-efficiency for Medicaid providers of in-home care/attendant services.
2. Identify new or expanded training and reporting requirements for home care attendants to improve the care experience and health outcomes for the Medicaid population.

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Proposed Recommendations: Home Health (2 of 2)

HHSC should work with Managed Care Organizations, home health agencies, and stakeholders to:

3. Analyze enrollee movement between home health agencies to identify patterns, trends, and opportunities for improvement.
4. Identify and develop value-based payment models specific to community-based Long-Term Services and Supports delivered through the STAR+PLUS and STAR Kids programs.

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Workgroup 1: Pharmacy

Dr. Benjamin McNabb (Lead)

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Proposed Recommendations: Pharmacy Workgroup

1. HHSC should establish an Accountable Pharmacy Organization (APO).
   - First, defining an APO provides clarity when discussing the types of pharmacy organizations involved in VBP contracting. The concept of an APO is distinct from other pharmacy contracting entities (i.e. pharmacy services administrative organization or PSAO).
   - Second, increasing VBP arrangements with APOs should improve patient outcomes. Pharmacists will be incentivized to longitudinally engage patients when paid to produce outcomes and lower costs.

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Proposed Recommendations: Pharmacy Workgroup

2. HHSC should develop guidance for MCOs to reimburse pharmacists for services within a pharmacist's scope of practice.
   - It would be helpful if HHSC could provide additional clarity and guidance to MCOs for paying pharmacists for services under the medical benefit like all other providers.
   - While MCOs could pay pharmacists today, low utilization may indicate a lack of knowledge about these payment options.
   - It would be helpful for HHSC to provide a list of services that fall within a pharmacist's scope, which may be reimbursable by MCOs.

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Workgroup 2: SDOH[1] Recommendations

Dr. Janet Hurley (Lead)

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Proposed Recommendations: SDOH Workgroup (1 of 4)

1. The Legislature should direct HHSC to approve at least one service that addresses non-medical drivers of health as an in lieu of service (ILOS) under 42 C.F.R. § 438.3(e)(2).

   HHSC should consider at a minimum the following services as potential ILOS:

   a. Asthma remediation,
   b. Food is Medicine interventions,
   c. Services designed to support existing housing programs.

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Proposed Recommendations: SDOH Workgroup (2 of 4)

HHSC should consider at minimum the following services as potential ILOS:

Asthma remediation

- Identification of environmental triggers commonly found in and around the home, including allergens and irritants.
- Using dust-proof mattress and pillow covers, high-efficiency particulate air vacuums, asthma-friendly cleaning products, dehumidifiers, and air filters.
- Health-related minor home repairs such as pest management or patching holes and cracks through which pests can enter

Food is Medicine interventions

- Meals delivered to the home immediately following discharge from a hospital or nursing home
- Medically-tailored meals
- Medically-supportive food and nutrition services, including medically tailored groceries, healthy food vouchers, and food pharmacies/prescriptions
- Behavioral, cooking, and/or nutrition education, when paired with direct food assistance

Housing-related supports and services

- Housing transition navigation services
- Housing deposits/one-time community-transition costs
- Housing tenancy and sustaining services

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Proposed Recommendations: SDOH Workgroup (3 of 4)

2. The Legislature should direct HHSC to create an incentive arrangement that rewards MCOs that partner with community-based organizations, other MCOs, and network providers to offer ILOS that address non-medical drivers of health and build related capacity.
   - The Legislature should authorize HHSC to use a portion of amounts received by the state under Tex. Gov't Code § 533.014 (i.e., "experience rebates") for this purpose.

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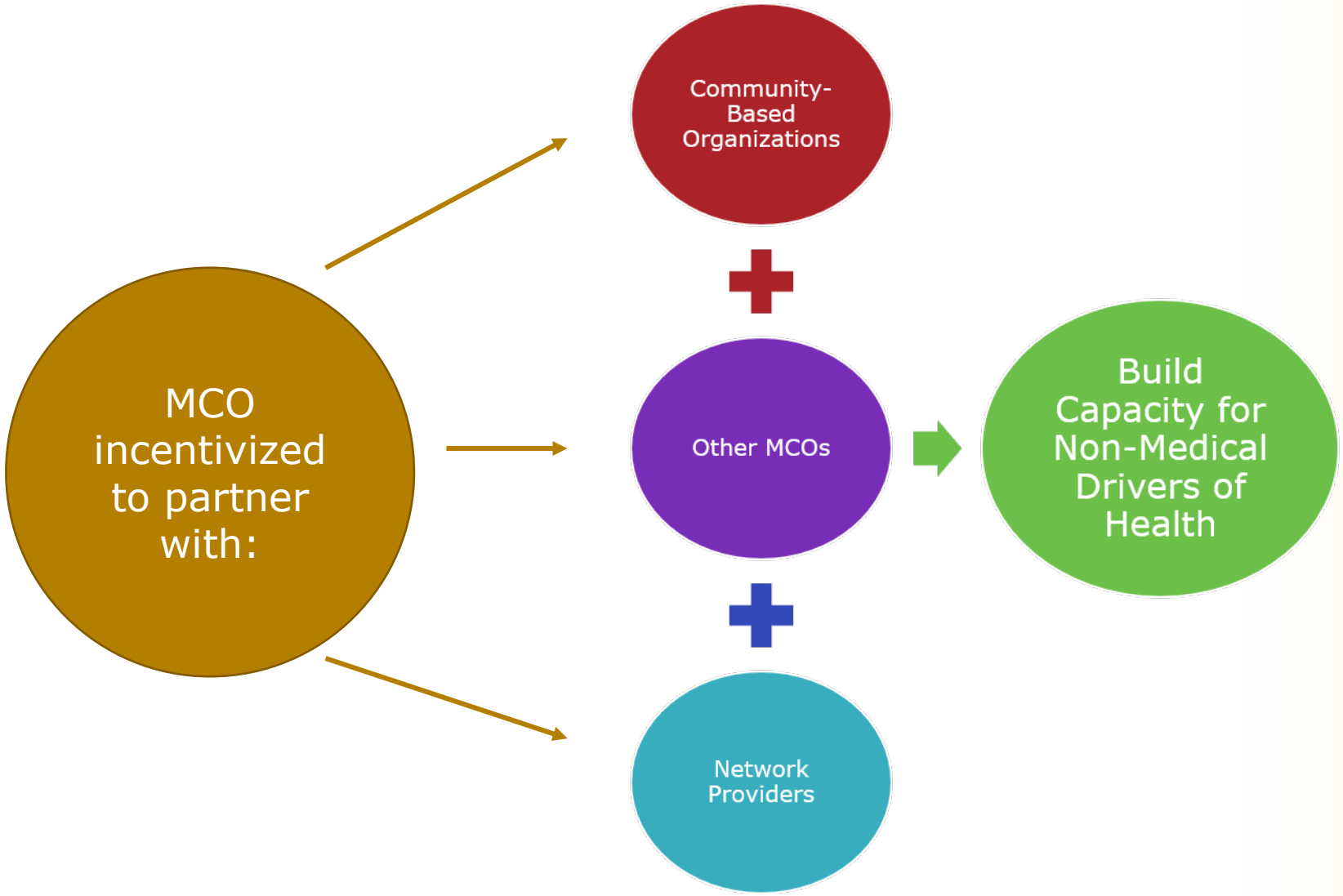
Proposed Recommendations: SDOH Workgroup (4 of 4)



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

Lisa Kirsch (Lead)

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Current APM Targets

Table 1 - Annual total APM and risk based APM ratios		
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**
Measurement Year 1	>= 25%	>= 10%
Measurement Year 2	Year 1 Overall APM Ratio +25%	Year 1 Risk-Based APM Ratio +25%
Measurement Year 3	Year 2 Overall APM % + 25%	Year 2 Risk-Based APM % + 25%
Measurement Years 4 and 5	>= 50%	>= 25%
* A Measurement Year (MY), is a 12-month period from January 1 to December 31. Measurement Year 1 is calculated starting January 1 after the respective MCO enters into a new Medicaid or CHI Program.		

