Texas Value-Based Payment and Quality Improvement Advisory Committee Recommendations to the 86th Texas Legislature

Opportunities to Advance Value-Based Payment in Texas

November 2018

About This Report

This report was prepared by members of the Value-Based Payment and Quality Improvement Advisory Committee. The opinions and recommendations expressed in this report are the members' own and do not reflect the views of the Texas Health and Human Services Commission Executive Council or the Texas Health and Human Services Commission.

The information contained in this document was discussed and voted upon at regularly scheduled meetings in accordance with the Texas Open Meetings Act. Information about these meetings is available at https://hhs.texas.gov/about-hhs/leadership/advisory-committees/value-based-payment-quality-improvement-advisory-committee.

Report Date

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Contact Information

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1. Letter from Chair

Dear Members of the Texas Legislature and Health and Human Services Executive Commissioner Courtney Phillips:

The Value-Based Payment and Quality Improvement (VBPQI) Advisory Committee is pleased to submit our biannual report, due by December 1, 2018. We are a diverse committee representing providers, health plans, academia and other experts, and have reached unanimous consensus on the report's recommendations. Our mission as a committee is to promote broad-based partnerships and collaborations for better health care, smarter spending, and healthier communities.

The terms "value-based care" and "value-based payment" (VBP) are used all the time these days, so our committee spent some time exploring what they mean in the context of our charge. Value in health care means outcomes that matter to patients for the cost of achieving those outcomes. Value-based payment is paying providers in a way that incentivizes them to focus on better outcomes for their patients (vs. volume of services). There are many value-based payment initiatives underway, especially in Medicaid. Given the complexity of health and health care delivery, it is no surprise that there are many challenges and opportunities for Texas as we strive to move to higher-value care.

Over the past two years, several themes emerged as the committee went about its work. First, the committee found that greater awareness among all stakeholders is a necessary precursor for successful VBP initiatives. Second, lack of access to timely data hinders VBP and the realization of population management strategies. Third, current reimbursement methods in Texas Medicaid do not encourage long-term investment in payment and care reform models and do not adequately reward success.

The report includes seven recommendation areas to advance value-based care and payment in Texas Medicaid. The recommendations fall under the following broad categories: the importance of timely, actionable data to improve care; value-based care areas for which Texas Medicaid can be a leader – maternity/newborn care, mental health care, and substance use disorder services; and ways that the Health

and Human Services Commission (HHSC) as the State Medicaid Agency can facilitate value-based care by providing additional guidance and reducing administrative burden.

Throughout our meetings, the committee had much dialogue about the importance of data, which is the focus of the first two recommendations. Texas Medicaid has a lot of data, but that doesn't mean that HHSC, its contracted health plans, and their network providers always have the information necessary to provide high-value, coordinated care. HHSC must have informative data –- both clinical and administrative -– to guide the program, and health plans and providers must have access to timely, trusted information as a foundation for engaging in value-based payment arrangements.

A third recommendation focuses on maternal and newborn health. Texas Medicaid pays for more than half of the births in the state, with large variability in outcomes and costs and significant disparities among population groups. The committee recommends considering an episode-based payment approach for maternity care as other state Medicaid programs and one of Texas Medicaid's health plans have done. The committee also recommends studying the cost effectiveness and feasibility of a Medicaid waiver proposal to extend postpartum care beyond the current 60-day Medicaid benefit within a value-based model to improve maternal and newborn outcomes. Most maternal mortality occurs after this time period. If women are able to maintain continuity of care beyond the current Medicaid postpartum coverage period, this will support healthier moms and healthier babies through better management of chronic conditions like diabetes and high blood pressure, postpartum depression, substance use issues, and birth spacing.

Along with maternity care, the committee recommends developing VBP strategies for mental health and substance use disorders. Many Texans with the most complex health conditions and highest costs suffer from serious mental illness and/or substance use disorders. The Delivery System Reform Incentive Payment (DSRIP) program in Texas' 1115 Transformation Waiver has enhanced these services and filled many gaps in care over the past several years, but DSRIP funding ends October 1, 2021. Texas needs to build on the regional foundation laid through DSRIP to continue to improve care for mental health and substance use, including the opioid epidemic, through value-based payment models.

Finally, the committee recommends HHSC take further steps to enable value-based payment in its role as the State Medicaid Agency. Two years ago, HHSC informed its health plans they could use a new cost category for services that improve quality (such as care navigators), but that are not billable Texas Medicaid services. The committee believes this cost category could be leveraged to continue some of the innovative, effective care coordination work underway through DSRIP, but health plans and providers need additional guidance on what is allowed to be included in this category. Further, to promote provider participation in value-based payment models, HHSC should work to reduce associated administrative burdens by guiding model consistency across health plans and clarifying that reduced administrative burden may be a non-financial incentive for a provider within an alternative payment model. Providers and health plans are consumed with paperwork burdens that don't add value.

Thank you for considering the recommendations of our committee. The VBPQI Advisory Committee stands ready to continue our work to advance health care programs rooted in quality and value.

Respectfully,

Mary Dale Peterson, MD, MSHCA

Chair, Value-Based Payment and Quality Improvement Advisory Committee

2. About the Committee

The Value-Based Payment and Quality Improvement Advisory Committee ("Committee") was established by the Executive Commissioner of the Health and Human Services (HHS) system to provide a forum to promote public-private, multi-stakeholder collaboration in support of quality improvement and value-based payment initiatives for Medicaid, other publicly funded health services, and the wider health care system. Committee members representing diverse sectors of the healthcare system are tasked with providing input on quality improvement initiatives. By December 1 of each even-numbered year, the committee submits a written report to the executive commissioner and Texas Legislature with recommendations to help Texas achieve the highest value for healthcare in the nation. These recommendations, by rule, may cover the following scope:

- Value-based payment and quality improvement initiatives to promote better care, better outcomes, and lower costs for publicly funded health care services.
- Core metrics and a data analytics framework to support value-based payment and quality improvement in Medicaid/Children's Health Insurance Program (CHIP).
- HHSC and managed care organization incentive and disincentive programs based on value.
- The strategic direction for Medicaid/CHIP value-based programs.

