



**Texas Value-Based  
Payment and Quality  
Improvement  
Advisory Committee  
Recommendations to  
the 87<sup>th</sup> Texas  
Legislature**

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**Opportunities to Advance  
Value-Based Payment in  
Texas**

**November 2020**

## **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/abouthhs/leadership/advisory-committees/value-based-payment-quality-improvementadvisory-committee>

## **Report Date**

November 2020

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## 1. Letter from the Chair

Dear Members of the Texas Legislature and Health and Human Services  
Executive Commissioner Cecile Young:

The Value-Based Payment and Quality Improvement (VBPQIAC) Advisory Committee is pleased to submit our biannual report, due by December 1, 2020. Our committee is diverse, representing providers, health plans, academia and other experts. We have reached unanimous consensus on the report's recommendations. Our mission is to promote broad-based partnerships and collaborations for better health care, smarter spending, and healthier communities.

Value in health care means outcomes that matter to patients for the cost of achieving those outcomes. Value-based payment (VBP) 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, including in Medicaid and the Children's Health Insurance Program. 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 four 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 committee developed the recommendations for this report both before and after the onset of the COVID-19 pandemic. This report encompasses recommendations to further value-based care that considers the evolution of

value-based payment in general and lessons learned so far from COVID-19's impact on Texans and the health care system in Texas.

Finally, for this year's report, the committee's recommendations were informed by Delivery System Reform Incentive Payment (DSRIP) program transition planning work. With DSRIP funding in Texas' Medicaid 1115 waiver ending in October 2021, Texas should leverage VBP to continue many of the innovations enabled by DSRIP.

The current report includes five recommendation areas to advance value-based care and payment in Texas Medicaid. The recommendations fall under the following broad categories:

- Promote alternative payment models for maternal and newborn care in Medicaid managed care by standardizing outcome measures and creating a mother-baby registry.
- Leverage multi-payer data to advance the alignment of value-based payment and quality improvement efforts across major payers of health care.
- Support addressing social drivers of health (SDOH) as part of value-based improvement in Medicaid managed care.
- Develop strategies to increase adoption of the most effective alternative payment models (APMs) by Medicaid managed care organizations (MCOs) and providers.
- Use lessons learned from the COVID-19 public health emergency to strengthen care delivery and value based care in Medicaid.

Specific recommendations in each of these five areas are included in the Executive Summary and discussed in more detail in the body of the report. Thank you for considering the recommendations of our committee. The VBPOIAC stands ready to continue our work to advance health care programs rooted in quality and value to improve the health of Texans.

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.

## VBPQIAC 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.

### VBPQIAC Members:

**Mary Dale Peterson, MD, Chair**

Driscoll Health System  
Corpus Christi, Texas

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Coryell Memorial Healthcare System  
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**Cliff Fullerton, MD**

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## 3. Executive Summary

As health care costs in the US continue to increase with mixed outcomes, there is momentum nationwide to promote higher value care by changing how we pay for care. Throughout this report, the terms “value-based care”, “value-based payment” (VBP), and “alternative payment model” (APM) are used interchangeably to describe Texas’ efforts 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.

In 2016, the Executive Commissioner of the Health and Human Services (HHS) system established the Value-Based Payment and Quality Improvement Advisory Committee (VBPQIAC or Committee) to evaluate the evidence on emerging value-based approaches and make recommendations to both HHS and the Legislature aimed at optimizing how health care dollars are spent in Texas.

The Committee released its first biennial report in 2018. The 2018 recommendations included implementing a comprehensive informatics strategy, making data more readily available to support value-based initiatives, addressing patients’ non-clinical health related needs, prioritizing maternal and child health, sustaining innovative behavioral health models, expanding VBP for substance use disorders, and reducing administrative complexity to promote provider participation in VBP models. These recommendations informed discussion and legislation when the Texas Legislature met in 2019.

Building on its 2018 report, the Committee’s second biennial report includes 14 recommendations in five policy areas: maternal and newborn health, leveraging multi-payer data, social drivers of health, advancing alternative payment models in Medicaid, and lessons learned from COVID-19. The Committee adopted these recommendations without a dissenting vote to offer good faith solutions to help Texas continue to advance high quality, efficient care in its state health care programs, and particularly Medicaid and the Children’s Health Insurance Program (CHIP).

The Committee's 2020 recommendations reflect the themes that have informed its work since 2016. Successful VBP initiatives require broad stakeholder engagement, timely data, and aligned incentives for managed care organizations and providers to improve care delivery and health outcomes. Many of this year's recommendations relate to information gathering, such as conducting landscape assessments of current programs, barriers, and tools for VBP and addressing social drivers of health. In addition, the recommendations underscore the importance of convening stakeholders to review and identify standardized performance measures and best practice models. Finally, this year's report again stresses the importance of data, and, in particular, aggregating and integrating data sources to analyze trends and opportunities for improvement across populations.

## Recommendations

### Maternal and Newborn Care

1. HHSC should establish a consensus endorsement of a set of standardized performance measures, measure specifications, and reporting periods for maternal and newborn care through a two-stage process:
  - Regional stakeholders in diverse pilot regions establish consensus measures and measurement approaches that address local needs, priorities, and barriers to provider participation.
  - Convene stakeholders from the Department of State Health Services (DSHS), Health and Human Services Commission (HHSC), and other relevant advisory committees and collaboratives to establish a statewide endorsement informed by regional needs.
2. Texas should establish a statewide de-identified database linking mothers and babies that enables providers to explore and improve on their performance on key measures in near real-time.

## Recommendations

### Leveraging Multi-Payer Data

3. The Legislature should build on the multiple legislative sessions of direction to encourage collaboration in the use of health care data by:
  - Extending the term of the 10.06 rider for cross-agency collaboration for another five years, maintaining the services of the Center for Healthcare Data at The University of Texas Health Science Center at Houston School of Public Health (UT Data Center).
  - Directing remaining state funded health plans and health services to participate in the rider 10.06 cross-agency collaboration, specifically the state run hospitals (including psychiatric hospitals) and state supported living centers, juvenile justice health system, and employer sponsored health plans for state colleges and universities.
  - Requiring the agencies involved in the 10.06 rider to permit their data to be included in aggregated multi-payer analyses and reporting activities conducted by the UT Data Center.
  - Exploring how to strategically partner with additional commercial payers, including self-insured payers and county indigent care programs, so that their data could be included in the UT Data Center as well.
  - Directing that data aggregated by the UT Data Center, including state agency data and data from other payers who have provided authorization, be shared at a de-identifiable level through a Public Use Data File (PUDF). An application programming interface (API) should be developed and made available as one way of accessing the PUDF, in addition to a streamlined request process similar to that used for the Texas Health Care Information Collection (THCIC).
  - Exploring price and utilization variation among providers for similar services, both within metro areas and across the state, to

## Recommendations

identify instances and programs where savings can be achieved without sacrificing quality.

- Directing UT Data Center to aggregate all available clinical, claims, pharmacy, cost, and quality data regarding specific high cost/high prevalence conditions, such as diabetes, to develop additional web features and de-identified data files for public and research use.
  - Exploring federal funding opportunities, such as those offered by the Center for Medicare & Medicaid Innovation, that advance value-based payment and that are enabled by access to multi-payer data.
4. Texas should identify new and expanded use cases for the Texas Healthcare Learning Collaborative (THLC) Portal as well as analyze potential use cases for aggregating data from the THLC, the UT Data Center, the Texas Health Care Information Collection, and any other data sources that could prove beneficial. Texas should develop an implementation strategy for the most valuable use cases that leverages the strengths of these existing data sources while minimizing duplication of state resources.

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### Social Drivers of Health (SDOH)

5. HHSC should conduct a landscape analysis of which SDOH assessment tools and electronic referral platforms are currently being utilized in Texas Medicaid, and also review strong models throughout the US. Working with Medicaid managed care organizations (MCOs), providers, and other stakeholders, HHSC could assess whether a state-level or regional tool(s) and/or platform(s) would better enable Texas Medicaid to address SDOH.
- Based on the landscape analysis, HHSC should work with Medicaid MCOs to implement an assessment tool and electronic referral platform strategy that can be used to better facilitate the ability to address SDOH needs.

## Recommendations

6. HHSC should work with stakeholders to explore how initiatives to address SDOH that drive healthcare costs and poor health outcomes are/could be supported through APMs, including:
    - Promoting better reporting of ICD-10 Z codes for social needs. The information could be useful for eventually identifying areas for improvement or intervention.
    - Developing accountability metrics in the Medicaid program related to SDOH/health equity.
    - Looking at pilot/study/proof of concept opportunities with MCOs to develop evidence to inform future HHSC policy.
    - Reviewing opportunities in 1115 waivers, such as the DSRIP transition.
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## Recommendations

### Advancing Alternative Payment Models in Medicaid

7. HHSC should conduct a landscape assessment to determine the barriers and opportunities to advancing APMs. The landscape assessment should include:
  - Considerations and opportunities specific to rural and small providers and provider types not significantly represented in current APMs, including emerging models for these provider types
  - An assessment of the current Texas Medicaid APM requirements and targets for any modifications that could incentivize implementation of the highest impact models
  - Identification of opportunities for measure standardization to reduce provider administrative burden to participate in Medicaid APMs, while acknowledging flexibilities may be required to address specific regional or sub-population needs
  - Review of strong models related to maternal and newborn health, behavioral health, and opioid and other substance use identification and treatment
8. HHSC should convene Medicaid MCOs and provider stakeholders to share the results of the landscape assessment as well as discuss best and promising APM models in Texas and other states.
9. HHSC should leverage findings from the DSRIP Best Practices Workgroup and the Delivery System Reform Incentive Payment (DSRIP) Transition Plan milestone analysis of DY 7-8 DSRIP quality data to identify key outcomes and effective interventions to inform HHSC strategies to advance alternative payment models.
10. HHSC should encourage MCOs to work with providers to make adjustments to APMs, including adjusting risk-based requirements, that acknowledge the barriers COVID-19 has posed to achieving metrics agreed upon prior to COVID-19 and engaging patients in certain preventive health care practices.

## Recommendations

### Lessons Learned from COVID-19

11. HHSC should work with stakeholders to evaluate the Medicaid waivers used in telehealth during the pandemic including access to care, patient experience, health outcomes and cost effectiveness to share best practices and determine policy changes that should continue post-pandemic.
  - Consider how telehealth can count toward network adequacy.
12. HHSC should work with stakeholders to reward and incentivize creative practices that improve health based on the experience during COVID-19, such as prospective payments for primary care providers.
13. Texas should review the experience of social drivers of health (SDOH) Medicaid members experienced during the COVID-19 pandemic for waivers that could be instituted in an expedited approval process in future emergencies/disasters. Areas of focus could include:
  - Establishing enhanced rates for disaster-related services, such as used by Medicare for COVID-19.
  - Flexibility for additional administrative costs required during a disaster, such as purchase of pre-paid smart phones for beneficiaries to use for telehealth during a disaster.
14. HHSC should work with stakeholders to align value-based payment measures and incentives as much as possible within each region of Texas to reduce provider administrative burden.

## 4. Introduction

Since its creation in August 2016, the Value-Based Payment and Quality Improvement Advisory Committee (VBPQIAC or 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, the Committee reports its consensus finding and recommendations to the Executive Commissioner of the HHS system and the Texas Legislature.

As defined in the Committee's first report, value-based payment (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.<sup>1</sup> 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 health care providers for value -- that is, better outcomes at lower cost -- rather than volume. 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.