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Proposed Recommendation #1

HHSC should adopt a more comprehensive contractual APM framework to assess MCO achievement.

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

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APM Menu Options Discussed by Workgroup (1 of 3)

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	

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APM Menu Options Discussed by Workgroup (2 of 3)

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	

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APM Menu Options Discussed by Workgroup (3 of 3)

Example Menu	Points
• Developing innovative approaches to address SDOH: 1. Leveraging VBP to incentivize the reduction of health disparities 2. Addressing SDOH as part of an APM	
• Developing a formal strategic plan for advancing APMs	
• Collaborating with other MCOs within a service area (region) on standard measures and APM models	
• Establishing formal APM evaluation criteria and reporting on evaluation results for key APMs	

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Proposed Recommendation #2

HHSC should work to align next steps for its APM program with the CMS Innovation Center's strategy refresh released in October 2021, including working to increase the number of Medicaid beneficiaries in a care relationship with accountability for quality and total cost of care.

- For Texas to work toward this goal, it would be beneficial for HHSC to endorse a standard primary care health home model that MCOs may adopt for some providers, possibly starting with alignment with the CMS Primary Care First model, a pregnancy medical home model, and/or key Texas Health Steps measures.
- In addition, consider a more formal structure for dissemination of best practices of value-based payment models.

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Workgroup 4: Timely and Actionable Data

Andy Keller (Co-Lead)
Lisa Kirsch (Co-Lead)

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Proposed Recommendations: Data Workgroup (1 of 4)

1. HHSC should educate key Texas Medicaid staff and stakeholders about the admit, discharge, and transfer (ADT) and clinical (C-CDA) data it receives from the Texas Health Services Authority and establish an annual process to prioritize implementation of new use cases to leverage the data to improve the Medicaid program in light of evolving operational needs and implementation of new projects.
2. HHSC should assess options for how to securely share additional data with Medicaid providers about their patients to help inform their participation in more advanced alternative payment models and identify strategies to support providers' use of that data.

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Proposed Recommendations: Data Workgroup (2 of 4)

3. HHSC should conduct a 6-month review of the CMBHS system to determine how the system can share data with all Medicaid Mental Health Targeted Case Management and Rehabilitative Service providers, MCOs, and how aggregate data can be easily shared with the public.
   - The review workgroup must include members from the VBPQI Advisory Committee, the Texas Council for Community Centers, MCOs, providers and other stakeholders.

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Proposed Recommendations: Data Workgroup (3 of 4)

4. HHSC should help support the development of a modernized data system at the county level that would permit rapid access to data related to suicide for researchers and the public while protecting individual privacy. The infrastructure could be developed through several initiatives:
   a. All Texas counties create a publicly available suicide data system in which data are derived directly from the medical examiner or justice of the peace electronic records. This would be modeled after the Tarrant County system with identifying information redacted (Link - https://mepublic.tarrantcounty.com),

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Proposed Recommendations: Data Workgroup (4 of 4)

b. All Texas counties feed suicide data (including provisional data) into a state-level system that is updated more frequently than the federal data systems and publicly available; and concurrently,

c. Create linkages between vital records/mortality data and other public health and health care databases maintained by DSHS, such as the Texas Health Care Information Collection (THCIC).

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Public Comment Procedures

- Written comments are encouraged
- Registration and call-in process for oral public comment
- All speakers must identify themselves and the organization they are representing before speaking
- Rules of conduct apply to public comments made by teleconference

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Voting on recommendations

Dr. Carol Huber will lead the voting.

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Staff Action Items for Follow-up

Jenn Hamilton will present action items for follow-up

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Thank You

For more information contact:

Jimmy Blanton, Director
Office of Value-Based Initiatives
Medicaid and CHIP Services
HHSC_VBPQIAC@hhs.texas.gov

Visit the VBPQIAC Committee webpage to learn more:

https://hhs.texas.gov/about-hhs/leadership/advisory-committees/value-based-payment-quality-improvement-advisory-committee

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Texas Value-Based Payment and Quality Improvement Advisory Committee Recommendations to the 88th Texas Legislature

…

Policy Issue: Non-Medical Drivers of Health

With support from Episcopal Health Foundation, the Center for Health Care Strategies (CHCS) provided technical assistance and learning opportunities to the Value-Based Payment & Quality Improvement Advisory Committee on this topic.[1] The Committee thanks Anne Smithey and Diana Crumley, CHCS, for their contributions to this section of the report.

Non-medical drivers of health (DOH) are the conditions in which people live, work, play, and age that influence their health. Non-medical DOH can dramatically impact health outcomes. As a result, health care payers and providers in Texas and across the country are increasingly interested in addressing these factors and have introduced numerous pilot programs with notable effects on health care cost, quality, and experience of care.

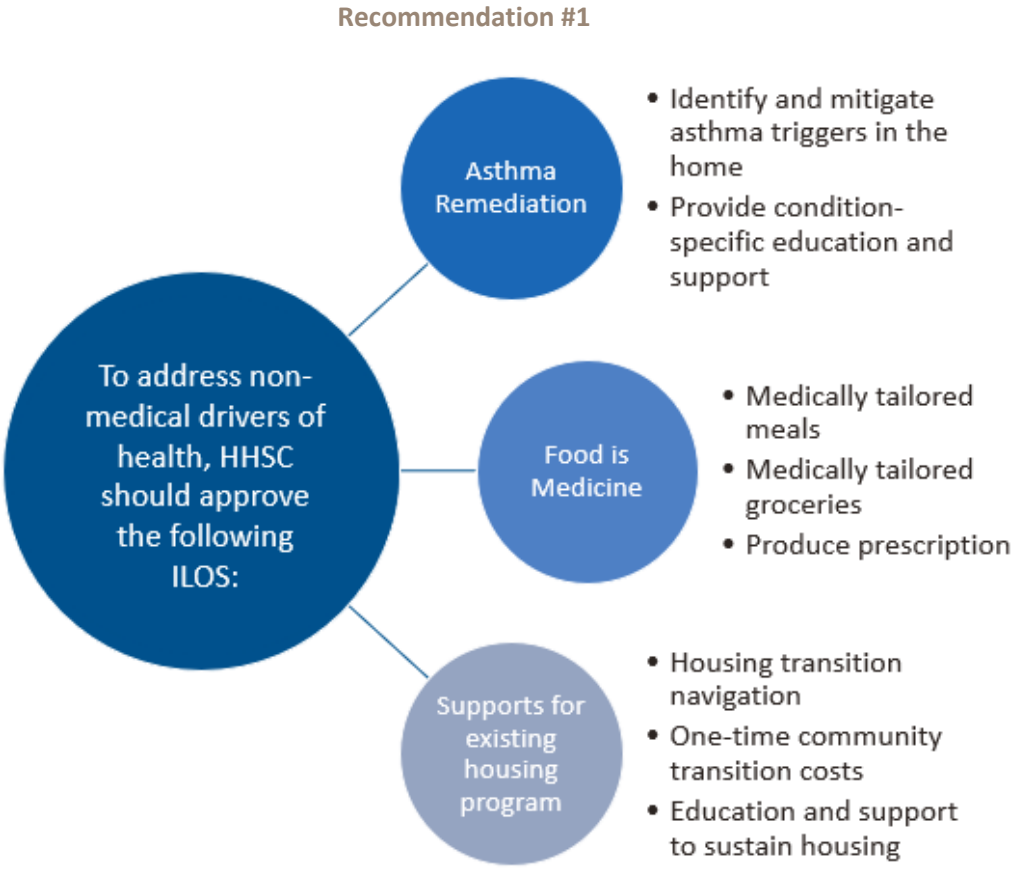
Recently, the Centers for Medicare & Medicaid Services (CMS) has allowed states to nominate DOH-related interventions as in lieu of services (ILOS). Once approved by the state, Medicaid managed care organizations (MCOs) can elect to provide these services to their enrollees.