The committee operates on a consensus basis and conducts its work in full public view in compliance with the Texas Open Meetings Act. Stakeholders and the public are provided multiple opportunities to comment on the findings and recommendations of the committee.

VBPQI Committee Members

The Value-Based Payment and Quality Improvement Advisory Committee consists of members appointed by the HHS Executive Commissioner representing a variety of stakeholders, including:

1. Medicaid managed care organizations;
2. Regional Healthcare Partnerships;
3. Hospitals;
4. Physicians;
5. Nurses;
6. Providers of long-term services and supports;
7. Academic systems;
8. Pharmacy; and
9. Members from other disciplines or organizations with expertise in health care finance, delivery, or quality improvement.

The HHS Executive Commissioner may also appoint non-voting, ex officio representatives.

VBPQI Committee Members:

Sarojini Bose, MD, McAllen
Cliff Fullerton, MD, Dallas
Cecilia Ganduglia Cazaban, MD, Houston
Adam M. Garrett, Lewisville
Angie Haney-Urrea, Round Rock
Beverly Hardy-Decuir, DNP, Dallas
Andy Keller, PhD, Dallas
Kathy Lee, Gatesville
Benjamin McNabb, PharmD, Eastland
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Michael Stanley, MD, Dallas
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Rose Taylor Calhoun, Bellaire

Ex Officio Representatives:
Daverick Isaac, Austin
Lisa C. Kirsch, Austin
Joseph Ramon III, RPh, McAllen

3. Executive Summary

An increased focus on quality or value instead of quantity has taken hold in the discussion over health care. Within this discussion the terms "value-based care", "value-based payment", and "alternative payment model" are used by organizations exploring ways to improve outcomes for patients while reducing the cost of achieving these outcomes. These value-based approaches incentivize high-quality and cost-efficient care by linking healthcare payments to measures of value. Due to the increased usage of these payment methods by public healthcare programs, commercial insurers, and health providers, the Executive Commissioner of the Health and Human Services (HHS) system established the Value-Based Payment and Quality Improvement Advisory Committee in 2016 to evaluate the evidence on emerging value-based approaches and make recommendations to both HHS and the Legislature aimed at optimizing how healthcare dollars are spent in Texas. The ensuing two years of meetings and discussions by the Committee led to the unanimous adoption of the following recommendations to advance value-based care and payment in Texas Medicaid:

Recommendations

1. The Legislature should direct HHS to develop a comprehensive initiative to leverage enhanced federal matching funds to maximize the usability of HHS system data resources, including by building capacity to integrate clinical and health risk data available through electronic health records (EHR) systems with Medicaid claims, pharmacy, and other administrative data sets.

2. HHSC should work with stakeholders to better leverage the Texas Healthcare Learning Collaborative portal (and other tools as appropriate) to increase and improve the data available to health plans, providers, and policy makers for core metrics, analytics, and care coordination to support value-based purchasing and quality improvement, including by:

    a. Enabling providers to see their performance on core measures to benchmark against other Medicaid providers.

    b. Enabling the sharing of historic patient-level data over time, as enrollees move in and out of Medicaid and between plans and providers (similar to the type of information included in the STAR Health Passport – user-friendly list of history

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of medications, diagnoses, immunizations, etc.).

c. Adding more data by health plan on cost and utilization trends to the portal.

3. HHSC should provide guidance for managed care organizations (MCOs) and providers on how to leverage the Quality Improvement cost strategy available in managed care to provide patient navigation services to patients with high needs and high utilization patterns. The guidance should clarify what latitude the plans have to use this cost category and reflect consensus from relevant areas within HHSC and the HHS Office of Inspector General (OIG).

4. HHSC should work with stakeholders on value-based payment approaches to improve maternal and newborn care by:

   a. Developing a maternity/newborn episode of care payment bundle (and/or other maternity/newborn VBP approaches) to present to Texas leadership for endorsement. Maternity/newborn VBP approaches should also reduce barriers to accessing long acting reversible contraceptives (LARCs) to help lower rates of maternal mortality and morbidity and improve neonatal health.

   b. Studying the cost effectiveness and feasibility of a Medicaid waiver proposal to extend postpartum care beyond the current 60-day Medicaid benefit within a value-based model to improve maternal and newborn outcomes, including by reducing maternal mortality during the interconception period.

5. HHSC should develop value-based payment strategies to sustain strong behavioral health (BH)-related DSRIP work, which has enhanced BH services and filled many gaps in BH care over the past several years. DSRIP initiatives include integrated behavioral health/primary care, evidence-based community care, and crisis alternatives. These strategies should:

   a. Include Certified Community Behavioral Health Clinics (CCBHC) as a sustainable value-based strategy for providing comprehensive, integrated behavioral health.

   b. Review current Medicaid authorities (State Medicaid Plan, home and community based services [HCBS] waivers, and options under Medicaid managed care and the 1115 waiver) and potential amendments to those authorities to develop a plan to sustain DSRIP behavioral health services (such as crisis alternatives and evidence-based community care) demonstrated to prevent high cost inpatient admissions.

6. HHSC should study and present a proposal to State leadership on VBP approaches to improve the identification and treatment of opioid and other substance use

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disorders (SUD) (e.g., cocaine, methamphetamines, and emerging threats such as synthetic marijuana and the synthetic opioid fentanyl) affecting populations served by state and federally funded programs in Texas, including a model that increases access to medication-assisted treatment (MAT) for Opioid Use Disorders (OUD) and Alcohol Use Disorders (AUD) through a bundled rate.

7. To promote provider participation in alternative payment models (APMs), HHSC should work to reduce associated administrative burdens.
    a. For all of the episode related recommendations (#4-#6), to reduce administrative burden, there should be support for implementing consistent models across health plans, well-understood supporting definitions (e.g. regarding attribution and outcome measures), and regular review and updating of service bundles.
    b. HHSC should clarify that MCO APMs with providers may include approaches that reduce administrative burden for high performing providers as a non-financial incentive. This may require changes to the Uniform Managed Care Contract (UMCC) and/or Uniform Managed Care Manual (UMCM), including the Value-Based Contracting Data Collection Tool.