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<sup>1</sup> <https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2019/value-based-payment-qual-improvement-recommendations-nov-2018.pdf>

The transition to managed care has been complemented by other system initiatives to improve quality and efficiency in state health care 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 health care, 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 health care include: the MCO Pay for Quality Program (P4Q); 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; and Quality Incentive Payment Program (QIPP) to promote patient safety in nursing homes.

Finally, MCO Value-Based Contracting with Providers seeks to facilitate and encourage the development of alternative payment and flexible practice approaches between MCOs and their providers. Under this initiative, HHS created contractual targets for MCOs to connect provider payments to value using APMs starting in calendar year 2018. The APM percentage targets increase over time. (See Table 1 on page 44 for the target requirements from 2018-2021.) 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.

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.<sup>2</sup> Additionally, the implementation of APMs has often proven difficult due to administrative complexity and the availability of timely data and suitable performance measures.

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<sup>2</sup> 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/>

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 HHSC's Value Based Payment 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. The roadmap is being updated as part of the DSRIP Transition Plan and will be submitted to the Centers for Medicare & Medicaid Services (CMS) by March 31, 2021.

## **Progress since the Committee's 2018 Report**

The Committee made a number of recommendations in its 2018 report.<sup>3</sup> The recommendations fell 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 and newborn care, mental health care, and substance use disorder services; and
- ways that HHSC as the State Medicaid Agency can facilitate value-based care by reducing administrative burden and providing additional guidance relating to meeting complex enrollees' non-clinical needs.

The Committee's 2018 recommendations helped inform subsequent state initiatives, including legislation passed in 2019 and many of the milestones in the Delivery System Reform Incentive Payment (DSRIP) Program Transition Plan Texas submitted to CMS.

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<sup>3</sup> <https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2019/value-based-payment-qual-improvement-recommendations-nov-2018.pdf>

## Ongoing State Initiatives and Legislation in the Texas 86<sup>th</sup> Legislature, Regular Session, 2019

In 2019, the Texas Legislature continued to demonstrate its commitment to promoting value-based care and the Committee's focus areas.

The Committee report acknowledged the critical role of actionable health care data to enhance value-based care. For three consecutive legislative sessions, there have been budget riders to promote interagency data coordination to improve quality and cost effective care among state-funded health payers. The 2020-21 General Appropriations Act, Article IX, Section 10.06 (H.B. 1, 86th Legislature, Regular Session, 2019) directs HHSC to coordinate with the Department of State Health Services (DSHS), Employees Retirement System (ERS), Teachers Retirement System (TRS), and Texas Department of Criminal Justice (TDCJ) to compare health care data, including outcome measures, to identify outliers and improvements for efficiency and quality that can be implemented within each health care system. Section 10.06 provided funding for the Center for Healthcare Data at The University of Texas Health Science Center at Houston School of Public Health to administer the data comparison. Section 10.06 also requires collaboration on the development and implementation of potential value-based payment strategies, including opportunities for episode-based bundling and pay for quality initiatives.

In addition, during this legislative interim, CMS approved HHSC's Health Information Technology (IT) Strategic Plan, a requirement of Texas 1115 Healthcare Transformation and Quality Improvement Program Waiver, Special Terms and Conditions #39.<sup>4</sup> The plan includes milestones related to health (IT) adoption and health information exchange (HIE), including building connectivity to the state HIE infrastructure and enhancing care coordination and quality enabled by health IT adoption.

Maternal and newborn health continues to be a priority area for Texas. The Legislature re-named the Texas Maternal Mortality and Morbidity Review

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<sup>4</sup> <https://hhs.texas.gov/sites/default/files/documents/laws-regulations/policies-rules/1115-waiver/waiver-renewal/health-it-strategic-plan.pdf>

Committee in 2019 and related that ongoing state advisory groups focused on maternal and newborn health include the Texas Collaborative for Healthy Mothers and Babies and the Perinatal Advisory Council.

One major piece of legislation from the 86<sup>th</sup> Legislature that will help advance value-based care in maternal and newborn health is S.B. 750. The bill requires HHSC to pursue any federal money available to implement a model of care that improves the quality and accessibility of care for pregnant women in Medicaid with opioid use disorder during the prenatal and postpartum periods and their children. In December 2019, Texas received approval to implement in Houston the Maternal Opioid Misuse (MOM) model of care, which provides integrated care to increase access to treatment and improve outcomes for postpartum and expectant mothers with an opioid use disorder who are enrolled in Medicaid.<sup>5</sup>

S.B. 750 also requires multiple initiatives in Medicaid managed care and the Healthy Texas Women (HTW) program to improve prenatal and postpartum care, including implementing a postpartum depression treatment network and strategies to ensure continuity of care when transitioning from Medicaid to HTW. It requires HHSC to specify the initiatives that each MCO must incorporate to improve the quality of maternal health care services and outcomes for women, which may involve pre- and postnatal care, health disparities, social drivers of health, or other selections by HHSC.

Other key legislation in the area of maternal and newborn health is S.B. 748, which requires data collection and reporting on maternity care and postpartum depression, establishes a pilot program using community health workers to provide high-risk maternal care coordination services, and establishes a pregnancy medical home pilot. The Legislature also placed specific focus on postpartum depression with H.B. 253 requiring HHSC to develop and implement a five-year strategic plan to improve access to postpartum depression screening, referral, treatment, and support services.

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<sup>5</sup> <https://hhs.texas.gov/about-hhs/communications-events/news/2019/12/texas-awarded-funding-help-pregnant-postpartum-women-affected-opioid-use-disorders-houston>

Improving mental health and addressing substance use disorders has been and continues to be an area of focus for Texas. Over the past several legislative sessions, Texas has increased state funding to improve mental health services. Texas appropriated about \$7.8 billion in all funds for the 2020-21 biennium for behavioral health services. Like other states, Texas also is leveraging federal funds from the Substance Abuse & Mental Health Services Administration (SAMSHA) to work with local partners to tackle the opioid epidemic.

The Legislature previously established the Statewide Behavioral Health Coordinating Council to develop a five-year statewide behavioral health strategic plan. Texas published the Second Edition of the Texas Statewide Behavioral Health Strategic Plan in February 2019.<sup>6</sup> The plan includes a major goal to ensure that the financial alignment of behavioral health funding best meets the needs across Texas, including a strategy to explore and promote alternative payment structures that reward or incentivize the provision of services that avert costlier care. The plan also includes an emphasis on the use of piloting and expansion of the Certified Community Behavioral Health Clinics (CCBHC) model, which offers integrated behavioral health with targeted acute care screening and care coordination to individuals with complex needs.

The Legislature's emphasis on behavioral health continued during the 2019 session. S.B. 11 focuses on addressing mental health challenges and improving the mental health care system for children and adolescents. H.B. 3285 contains provisions related to opioid misuse and other SUD, such as adding SUD requirements to the statewide behavioral health strategic plan, expanding access to telehealth to treat SUD, prohibition on prior authorization (PA) requirements to receive Medicaid reimbursement for medication-assisted opioid or SUD treatment, and relevant data collection and analysis efforts on opioid overdose deaths and co-occurring SUD.

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<sup>6</sup> The 2016-17 General Appropriations Act, H.B. 1, 84th Legislature, Regular Session, 2015 (Article IX, Section 10.04) required Texas to create a statewide BH strategic plan. *Texas Statewide Behavioral Health Strategic Plan Update (February 2019)* available at: <https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2019/hb1-statewide-behv-hlth-idd-plan-feb-2019.pdf>.

Another major theme that continues is the role that reduction in provider administrative burden can play in supporting provider participation in value-based care and enabling providers to focus on the health and well-being of their patients. Various pieces of legislation passed in 2019 contained provisions promoting administrative simplifications, like streamlining prior authorization requirements and using standard performance measures.

Regarding new value-based care models, S.B. 1780 provides HHSC the legal authority to seek value-based agreements with Medicaid drug vendors. The 86<sup>th</sup> Legislature required a pilot to test the delivery of long-term services and supports (LTSS) through Medicaid managed care for people with intellectual and developmental disabilities (IDD) and traumatic brain injuries to inform the longer term transition of IDD waiver services into Medicaid managed care. H.B. 4533 adds the requirement that the pilot test innovative payment methodologies for the provision of LTSS, including bundled payments with downside risk and incentive payments for meeting outcomes and quality metrics. While LTSS is not a major theme in the current recommendations, the Committee acknowledges the importance of LTSS and plans for this area to be among its next steps.

## **Delivery System Reform Incentive Payment Program Transition Plan**

The DSRIP program in Texas' 1115 Healthcare Transformation and Quality Improvement Program Waiver provides incentive payments to participating hospitals, physician groups, mental health centers, and local health departments for strategies to enhance access to health care and test care innovations. DSRIP is designed to increase the quality and cost effectiveness of care and improve the health of patients and families.

DSRIP has been an effective incubator for testing how flexible payment models can support patient centered care and clinical innovation. Since 2012, DSRIP providers have earned over \$19 billion all funds (federal funds matched with intergovernmental transfer funds). The DSRIP pool is scheduled to end on October 1, 2021. HHSC continues to work closely with MCOs and DSRIP providers on ways to incorporate promising clinical models into the Medicaid MCO provider payment stream in the form of VBP models.

The DSRIP program structure, beginning in FFY 2018, evolved from a focus on projects and project-level reporting to targeted measure bundles (or measures, depending on performing provider type).

Among the allowable menu of measure bundles and measures, State priority measure bundle areas for hospitals and physicians include:

- Chronic care: diabetes and heart disease care, pediatric asthma management
- Primary care prevention
- Pediatric primary care
- Maternal care (high state priority)
- Integrated behavioral health/primary care
- Chronic non-malignant pain management (high state priority)
- Behavioral health and appropriate utilization

Required reporting for DSRIP performing providers in the waiver renewal period also includes progress on Core Activities, Alternative Payment Model (APM) arrangements, Costs and Savings, and Collaborative Activities. The DSRIP Transition Plan that Texas submitted to CMS in April 2020 contains specific goals for next steps in delivery system transformation for which value-based care is a key feature. Milestones are categorized by the following broad goals:

- Advance APMs that target specific quality improvements.
- Support further delivery system reform that builds on the successes of the Waiver and includes current priorities in health care.
- Explore innovative financing models.
- Develop cross-focus areas such as social drivers of health that use the latest national data and analysis to continue to innovate in Texas.
- Strengthen supporting infrastructure for increased access to health care and improved health for Texans.<sup>7</sup>

DSRIP Transition Plan milestones align with many of this Committee's 2018 recommendations, including related to:

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<sup>7</sup> <https://hhs.texas.gov/sites/default/files/documents/laws-regulations/policies-rules/Waivers/medicaid-1115-waiver/1115-medicare-waiver-tools-guidelines-regional-healthcare-partnership-participants/draft-revised-dsrp-transition-plan.pdf>

- data sharing and transparency to advance VBP,
- focus on key populations served through Medicaid such as the population with serious mental illness (SMI) and maternal and newborn health, and
- the need for additional guidance on allowable Quality Improvement costs in Medicaid managed care to help sustain innovative DSRIP activities that improve health but are not Medicaid billable services.

Other DSRIP Transition Milestones informed recommendations in this year's report, including related to social drivers of health, telemedicine/telehealth, and the importance of strong data to improve care and health.

## 5. Policy Issues, Recommendations, and Discussion

In 2019-2020, the Committee heard from numerous healthcare professionals, experts, and stakeholders and has reviewed a wide array of relevant research and literature to create the new recommendations discussed in this report. During this review, key themes included the importance of stakeholder engagement, timely data, and aligned incentives to move to value. The current Texas health care environment, including the COVID-19 pandemic and DSRIP transition planning, also informed the Committee's work. 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 health for patients and families served by the Texas Medicaid program.