The following recommendations support ILOS that address DOH in three categories: (1) asthma remediation, (2) Food is Medicine, and (3) services and supports designed to complement existing housing programs. The discussion will explore related evidence, and specific populations that may particularly benefit from these interventions, including children, pregnant women, and people experiencing serious mental illness. It will also explore other options for Medicaid coverage and implementation considerations.

Recommendations

1. The Legislature should direct the Texas Health and Human Services Commission (HHSC) to approve at least one service that addresses non-medical drivers of health as an in lieu of service under 42 C.F.R. § 438.3(e)(2). HHSC should consider at a minimum the following services as potential in lieu of services: (1) asthma remediation, (2) Food is Medicine interventions, and (3) services and supports designed to complement existing housing programs.

2. The Legislature should direct HHSC to create an incentive arrangement that rewards MCOs that partner with community-based organizations, other MCOs, and network providers to offer in lieu of services that address non-medical drivers of health and build related capacity. Potential funding for this incentive arrangement could include excess MCO profits returned to the state under Texas Government Code § 533.014 (i.e., "experience rebates").*



* *See* Tex. Gov't Code § 533.014(c) ("If cost-effective, the commission may use amounts received by the state under this section to provide incentives to specific managed care organizations to promote quality of care, encourage payment reform, reward local service delivery reform, increase efficiency, and reduce inappropriate or preventable service utilization.")

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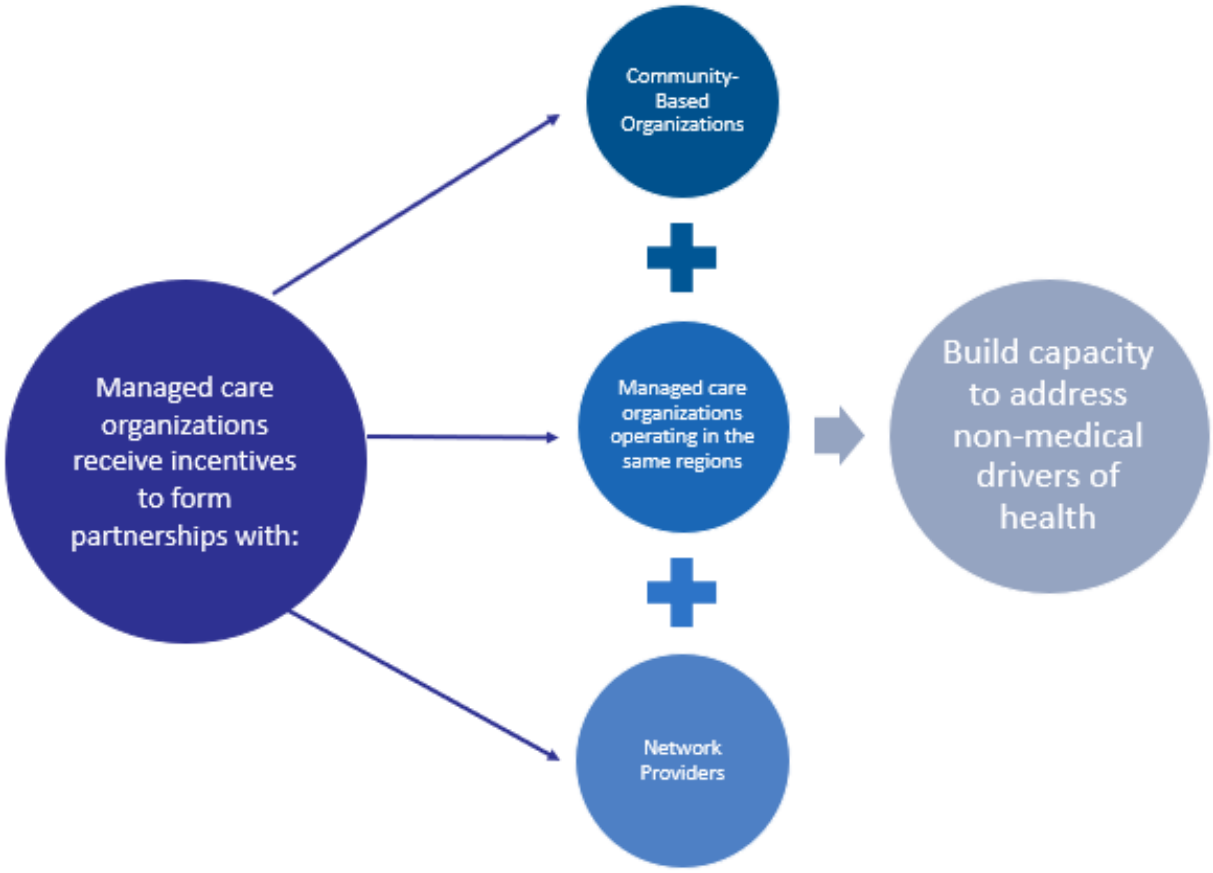
Recommendation #2



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Discussion

In Lieu of Services and Non-Medical Drivers of Health

Managed care organizations (MCOs) have the flexibility to provide services that are not formal Medicaid benefits. This flexibility has allowed MCOs to experiment with pilot programs that improve the quality and cost-effectiveness of their members' care. However, MCOs do not always "get credit" for these activities when states are setting their payment rates, which can discourage MCOs from offering them at a larger scale.

States can address this gap by categorizing certain services as "in lieu of services," a category defined in federal rule. This designation allows states to consider the cost and utilization of these services when setting rates for MCOs.

The use of ILOS is not new in Texas; in fact, the state is currently in the process of negotiating behavioral health ILOS[2] with CMS.

ILOS have typically been used to substitute one medical service for another (e.g., providing a prenatal home visit in place of an office visit for a high-risk pregnancy), and its application to non-medical DOH was theoretical, and not widely implemented. Recent developments have shown that CMS is open to a broader definition of ILOS that includes covering interventions addressing non-medical DOH like food and housing insecurity.