4. Introduction

Since its creation in August 2016, the Value-Based Payment and Quality Improvement Advisory Committee has pursued a mission to promote broad-based partnerships and collaborations for better health care, smarter spending, and healthier communities. As part of this charge, every two years, this interdisciplinary, multi stakeholder committee will report its consensus finding and recommendations to the Executive Commissioner of the HHS system and the Texas Legislature. The focus of this first report is opportunities and challenges for improving healthcare in Texas through value-based payment (VBP).

VBP, also known as Alternative Payment Models (APMs), are payment approaches whose goal is to incentivize high-quality and cost-efficient care by linking healthcare payments to measure(s) of value. These models can apply to a specific clinical condition, a care episode, or a population and may incorporate financial risk and rewards or simply be rewards-based.

VBP operates under a theory that efficient health-care delivery models should reward healthcare providers for value -- that is, better outcomes at lower cost -- rather than volume. As compared to traditional fee-for-service approaches that compensate providers for each service they deliver, payments aligned with value encourage providers to engage in evidence-based practices, collaborate and coordinate with peers, and connect people to appropriate clinical and nonclinical services. APMs with the greatest potential to transform the healthcare system shift more accountability directly to providers and promote population-wide strategies to improve outcomes.

The Texas Medicaid program has been transitioning to a value-based model for some time now. Over the past 25 years, the state has gradually moved care delivered through Medicaid away from traditional fee-for-service reimbursement to a managed care system where private health plans are financially responsible for controlling costs and improving quality. Over 90% of the state's Medicaid and CHIP clients now receive services through risk bearing managed care organizations (MCOs) and dental managed care organizations (DMOs), making Texas a national leader in delivering healthcare through a value-based model to people with low income or disabilities.

Medicaid managed care operates within a structure designed from inception to provide policy makers, administrators, and clients with systematic feedback on health plan and program performance. As early as 1997, federal law required state Medicaid agencies to commission on behalf of their managed care programs an annual external independent review of quality outcomes, timeliness of services, and access to services, including by collecting information directly from clients on their experiences with the care system, analyzing healthcare claims and encounter data, and reporting on evidence based performance measures. No such quality improvement structure existed within the fee-for-service system.

These federal regulations implemented through managed care set the floor but not the ceiling for the state's healthcare quality improvement activities. Chapter 536 of the Texas Health and Safety Code goes beyond federal requirements by creating a comprehensive framework for promoting quality in public medical assistance programs, including by directing that provider payments and MCO premiums be linked to outcomes. Chapter 536 obligates HHSC to develop outcome measures to support performance-based initiatives that are indicative of high quality and efficient healthcare, with an emphasis on reducing preventable events such as avoidable readmissions, hospital admissions, and emergency department visits.

The transition to managed care has been complemented by other system initiatives to improve quality and efficiency in state healthcare services. Chief among these is the state's 1115 Healthcare Transformation and Quality Improvement Program Waiver, which includes incentive payments to hospitals and other providers for strategies to enhance access to healthcare, increase the quality and cost-effectiveness of care, and improve the health of patients and families through the Delivery System Reform Incentive Payment (DSRIP) program. Other significant initiatives for increasing value in state healthcare include the MCO Pay for Quality Program along with Program Improvement Projects (PIPs), which focus on improving quality across the managed care system; Hospital Quality Based Payment Program for Potentially Preventable Readmissions and Complications to incentivize quality and efficiency among hospitals; Quality Incentive Payment Program (QIPP) to promote patient safety in nursing homes; and MCO Value-Based Contracting with Providers, which seeks to facilitate and encourage the development of alternative payment and flexible practice approaches between MCOs and their providers.

Texas Medicaid has demonstrated high performance on some key areas under its managed care model. For example, The Centers for Medicare & Medicaid Services

(CMS) recently developed and published a national Medicaid and Children's Health Insurance Program (CHIP) Scorecard. For nearly all children's measures, where eligibility criteria for state Medicaid programs are most comparable, Texas is among the highest performing states in the nation (see Table 1 below).

Table 1: CMS Scorecard, Child Related Measures

Scorecard Category	Relative Ranking	Adult/ Child
Adolescent well-care visit: Ages 12-21	Top	Child
Percentage Up-to-date on Immunizations (Combination 1) by their 13th birthday	Top	Child
Percentage of eligible who received at least 1 preventive dental services: Ages 1-20	Top	Both
Percentage of children with Well-child visits in the first 15 months of life (6+ visits)	Median	Child
Well-child visits in the third, fourth and sixth years of life	Top	Child
Use of multiple concurrent antipsychotics in children and adolescents	Top	Child

The recent Texas Sunset Advisory Commission review of the HHS system further advanced the movement away from volume towards value in the Medicaid and CHIP programs. That review, and subsequent legislation -- Senate Bill (SB) 200, 84th Texas Legislature, 2015 -- found that Texas should establish clear quality and efficiency goals for its healthcare programs and implement strategies to encourage adoption of VBP models between MCOs and providers. As a result, HHS has now published a Healthcare Quality Plan along with a Roadmap to Value-Based Purchasing and has established specific contractual targets for MCOs to link provider payments to measures of quality and value.[1,2]

The SB 200 Healthcare Quality Plan outlines a comprehensive approach for improving the coordination and transparency of state healthcare quality initiatives.

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[1] Texas Health and Human Services. (2017). *Health and Human Services Healthcare Quality Plan*. Retrieved from https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2017/HHS-Healthcare-Quality-Plan-2017.pdf

[2] Texas Health and Human Services. (2017). *Health and Human Services Commission (HHSC) Value-Based Purchasing Roadmap*. Retrieved from https://hhs.texas.gov/sites/default/files/documents/about-hhs/process-improvement/quality-efficiency-improvement/draft-texas-vbp-apm-roadmap-august-2017.pdf

The six priorities established for HHS through this planning process will guide system policymaking and program activities over the next five years:

1. Keeping Texans healthy at every stage of life through prevention and by engaging individuals, families, communities, and the healthcare system to address root causes of poor health;
2. Providing the right care in the right place at the right time to ensure people receive timely services in the least intensive or restrictive setting appropriate;
3. Keeping patients free from harm by building a safer healthcare system that limits human error;
4. Promoting effective practices for chronic disease to better manage this leading driver of healthcare costs;
5. Supporting patients and families facing serious illness to meet physical, emotional, and other needs; and
6. Attracting and retaining high performing providers and other healthcare professionals to participate in team based, collaborative, and coordinated care.