### Policy Issue: Maternal and Newborn Care

Maternal and newborn health is a key area in which Texas can affect change through VBP, because Medicaid pays for over half the births in the state, yet there is large variability in outcomes and costs and significant disparities among population groups. Texas is a vast state, and some of the variability is driven by regional differences in population health and local social drivers. Providers indicate the complexities of collecting and reporting data for a multitude of performance measures is a barrier to their new or continued participation in VBP arrangements. Providers also need data that is timely and actionable to enhance maternal health and improve birth outcomes.

### Recommendations:

1. HHSC should establish a consensus endorsement of a set of standardized performance measures, measure specifications, and reporting periods for maternal and newborn care through a two-stage process:

- Regional stakeholders in diverse pilot regions establish consensus measures and measurement approaches that address local needs, priorities, and barriers to provider participation
  - Convene stakeholders from DSHS, HHSC, and other relevant advisory committees and collaboratives to establish a statewide endorsement informed by regional needs
2. Texas should establish a statewide de-identified database linking mothers and babies that enables providers to explore and improve on their performance on key measures in near real-time.

## Discussion

### Standardization of Performance Measures

Providers report that the multitude of differing performance measures, measure specifications, and reporting periods for various incentive programs and APMs is a barrier to their new or continued participation in APMs. For example, one Houston physician practice tallied that they had to report on more than 150 performance measures across all payers and programs for all disciplines. Some providers report that the administrative cost to track and report performance measures exceeds any incentives they can receive through participation in payer programs. This administrative cost and complexity is a disincentive for providers to participate in VBP arrangements.

Because over half the births in Texas are paid for by Texas Medicaid, the stakeholders associated with Texas Medicaid have the ability to influence maternal health and birth outcomes. There is an opportunity to align measures among a variety of initiatives and programs, including legislative initiatives such as the required pregnancy medical homes pilots (S.B. 748, 86th Legislature, Regular Session, 2019) and HHSC quality initiatives such as the Pay for Quality (P4Q) program and assessment of Medicaid alternative payment methodologies. DSHS implements and collaborates in a number of efforts to improve maternal health in Texas.

In a state as diverse and vast as Texas, any statewide endorsement of standardized measures should be informed by regional input. For this reason, the Committee recommends that regional stakeholders first convene

in diverse pilot regions to establish consensus measures and measurement approaches that address local needs, priorities, and barriers to provider participation. They then can engage in regionally-based quality improvement efforts that use the selected measures to assess the outcomes of their efforts on addressing local priorities.

Selection of pilot regions should consider representation of both urban and rural areas and account for areas with diverse health concerns and community needs, including the Regional Health Partnerships formed for the Texas' 1115 Healthcare Transformation and Quality Improvement Program Waiver. Consideration could also be given to aligning the regions chosen for the measure standardization pilots with counties participating in the S.B. 748 pregnancy medical homes pilots. Lessons learned from existing S.B. 748 efforts could prove invaluable to the measure development process, and there will already be a ready group of stakeholders aligned around the activities and assessment of these pregnancy medical home pilots.

Participants in the pilot measure development process should include membership of perinatal regional advisory committees, Medicaid MCOs that serve the region, and other interested stakeholders. The goal of the regional pilot efforts would be to establish an agreement about a limited set of measures and measure definitions to recommend for further consideration at a statewide level.

Equipped with the recommendations resulting from the regional pilot process, DSHS, HHSC, and other stakeholders, such as interested advisory committee members and the Texas Collaborative for Healthy Mothers and Babies, could convene to assess the various maternal and newborn health measures and endorse a set of key measures, measure specifications, and reporting periods. HHSC could encourage the statewide use of the endorsed measures among Medicaid MCOs and for future quality initiatives to reduce administrative burden and encourage provider participation in APMs. Standardized measures also would enable more meaningful comparison of the outcomes of various programs and interventions.

As a starting point for measure consideration, stakeholders could look to Tennessee<sup>8</sup> and Ohio<sup>9</sup> for the measures historically used in their perinatal episodes of care models. The Healthcare Payment Learning & Action Network (HCP LAN) also developed a *Maternity Episode Payment Model Online Resource Bank*<sup>10</sup> that features a Robert Wood Johnson Foundation-supported *Buying Value Measure Selection Tool*.<sup>11</sup>

### Statewide De-identified Mother-Baby Database

Performance measurement is most meaningful when the data is timely and actionable. Texas should establish a statewide de-identified database linking mothers and babies that enables providers to explore and improve on their performance on key measures in near real-time. The Texas Regional Advisory Committee—Perinatal Care Region Chairs Alliance stated in late 2019 it “fully supports and emphasizes the critical need for a statewide de-identified patient-level Quality and Outcomes Database for Maternal, Fetal and Neonatal patients in the State of Texas.”

There are some examples providers point to as a gold standard for implementing de-identified databases focused on maternal and birth outcomes. One example is the Vermont Oxford Network, which has over 1300 hospital participants collaborating to improve neonatal care outcomes.<sup>12</sup>

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<sup>8</sup> Tennessee *Detailed Business Requirements for Perinatal Episode, v5.1*: <https://www.tn.gov/content/dam/tn/tenncare/documents2/Peridbr2019v5.pdf> and Tennessee *Detailed Business Requirements for Neonatal Episode, v1.1*: <https://www.tn.gov/content/dam/tn/tenncare/documents2/NEO3236DBRV1.1.pdf>

<sup>9</sup> Ohio Perinatal measures CY2019: <https://medicaid.ohio.gov/Portals/0/Providers/PaymentInnovation/Threshold/Perinatal-Thresholds.pdf>

<sup>10</sup> HCP LAN *Maternity Episode Payment Model Online Resource Bank*: <https://hcp-lan.org/maternity-resource-bank/>

<sup>11</sup> RWJF *Buying Value Measure Selection Tool*: <http://www.buyingvalue.org/resources/toolkit/>

<sup>12</sup> Vermont Oxford Network site: <https://public.vtoxford.org/>

The California Maternal Data Center (MDC),<sup>13</sup> which was launched in 2012 and now supports data from Washington and Oregon as well, provides an example of the potential for a database that addresses maternal and newborn health outcomes more broadly. The Maternal Data Center is currently supported by participating hospitals and grants from the California Health Care Foundation (CHCF). The CHCF and the Centers for Disease Control and Prevention provided financial support for developing the Maternal Data Center. California has used the database to help it rank among the top ten states for measures such as maternal and infant mortality and avoiding low birth weight deliveries.<sup>14</sup>

The MDC is an online web tool that generates near real-time data and performance metrics on maternity care services for hospital participants. Hospitals submit patient discharge data to the MDC, which instantaneously links the discharge data to birth certificate or clinical data. The result is a low-burden tool that enables hospitals to compare their performance to statewide, regional and system benchmarks or generate provider-level quality metrics.

Texas could streamline and build on existing statutory and regulatory precedent for data gathering in the perinatal arena for development of a Texas database linking available data about mothers and babies.<sup>15</sup> This

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<sup>13</sup> California Maternal Data Center site: <https://www.cmqcc.org/maternal-data-center>

<sup>14</sup> America's Health Rankings for California: [https://www.americashealthrankings.org/explore/health-of-women-and-children/measure/maternal\\_mortality\\_a/state/CA](https://www.americashealthrankings.org/explore/health-of-women-and-children/measure/maternal_mortality_a/state/CA)

<sup>15</sup> Texas Health and Safety Code (HSC), Sec. 34.012, authorizes DSHS to establish an electronic de-identified database to track cases of pregnancy-related deaths and severe maternal morbidity. HSC, Sec. 241.183(d) states: "Each level of care designation must require a hospital to regularly submit outcome and other data to the department as required or requested." Per HSC, Sec. 32.017, each provider receiving reimbursement under the Maternal and Infant Health Improvement Act must maintain records and information for each applicant for or recipient of services. The Legislature established the perinatal healthcare system under HSC, sec. 32.041, and under sec. 32.042 gave HHSC rulemaking authority for "requirements for data collection, including operation of the perinatal health care system and patient outcomes". HSC, sec. 32.074(5) requires that centers of excellence for fetal diagnosis and therapy must provide annual reports containing aggregate data on short-term and long-term diagnostic and therapeutic outcomes as required by DSHS and makes those reports available to the public.

could automate, to the extent possible, the generation of the standardized maternal and newborn health measures endorsed by HHSC, DSHS, and other Texas Medicaid stakeholders. Such a tool could become a driver of provider-specific quality interventions. It also could minimize provider administrative burden in collecting and reporting data that could facilitate participation in VBP arrangements and other quality initiatives.

Considerations for development of a de-identified mother/baby database should include:

- financing mechanisms,
- how providers could be incentivized to participate,
- how to minimize provider administrative burden to participate, and
- how to implement risk adjustment strategies to ensure apples-to-apples comparison of the performance of like providers with like patient risk profiles.

Consideration also should be given to whether data sources with existing data collection infrastructure could be leveraged for a Texas database. The UT Data Center has claims and other data from ERS, TRS, Medicaid, Medicare and many commercial payers. The Texas Health Care Information Collection (THCIC) has inpatient and outpatient discharges from Texas hospitals, including patient and facility characteristics, diagnoses, procedures, and charges. DSHS Vital Statistics collects birth certificate data. The Texas Healthcare Learning Collaborative portal has Medicaid quality data.

If identifying start-up funding is a challenge, leveraging existing data infrastructure could be a component of a staged approach to database development that initially would be less resource intensive. For example, though more real-time data would be ideal, claims data can be analyzed to map ICD-10 metrics to ICD-10 diagnoses. In addition, it would be ideal to have data down to the individual provider level, but the initiative could start with unit level and higher data. Regardless, the registry would present a value proposition to hospital providers of diminishing some administrative burden in quality reporting and enabling a broader view of their performance, which may enable them to hone their health-promoting and cost-saving interventions.

## Policy Issue: Leveraging Multi-Payer Data

In Texas, there are a number of health care payers, including the Employees Retirement System (ERS), Teachers Retirement System (TRS), Texas Department of Criminal Justice (TDCJ), Medicare, Medicaid, and commercial payers. Commercial payers include market-based plans, fully-insured employer group plans and other plans that are self-insured by large employers and are operated by third-party administrators or administrative service organizations. It is challenging to align value-based payment and quality improvement efforts across these major payers of health care without timely, transparent, comparable data and common measures. During the past three legislative sessions, Texas has encouraged cross-agency collaboration in the use of health care data. Most recently, the state directed the Center for Healthcare Data at the University of Texas Health Science Center at Houston School of Public Health (UT Data Center) to conduct data comparisons, resulting in its receipt of claims data from the largest state-funded payers.<sup>16</sup>

Multi-payer data can be a powerful tool to enable data-driven approaches to improving population health, including understanding cost-drivers, factors that lead to more or less favorable outcomes, and other variables that affect the Texas population. Access to robust multi-payer data can inform next steps to align payment reform efforts, improve quality and outcomes, increase transparency of costs, and reduce the cost of care.