Federal Rule Regarding In Lieu of Services

An MCO, Pre-Paid Inpatient Health Plan (PIHP), or Pre-paid Ambulatory Health Plan (PAHP) may cover, for enrollees, services or settings that are in lieu of services or settings covered under the State plan as follows:

(i) The State determines that the alternative service or setting is a medically appropriate and cost-effective substitute for the covered service or setting under the State plan;

(ii) The enrollee is not required by the MCO, PIHP, or PAHP to use the alternative service or setting;

(iii) The approved in lieu of services are authorized and identified in the MCO, PIHP, or PAHP contract, and will be offered to enrollees at the option of the MCO, PIHP, or PAHP; and

(iv) The utilization and actual cost of in lieu of services is taken into account in developing the component of the capitation rates that represents the covered State plan services, unless a statute or regulation explicitly requires otherwise.

In 2022, California's Medicaid program began providing 14 Community Supports[3] – interventions designed to address needs such as food and housing insecurity. CMS approved twelve of these Community Supports as ILOS because these services could avoid more costly, acute care.[4] For example, asthma remediation can be used to minimize asthma triggers in the home of a Medicaid enrollee, resulting in decreased emergency department utilization related to asthma attacks.

FORTHCOMING CMS GUIDANCE

Dan Tsai, Deputy Administrator and Director of the Center for Medicaid and CHIP Services, has shared that CMS is excited about this new, broader view of ILOS and is planning to release detailed guidance to states who are interested in pursuing the use of ILOS to support interventions addressing non-medical DOH. Detailed guidance will explore how states can pursue the ILOS authority and what evidence is needed to support their request. This guidance is based on CMS' approval of California's program. Key criteria for approval include: [5]

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- ILOS must be cost-effective when evaluated at the aggregate level;
- ILOS must be evidence-based;
- ILOS must be a defined, clinically-oriented service linked to Medicaid's objectives; and
- ILOS must serve a defined Medicaid population.

Based on this precedent-setting approval, states across the country, including Texas, can consider if and how to use the ILOS authority to support interventions designed to address non-medical DOH for Medicaid enrollees.

TEXAS CONTEXT

A recent HHSC focus study[6] explores the impact of non-medical DOH on CHIP and Medicaid populations who live in Texas. This study found that non-medical factors such as physical infrastructure (e.g., clean air, safe housing) and economic environment (e.g., income level, educational attainment) have an influence on health outcomes, as measured by standard CHIP and Medicaid quality metrics. Child and adolescent health outcomes are particularly sensitive to these DOH, and outcomes among pregnant women were also meaningfully associated with some non-medical factors. As a result, the Focus Study recommends that policymakers consider how they can prioritize interventions to address non-medical DOH for CHIP and Medicaid members.

Asthma Remediation

INTERVENTION DESCRIPTION

Asthma remediation programs are designed to identify and ameliorate asthma triggers in the home and are often paired with case management and health education services. These programs typically include the following steps (Exhibit 1).

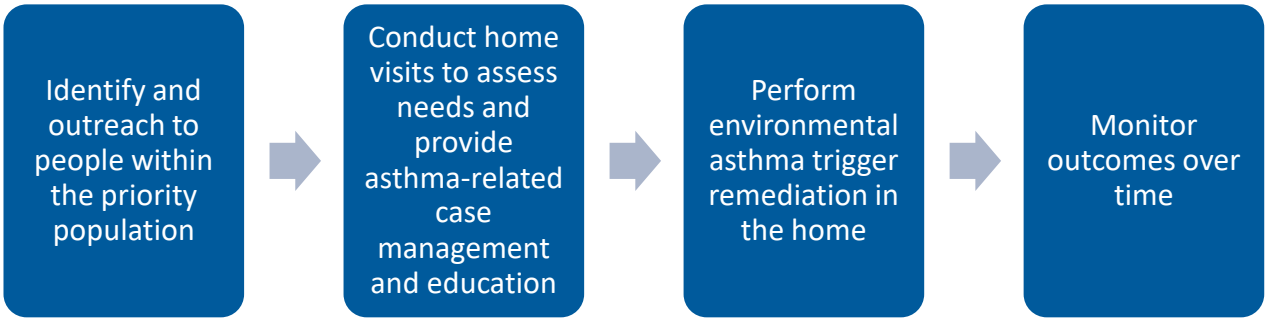

Exhibit 1: Asthma Remediation Program Components

Asthma remediation programs can reside in MCOs, provider organizations, community-based organizations (CBOs) or government agencies. These programs typically employ (1) community health workers to provide the case management and education components and (2) trained specialists and contractors to provide the home modifications.[7]

POPULATIONS OF INTEREST

Most asthma remediation programs are designed to support the health needs of children and adolescents with poorly controlled asthma. Children can become eligible for these programs through several pathways. For example, the San Antonio Kids BREATHE program[8] identifies children who are experiencing acute medical utilization or who are having their quality of life negatively impacted by their asthma. This includes children who have experienced any of the following related to their asthma: (1) two or more visits to the emergency department or urgent care; (2) one or more hospitalization(s); (3) 10 or more missed days of school; or (4) two or more unscheduled school nurse visits per week.[9]

Some adults may also benefit from asthma remediation program, including adults with asthma or with other respiratory conditions (e.g., COPD). However, these programs have not been studied much in the adult population and therefore their impact on health outcomes for adults is unknown. [10]

Case Study: Child with asthma

A 12-year-old with asthma experiences frequent asthma attacks, leading to school absences, costly trips to the emergency room, and high stress for her and her family. When her pediatrician hears about how much asthma is disrupting her life, the doctor refers her to a local asthma remediation program. The asthma remediation program provides health coaching, which helps the 12-year-old and her parents identify triggers for her asthma and develop a better asthma control plan. Employees of the program also identify mold in her home that was exacerbating her asthma and can remove and replace the moldy carpeting. Six months after this intervention, the 12-year-old has experienced far fewer asthma attacks, no school absences, and no emergency room visits. Her family is more confident in their ability to help her control her asthma, spending on her health care has decreased dramatically, and she is happier and healthier.

EVIDENCE ON CLINICAL AND COST-EFFECTIVENESS

The CDC Task Force on Community Preventive Services has conducted systematic reviews on asthma remediation programs, which indicate that these programs are clinically impactful and result in a financial return-on-investment (ROI):

HEALTH BENEFITS[11]	FINANCIAL ROI[12]
Average decrease of: • 0.57 acute care visits per year • 21 symptom days per year • 12.3 school absences per year	• $5.30 - $14.00 returned for every $1 invested

Additional rigorous evaluations of individual programs support these findings – showing that asthma remediation programs are cost-effective in the general pediatric and pediatric Medicaid populations:

BOSTON CHILDREN'S HOSPITAL PROGRAM[13] (BOSTON, MA)	LE BONHEUR CHILDREN'S HOSPITAL PROGRAM[14] (MEMPHIS, TN)
• Financial ROI of 1.91 over 5 years for a general pediatric population – indicating that every one dollar spent resulted in savings of $1.91	• Medicaid total cost of care savings of $2,207 per child over 2.3 years

Pediatric asthma remediation programs in Texas have had similarly beneficial impacts. For example, the San Antonio Kids BREATHE program is run through the San Antonio Metropolitan Health Department and has been providing asthma remediation services since May 2019. This program found that children who graduated from this intervention saw improvements in asthma control, as measured by average metered dose inhaler scores and asthma control test scores. San Antonio Kids BREATHE has partnered with Community First Health Plans to provide their services in a pilot program, and children engaged in the program had a reduction in emergency department visits. [15]

OTHER OPTIONS FOR MEDICAID COVERAGE

In December 2021, CMS approved asthma remediation as an ILOS in **California**[16]. The state developed service definitions and eligibility criteria[17], as well as non-binding price guidance[18].