In authorizing the quality plan, the Legislature anticipated that HHS agencies and programs would revise quality initiatives to align with the plan's priorities and would develop and report outcome measures and other analytics to help policy makers and stakeholders better understand notable trends for healthcare quality and efficiency. The Quality Plan identifies VBP as a key strategy for improving performance on its priorities.

In 2012, HHS began assessing payment methodologies between MCOs and providers. This review indicated that while MCOs receive a capitated payment, they still predominantly reimburse their contracted providers using a fee-for-service approach, thus maintaining incentives for volume over value in the payment model. To help push value-based incentives to the provider level, HHS created contractual targets for MCOs to connect provider payments to value using APMs starting in calendar year 2018 (Table 2). If an MCO fails to meet the APM targets or certain allowed exceptions for high performing plans, the MCO must submit a corrective action plan, and HHSC may impose contractual remedies, including liquidated damages.

Table 2: Texas Medicaid MCO Contract Targets for APMs

Period	Minimum Overall APM Target	Overall APM Target %*	Minimum Risk-Based APM Target	Risk-Based APM Target %*
Year 1 (CY 2018)	>=25%	>25%	>=10%	>=10%
Year 2 (CY 2019)	Year 1 Overall APM % +25% Growth	>=31.25%	Year 1 Risk-Based APM % +25% Growth	>12.5%
Year 3 (CY 2020)	Year 2 Overall APM % +25% Growth	>39.0625%	Year 2 Risk-Based APM % +25% Growth	>=15.625%
Year 4 (CY 2021)	>50%	>=50%	>=25%	>=25%

**An MCO could gain an exception to the targets based on high performance on metrics such as preventable hospital stays and emergency department visits.*

Meeting these new targets with meaningful APMs will challenge MCOs and providers. Some recent reports have failed to show significant progress among VBP models at improving outcomes while lowering total cost of care.[3] Additionally, the implementation of VBP/APMs has often proven difficult due to administrative complexity and the availability of timely data and suitable performance measures.

To address concerns with VBP and provide a collaborative framework for achieving progress, HHS contractual targets are accompanied by a set of guiding principles for VBP, set forth in the Roadmap. These principles call for 1) continuous engagement of stakeholders, 2) harmonization and coordination of value-based initiatives, 3) administrative simplification, 4) data driven decision-making, 5) movement through a VBP continuum as represented by the Health Care Learning Action Network APM framework, and 6) rewarding success.

This committee is resolved to develop recommendations that maximize opportunities for successful VBP in Texas Medicaid under this collaborative framework. Over the past two years, the committee has heard from numerous healthcare professionals, experts, and stakeholders and has reviewed a wide array

[3] Landman, James H., et al. (2018). *What is Driving Total Cost of Care?* Retrieved from http://leavittpartners.com/whitepaper/what-is-driving-total-cost-of-care/

of relevant research and literature to create the recommendations discussed in this report. During this review a number of key themes emerged. First and foremost, the committee found that greater awareness among all stakeholders and enhanced communication around opportunities, challenges, and goals is a necessary precursor for successful VBP initiatives. Second, lack of access to timely data by MCOs, providers, and policy makers hinders VBP and the realization of population management strategies in Medicaid and CHIP. Third, current reimbursement methods in Texas Medicaid do not adequately encourage long term investment in payment and care reform models, reward success, or recognize non-clinical health-related needs of clients. And fourth, Texas would be better served by narrowing its immediate focus for VBP to a small number of core areas than by attempting to make progress across all services. The consensus recommendations that follow, all adopted by unanimous vote of the committee's multi stakeholder membership, reflect these themes, offering good faith solutions toward successful implementation of VBP in Medicaid and, most importantly, a pathway toward better care and services for patients and families served by the Texas Medicaid program.

5. Policy Issues, Recommendations, and Discussion

The following seven recommendations adopted by unanimous vote of the Value-Based Payment and Quality Improvement Advisory Committee address key issues for advancing VBP models in Texas Medicaid. Each of the recommendations reflect consensus input by a wide range of healthcare stakeholders in Texas. Transforming healthcare into a value-based system will be a long term endeavor involving many decisions and the coordinated actions of numerous stakeholders. The committee submits these initial recommendations with hopes to spur continued collaboration for system wide change that pushes Texas to achieve better care, better health, and lower costs.

Policy Issue: Implement a comprehensive informatics strategy

Successful organizations routinely transform data into actionable information for decision making; however, according to leading experts, such a focus is often lacking in the healthcare industry.[4] Ultimately, to implement effective value-based and quality improvement initiatives, the HHS system will need an informatics strategy that enables near real-time learning and incorporates both clinical and administrative data into robust measures of performance.

Recommendation

The Legislature should direct HHS to develop a comprehensive initiative to leverage enhanced federal matching funds to maximize the usability of HHS system data resources, including by building capacity to integrate clinical and health risk data available through electronic health records (EHR) systems with Medicaid claims, pharmacy, and other administrative data sets.

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[4] Institute of Medicine. (2012). *Best Care at Lower Cost: The Path to Continuously Learning Health Care in America, Report at a Glance*. Retrieved from http://www.nationalacademies.org/hmd/Reports/2012/Best-Care-at-Lower-Cost-The-Path-to-Continuously-Learning-Health-Care-in-America/Report-Brief.aspx

Discussion

As HHS leads Texas Medicaid through transformation from a volume-based to a value-based system, health informatics should increasingly drive decisions at every level, from state policymaker to clinician to individual patient. To support this emphasis on analytics, best practice, and patient empowerment, Texas must continue to invest in building a state-of-the-art business intelligence system for the HHS system. HHS would need to cost out the required non-federal share to access the enhanced federal matching funds. This effort should focus on improving the organization and usability of current HHS data resources, while also establishing the infrastructure to incorporate new sources of clinical and health risk data.