### Recommendations:

3. Texas should build on the multiple legislative sessions of direction to encourage collaboration in the use of health care data by:
  - Extending the term of the 10.06 rider for cross-agency collaboration for another five years, maintaining the services of the UT Data Center.
  - Directing remaining state funded health plans and health services to participate in the Rider 10.06 cross-agency collaboration,

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<sup>16</sup> 2020-21 General Appropriations Act, Article IX, Section 10.06 (H.B. 1, 86th Legislature, Regular Session, 2019)

- specifically the state run hospitals (including psychiatric hospitals) and state supported living centers, juvenile justice health system, and employer sponsored health plans for state colleges and universities.
- Requiring the agencies involved in the 10.06 rider to permit their data to be included in aggregated multi-payer analyses and reporting activities conducted by the UT Data Center.
  - Exploring how to strategically partner with additional commercial payers, including self-insured payers and county indigent care programs, so that their data could be included in the UT Data Center as well.
  - Directing that data aggregated by the UT Data Center, including state agency data and data from other payers who have provided authorization, be shared at a de-identifiable level through a public-use data file (PUDF). An application programming interface (API) should be developed and made available as one way of accessing the PUDF, in addition to a streamlined request process similar to that used for the Texas Health Care Information Collection (THCIC).
  - Exploring price and utilization variation among providers for similar services, both within metro areas and across the state, to identify instances and programs where savings can be achieved without sacrificing quality.
  - Directing UT Data Center to aggregate all available clinical, claims, pharmacy, cost, and quality data regarding specific high cost/high prevalence conditions, such as diabetes, to develop additional web features and de-identified data files for public and research use.
  - Exploring federal funding opportunities, such as those offered by the Center for Medicare & Medicaid Innovation, that advance value based payment (VBP) and that are enabled by access to multi-payer data.
4. Texas should identify new and expanded use cases for the Texas Healthcare Learning Collaborative (THLC) Portal as well as analyze potential use cases for aggregating data from the THLC, the UT Data Center, the Texas Health Care Information Collection, and any other data sources that could prove beneficial. Texas should develop an implementation strategy for the most valuable use cases that

leverages the strengths of these existing data sources while minimizing duplication of state resources.

## Discussion

Analysis of multi-payer data in a de-identified way can increase understanding of cost drivers, outcome measures, and other variables that affect the Texas population. Such analysis can be used to advance alignment of VBP and quality improvement efforts across major payers of health care. A number of states have recognized the promise of multi-payer claims data and have begun implementing all-payer claims databases (APCDs):<sup>17</sup>

- 18 states have existing APCDs
- 3 states are currently implementing APCDs
- 5 states have voluntary efforts

### Interagency Data Sharing and the UT Data Center

Texas is among the states considered to have a voluntary APCD. Three consecutive sessions of legislative direction aimed at interagency data coordination to improve quality among state-funded programs have resulted in the Center for Healthcare Data at The University of Texas Health Science Center at Houston School of Public Health (UT Data Center) receiving claims data from the largest payers in the state. Most recently, the 2020-21 General Appropriations Act, Article IX, Section 10.06 (H.B. 1, 86th Legislature, Regular Session, 2019) directs HHSC to coordinate with DSHS, ERS, TRS, and TDCJ to compare health care data, including outcome measures, to identify outliers and improvements for efficiency and quality that can be implemented within each health care system.

To administer the data comparison, Section 10.06 directs HHSC to work with the UT Data Center for data analysis, including individual benchmark and progress data for each agency. Section 10.06 also requires collaboration on the development and implementation of potential value-based payment

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<sup>17</sup> All Payer Claims Database Council: <https://www.apcdouncil.org/state/map>

strategies, including opportunities for episode-based bundling and pay for quality initiatives.

### Opportunities to Build on Texas' Multi-Payer Data

The UT Data Center now holds claims data for most of the state's insured residents, including those insured by Medicare, Medicaid, ERS, TRS, TDCJ, and commercial payers. The Center also has some electronic medical records data, several public use data files of aggregated health events data, and survey data.

Currently, the UT Data Center offers services related to health care data analyses and reporting to state entities, qualified researchers, non-profit organizations, institutions and foundations, and other clients with a non-proprietary interest in health care costs and quality. The UT Data Center has also used the information it collects to develop The Health of Texas Dashboard,<sup>18</sup> which is a publicly available display of various summary-level data on all of Medicaid clients and a significant portion of Medicare and commercial covered lives down to the 3-digit zip code. The UT Data Center would need legislative direction to include ERS and TRS in the aggregate data for Health of Texas. The specific dashboards include:

- Drug and medical costs relative to the average annual total cost per member
- Utilization of ED visits, inpatient and observation stays, outpatient facilities, professional visits, and readmissions
- Prevalence of chronic diseases, such as asthma, diabetes, hypertension, and cancers, and autoimmune conditions and epilepsy
- Select quality measures related to diabetes, COPD, and asthma
- 3M clinical risk groups
- Social drivers of health, including overall scores and composite scores on access, health behaviors, health outcomes, physical environment, and social economic environment

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<sup>18</sup> <https://sph.uth.edu/research/centers/chcd/health-of-texas/?s=1>

While the amount of data the UT Data Center currently possesses is significant, the UT Data Center lacks some sources of state payer data that could lend additional insight into specific populations, including state hospital data, state supported living center data, juvenile justice data, and data for university employee health insurance paid outside of TRS. Additionally, commercial payer participation is voluntary, and Texas' multi-payer data effort would benefit from strategic partnerships with additional commercial payers, especially those that would include specific and accurate information related to charges and payments and provider identification. Patient identifiable data would be useful as well. The UT Data Center has been audited and certified in its privacy and security practices to protect such data. Patient identifiable data would be encrypted and only used when required and with Institutional Review Board (IRB) approval.

The Texas Health Improvement Network (THIN)<sup>19</sup> provided data-related recommendations in a report released March 2019 titled *Facilitating Use of Data to Drive Population Health in Texas*.<sup>20</sup> The report includes a variety of recommendations for data sharing from the Texas Health Care Information Collection (THCIC), Medicaid, and Vital Statistics data, including recommendations pertaining to:

- Removing statutory barriers for sharing identified public health data within and across state agencies (e.g., HHSC, DSHS, ERS, TRS, TDCJ) and local health departments.
- Improving quality, timeliness, and utility of data held by state agencies through initiatives such as standardizing some public reports and data query tools, standardizing processes for public and interagency requests for data sharing, standardizing data use agreements, and establishing circumstances under which provisional data is acceptable for more timely access to data.

In a similar spirit to the THIN recommendations, there is opportunity to expand upon the excellent analytics conducted at the UT Data Center by

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<sup>19</sup> Created by H.B. 3781, 84<sup>th</sup> Legislature, Regular Session, 2015

<sup>20</sup> [https://utsystem.edu/sites/default/files/sites/texas-health-journal/new%20site/THIN\\_Facilitating-Data-Use-For-Population-Health\\_Mar2019.pdf](https://utsystem.edu/sites/default/files/sites/texas-health-journal/new%20site/THIN_Facilitating-Data-Use-For-Population-Health_Mar2019.pdf)

enabling other researchers throughout the state to explore their own research questions using state payer claims data. The potential applications of the data available at the UT Data Center could be greatly expanded by creating a public use data file (PUDF) that enables the public and researchers to download and manipulate a significant set of de-identified state payer claims data for their own analyses. In addition to facilitating capacity for the broader research community to explore what questions Texas' multi-payer data could address, a PUDF would diminish administrative burdens on the part of state agencies and the UT Data Center in responding to data requests and expedite access to data for researchers who otherwise might have to await the results of a data request review process. A streamlined data request process for any data not available in the PUDF could be established.

The PUDFs of hospital discharge data available through the Texas Health Care Information Collection (THCIC) provides a good public data access model.<sup>21</sup> THCIC has a significant number of PUDFs available for free download directly off the website. There is also a well-defined process for interested parties to request more recent hospital discharge PUDFs using a form and common data use agreement.

Texas multi-payer data holds great promise to be used in varying ways by policymakers, state agencies, researchers, health care consumers, payers, and providers to gain insights into health care quality, outcomes, and costs. Multi-payer claims data can also enable better health care consumer decision-making through insights into provider and facility cost and quality variation.

The Legislature could provide direction to prioritize the use of current resources for analytics of the UT Data Center data. Prioritization should be given to directing UT Data Center to aggregate all available clinical, claims, pharmacy, cost, and quality data regarding specific high cost/high prevalence conditions, such as diabetes, to develop additional features and de-identified data files for public and research use. Also, the data could be used to establish benchmarks to better understand prevalence,

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<sup>21</sup> <https://www.dshs.texas.gov/thcic/>

interventions, and payments for treatment for chronic conditions to facilitate collaborative quality improvement efforts on the part of state payers and providers.

Other states have benefitted from their existing APCDs in making applications for federal funding opportunities to test health care innovations. For example, CMS has embraced the use of multi-payer data as a tool in its Comprehensive Primary Care Plus (CPC+) model designed to transition primary care from fee-for-service (FFS) to a value-based structure. CPC+ includes not only Medicare FFS but also 56 partner payers in Medicare Advantage, Medicaid and commercial insurance. Seven of the CPC+ regions aggregate claims data, while four also integrate admission, discharge, transfer (ADT), clinical, and/or SDOH data. Program objectives including reducing provider burden, improving regional payer alignment, and increasing use and usefulness of aggregated data reports to drive better care, lower costs, and improve health.

There may be future federal funding opportunities that leverage multi-payer data sources, including in the rural health care space. CMS recently launched a Rethinking Rural Health Initiative and among its focuses are rural maternal health, rural hospital reimbursement, and rural APMs.<sup>22</sup> CMS also partnered with Pennsylvania on the Pennsylvania Rural Health Model, which implemented a global payment for rural hospital inpatient and outpatient care.<sup>23</sup> Finally, CMS just announced the Community Health Access and Rural Transformation (CHART) Model with an accountable care organization track and community transformation track. In the community transformation track, a lead entity, in collaboration with community partners and aligned payers, develops a transformation plan with a rural health care delivery redesign strategy.<sup>24</sup> Texas would be an ideal state to test rural funding models that possibly include rural health clinics as well. Until recently, Texas has not been able to leverage multi-payer data to enable the state to

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<sup>22</sup> Verma, Seema. CMS. *Rural Health at CMS: What's Been Done and What's to Come*. Retrieved at: <https://www.cms.gov/blog/rural-health-cms-whats-been-done-and-whats-come>

<sup>23</sup> <https://innovation.cms.gov/innovation-models/pa-rural-health-model>

<sup>24</sup> <https://innovation.cms.gov/innovation-models/chart-model>

leverage federal matching funds to support VBP transformations. Texas should consistently assess opportunities to pursue federal matching funds for VBP initiatives such as those sponsored by entities such as the Center for Medicare & Medicaid Innovation and leverage its new multi-payer analytics capacity in making application.

### Leveraging the Texas Healthcare Learning Collaborative Portal and Other Data Sources

The Texas Healthcare Learning Collaborative (THLC) portal is a strong, public-facing tool that provides data on Medicaid MCO and dental maintenance organization (DMO) performance, including on potentially preventable events, medical and dental quality of care measures, and CMS core measures.<sup>25</sup> Information is available in dashboards that can be searched by year, program type, MCO, and measure set, and the aggregated data may be downloaded. THLC data is primarily used by HHSC, MCOs, and DMOs, though it can also be accessed directly by providers, enrollees, and other stakeholders.

There is the opportunity to grant providers access to their own outcome data to enable them to compare their performance to state and regional benchmarks of similar providers, manage patient care, and assess opportunities for value-based purchasing. In addition, protected access could be granted for longitudinal, patient-level data that would facilitate continuity of care and care transitions even when patients move or switch MCOs.

Additional potential use cases could also be considered for the Texas Healthcare Learning Collaborative Portal and other data sources. One such use case may be to leverage available data within THLC, the UT Data Center, the Texas Health Care Information Collection (THCIC) and other data to focus on a specific high-incidence condition like diabetes not only in Medicaid but also among other state payers. Another use case may be to leverage data in THCIC on uncompensated care provided in hospitals to identify any more granular information that could be discerned about the care and health of the uninsured population.