CMS has also approved coverage for asthma remediation through:

- **CHIP health services initiatives**. **Wisconsin**[19] used its CHIP health services initiatives to cover case management, in-home education, environmental assessment, durable equipment, and environmental hazard remediation in homes of low-income children with moderate to severe asthma.
- **Medicaid state plan amendments**. **Missouri**[20] used state plan amendment (SPA) authority for an asthma preventive education and counseling and in-home assessment program for asthma triggers, focusing on youth participants who have evidence of uncontrolled asthma.
- **1115 demonstrations.** **Massachusetts**[21] Accountable Care Organizations can provide members that meet certain risk criteria home modification services as a "Flexible Service," approved by CMS via an 1115 demonstration. Services can include: in-home environmental risk assessments, HEPA filters, vacuum cleaners, pest management supplies and services, air conditioner units, and hypoallergenic mattress and pillow covers. **North Carolina's**[22] Healthy Opportunities Pilot program provides individuals enrolled in Medicaid that meet certain risk criteria: "repairs or remediation for issues such as mold or pest infestation if repair or remediation provides a cost-effective method of addressing occupant's health condition." The state developed related fee schedules for inspections for housing safety and quality and home remediation services[23].

Food is Medicine Programs

INTERVENTION DESCRIPTION

Medically supportive food and meals – also known as Food is Medicine interventions – can span a wide spectrum of services. Per the Aspen Institute's Food is Medicine Research Action Plan,[24] Food is Medicine programs can include: (1) medically tailored meals, (2) medically tailored groceries, and (3) produce

prescriptions. Exhibit 2 describes each of these interventions. All Food is Medicine interventions include (1) provision of food that supports health and (2) a connection to the health care system.

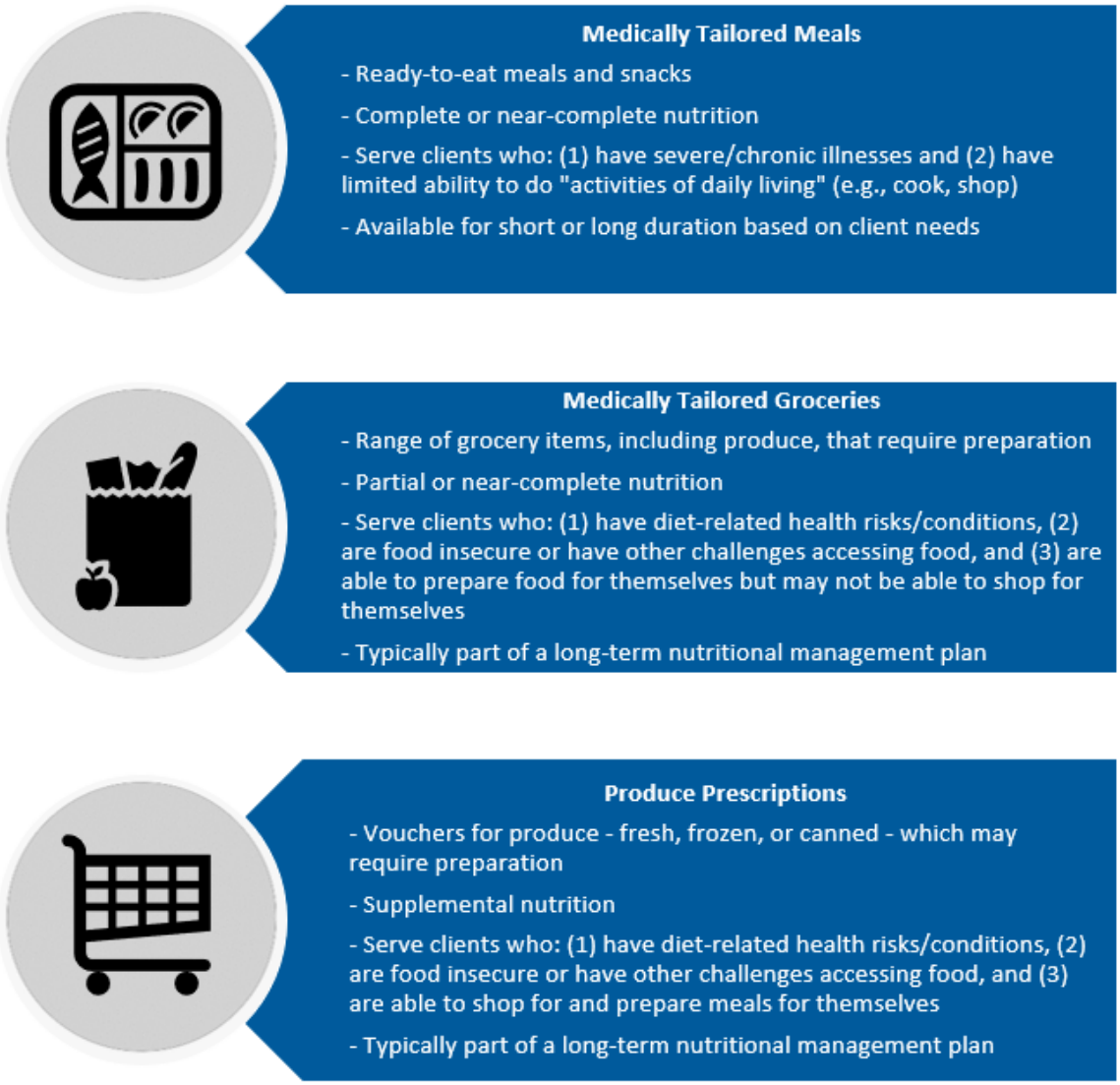

Exhibit 2: Types of Food is Medicine Programs

POPULATIONS OF INTEREST

Given the broad definition of Food is Medicine programs, these programs can be tailored to serve a wide variety of people with different needs. As noted in Exhibit 2, the more intensive medically tailored meals programs are designed for people with complex conditions and needs, while lighter-touch efforts like the medically tailored groceries or produce prescriptions are designed for people with more capacity to prepare food or shop on their own.[25]

Case Study: Pregnant woman experiencing food insecurity

A woman with a history of preeclampsia is pregnant with her second child. She is struggling to afford nutritious food and has recently been diagnosed with gestational diabetes and hypertension. The woman's obstetrician connects her with additional pregnancy supports, including a Food is Medicine program at a local food bank to address her food insecurity. The food bank helps the woman enroll in SNAP and WIC and provides her with daily healthy meals for her entire pregnancy and postpartum recovery, as well as cooking classes. With the support of the Food is Medicine program, the woman successfully manages her gestational diabetes and hypertension, and eventually gives birth to a healthy daughter at full-term with no complications. Continued support during her postpartum period ensures that the woman can support her own recovery and her daughter's needs early in life.