Clients who account for a majority of HHS system spending tend to suffer from multiple chronic and other health conditions and are likely to receive services provided and/or paid for across a number of agencies and programs. Many transactions related to these services are captured and stored in digital format; however, they often are compiled into separate, unlinked databases across the HHS system. Establishing processes and an infrastructure to integrate, analyze, and disseminate this data is a necessary precursor for a business intelligence platform. For example, HHSC and the Department of State Health Services (DSHS) are partners on a variety of projects to improve newborn and maternal outcomes informed by combining data from birth and death certificates collected by DSHS with data on Medicaid services maintained at HHSC. One such better birth outcomes initiative, targeting a reduction in early elective deliveries, was found to have lowered the rate of these deliveries by as much as 14%, which led to gains of almost five days in gestational age and six ounces in birthweight among impacted newborns.[5] Rather than integrating data on an ad hoc basis, as is often the current practice, an effective business intelligence platform would routinely link and analyze data across the many high value data sources maintained by HHS agencies.

However, better leveraging current data is just a start. Effective value-based care and payment models will require metrics that combine the administrative data now

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[5] Dahlen, Heather M. et al., (2017) *Texas Medicaid Payment Reform: Fewer Early Elective Deliveries and Increased Gestational Age and Birthweight.* Health Affairs Vol .3, No. 3. 460-467. Retrieved from http://content.healthaffairs.org/content/36/3/460.full

widely available with clinical and health risk data emerging through electronic health records systems. As part of HHSC's recently approved 1115 Transformation Waiver renewal, CMS required that HHSC develop a plan as part of the demonstration to use Health information technology (IT) to link services and core providers across the continuum of care to the greatest extent possible. Access to clinical and health risk data enables providers to deliver better care and informs HHSC's measurement of program quality. For example, indicators recommended by experts through organizations such as the National Quality Forum to identify high achievement in a field such as diabetes include the following:

- A patient's most recent HbA1C in the measurement period has a value < 8.0;
- The most recent blood pressure in the measurement period has a systolic value of < 140 and a diastolic value of <90; and
- The patient is currently a nonsmoker.

Measures, such as above, that incorporate clinical and health risk data like blood pressure control and tobacco use are needed to truly understand and improve the effectiveness of care delivery. Individuals and the public will benefit from the timely computation, analysis, and reporting of enhanced quality indicators based on combined clinical and administrative data because it paves the way to a more accountable, learning healthcare system.

Policy Issue: Make data available to support value-based initiatives

Through state led efforts, existing data tools can be improved and better leveraged to support VBP and population health management.

Recommendation

HHSC should work with stakeholders to better leverage the Texas Healthcare Learning Collaborative portal (and other tools as appropriate) to increase and improve the data available to health plans, providers, and policy makers for core metrics, analytics, and care coordination to support value-based purchasing and quality improvement, including by:

a) Enabling providers to see their performance on core measures to benchmark against other Medicaid providers.

b) Enabling sharing of historic patient-level data over time, as enrollees move in and out of Medicaid and between plans and providers (similar to the type of information included in the STAR Health Passport – user-friendly list of history of medications, diagnoses, immunizations, etc.).

c) Adding more data by health plan on cost and utilization trends to the portal.

Discussion

Information sharing, transparent communication, and many levels of data sharing are critical for payers and providers to succeed in VBP. Health plans and providers need timely, actionable data to improve patient care, including patient-level data to manage individuals and dashboard-level data for plans and providers to compare performance and track improvement at a population level.

The Texas Healthcare Learning Collaborative portal contains valuable information about regional and plan performance on key quality measures. HHSC and managed care plans have a detailed private user view into the data based on permissions, while providers can see only a more limited set of information about general Medicaid performance. This lack of access to important information limits the ability of providers to manage patient care and assess opportunities for value-based purchasing with specific health plans.

Some MCOs are working with select providers (generally higher volume providers) ready to engage in VBP/APMs to supply them with periodic dashboard and patient-level information to help them improve performance on key measures (e.g., well child visits, potentially preventable emergency department (ED) visits, prenatal/postpartum care, diabetes care, total cost of care). As more providers seek to participate in APMs with Medicaid MCOs, and MCOs strive to meet the APM thresholds in their contracts, it would benefit all Medicaid providers to have access to the detailed information necessary to support better patient care and care coordination. Such information also is critical to DSRIP providers, who in the next two years will earn most of their funds based on whether their Medicaid and low income/uninsured patients show improvement on key measures such as diabetes foot exams, breast cancer screening, and flu vaccines.

Policy Issue: Address patients' non-clinical health related needs

Positive health outcomes are driven by more than healthcare alone. What happens in homes and communities matters at least as much. The best available evidence indicates that for many low income individuals, addressing significant non-clinical needs can lead to real savings for the medical system and improvements in health.[6,7] Successful VBP models that improve outcomes while lowering total cost of care connect people to the most appropriate services for their circumstances whether clinical or nonclinical.

Recommendation

HHSC should provide guidance for MCOs and providers on how to leverage the Quality Improvement cost strategy available in managed care to provide patient navigation services to patients with high needs and high utilization patterns. The guidance should clarify what latitude the plans have to use this cost category and reflect consensus from relevant areas within HHSC and the HHS Office of Inspector General (OIG).