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<sup>25</sup> <https://thlcportal.com/home>

The potential use cases developed should be analyzed for the value they bring to advancing health care in Texas, and a strategy should be developed to implement the most valuable and feasible use cases. During this process, Texas should clearly delineate the roles and responsibilities of each data source (i.e., THLC, THCIC, UT Data Center, etc.) so that health care data consumers understand which data source is the access point for each purpose, and there is not duplication of resources. Consideration should be given to the strengths of each existing data source, their existing authorities for data use and dissemination, and how to minimize disruption or confusion among the existing base of consumers for each data source.

### Other State APCDs

Texas can look to several other states for examples of potential uses of APCDs. States are using APCDs to enable insights into the relative health of their populations, including regional variations. They can demonstrate trends in utilization and spending, showing how health care resources are allocated from the standpoint of preventive care versus interventions for preventable conditions. Such efforts can reveal areas of wasteful health care spending, opportunities for quality initiatives, and opportunities for payment reform. From the consumer standpoint, APCDs can assist in understanding variations in cost and quality among providers.

In its 2019 report on *Facilitating Use of data to Drive Population Health in Texas*, the Texas Health Improvement Network (THIN) cited Colorado as an exemplary APCD model for its balance of public governance and external expertise.<sup>26</sup> The Colorado APCD's appointed administrator is a non-profit organization, Center for Improving Value in Health Care (CIVHC), which receives significant grant funding for its operations and was developed through a legislatively established advisory committee.<sup>27</sup> It has a committee that reviews requests for data, holds quarterly meetings to discuss ways to transform health care, and convenes stakeholders for more

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<sup>26</sup> [https://utsystem.edu/sites/default/files/sites/texas-health-journal/new%20site/THIN\\_Facilitating-Data-Use-For-Population-Health\\_Mar2019.pdf](https://utsystem.edu/sites/default/files/sites/texas-health-journal/new%20site/THIN_Facilitating-Data-Use-For-Population-Health_Mar2019.pdf)

<sup>27</sup> Colorado [Senate Bill 13-149](#)

specific initiatives that can be informed by the data, such as palliative care, care transitions, and episodes of care. CIVHC maintains a publication library of reports that have used the APCD data. It also has a clear process for custom data requests and an easy-to-use interface for the public to generate infographics and key data of interest with county-level mapping or facility-level data where applicable.<sup>28</sup>

Other examples of strong APCDs:

- Maine has used its APCD to enhance pricing transparency for consumers with search functionality that yields facility-specific quality ratings and facility-specific cost information by procedure and payer.<sup>29</sup>
- The Massachusetts APCD has less data immediately accessible to the public researchers, but the data available by request is robust.<sup>30</sup> Case Mix Data includes inpatient, outpatient and emergency department data.
- The Medicare Diabetes Analysis generated from the Arkansas APCD is an example of how APCD data could be used to generate detailed analyses of chronic conditions for aggregate or individual payer types.<sup>31</sup> This analysis uses the APCD to produce diabetes prevalence and complications data, enabling mapping of hot spots by complication and county.

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<sup>28</sup> <http://www.civhc.org/get-data/public-data/>

<sup>29</sup> <https://mhdo.maine.gov/>

<sup>30</sup> <https://www.chiamass.gov/data-index/>

<sup>31</sup> <https://www.arkansasapcd.net/Docs/166/>

## Policy Issue: Social Drivers of Health

Positive health outcomes are driven by more than health care alone. What happens in homes and communities matters at least as much. The best available evidence indicates that particularly for many low-income individuals, addressing significant non-clinical needs can lead to real savings for the medical system and improvements in health.

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. Value-based care is increasingly using strategies to address social drivers of health (SDOH). Texas is engaged with exploring value-based care strategies considering SDOH from multiple perspectives.

The COVID-19 pandemic has exacerbated the effects of SDOH on health inequities. For example, many social drivers of health such as poverty, physical environment (e.g., smoke exposure, homelessness), and race or ethnicity—can have a considerable effect on COVID-19 outcomes.<sup>32</sup> The Centers for Disease Control and Prevention (CDC) recognizes the disparate impact that COVID-19 has on racial and ethnic minority groups and encourages learning more about SDOH and how to improve conditions in communities experiencing these disparities.<sup>33</sup>

The following recommendations support addressing SDOH needs for individuals, including during the pandemic and following the acute response to the pandemic through “lessons learned.” Recommendations are focused both on a statewide organization framework to support SDOH activities and on the development of APMs.

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<sup>32</sup> <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7234789/>

<sup>33</sup> <https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/racial-ethnic-minorities.html>

## Recommendations:

5. HHSC should conduct a landscape analysis of which SDOH assessment tools and electronic referral platforms are currently being utilized in Texas Medicaid, and also review strong models throughout the US. Working with Medicaid managed care organizations (MCOs), providers, and other stakeholders, HHSC could assess whether a state-level or regional tool(s) and/or platform(s) would better enable Texas Medicaid to address SDOH.
  - Based on the landscape analysis, HHSC should work with Medicaid MCOs to implement an assessment tool and electronic referral platform strategy that can be used to better facilitate the ability to address SDOH needs.
6. HHSC should work with stakeholders to explore how initiatives to address SDOH that drive healthcare costs and poor health outcomes are/could be supported through APMs, including:
  - Promoting better reporting of ICD-10 Z codes for social needs. The information could be useful for eventually identifying areas for improvement or intervention.
  - Developing accountability metrics in the Medicaid program related to SDOH/health equity.
  - Looking at pilot/study/proof of concept opportunities with MCOs to develop evidence to inform future HHSC policy.
  - Reviewing opportunities in 1115 waivers, such as the DSRIP transition.

## Discussion:

### Assessment Tools and Referral Platforms

To effectively manage SDOH interventions, health care organizations are increasingly utilizing technology platforms for screening/assessment and to identify and refer patients to social service organizations. This is an area of focus of Texas Medicaid. Texas Medicaid is working with stakeholders,

including managed care organizations, to consider what screening and referral platforms would be good models to use for a statewide strategy.

### Screening Tool Examples

#### *Accountable Health Communities Health Related Social Needs Screening Tool*

The CMS Center for Medicare and Medicaid Innovation (CMMI) made the Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool to use in the AHC Model. They are testing to see if “systematically finding and dealing with the health-related social needs of Medicare and Medicaid beneficiaries has any effect on their total health care costs and makes their health outcomes better.”<sup>34</sup>

#### *Protocol for Responding to and Assessing Patients’ Assets, Risks, and Experiences (PRAPARE)*

PRAPARE is a national effort to help community health centers and other providers collect the data needed to better understand and act on their patients’ social drivers of health. “As providers are increasingly held accountable for reaching population health goals while reducing costs, it is important that they have tools and strategies to identify the upstream socioeconomic drivers of poor outcomes and higher costs. With data on the social drivers of health, health centers and other providers can define and document the increased complexity of their patients, transform care with integrated services and community partnerships to meet the needs of their patients, advocate for change in their communities, and demonstrate the value they bring to patients, communities, and payers.”<sup>35</sup>

### Referral Platform Examples

Specific to Texas, the Episcopal Health Foundation (EHF) invited Methodist Health Ministries of South Texas and Saint David’s Foundation to support a comprehensive study of community resource referral platforms. The purpose

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<sup>34</sup> <https://innovation.cms.gov/Files/worksheets/ahcm-screeningtool.pdf>

<sup>35</sup> <http://www.nachc.org/research-and-data/prapare/>

was to continue learning about how health care organizations screen their patients for SDOH and the tools that are available to providers to effectively refer and link patients to appropriate community-based resources and social services. Social Interventions Research & Evaluation Network (SIREN) at the University of California, San Francisco (UCSF) were commissioned to answer critical questions about the referral platforms that are currently available. The study focused on “the unique capabilities of the tools, how the tools differ from each other, and details about the actual experiences of healthcare organizations who have invested in and used these tools.” The following are the tools included: Aunt Bertha, CharityTracker, CrossTx, Healthify, NowPow, One Degree, Pieces Iris, TAVConnect (TAVHealth), and Unite Us.<sup>36</sup>

### Example of a statewide approach

North Carolina is a state that has focused on SDOH and has a Medicaid 1115 Waiver to test SDOH interventions. North Carolina uses NCCARE360, a statewide coordinated care network connecting individuals to local services and resources. Through NCCARE360, community partners have access to a statewide resource data repository that will include a call center with dedicated navigators and a shared technology platform that enables healthcare and human service providers to send and receive secure electronic referrals, communicate in real-time, securely share client information, and track outcomes. This solution ensures accountability around services delivered, provides a “no wrong door” approach, and closes the loop on every referral made, according to the state. NCCARE360 started in January 2019 and plans to be available in every county in North Carolina by the end of 2020.<sup>37</sup>

### Addressing SDOH through APMs

The Committee has focused on promoting value-based care given limited public dollars and the capitated financing model used in Texas Medicaid

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<sup>36</sup> <https://sirennetwork.ucsf.edu/sites/sirennetwork.ucsf.edu/files/wysiwyg/Community-Resource-Referral-Platforms-Guide.pdf>

<sup>37</sup> <https://www.ncdhhs.gov/about/department-initiatives/healthy-opportunities/nccare360>

through managed care. An issue is how to align health plan and provider incentives with improving health outcomes and reducing costs in a largely fee-for-service capitation model. Strategies for addressing this key issue of containing costs while supporting quality is one of the key concerns of the State, health plans, and providers, including with SDOH strategies.

As outlined in the Committee report submitted to the Texas Legislature in 2018, federal regulation (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 risks. Oregon explicitly uses this regulation to enable their Medicaid Coordinated Care Organizations to cover SDOH.<sup>38</sup>

Effective strategies to reduce the incidence of preventable events and conditions for complex patients require partnerships between health care, 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.

For example, improvements in health literacy could be an area of focus. Health literacy is defined as the cognitive and social skills that determine the motivation and ability of individuals to gain access to, understand and use information which promote and maintain good health.<sup>39</sup> Peer support specialists and community health workers (CHWs) could be employed to assist with health literacy efforts as a quality initiative. Community

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<sup>38</sup> <https://www.oregon.gov/oha/HPA/dsi-tc/Documents/Health-Related-Services-SDOH-E-Guide.pdf>

<sup>39</sup> <https://www.who.int/healthpromotion/conferences/7gchp/track2/en/>

pharmacies should be explored as a novel access point for CHWs and/or patient navigation services. Pharmacy teams are uniquely positioned to document SDOH findings and assist with appropriate interventions because they have local trusted relationships, knowledge of local community resources, trained home delivery personnel, walk-in accessibility, abundant patient touchpoints, and medication use expertise.

Along with quality-related costs, some states are also using provisions such as value-added services and in-lieu of services. There are a number of financing strategies that are possible to use for SDOH-related services. The Center for Healthcare Strategies outlines potential MCO strategies and also the complexities:

“In their contracts, states often require managed care organizations (MCOs) to screen for social needs and link members to needed community resources, but do not often establish specific expectations around the direct provision of services that address those needs. Nonetheless, states do have some flexibility under existing law, and CHCS’ review of managed care contracts suggests that states have, for the most part, not taken full advantage of this flexibility.”<sup>40</sup>

California engaged Manatt for a study to review California Medicaid’s capitation rate-setting strategy. This report shows the complexities for capitation rate setting for incentivizing health plans and the role the state plays for activities that improve quality of care, including SDOH.<sup>41</sup>

#### *Promoting better reporting of ICD-10 Z codes*

As Texas Medicaid works to identify and address SDOH, one tool available on the social needs of patients is ICD-10 Z codes, which identify non-medical factors that may affect health status. Codes Z55-Z65 may be used to capture social factors related to housing, employment, education and literacy, and family circumstances, among others.