An example of someone who would benefit from a medically tailored meal program might be a patient at a dialysis center who has type 2 diabetes and end-stage renal disease. During their enrollment in the program, a registered dietician would perform a nutrition assessment and develop an appropriate meal plan as part of a larger nutritional treatment plan. Meals would be prepared by the program and delivered to the patient's home, with no or minimal preparation required for meals to be eaten.[26]

In addition to focusing on people with severe, chronic conditions, Food is Medicine programs can also be used for diet-related health conditions. There is growing evidence around the use of Food is Medicine programs to serve pregnant and postpartum women, who may have diet- and pregnancy-related health conditions (e.g., gestational hypertension or diabetes) or who may benefit from additional access to nutritious food to improve maternal and infant health outcomes. Factor Health, a partnership between Dell Medical School and Episcopal Health Foundation that focuses on non-medical DOH, is testing Food is Medicine programs to decrease pre-term birth and increase infant birthweight.[27]

The broad spectrum of Food is Medicine programs means they are well-suited to any person who has difficulties accessing nutritious food based on their health status, geographic location, or income level. The new directed payment program[28] for physicians and professional services in Texas Medicaid, which includes a rate enhancement for food insecurity screening, could be leveraged as one way to identify eligible individuals for these programs.

EVIDENCE ON CLINICAL AND COST EFFECTIVENESS

The strongest evidence on clinical and cost-effectiveness of Food is Medicine programs is related to medically tailored meals. Research on medically tailored meals consider a variety of primary outcomes, including health care utilization, diet quality, quality of life considerations, and disease-specific outcomes.

A summary of key research on medically tailored meals found the following overall results[29]:

HEALTH BENEFITS	FINANCIAL ROI
Average decreases in: • Emergency department visits • Inpatient admissions • Admissions to skilled nursing facilities Average improvements in: • Self-reported healthy eating • Self-reported health status Some improvements in: • Disease-specific outcomes	• Decreased overall health care costs, resulting from decreased acute care utilization

One of these studied explored outcomes for a medically tailored meals pilot program focused on adults with serious, chronic illnesses (e.g., kidney disease, HIV/AIDS, cancer) who were enrolled in Medicaid, a particularly impactable group, and found the following results:[30]

HEALTH BENEFITS	FINANCIAL ROI
Average decreases in: • Emergency department visits • Inpatient admissions • Inpatient length of stay More likely to be discharged to home vs. an acute care facility	Average decreases in: • Monthly health care costs (31% decrease) • Monthly inpatient costs (40% decrease) • Monthly costs for HIV/AIDS care (55% decrease)

Medically tailored groceries and produce prescription interventions are less specifically tailored to the needs of the person being served, which seems to result in smaller program impacts. However, a summary of key research studies conducted over the last seven years does show that participants in these programs tend to report improved health status and increased healthy food intake, alongside decreased hospital readmissions.[31]

OTHER OPTIONS FOR MEDICAID COVERAGE

CMS has approved the following Food is Medicine services as ILOS in **California**[32]: meals delivered to the home immediately following discharge from a hospital or nursing home; medically tailored meals; medically tailored groceries, healthy food vouchers, and food pharmacies; and behavioral, cooking, and/or nutrition education when paired with direct food assistance.

CMS has also approved other similar services through:

- **1915(c) and 1915(i) home and community-based services (HCBS).** Home-delivered meals are a common component of HCBS programs. **Texas** covers home-delivered meals as part of its 1915(i)[33] and many 1915(c) programs.
- **1115 demonstrations.** **North Carolina**[34] offers healthy food boxes and healthy meals for delivery and pick up. In addition, its Healthy Opportunities pilot program pays for[35] the Diabetes Prevention

Program and food and nutrition access case management services (e.g., assistance with SNAP applications). **Massachusetts**[36] also offers "nutrition sustaining supports" through its Flexible Services Program.

Services and Supports Designed to Complement Existing Housing Programs

INTERVENTION DESCRIPTION

According the Corporation for Supportive Housing, "supportive housing programs combine affordable housing with services that help people who face complex challenges to live with stability, autonomy, and dignity." Because Medicaid programs are prohibited from paying for room and board, one way Medicaid agencies can help address the needs of their enrollees is through providing supportive services that complement existing housing programs run through other state agencies or service organizations—making those programs more effective and responsive to individuals' needs.[37]

The Housing Choice Plan,[38] a stakeholder-led housing roadmap developed for Texas HHSC in May 2022, found that key barriers to accessing housing for people with complex health needs include a lack of affordable housing supply and difficulty navigating the complex housing system. While Medicaid's role in affordable housing supply is limited, Medicaid's role in housing-related services and supports is more established. These interventions, when combined with other behavioral health and physical health services, can help people obtain and maintain housing.[39] Recommended housing-related services and supports include: (1) housing transition navigation services, (2) one-time community transition costs, and (3) tenancy support services. These interventions are described in Exhibit 3.[40, 41]

Housing Transition Navigation Services

- Assist people in obtaining housing in the community as they leave an institutional setting, such as a state hospital. Services may include:
  - Identification of member needs and preferences related to obtaining housing;
  - Development of an individual housing support plan that includes barriers to stable housing and goals to overcome these barriers;
  - Assistance searching for and securing housing including completion of housing applications; and
  - Identifying and securing additional benefits and supports to sustain housing (e.g., securing rent subsidies).

One-Time Community Transition Costs

- Financial assistance which pays for one-time costs associated with transitioning into the community. Costs may include:
  - Environmental modifications (e.g., disability accessibility);
  - Security deposit payment;
  - Moving expenses; and
  - Essential household furnishings.

Tenancy Support Services

- Assist people in learning how maintain tenancy once housing has been obtained. Services may include:
  - Education and training on the role, rights, and responsibilities of tenant and landlord;
  - Identifying behaviors that may jeopardize housing (e.g., late rent payment) and addressing them;
  - Assisting in negotiating conflict with landlords or neighbors to prevent eviction; and
  - Advocacy and connection to resources to prevent eviction should the need arise.

Exhibit 3: Types of Housing Support Services[42]

POPULATIONS OF INTEREST

Given the broad nature of supportive housing programs, these interventions may be helpful for many different populations served by Medicaid. In general, people with high health care needs who quality for existing housing programs may benefit from interventions designed to complement these housing programs. For example, pregnant women are a key population covered by Texas Medicaid, and pregnant women with unstable housing and at risk for poor health outcomes may have healthier pregnancies and better birth outcomes when connecting to housing-related services and supports. People experiencing domestic violence, who are seeking alternative housing to escape an abusive situation, may also benefit from additional aid securing and maintaining housing.

In addition, based on existing programs in Texas and the opportunities identified above, a particularly appropriate priority population for housing supports would be adults with serious mental illness, who are covered by Medicaid and transitioning into the community from a state hospital or a nursing facility. Adults with serious mental illness make up a meaningful percentage of the people experiencing homelessness in

Texas, particularly because there is a lack of community-based treatment and support programs for these individuals.[43]

Case Study: Individual transitioning from state hospital into community living

A young man with schizophrenia has a history of inpatient stays at state hospitals and psychiatric facilities. During each stay, with a degree of stability and support, he learns to manage his mental health condition and begins to see improvements in his overall health and quality of life. After each discharge, however, he struggles with maintaining housing. Housing instability and homelessness exacerbate his conditions, and an acute behavioral health crisis often lands him in a state hospital for another inpatient stay. Each extended stay disrupts or suspends his Medicaid enrollment, and he must navigate a separate state program for his care, supported by limited state-only funds.