Discussion

Federal law (45 CFR Sec. 158.150-151) allows certain quality-related costs to be treated as medical expenses. This provision recognizes the increasing evidence that targeted non-clinical interventions can have a substantial impact on improving health outcomes and lowering medical spending, particularly for low income populations and individuals with serious mental illness and other complex health

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[6] National Quality Forum. (2014). *Risk Adjustment for Socioeconomic Status or Other Sociodemographic Factors*. Retrieved from https://www.qualityforum.org/Publications/2014/08/Risk_Adjustment_for_Socioeconomic_Status_or_Other_Sociodemographic_Factors.aspx

[7] Byrne, T., Smart, G. (2017). *Estimating Cost Reductions Associated with the Community Support Program for People Experiencing Chronic Homelessness*. The Blue Cross Blue Shield Foundation of Massachusetts Foundation. Retrieved from https://bluecrossmafoundation.org/sites/default/files/download/publication/CSPECH_Report_Mar17_FINAL.pdf

risks. Effective strategies to reduce the incidence of preventable events and conditions for these complex patients require partnerships between healthcare, community-based, and public health organizations to identify and address root causes for poor outcomes; promote evidence based wellness education and activities focused on modifying risk factors for tobacco use, poor nutrition, low physical activity, and substance use; and improve access within communities to best practices for healthy living. Leveraging federal law to expand navigation to community based, non-clinical services, especially for patients with high medical utilization, is one such promising strategy for MCOs.

CMS is currently testing models to improve outcomes and lower costs for individuals with complex needs. These Accountable Health Communities focus on connecting Medicare and Medicaid beneficiaries to community services to address non-clinical needs. MCOs can build on the data and information gleaned from these initiatives to develop cost effective approaches tailored to their own clients.

The UMCM currently provides some information on how MCOs should count quality improvement expenditures. However, MCOs and providers have requested additional clarification so that future auditing would not result in disallowed costs. Providers and MCOs may have data and use cases, including DSRIP data, which could assist HHSC to develop policy guidance and to potentially sign off on certain strategies. HHSC already requires managed care organizations to have a program for outreach, education, and intervention for members who have high utilization patterns. In 2019, HHSC will require MCO Performance Improvement Projects (PIPs) to address the needs and improve outcomes for this population.

Policy Issue: Prioritize maternal and child health

As the payer for over half of all childbirth related care, Medicaid has a special responsibility for supporting the health and well-being of Texas mothers and newborns.

Recommendation

HHSC should work with stakeholders on value-based payment approaches to improve maternal and newborn care by:

a) Developing a maternity/newborn episode of care payment bundle (and/or other maternity/newborn VBP approaches) to present to Texas leadership for

endorsement. Maternity/newborn VBP approaches should also reduce barriers to accessing long acting reversible contraceptives (LARCs) to help lower rates of maternal mortality and morbidity and improve neonatal health.

b) Studying the cost effectiveness and feasibility of a Medicaid waiver proposal to extend postpartum care beyond the current 60-day Medicaid benefit within a value-based model to improve maternal and newborn outcomes, including by reducing maternal mortality during the interconception period.

Discussion

Texas Medicaid pays for more than half of all births in Texas, with large variability in outcomes and costs across the state and significant disparities among population groups. Moreover, maternity care is recognized as a high-opportunity area for episode based payment to improve quality and contain costs. Other payers, including other state Medicaid programs (e.g. TN, OH, and AR), have implemented successful maternity care episodes.

If HHSC endorses a maternity/newborn episode of payment bundle, there should be a data infrastructure in place to measure outcomes and reward high quality, cost effective care (including provider activities that may not be Medicaid billable services, but are effective ways to help manage complex pregnancies and newborns). A challenge for all payers, including Medicaid managed care programs, is how to reward successful value-based payment programs in the long run given that associated savings are inherently removed from future funding through the capitation rate setting process. Texas Medicaid has an experience rebate program through which annual managed care profits above a certain level must be shared with the State to help fund the Medicaid program. In 2013, Senate Bill 7 from the 83rd Legislature added a caveat to this statute related to leveraging experience rebates to promote quality, efficiency, and payment reform. "If cost-effective, the Commission [HHSC] 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." Another option Texas may consider, employed by Utah Medicaid and some other public payers, would extend the health plan capitation rate rebasing period from one year to three years to encourage longer term investments by plans and providers in delivery reform.

A value-based payment model for maternity care also should reduce barriers to women accessing long-acting reversible contraceptives (LARCs). LARCs provide the highest level of effectiveness of any reversible method of contraception.[8] LARCs should be available to Texas women throughout their reproductive life cycle. HHSC released a Texas LARC Toolkit in 2016 and updated it in 2018 to share information about LARC program development, training, protocols, and billing.[9] However, in spite of this and other efforts, patient access to LARCs in both inpatient and outpatient settings and provider reimbursement continues to be a challenge. A maternity value-based payment model can address barriers to making this important option available to women.

The focus of a maternity VBP initiative should extend further into the postpartum period than is possible under current state policy. Poor outcomes for mothers can reverberate for a significant period of time, impacting outcomes and costs for future pregnancies, and leading to many years of high medical costs. The current Medicaid program covers most women for only two months post-delivery. After this two-month period, a majority of these women become uninsured, complicating the medical and public health systems' ability to provide effective pre- and interconception care that can prevent unwanted pregnancies, promote a healthy start for a future pregnancy, and transition seamlessly to early prenatal care.[10] In Texas, among women with an intended pregnancy, lack of coverage before pregnancy has been associated with 70% higher prevalence of anemia, 50% higher prevalence of being underweight, 30% higher prevalence of obesity and not consuming daily multivitamins, and 20% higher prevalence of physical inactivity.[11]

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[8] The American College of Obstetricians and Gynecologists. (2017). *ACOG Practice Bulletin: Long-Acting Reversible Contraception: Implants and Intrauterine Devices*. Retrieved from https://www.acog.org/Clinical-Guidance-and-Publications/Practice-Bulletins/Committee-on-Practice-Bulletins-Gynecology/Long-Acting-Reversible-Contraception-Implants-and-Intrauterine-Devices

[9] Texas Health and Human Services Commission. *Women's Health Services Provider Toolkits*. Retrieved from https://hhs.texas.gov/doing-business-hhs/provider-portals/health-services-providers/womens-health-services/womens-health-services-provider-toolkits

[10]Centers for Disease Control and Prevention. (2012) *Preconception Health Indicators Among Women- Texas, 2002-2010*. From http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6129a3.htm

[11] *Ibid (19).*

Health care experts believe that placing greater emphasis on pre- and interconception care and early intervention offers a promising strategy for improving birth outcomes.[12] In its 2018 report to the Texas Legislature, the Maternal Mortality and Morbidity Task Force recommends increasing access to health services during the year after pregnancy and throughout the interconception period to improve the health of women, facilitate continuity of care, enable effective care transitions, and promote safe birth spacing.[13] The state should fully investigate cost effective opportunities to extend postpartum care for up to a full year as part of a maternity VBP model.