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<sup>40</sup> <https://www.chcs.org/media/Addressing-SDOH-Medicaid-Contracts-1115-Demonstrations-121118.pdf>

<sup>41</sup> [https://www.manatt.com/Manatt/media/Documents/Articles/MediCalRateSetting\\_v3.pdf](https://www.manatt.com/Manatt/media/Documents/Articles/MediCalRateSetting_v3.pdf)

So far, use of Z codes has been limited, but is increasing. HHSC's Center for Analytics and Decision Support (CADS) did a data review for STAR+PLUS from October 1, 2015 through December 31, 2018. The review found that while Z codes were documented for under two (2) percent of STAR+PLUS enrollees, the use of Z codes increased 37 percent between 2016 and 2018. During that time, the most commonly documented code was homelessness (Z590). Housing/economic problems were by far the most commonly reported, followed by other psychosocial and employment problems.

### Delivery System Reform Incentive Payment Program Transition Plan

DSRIP has been implemented in Texas as locally driven and based on community needs. It is an incentive payment program and offers flexibility to: 1) innovate to deliver better care and improve health outcomes; and 2) deliver services not traditionally billable to insurance but that can improve health. The DSRIP program has included the opportunity to address SDOH, such as through care navigation for individuals with complex conditions, housing supports, and transportation assistance. An increased knowledge base nationally, along with the early work in DSRIP, offers opportunities for next steps. The milestones included in the transition plan lay the groundwork to develop strategies, programs, and policies to sustain successful DSRIP activities and for emerging areas of innovation in health care. One of the milestones (Milestone 8) specifically focuses on SDOH: HHSC completes an assessment of which social factors are correlated with Texas Medicaid health outcomes, including pediatric health outcomes (due by March 31, 2021).<sup>42</sup>

In DY 9-10, providers will begin reporting on which related strategies they are deploying to improve the health of their DSRIP target population and associated outcome measures. Nine related strategies specifically indicate whether providers have already implemented or are planning to implement strategies focused on SDOH (e.g., assistance with food insecurity, housing, transportation). Analysis of this data will help inform HHSC strategies for

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<sup>42</sup> <https://hhs.texas.gov/sites/default/files/documents/laws-regulations/policies-rules/Waivers/medicaid-1115-waiver/1115-medicaid-waiver-tools-guidelines-regional-healthcare-partnership-participants/draft-revised-dsrp-transition-plan.pdf>

continuing to advance APMs and further develop delivery system reform post waiver.

As Texas has been planning for the DSRIP transition, HHSC has convened a Best Practices Workgroup. One of the activities of the group was to prioritize practices from DSRIP that have been key for driving improvements in the health status of clients within focus areas and populations for continued delivery system reform and quality improvement.

From the Best Practices Workgroup, the following are the top key practices implemented in the DSRIP program to assist in meeting SDOH needs:

- Screening patients for transportation needs
- Care team includes personnel in a care coordination role not requiring clinical licensure (e.g. non-clinical social worker, community health worker, medical assistant, etc.)
- Formal partnership or arrangement with food resources to support patient health status (e.g. local food banks, grocery stores, etc.)
- Screening patients for housing needs
- Culturally and linguistically appropriate care planning for patients

## Policy Issue: Advancing Alternative Payment Models in Medicaid

HHSC has established alternative payment methodology (APM) percentage targets and specifications for Medicaid managed care. While Medicaid MCOs and providers have developed a significant number of primary care and hospital-based value based payment (VBP) arrangements, there is less work among other provider types and among small and rural providers. To recognize the full potential of APMs in Texas Medicaid, there is a need to incorporate multi-stakeholder input to develop strategies to increase adoption of effective APMs by Medicaid MCOs and providers. The ongoing lessons learned from COVID-19 response should be considered when developing new APM approaches both for the current pandemic as well as in planning for a health system that is more nimble and supportive in the event of future health crises. APMs are also an area of opportunity to incorporate effective Medicaid-focused DSRIP program work into Medicaid managed care.

### Recommendations:

7. HHSC should conduct a landscape assessment to determine the barriers and opportunities to advancing APMs. The landscape assessment should include:
  - Considerations and opportunities specific to rural and small providers and provider types not significantly represented in current APMs, including emerging models for these provider types
  - An assessment of the current Texas Medicaid APM requirements and targets for any modifications that could incentivize implementation of the highest impact models
  - Identification of opportunities for measure standardization to reduce provider administrative burden to participate in Medicaid APMs, while acknowledging flexibilities may be required to address specific regional or sub-population needs

- Review of strong models related to maternal and newborn health, behavioral health, and opioid and other substance use identification and treatment
8. HHSC should convene Medicaid MCOs and provider stakeholders to share the results of the landscape assessment as well as discuss best and promising APM models in Texas and other states.
  9. HHSC should leverage findings from the DSRIP Best Practices Workgroup and the DSRIP Transition Plan milestone analysis of DY 7-8 DSRIP quality data to identify key outcomes and effective interventions to inform HHSC strategies to advance alternative payment models.
  10. HHSC should encourage MCOs to work with providers to make adjustments to APMs, including adjusting risk-based requirements, that acknowledge the barriers COVID-19 has posed to achieving metrics agreed upon prior to COVID-19 and engaging patients in certain preventive health care practices.

## Discussion

### Texas MCO Contract Requirements for APMs

Texas has chosen to advance the shift of Texas Medicaid payments to VBP arrangements by establishing target percentages for MCOs to achieve in total dollars spent in APMs or risk-based APMs relative to the total medical, pharmacy and long term care claims paid by the MCO.<sup>43</sup> The current contractual targets for APMs for Medicaid (STAR, STAR+PLUS, STAR Health and STAR Kids) and CHIP MCOs appear in Table 1. Targets increase from calendar year (CY) 2018 to CY 2021. By CY 2021, MCOs are expected to have at least 50 percent of total provider payments for medical and

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<sup>43</sup> Uniform Managed Care Manual (UMCM), Sec. 8.10, *Alternative Payment Model Data Collection Tool, V 2.2.1*, retrieved from: <https://hhs.texas.gov/sites/default/files/documents/laws-regulations/handbooks/umcm/8-10.xlsx>

prescription expenses in APMs, and at least 25 percent of the total must be risk-based.<sup>44</sup> 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 (up to \$.10 per member per month).

**Table 1: 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.

Other obligations for MCOs related to APMs include:<sup>45</sup>

- MCOs must implement processes to share data and performance reports with providers on a regular basis.
- MCOs shall dedicate sufficient resources for Provider outreach and negotiation, assistance with data and/or report interpretation, and other activities to support provider improvement.

<sup>44</sup> APM targets, calculations, relevant definitions, and APM reporting instrument are included in UCM, Sec 8.10

<sup>45</sup> For STAR, STAR+PLUS, CHIP, see [Uniform Managed Care Contract](#), sec. 8.1.7.8.2 *MCO Alternative Payment Models with Providers*. Substantively similar provisions exist as sec. 8.1.7.9.2 in the [STAR Health Managed Care Contract](#) and the [STAR Kids Managed Care Contract](#).

- To the extent possible MCOs within service areas should collaborate on development of standardized formats for performance reports and data requested from providers.
- MCOs must dedicate resources to evaluate the impact of APMs on utilization, quality and cost, as well as return on investment.

### Need to Assess Barriers and Opportunities for Advancing APMs

HHSC has established contractual targets for Medicaid and CHIP MCOs to connect provider payments to value using APMs. As in other state Medicaid programs, the design of APM participation requirements can be a driver for the types of APMs in which payers and providers engage. A significant portion of Texas Medicaid/CHIP APMs revolve around achievement of measures driven by primary and hospital care. However, there is little participation by smaller and rural providers nor by certain provider types, like pharmacy and home health.

HHSC should perform a landscape assessment of the barriers and opportunities for participation in APMs by a broader spectrum of providers. This should review the current Texas program to see if contractual APM targets have been achieved and the effectiveness of the program structure in encouraging the highest impact APMs. The landscape assessment also should review best practice models in other states. Collectively, this information will inform conclusions regarding optimal program design to achieve the objectives that Texas Medicaid would like to promote.

Texas also must consider ways to minimize any barriers to providers participating in APMs. Many stakeholders perceive the push to risk-based APMs as a key barrier to provider participation. They consider risk-based APMs unnecessary when well-structured upside-only APMs can help control costs and improve quality. A continued push toward risk-based APM targets may be particularly detrimental now as it could further penalize providers already struggling during the COVID-19 response at a time when a robust health care workforce is most critical.

The landscape assessment should include a summary of how each of the MCOs' contractual obligations intended to reduce provider burden is being implemented, and any limitations on their implementation. The state can

attempt to reduce administrative burdens for provider participation through measure standardization, ensuring adequate data sharing, and facilitating reporting, for example. There should be processes to perform data-driven risk adjustment, when appropriate. The state also should engage providers in the development of workable provider approaches. For example, New Mexico has placed in its managed care contracts a requirement for MCOs to engage a provider-led behavioral health workgroup to design a full risk-based VBP model.

Following up on the recommendations in this Committee's 2018 report, the landscape assessment should include a review of strong models for certain areas of care that are high impact for the Texas Medicaid population – maternal and newborn health, behavioral health, and opioid and other substance use identification and treatment.<sup>46</sup>

All these considerations and any more identified by MCOs and providers underrepresented in APM arrangements, such as rural, small, home health, and pharmacy providers, should be included in the APM landscape assessment.

### *Considerations for MCO APM Target Calculation and Incentivizing the Highest Impact APM Models*

HHSC requires participation in the Hospital Quality Based Payment Program for Potentially Preventable Readmissions and Complications (PPRs and PPCs) to incentivize quality and efficiency among hospitals. Since this program meets the definition of an APM that entails downside risk, associated MCO hospital inpatient expenditures are counted in MCOs' total APM targets and risk-based APM targets. This has multiple implications:

- MCOs cannot get additional credit toward the overall APM percentage targets for APMs either with hospitals or other providers that attempt to reduce unnecessary hospital costs and/or lower total cost of care.

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<sup>46</sup> <https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2019/value-based-payment-qual-improvement-recommendations-nov-2018.pdf>

- If a pharmacy or other APM provider model aims to reduce unnecessary hospital costs or total cost of care, HHSC might be “double counting” these payments since it already has the PPR/PPC hospital inpatient APMs.

In addition, the PPR/PPC specifications themselves could benefit from a provider workgroup review to make measures better understood and as clinically relevant, timely, and actionable as possible. Potentially Preventable Readmissions, Complications, Admissions, and ED Visits measures are developed and owned by 3M™ Health Information Systems. Providers report challenges in understanding how the PPRs and PPCs for which they are held accountable are calculated and knowing whom among their patient panel is included in the metrics. Providers want to ensure the 3M calculations reflect clinical best practice guidelines for different patient populations, such as pediatric patients. During the Committee’s work on this report, representatives from 3M indicated they would be willing to spend more time with HHS and Texas providers on this, as they have done in other states that use their potentially preventable event algorithms. They also noted that more details on their programs used by Texas Medicaid are available online to Texas stakeholders.<sup>47</sup>

The unintended consequences of the way that PPRs and PPCs are counted in the APM percentage target calculation highlight the opportunity to look at best practice models for APM approaches around the country. A recent Medicaid and CHIP Payment and Access Commission (MACPAC) report on state Medicaid VBP arrangements discussed three approaches to VBP in Medicaid managed care contracts.