During the man's next transition from the state hospital to the community, his Medicaid managed care organization care coordinator connects him to a supportive housing program, which helps him find and apply for housing and connect with a primary care and behavioral health team to help him manage his conditions. Once he is housed, supportive housing staff work with him on a regular basis to help identify and resolve any issues, such as support with budgeting to pay rent on time, maintaining positive relationships with his neighbors, and addressing any maintenance needs with the landlord. This program helps the young man live safely in the community on his own and maintain stable mental and physical health – leading to lower health care costs – and he continues to be stably housed more than a year after his discharge from the hospital.

The Texas Health and Human Services Commission already runs a variety of supportive housing programs for this population, including:[44]

- Supportive housing rental assistance for adults with behavioral health needs who are currently homeless or are at risk of becoming homeless;
- Money Follows the Person Behavioral Health Pilot, which created multi-stakeholder partnerships to transition adults with mental illness from nursing facilities to the community;
- MCO Transition Pilot, which embedded a housing navigator within MCOs to transition people with mental illness from nursing facilities to the community; and
- Bridge to STAR+PLUS pilot, which transitions people with serious mental illness from state hospitals to home- and community-based services in Travis and Bexar counties through provision of intensive housing and health supports before and after the transition.

Participants in these programs all experience behavioral health conditions and are going through major housing transitions, which makes them particularly vulnerable to exacerbated health issues and re-institutionalization. They may also have complex histories including lack of a rental history, prior involvement in the criminal justice system, poor credit, or previous evictions that add to challenges obtaining and sustaining housing.[45] Supportive housing programs, along with the complementary programs described above, can help people stay stable during these transitions and successfully remain in the community, improving quality of life and decreasing costs to Medicaid and state programs.

EVIDENCE ON CLINICAL AND COST EFFECTIVENESS

Permanent supportive housing programs have been shown to improve health, decrease acute care utilization, and provide savings to Medicaid and other government programs. The report Permanent Supportive Housing: Evaluating the Evidence for Improving Health Outcomes Among People Experiencing Chronic Homeless[46] from the National Academies of Sciences, Engineering, and Medicine explores the clinical and cost-effectiveness of these programs, with the following findings:

HEALTH BENEFITS	FINANCIAL ROI
Average decreases in: • Days of homelessness (indicating that programs can stabilize and retain participants) • Inpatient stays • Emergency room visits • Residential behavioral health (substance abuse or psychiatric treatment) stays • Nursing home stays	Average decreases in: • Spending on residential treatment • Spending on legal fees Findings related to hospital costs support evidence that individuals are more likely to seek outpatient care – showing increased outpatient cost – and less likely to need inpatient and emergency care – showing decreased inpatient and emergency costs. Studies do not clearly indicate if total health care spending tends to increase or decrease, but findings are consistent with increased access to more timely, appropriate care that help individuals manage physical and behavioral health needs.

Research cited in the CalAIM In Lieu of Services Evidence Library[47] explores the impact of housing navigation services, case management, and rental subsidies. These programs generally had positive health and cost impacts. For example, a New York State program providing rental subsidies and housing navigation to high-cost Medicaid members who were homeless or living in institutional settings has the following impacts:

HEALTH BENEFITS	FINANCIAL ROI
Average decreases in: • Inpatient stays (40% reduction) • Emergency department visits (26% reduction) • Inpatient psychiatric admissions (27% reduction)	• Savings for high-cost (top decile) enrollees totaled $23,000-$52,000

Finally, research from Washington State's Medicaid program, which covers housing support services such as those found in Exhibit 3, found that adults enrolled in this program were more likely to access needed care, more likely to successfully transition out of homelessness, and less likely to use the emergency department compared to similar adults who did not receive these services.[48]

OTHER OPTIONS FOR MEDICAID COVERAGE

California has pre-approved several housing-related services as ILOS. States have also used other vehicles to cover housing-related services and supports. For example,

- **1915(i) and 1915(c) home and community-based services**. **Minnesota**[49] uses 1915(i) authority for its housing stabilization services program, which includes housing transition and sustaining services. **Texas**[50] includes some limited housing supports in its Home and Community-based Services – Adult Mental Health program, which includes some assistance with maintaining housing through recovery management and community psychiatric supports and treatment. Transition assistance services, including security deposits and home furnishings, are also a part of Texas's 1915(i) state plan package, as well as other 1915(c) waiver programs.
- **1115 demonstrations**. **Hawaii**[51], **Washington**[52], **North Carolina**[53], and **Massachusetts**[54] have included coverage for tenancy supports and transition costs in their 1115 demonstrations.

Implementation Considerations

The Quality Committee has issued two recommendations relating to (1) approving ILOS that address non-medical DOH and (2) incenting MCOs to take up and expand access to these services. This section discusses how HHSC can financially and logistically support MCOs as they work to build the infrastructure, capacity, and partnerships needed to deliver ILOS that address non-medical DOH, as it relates to these two recommendations.

ASK FOR FEEDBACK.

HHSC should seek input from community members, community-based organizations, health plans, and health systems to ensure that ILOS definitions, eligibility criteria, and related guidance are clear and effective. HHSC can explore a range of options – including advisory committees, requests for information, and listening and roadshow sessions in local communities across Texas. HHSC can particularly look at opportunities to strengthen and not duplicate existing pilots and programs.

BUILD COMMUNITY-BASED CAPACITY.

ILOS will require close partnerships with community-based organizations that have traditionally been underfunded and not formally integrated into the health care system. HHSC should consider how to prepare community-based organizations for these new partnerships with Medicaid MCOs and providers. Sources of funding for these capacity-building efforts could include: MCO incentive arrangements, value-based payment arrangements with upfront seed money or capacity-building funds, and new federal flexibilities under the American Rescue Plan Act for HCBS Spending Plans.[55] These Medicaid funds would be intended to supplement, and not supplant, other non-Medicaid resources, such as public health funds and grants associated with COVID-19 (e.g., a 45.2 million grant[56] focused on health disparities in Texas).

The Quality Committee recommends an MCO incentive arrangement to support these capacity-building efforts. Currently, HHSC has existing authority under Texas Government Code § 533.014(c) to create incentive arrangements using excess MCO profits returned to the state. MCOs must pay these excess profits ("experience rebates") back to the state if the MCO's net income before taxes is greater than a certain percentage of total revenue for the period. An ILOS-focused incentive arrangement is consistent with the statutory goals enumerated in Texas Government Code § 533.014(c): "to provide incentives to

specific managed care organizations to promote quality of care, encourage payment reform, reward local service delivery reform, increase efficiency, and reduce inappropriate or preventable service utilization" – if "cost-effective."

ALLOW FLEXIBILITY TO TAILOR ILOS TO LOCAL COMMUNITY NEEDS, PREFERENCES, AND ASSETS.

Texas is a large, diverse state – with many urban and rural areas. HHSC should encourage interventions that are co-designed with individuals who have experienced non-medical risk factors like food or housing insecurity, in each relevant community or region. This engagement will help develop effective, responsive programs that are tailored to local community needs, preferences, and assets. For example, HHSC should encourage culturally appropriate food and meal services that respects individuals' dignity and agency to choose the foods they would like to eat – delivered by organizations that they trust, in a way that is most convenient to them (e.g., at a community health center, at home, at a food bank). Taking these steps will help engage Medicaid members and maximize use and impact of these services.

INTEGRATE PRIMARY CARE TEAMS.