Policy Issue: Sustain innovative behavioral health models

Innovative behavioral health services catalyzed by the state's 1115 Transformation Waiver have become a critical component of the state's health care infrastructure.

Recommendation

HHSC should develop value-based payment strategies to sustain strong behavioral health (BH)-related DSRIP work, which has enhanced BH services and filled many gaps in BH care over the past several years. DSRIP initiatives include integrated behavioral health/primary care, evidence-based community care, and crisis alternatives. These strategies should:

a) Include Certified Community Behavioral Health Clinics (CCBHC) as a sustainable value-based strategy for providing comprehensive, integrated behavioral health.

b) Review current Medicaid authorities (State Medicaid Plan, home and community based services [HCBS] waivers, and options under Medicaid

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[12] For example, see: The American College of Obstetricians and Gynecologists (ACOG). (2005, reaffirmed 2017). *Committee on Gynecologic Practice: The Importance of Preconception Care in the Continuum of Women's Health Care*. Retrieved from http://www.acog.org/Resources_And_Publications/Committee_Opinions/Committee_on_Gynecologic_Practice/The_Importance_of_Preconception_Care_in_the_Continuum_of_Womens_Health_Care

[13] Texas Department of State Health Services. (2012). *Maternal Mortality and Morbidity Task Force and Department of State Health Services Joint Biennial Report*. Retrieved from http://www.dshs.texas.gov/mch/Maternal-Mortality-and-Morbidity-Task-Force/.aspx

managed care and the 1115 waiver) and potential amendments to those authorities to develop a plan to sustain DSRIP behavioral health services (such as crisis alternatives and evidence-based community care) demonstrated to prevent high cost inpatient admissions.

Discussion

In the Special Terms and Conditions (STCs) of the renewal of the Medicaid 1115 Demonstration Waiver, Texas is required to submit a draft transition plan to CMS by October 1, 2019 for CMS review and approval, describing how the state will further develop its delivery system reform efforts without DSRIP funding and/or phase out DSRIP funded activities. As Texas' DSRIP is a time-limited federal investment that will conclude by October 2021, Texas must propose milestones by which it will be accountable for measuring sustainability of its delivery system reform efforts absent DSRIP funding. CMS specifies that milestones may relate to the use of alternative payment models, the state's adoption of managed care payment models, payment mechanisms that support providers' delivery system reform efforts, and other opportunities.

The continuum of care that is the focus of CCBHCs represents many of the areas of gain in behavioral health through DSRIP. The CCBHC model is a value-based purchasing design that with further development could be used for the required DSRIP Sustainability Plan.

The purpose of CCBHC as communicated by the Substance Abuse Mental Health Services Administration is to improve behavioral healthcare by:

- Providing community-based mental health and substance abuse services (including crisis services)
- Advancing integration of behavioral health care and physical health care
- Assimilating and utilizing evidence-based practices
- Promoting improved access to quality care
- Coordinating care effectively (considered the "linchpin" for the model)[14]

[14] Substance Abuse and Mental Health Services Administration. (2018). *FY 2018 Certified Community Behavioral Health Clinic Expansion Grants*. Retrieved from https://www.samhsa.gov/grants/grant-announcements/sm-18-019

These areas of focus are aligned with key DSRIP projects that the community mental health center (CMHC) performing providers implemented in the initial stage of the waiver, such as increased access to care, adequate crisis services, integrated care, and peer supports. DSRIP 2.0, which is currently in implementation, is aligned with the quality measures required for the CCBHC model.

In addition, two of the eight CCBHC planning grant sites (Tropical Texas and the Burke Center) are pilot VBP initiatives for SB 58, 83rd Legislature, Regular Session, 2013 for health home pilots serving individuals with a serious mental illness and at least one chronic condition.

In addition to the integrated care approach supported through the CCBHC model, Texas must explore ways to sustain many of the other behavioral health advances enabled by DSRIP. Based on local and regional needs, behavioral health initiatives represented over 25% of DSRIP projects (400+) undertaken in the initial phase of the waiver. DSRIP has been leveraged to fill gaps in care and to test targeted, evidenced based care models.

DSRIP also brought together mental health providers, hospitals, and other partners in the community who previously had not worked as closely together. For example, 87 of the DSRIP behavioral health projects involved coordination with the criminal justice system and 115 focused on emergency department utilization and diversion. DSRIP behavioral health initiatives also focused on substance use disorders (80 projects), crisis intervention (142), better managing super-utilizers (53), and utilization of peer support specialists (46). Many Texans from across the state have attested to how DSRIP has increased access to and improved the array of behavioral health services available in their communities.

To help sustain the behavioral health care continuum enabled through DSRIP, HHSC should review current Medicaid authorities and potential amendments to those authorities to develop a plan to sustain DSRIP behavioral health services (such as crisis alternatives and evidence-based community care) demonstrated to prevent high cost inpatient admissions.

HHSC also should work with health plans and providers to sustain strong BH work through alternative payment models. HHSC is requiring that health plan payments to providers increasingly be through APMs that encourage high-quality care. In 2016, only one of HHSC's 20 health plans reported APMs with outpatient behavioral healthcare providers to reward them for helping reduce potentially preventable ED visits. In 2017, based on a preliminary review of APM information, six health plans

have some type of APM with an outpatient behavioral health provider or behavioral health services vendor. These arrangements include gold carding providers and pay for performance based on measures including potentially preventable readmissions, emergency room utilization, seven and 30-day post hospital follow-up, and total inpatient spend. Effective September 2018, HHSC is requiring that STAR+PLUS plans enter into APMs with CCBHCs.