<b>Approach</b>	<b>State Example</b>
Establishing a VBP target(s) for MCOs related to the percentage of payments, members, or providers to be	New Mexico, similar to Texas, has VBP targets for the percentage of provider payments associated with APMs. The total percent increases over the course of four years, as does the percent associated with each of three levels of APMs associated with increasing levels of risk.

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<sup>47</sup> [www.aprdrgassign.com](http://www.aprdrgassign.com)

<p>engaged in APMs by a specified date.</p>	<p>In addition, New Mexico requires participation of specific provider types – physical health, small providers, behavioral health, long term care, and nursing facilities – and includes percentage targets specific to BH and physical health providers in Level 3 APMs.<sup>48</sup></p>
<p>Requiring and/or incentivizing MCOs to implement one or more delivery system reform models with providers but allowing health plans flexibility in how the models are designed and implemented.</p>	<p>New York has VBP targets and through measurement year 2019, providers could choose to implement the following VBP arrangements, which were not subject to a review requirement:</p> <ul style="list-style-type: none"> <li>• Total Care for General Population</li> <li>• Integrated Primary Care Arrangement, which includes 18 episodes from preventive care episodes to various chronic episodes (e.g., episodes for diabetes, hypertension, low back pain, asthma)<sup>49</sup></li> <li>• the Maternity Care Arrangement (episodes: Pregnancy, Vaginal Delivery, C-Section, Newborn);<sup>50</sup></li> <li>• Total Care for Special Needs Subpopulations - HIV/AIDS, members included in a Health and Recovery Plan (HARP), Managed Long-Term Care (MLTC) members and members with significant developmental disabilities.</li> </ul> <p>'Off menu' options are permissible as long as they supported the underlying goals of payment reform and sustained the transparency of value</p>

<sup>48</sup><https://www.hsd.state.nm.us/uploads/files/Looking%20For%20Information/General%20Information/Contracts/Medical%20Assistance%20Division/MCO's%20Centennial%20Care%202.0/BCBS%20Contract%20PSC%202018-630-8000-0033%20A1.pdf>

<sup>49</sup> [https://www.health.ny.gov/health\\_care/medicaid/redesign/dsrip/vbp\\_library/2019/2019-03-14\\_ipc.htm](https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/vbp_library/2019/2019-03-14_ipc.htm)

<sup>50</sup> [https://www.health.ny.gov/health\\_care/medicaid/redesign/dsrip/vbp\\_library/2018/2018-02-09\\_maternity.htm](https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/vbp_library/2018/2018-02-09_maternity.htm)

	(costs versus outcomes). 'Off menu' subject to review. <sup>51</sup>
Requiring and/or incentivizing MCOs to implement one or more delivery system reform models with providers as defined by the state, with little variation across MCOs.	In South Carolina, MCOs must make additional per-member-per-month payments to PCMHs that obtain NCQA certification; Ohio mandates Perinatal Episodes of Care Model.

Texas should consider in the landscape assessment what kind of approach to high impact APMs the state would like to incentivize in its APM strategy. The state should then assess if the current program structure helps achieve the overall program priorities or if lessons could be learned from other state approaches.

*Measure standardization*

Providers report significant administrative burdens to collect data on and report performance metrics for a multitude of disciplines. Different payers and quality incentive programs may require varying measures for participation in APMs, even within the same discipline. Further, when similar measures are required, the measure specifications and reporting periods may vary.

Some providers report that the administrative burden of collecting and reporting on performance metrics exceeds the incentives they can achieve by participating in APMs. Further, when measurement of similar provider and service types varies, it is challenging to assess the relative efficacy of the interventions measured.

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<sup>51</sup>[https://www.health.ny.gov/health\\_care/medicaid/redesign/dsrip/vbp\\_library/2020/docs/2019-09\\_final\\_vbp\\_roadmap.pdf](https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/vbp_library/2020/docs/2019-09_final_vbp_roadmap.pdf)

The landscape assessment should identify opportunities for measure standardization, including specifications and reporting period alignment, to reduce provider administrative burden to participate in Medicaid APMs. In developing the assessment, the state should leverage existing resources, like measure sets developed for DSRIP and measures such as HEDIS that have been tested nationally. The state also should convene key stakeholders to build consensus around common measures to endorse that would establish a foundation for payers and programs to consider when implementing quality initiatives. Stakeholders could include representatives of varying provider associations, health plan associations, and consumer representatives. Flexibility should be maintained to implement alternative measures when dictated by regional and local community needs.

The assessment should also identify patient sub-populations and provider types for which performance measures may be more limited to assess specific opportunities to introduce innovative measures. If new measures are introduced to facilitate APMs for specific sub-populations or provider types, the measures should initially be pay for reporting to see if the measures are operationally feasible before tying payment to performance. Data collection behind those new measures should also be standardized.

#### Convene Stakeholders around Landscape Assessment Findings and Best Practice Discussions

HHSC should convene Medicaid MCOs and provider stakeholders in a structured way to share the results of the landscape assessment as well as discuss best and promising APM models in Texas and other states. HHSC should also encourage health plans to share available evaluation information regarding their strongest models. If health-safety needs dictate, stakeholders could be convened through web-enabled presentations and discussions.

#### *Identifying Best Practice Models for Specific Provider Types*

Through carefully planned and facilitated discussions, provider groups and MCOs could share models that have been implemented in Texas or elsewhere that help target APM participation by small and rural providers and provider types not significantly represented in current Texas Medicaid

APM models. For example, APMs related to pharmacy and home health, two provider types that represent significant Medicaid spending, are very limited. The convened groups could discuss the promising models in these areas, specifically how they could be implemented in Texas, and what, if any, challenges need to be surmounted to implement those models.

An example of a promising pharmacy APM model is an accountable pharmacy organization (APO), which could provide enhanced services subject to performance measurements that determine payment. An example of the APO model is the Community Pharmacy Enhanced Services Network (CPESN), which is a clinically integrated network with over 115 Texas participating pharmacies as of June 2020.<sup>52</sup> All CPESN pharmacies provide enhanced pharmacy services like immunizations, medication reconciliation to avoid medication errors, and clinical medication synchronization to enhance adherence for better disease management. Other pharmacy VBP models can incentivize pharmacies to address social drivers of health as part of comprehensive service sets (e.g., Mental Health, Asthma Management, Diabetes). Network pharmacies document care by using Systematized Nomenclature of Medicine--Clinical Terms (SNOMED CT) codes and Health Level Seven (HL7) compliant Pharmacist eCare Plan platforms.

In home health, an APM model could improve member satisfaction, health outcomes, and savings on total cost of care. An innovative approach could be to employ a quality rating system, similar to Medicare's Home Health Compare tool.<sup>53</sup> Home Health Compare establishes a quality rating for home health entities using a combination of claims system-derived process, outcomes measures and survey results from the Home Health Consumer Assessment of Healthcare Providers and Systems. Texas could establish APMs based on a similar quality rating system that would enable home health entities to receive higher than the standard reimbursement for higher quality performance and lower than the standard reimbursement for lower performance.

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<sup>52</sup> <https://www.cpesn.com/>

<sup>53</sup> Medicare Home Health Compare:  
<https://www.medicare.gov/homehealthcompare/search.html>

## Incorporating Strong Medicaid-Focused DSRIP Work into APMs

The DSRIP program ends on September 30, 2021. HHSC, with input from state leadership and DSRIP stakeholders, developed a draft DSRIP Transition Plan intended to describe how the state will further develop its delivery system reform efforts and associated funding after DSRIP ends.<sup>54</sup> Many of the initiatives undertaken through DSRIP have been transformative and should not be lost. A pathway to sustaining some key DSRIP practices and outcomes would be via Medicaid managed care APMs, though the state must be realistic in considering that many DSRIP initiatives supported the uninsured to a greater degree than Medicaid recipients. The draft Transition Plan contains multiple milestones and supporting work that could inform this transition of DSRIP work to Medicaid managed care.

The milestone to Advance APMs to Promote Healthcare Quality entails updates to the Texas Medicaid Quality Strategy and Texas Value-Based Payment (VBP) Roadmap to address program and stakeholder goals, such as promoting data sharing and transparency, advancing APMs for Medicaid recipients with high costs and high needs, and developing statewide initiatives that focus on improving quality and outcomes. This is also the milestone expressing commitment that at least 25 percent of all Medicaid MCO payments to providers will be associated with quality-based APMs.

Another milestone requires HHSC to conduct a preliminary analysis of DY 7-8 (October 1, 2017 - September 30, 2019) DSRIP quality data and related core activities to identify interventions associated with improvement in key health outcomes and any lessons learned or best practices in health system performance measurement and improvement. HHSC should use the DY 7-8 analysis, along with engagement from DSRIP stakeholders, research into emerging areas of innovations in healthcare, and value-based initiatives in other states, to help inform HHSC strategies for continuing to advance APMs and further develop delivery system reform.

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<sup>54</sup> <https://hhs.texas.gov/sites/default/files/documents/laws-regulations/policies-rules/Waivers/medicaid-1115-waiver/1115-medicaid-waiver-tools-guidelines-regional-healthcare-partnership-participants/draft-revised-dsrrip-transition-plan.pdf>

HHSC established a DSRIP Best Practices Workgroup of current DSRIP performing providers, DSRIP anchors, and executive waiver committee members to support the sustainability of delivery system reform best practices, the successful completion of DSRIP Transition Plan milestone deliverables, and the development of the next phase of delivery system reform in Texas. Texas Medicaid should leverage the findings from the Best Practices Workgroup for consideration in advancing APMs, including workgroup findings on key outcomes and the most effective interventions for successful DSRIP work.

Texas also could encourage MCOs to pursue APMs that align with the key focus areas of DSRIP transition and are measurable by the DSRIP state priority measure bundles, as identified in the DSRIP Transition Plan.

### Flexibilities in APMs in Response to COVID-19

Providers are encountering unprecedented challenges in response to COVID-19. Some hospitals and providers are overwhelmed dealing with surging COVID-19 cases while others may see their patient load dwindle as patients delay routine care for their chronic conditions or routine preventive care. Meanwhile, the severity of the non-COVID-19 patients seeking care may be increasing.

Providers who are already engaging in APMs such as prospective payments may be at a fiscal advantage over providers who still receive fee-for-service reimbursement and have less certainty in their payments. However, providers under APMs may also struggle to meet their APM contract requirements. For example, they may be unable to meet reporting deadlines or they may see a reduction in their quality scores as patients delay or cancel preventive care and the acuity of their average visit increases.

In a time during which it is so critical to keep provider networks intact, there are several steps to granting flexibility that HHSC should endorse. At the MCO contract level, HHSC should consider decreasing risk-based requirements so MCOs and providers can focus on providing the best care possible in light of the current challenges they are facing. HHSC also should encourage MCOs to consider flexibilities in their APM contracts, such as extending reporting deadlines, removing outliers, and adjusting benchmarks

or performance year expenditure targets. While certain flexibilities could be granted, and objectives may be modified, MCOs should not revert to payment methodologies that lack accountability.

## Policy Issue: Lessons Learned from COVID-19

The Committee supports evaluating services provided during the pandemic through waivers and other innovative activities to inform what changes would continue to support patients both during and after the COVID-19 pandemic. This information also can be used to further value-based care through APMs.