Primary care teams can help coordinate and manage care, identify non-medical DOH, and refer eligible members for additional services that address identified needs. HHSC can consider ILOS in tandem with other initiatives seeking to advance whole-person, team-based, person-centered primary care. For example, HHSC can consider value-based care initiatives seeking to expand trauma-informed screenings for risk factors relating to DOH and leverage the full spectrum of the health workforce (e.g., community health workers, peer support providers, pharmacists, community paramedics, doulas, and direct care workers).

SUPPORT DATA SHARING AND COORDINATION.

Providers, MCOs, HHSC, and community-based organizations in Texas will have to form partnerships with clear roles and responsibilities for identifying needs of Medicaid enrollees, referring enrollees to appropriate interventions, tracking progress, and sharing outcomes or other relevant information across the care team. HHSC can consider ways to support data sharing and coordination across stakeholders, such as developing a closed-loop referral system or community information exchange infrastructure, and building on existing strengths of its 2-1-1 system.

MINIMIZE ADMINISTRATIVE BURDEN.

The Quality Committee often discusses administrative burden as a barrier to provider uptake of value-based payment. Based on early experiences in California,[57] administrative burden can also be a barrier for uptake and implementation of ILOS, particularly for community-based organizations piloting new partnerships with plans, and medical providers referring individuals to new types of services. CBOs may be unable or unwilling to navigate different plans' negotiation and vetting processes, portals, claims submission, and data reporting processes. Primary care teams may shy away from making referrals to ILOS if each plan in their area has different authorization criteria, and different service offerings. Responding to these concerns, HHSC can consider ways to encourage plans in each managed care service area to streamline and standardize technical assistance, capacity-building efforts, authorization criteria, and workflows.

Summary

Based on forthcoming CMS guidance, states across the country will soon be able to cover interventions related to non-medical DOH through Medicaid. Evidence from existing programs across the nation and within Texas indicate that interventions addressing non-medical DOH tend to improve health outcomes and result in financial savings as health improves.

Texas Medicaid has the opportunity to address non-medical DOH that are (1) prevalent in the state, (2) have robust evidence supporting their positive impact, and, (3) in some cases, are already being addressed by MCOs and community-based organizations within the state. Recommended interventions include: (1) asthma remediation programs, (2) Food is Medicine programs, and (3) services and supports designed to complement existing housing programs.

MCOs will need to partner with community-based organizations, network providers, and other MCOs working in the same regions to develop the infrastructure and capacity to provide these services to Texas Medicaid enrollees. HHSC can explore pathways to financially support these efforts and can also assist with additional implementation considerations including exploring data sharing between stakeholders, aligning requirements across the state, and working closely with Medicaid providers and enrollees to ensure interventions are successfully addressing identified needs.

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Value-Based Payment and Quality Improvement Advisory Committee (VBPQIAC) Proposed Recommendations

REVISED
12:09 pm, Jul 26, 2022

Home Health

HHSC should work with Managed Care Organizations, home health agencies, and stakeholders to:

1. Define, measure, and publicly report quality, experience, and cost-efficiency for Medicaid providers of in-home care/attendant services.
2. Identify new or expanded training and reporting requirements for home care attendants to improve the care experience and health outcomes for the Medicaid population.
3. Analyze enrollee movement between home health agencies to identify patterns, trends, and opportunities for improvement.
4. Identify and develop value-based payment models specific to community-based Long-Term Services and Supports delivered through the STAR+PLUS and STAR Kids programs.

Pharmacy

1. HHSC should establish an Accountable Pharmacy Organization (APO).

   First, defining an APO provides clarity when discussing the types of pharmacy organizations involved in VBP contracting. The concept of an APO is distinct from other pharmacy contracting entities (i.e. pharmacy services administrative organization or PSAO).

   Second, increasing VBP arrangements with APOs should improve patient outcomes. Pharmacists will be incentivized to longitudinally engage patients when paid to produce outcomes and lower costs.

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

   It would be helpful if HHSC could provide additional clarity and guidance to MCOs for paying pharmacists for services under the medical benefit like all other providers. While MCOs could pay pharmacists today, low utilization may indicate a lack of knowledge about these payment options. It would be helpful for HHSC to provide a list of services that fall within a pharmacist's scope, which may be reimbursable by MCOs.

Social Determinants of Health (SDOH)[1]

1. The Legislature should direct HHSC to approve at least one service that addresses non-medical drivers of health as an in lieu of service (ILOS) under 42 C.F.R. § 438.3(e)(2).

   HHSC should consider at a minimum the following services as potential ILOS:

   a. asthma remediation,

   b. Food is Medicine interventions,

   c. services designed to support existing housing programs.

2. The Legislature should direct HHSC to create an incentive arrangement that rewards MCOs that partner with community-based organizations, other MCOs, and network providers to offer ILOS that address non-medical drivers of health and build related capacity. The Legislature should authorize HHSC to use a portion of amounts received by the state under Tex. Gov't Code § 533.014 (i.e., "experience rebates") for this purpose.

[1] The term "Social Determinants of Health" is transitioning to Non-Medical Drivers of Health (NDOH) for future meetings.

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Alternative Payment Models and Value-based Payment Contract Language

1. HHSC should adopt a more comprehensive contractual APM framework to assess MCO achievement.
    a. Move away from a specific focus on meeting APM targets.
    b. Provide a menu of approaches to give MCOs credit for a broader range of work promoting value-based care.
    c. Revise the current APM reporting tool to collect only needed data in as streamlined a format as possible.
2. HHSC should work to align next steps for its APM program with the CMS Innovation Center's strategy refresh released in October 2021, including working to increase the number of Medicaid beneficiaries in a care relationship with accountability for quality and total cost of care.
    a. For Texas to work toward this goal, it would be beneficial for HHSC to endorse a standard primary care health home model that MCOs may adopt for some providers, possibly starting with alignment with the CMS Primary Care First model, a pregnancy medical home model, and/or key Texas Health Steps measures.
    b. In addition, consider a more formal structure for dissemination of best practices of value-based payment models.

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Timely and Actionable Data

1. HHSC should educate key Texas Medicaid staff and stakeholders about the admit, discharge, and transfer (ADT) and clinical (C-CDA) data it receives from the Texas Health Services Authority and establish an annual process to prioritize implementation of new use cases to leverage the data to improve the Medicaid program in light of evolving operational needs and implementation of new projects.
2. HHSC should assess options for how to securely share additional data with Medicaid providers about their patients to help inform their participation in more advanced alternative payment models and identify strategies to support providers' use of that data.
3. HHSC should conduct a 6-month review of the CMBHS system to determine how the system can share data with all Medicaid Mental Health Targeted Case Management and Rehabilitative Service providers, MCOs, and how aggregate data can be easily shared with the public. The review workgroup must include members from the VBPQI Advisory Committee, the Texas Council for Community Centers, MCOs, providers and other stakeholders.
4. HHSC should help support the development of a modernized data system at the county level that would permit rapid access to data related to suicide for researchers and the public while protecting individual privacy. The infrastructure could be developed through several initiatives:

    a. All Texas counties create a publicly available suicide data system in which data are derived directly from the medical examiner or justice of the peace electronic records. This would be modeled after the Tarrant County system with identifying information redacted (Link - https://mepublic.tarrantcounty.com),

    b. All Texas counties feed suicide data (including provisional data) into a state-level system that is updated more frequently than the federal data systems and publicly available; and concurrently,

    c. Create linkages between vital records/mortality data and other public health and health care databases maintained by DSHS, such as the Texas Health Care Information Collection (THCIC).

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