Policy Issue: Expand treatment for substance use disorders

Treatment for opioid and other substance use disorders can be expanded in a cost effective way using value-based principles.

Recommendation

HHSC should study and present a proposal to State leadership on VBP approaches to improve the identification and treatment of opioid and other substance use disorders (SUD) (e.g., cocaine, methamphetamines, and emerging threats such as synthetic marijuana and the synthetic opioid fentanyl) affecting populations served by state and federally funded programs in Texas, including a model that increases access to medication-assisted treatment (MAT) for Opioid Use Disorders (OUD) and Alcohol Use Disorders (AUD) through a bundled rate.

Discussion

Opioids are a class of drugs that include heroin as well as prescription pain relievers (fentanyl and others). Medication-Assisted Treatment (MAT) combines the use of behavioral therapy with medications, such as methadone, naltrexone, and buprenorphine, to treat Opioid Use Disorders (OUD) and Alcohol Use Disorders (AUD). MAT, the evidence-based treatment for OUD and AUD, is not currently available for other disorders, but other effective treatments are.

MAT and other effective SUD treatment services are generally long term, and MAT in particular often requires daily administration of medications. Individuals typically begin treatment and are closely monitored by daily visits to an opioid treatment clinic, where medications are administered. When individuals become stable and meet federal criteria, they can be allowed to self-administer their medications at home, with periodic check-ins to the clinic. This is important as it enables the individual to avoid a long and early morning trip to the clinic and to be more independent and in control of their recovery through self-dosing (with periodic monitoring by clinic).

In Texas, there are two significant payers for MAT services: the substance abuse prevention and treatment (SAPT) block grant and Medicaid. The SAPT block grant pays a daily bundled rate for MAT (to include counseling and other services that support recovery) for both daily clinic and take-home doses. Medicaid does not pay a bundled rate, and there are separate reimbursement rates for clinic based dosing, take home dosing, and counseling.

Policy Issue: Reduce administrative complexity

State-of-the-art VBP models should reduce, not increase administrative complexity, which itself is a leading source of waste and excess cost in healthcare.

Recommendation

To promote provider participation in APMs, HHSC should work to reduce associated administrative burdens.

a) For all of the episode related recommendations (#4-#6), to reduce administrative burden, there should be support for implementing consistent models across health plans, well-understood supporting definitions (e.g. regarding attribution and outcome measures), and regular review and updating of service bundles.

b) HHSC should clarify that MCO APMs with providers may include approaches that reduce administrative burden for high performing providers as a non-financial incentive. This may require changes to the Uniform Managed Care Contract (UMCC) and/or Uniform Managed Care Manual (UMCM), including the Value-Based Contracting Data Collection Tool.

Discussion

Many providers indicate that reduced administrative burden is as important to them (or even more important) as financial incentives. HHSC held a series of stakeholder meetings in 2015 to identify opportunities to improve member and provider experience in Medicaid managed care. One recommendation received at that time was that HHSC should encourage MCOs to "gold star" provider practices that can show a history of proper utilization of medical services and waive certain prior authorization requirements for those practices. HHSC responded that health plans are able to utilize this practice, and that contract language for fiscal year 2018

would count administrative relief (i.e. gold carding a provider) toward MCO APM targets.[15]

However, the current UMCC and UMCM do not explicitly reference administrative relief as an allowable APM non-financial incentive. We recommend that HHSC explicitly include "gold carding" and associated administrative relief as an allowable component of an APM and encourage MCOs to explore these arrangements as appropriate with high performing provider practices.

[15] Texas Health and Human Services Commission. (2017). *Executive Commissioner's Commitment to Improving Member and Provider Experience in Medicaid Managed Care – Closed Items,* Page 18, updated March 15, 2017.

6. Conclusion

The Executive Commissioner of HHSC established the Value-Based Payment and Quality Improvement Advisory Committee to provide objective evaluation and consensus recommendations that help the state advance high quality, efficient care in state healthcare programs, particularly Medicaid and CHIP. To achieve this purpose, the committee convened seven times between November 2016 and August 2018 in Austin, Texas in full view of the public and in partnership with the many stakeholders committed to improving healthcare in Texas. The resulting deliberations and unanimously approved recommendations support the view that achieving better outcomes at lower cost in the Medicaid program is possible through the smart application of value-based principles. These principles are grounded on the availability of actionable information and business intelligence, reimbursement models that pay for health instead of just treatments, and processes that are administratively simple to implement. The committee hopes this initial report will serve as a catalyst for a sustained effort, centered on practice and payment innovation, to make Texas the national leader for promoting high value healthcare for its people.

List of Acronyms

Acronym	Full Name
APM	Alternative Payment Model(s)
AUD	Alcohol Use Disorder
BH	Behavioral Health
CCBHC	Certified Community Behavioral Health Clinics
CHIP	Children's Health Insurance Program
CMHC	Community Mental Health Center
CMS	Centers for Medicare and Medicaid Services
CY	Calendar Year
DMO	Dental Managed Care Organization
DSHS	Department of State Health Services
DSRIP	Delivery System Reform Incentive Payment
ED	Emergency Department
EHR	Electronic Health Records
HCBS	Home and Community Based Services

Acronym	Full Name
HHS	Health and Human Services
HHSC	Health and Human Services Commission
IT	Information Technology
LARC	Long Acting Reversible Contraceptives
MAT	Medication-Assisted Treatment
MCO	Managed Care Organization
OIG	Office of Inspector General
OUD	Opioid Use Disorder
PIP	Project Improvement Plan
PPA	Potentially Preventable Admissions
PPV	Potentially Preventable Emergency Department Visits
QIPP	Quality Incentive Payment Program
SAPT	Substance Abuse Prevention and Treatment
SB	Senate Bill
STC	Special Terms and Conditions
SUD	Substance Use Disorder

Acronym	Full Name
UMCC	Uniformed Managed Care Contract
UMCM	Uniformed Managed Care Manual
VBP	Value-Based Payment/Purchasing
VBPQI	Value-Based Payment and Quality Improvement Advisory Committee

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