### Recommendations:

11. HHSC should work with stakeholders to evaluate the Medicaid waivers used in telehealth during the pandemic including access to care, patient experience, health outcomes and cost effectiveness to share best practices and determine policy changes that should continue post-pandemic.
  - Consider how telehealth can count toward network adequacy.
12. HHSC should work with stakeholders to reward and incentivize creative practices that improve health based on the experience during COVID-19, such as prospective payments for primary care providers.
13. Texas should review the experience of social drivers of health (SDOH) Medicaid members experienced during the COVID-19 pandemic for waivers that could be instituted in an expedited approval process in future emergencies/disasters. Areas of focus could include:
  - Establishing enhanced rates for disaster-related services, such as used by Medicare for COVID-19.
  - Flexibility for additional administrative costs required during a disaster, such as purchase of pre-paid smart phones for beneficiaries to use for telehealth during a disaster.
14. HHSC should work with stakeholders to align value-based payment measures and incentives as much as possible within each region of Texas to reduce provider administrative burden.

## Discussion:

COVID-19 has magnified known health inequities and disparities in the US, illustrated by recently released Medicare data. CMS began publishing COVID-19 snapshot information based on claims data for Medicare enrollees in June 2020 and based on that data called for a renewed national commitment to value-based care to produce better outcomes. The snapshot breaks down COVID-19 cases and hospitalizations for Medicare beneficiaries by state, race/ethnicity, age, gender, dual eligibility for Medicare and Medicaid, and urban/rural locations.<sup>55</sup>

The snapshot data show that from January 1 – July 18, 2020, almost 215,000 Medicare beneficiaries were hospitalized with a COVID diagnosis, and that 24% of hospitalized beneficiaries died in the hospital. The data show stark differences in COVID cases – with dual eligible members, those with End Stage Renal Disease (ESRD), and black Medicare enrollees (both Medicare-only and dual eligible) disproportionately impacted by the disease. Dual eligible beneficiaries were hospitalized at a rate of 934 per 100,000, compared to 207 hospitalizations per 100,000 for Medicare-only beneficiaries. Per CMS Administrator Seema Verma, this is not unexpected as previous research and analysis have shown that dually eligible individuals experience high rates of chronic illness, with many having long-term care needs and social risk factors that can lead to poor health outcomes. In particular, duals also experience higher rates of poverty.

### Medicaid Telehealth Waivers

Beginning in March 2020, CMS approved Texas' request to waive certain Medicaid regulatory requirements to help physicians and other health care professionals more effectively respond to the COVID-19 pandemic.<sup>56</sup> Key telehealth provisions included:

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<sup>55</sup> <https://www.cms.gov/research-statistics-data-systems/preliminary-medicare-COVID-19-data-snapshot>

<sup>56</sup> <https://www.texmed.org/TexasMedicineDetail.aspx?id=53127>

- Telemedicine/audio only delivery of Texas Health Steps “well child” check-ups
- Telemedicine/audio only delivery of certain acute care office visits
- Telemedicine/audio only delivery of certain behavioral health services
- Federally Qualified Health Center (FQHC) and Rural Health Center (RHC) reimbursement for telemedicine and telehealth services

Additional details are available through Texas Medicaid and Healthcare Partnership (TMHP) policies.<sup>57</sup>

Initial experiences with telehealth through discussions with Committee members include:

- Telephonic options were highly utilized and critical given broadband, cell phone, and data plan limitations of members. This includes the delivery of psychotherapy services via telephone.
- Some health plans worked with providers to increase telehealth capacity very quickly, including helping with start-up costs for providers that did not have telehealth capability prior.
- Providers and health plans needed workflow adjustments, including with Electronic Medical Records (EMRs).
- The State, including the Texas Office of Inspector General (OIG), need to issue good guidelines as well as clear audit plans on documentation required.

### Telehealth and COVID-19 in Rural Areas

The Bipartisan Policy Center has studied the challenges of health care in rural areas extensively and published a report in April 2020. Much of the work for the report was completed prior to the onset of the COVID-19 pandemic. However, the recommendations for telehealth in rural areas are applicable for consideration both during and post-pandemic. The recommendations are primarily directed for Medicare consideration, but can also be reviewed for Medicaid purposes. These recommendations “remove

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<sup>57</sup> <http://www.tmhp.com/Pages/COVID-19/COVID-19-HOME.aspx>

restrictions that prevent full utilization of currently available technology in areas without broadband access.”

- Expand telehealth services to include non-face-to-face services.
- Allow virtual visits as substitutes to office visits at lengths beyond the currently allowed 5- to 10-minute (Medicare) check-ins.
- Expand asynchronous services beyond images to include written information shared by phone or through text and email.
- Include the home of an individual in the list of authorized originating sites for telehealth in rural areas.<sup>58</sup>

Texas has the opportunity to review data from the use of the Medicaid waivers for telehealth during the pandemic, and additional information, to identify practices that can be more cost effective and improve health care for individuals in Texas through the increased use of telehealth. Texas HHS also could explore other innovative approaches, such as partnering with the Texas Education Agency to leverage the initiatives TEA has undertaken to expand broadband access in local communities for patients in need of telehealth services.

### Innovative Practices That Further APMs and Improve Health

Providers and health plans had to adapt quickly to the COVID-19 pandemic to safely treat patients, both for COVID-19 and for ongoing care. This has included disruptions in care as well as adaptations to facilitate ongoing care. There is an opportunity to review activities by providers and health plans for lessons learned that could strengthen population health.

For example, tracking total cost of care and reduced ER utilization could be measures to allow greater flexibility for health plans and providers to manage population health. Capitated provider payment models instead of fee-for-service could be developed for improved population management. Information from MCOs indicates that there has been an uptick in prospective, capitated payments to primary care providers since the outset

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<sup>58</sup> <https://bipartisanpolicy.org/report/confronting-rural-americas-health-care-crisis/>

of the COVID-19 public health emergency to enable providers to innovate to better manage care for their patients.

- MCOs and providers may be spending the same amount of time in different ways during the pandemic, and increased use of technology has a cost to stand up and maintain.
- Follow-up compliance to health care should be a focus of review. For example, transportation challenges could impede patients from getting needed follow-up care. Innovative practices including telemedicine/telehealth/telemonitoring and increased services at home, which are being used at much higher levels during the pandemic, could be supporting better follow-up care.
- Nursing home experience considerations include increased investment in personal protective equipment, testing, and hazard pay to protect residents and staff.
- How rates are set will be important. The health plans need to be able to pay timely (and sometimes up front) for innovation, as illustrated by the COVID-19 experience, and have those costs recognized in future rate setting cycles.
- Data challenges would need to be reviewed for these approaches to be successful.
- Coordination is needed with the OIG for upfront information on fraud monitoring.

Some Medicaid health plans instituted APMs during the pandemic that provided flexibility to providers and also stabilized revenue. These VBP arrangements included flexibility as well as measurement requirements such as utilization of telehealth, access to care and quality measures such as immunizations and well-check visits. These arrangements should be reviewed to study the efficacy of continuing such arrangements to further value-based care. These arrangements were easier with larger provider practices but could also be considered for smaller providers as well as federally qualified health centers (FQHCs) and rural health clinics (RHCs).

COVID-19 has shown the resilience of value-based care during disruptions and emergencies: A health care organization's ability to respond to COVID-19 is driven in part by its payment structure. Organizations operating primarily under FFS payment are experiencing significant drops in revenue and often do not have the capabilities in place to respond to the pandemic.

On the other hand, organizations engaged in VBP models (especially those receiving prospective payments) have more stable revenue streams, and frequently have care coordination, telehealth, and data analysis capabilities in place that allow them to respond more effectively.<sup>59</sup>

### Social Drivers of Health During a Health Emergency/Disaster

The COVID-19 pandemic has brought longstanding issues to the forefront regarding health disparities through the disproportionate impact of COVID-19 on certain racial and ethnic minority groups. HHSC is studying these disparities and developing a plan of actionable steps, with an initial report planned for the Fall of 2020.

With respect to the Medicaid program, challenges occurred with timely direction from HHSC/OIG/Texas Department of Insurance (TDI) in enacting rules that provided flexibility to health plans and providers to implement strategies to help members/patients with medical and SDOH services during the pandemic.

Texas could consider pre-written rules that could be activated during any disaster for the health care delivery system to have a head start on implementing pandemic/disaster strategies. These rules could include an expedited approval process to address SDOH needs that are not otherwise allowed under Medicaid and CHIP. Certain guidelines may need to be lifted during these times to allow the system to properly handle unexpected SDOH needs. For example, to utilize telehealth/telephonic services, pre-paid phones with an adequate data plan may need to be provided to members. These rules would need to include the financial mechanisms for payment for allowing more non-covered services to be recognized as medical and administrative expense during disaster declaration periods.

### Align value-based payment measures and incentives as much as possible within each region of Texas to reduce provider administrative burden

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<sup>59</sup> <https://healthpolicy.duke.edu/news/enabling-health-care-resilience-during-and-after-COVID-19-pandemic>

The COVID-19 public health emergency has illustrated the need for a stronger primary care system, more integration of primary and preventive care with the broader health care system, and increased telemedicine/telehealth. As HHSC works to advance APMs in Medicaid, it should consider endorsing standardized models to reward high-value primary care in Medicaid.

HHSC should work with stakeholders to endorse certain standardized models that can be utilized for APMs with smaller providers (aligning with Medicare where possible). This recommendation would support providers that have smaller Medicaid patient panels, including rural providers.

It would benefit health plans and providers to have more standard programs available. Anti-trust provisions often prohibit health plans from sharing specific models. The state could provide a menu of approved options that could be used to enable more consistency for providers across health plans and reduce administrative burdens for both Medicaid health plans and providers.

## 6. List of Acronyms

<b>Acronym</b>	<b>Full Name</b>
AHC	Accountable Health Communities
APCD	All Payer Claims Database
API	Application Programming Interface
APM	Alternative Payment Model
BH	Behavioral Health
CCBHC	Certified Community Behavioral Health Clinics
CDC	US Center for Disease Control & Prevention
CHCF	California Health Care Foundation
CHIP	Children’s Health Insurance Program
CHW	Community Health Worker
CMHC	Community Mental Health Center
CMMI	Center for Medicare & Medicaid Innovation
CMS	Centers for Medicare & Medicaid Services
CPC+	Comprehensive Primary Care Plus model
CY	Calendar Year
DMO	Dental Maintenance Organization
DSHS	Department of State Health Services
DSRIP	Delivery System Reform Incentive Payment
DY	Demonstration Year
ED	Emergency Department
HER	Electronic Health Records
ERS	Employees Retirement System
FQHC	Federally Qualified Health Center
HB	House Bill
HCBS	Home and Community Based Services
HCPLAN	Health Care Payment Learning Action Network

<b>Acronym</b>	<b>Full Name</b>
HHS	Health and Human Services
HHSC	Health and Human Services Commission
IDD	Intellectual and Developmental Disabilities
IRB	Internal Review Board
IT	Information Technology
LTSS	Long Term Services and Supports
MCO	Managed Care Organization
MDC	California's Maternal Data Center
OIG	Office of Inspector General
PIP	Project Improvement Plan
PPA	Potentially Preventable Admissions
PPV	Potentially Preventable Emergency Department Visits
PUDF	Public Use Data File
RHC	Rural Health Clinic
SB	Senate Bill
SDOH	Social Drivers (or Determinants) of Health
STC	Special Terms and Conditions
SUD	Substance Use Disorder
TDCJ	Texas Department of Criminal Justice
THCIC	Texas Health Care Information Collection
THIN	Texas Health Improvement Network
THLC	Texas Healthcare Learning Collaborative Portal
TRS	Teachers Retirement System of Texas
UMCC	Uniformed Managed Care Contract
UMCM	Uniformed Managed Care Manual
UT Data Center	Center for Healthcare Data at The University of Texas Health Science Center at Houston School of Public Health
VBP	Value-Based Payment/Purchasing

<b>Acronym</b>	<b>Full Name</b>
VBPQIAC	Value-Based Payment and Quality Improvement Advisory Committee