MCO NMDOH Learning Collaborative

September 20. 2023

Agenda

1. Welcome and Introductions
2. HHSC Updates
3. Introduction to Texas-based CINs
4. Lunch Break
5. MCO Panel
6. Medicaid NMDOH Financing: A National Perspective
7. Learning Collaborative Workgroup Updates
8. Debrief and Next Steps

Non-Medical Drivers of Health Action Plan Updates

Joelle Jung, Senior Policy Advisor

Delivery System Quality & Innovation, Medicaid & CHIP Services

Non-Medical Drivers of Health Action Plan

Priorities

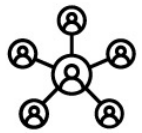
Food Insecurity

Housing

Transportation

Goals

A) Build data infrastructure



B) Coordinate services

C) Develop policies and programs

D) Support collaboration

Upcoming Activities

1. HB1575 Screening for Pregnant Women for Nonmedical Needs
2. State Directed Payment Programs
3. STAR+Plus Social Needs Screening Requirements

HB 1575 Texas Legislature 88th Regular Session

TEXAS Health and Human Services

Screening pregnant women for non-medical needs

Pregnant women must opt-in

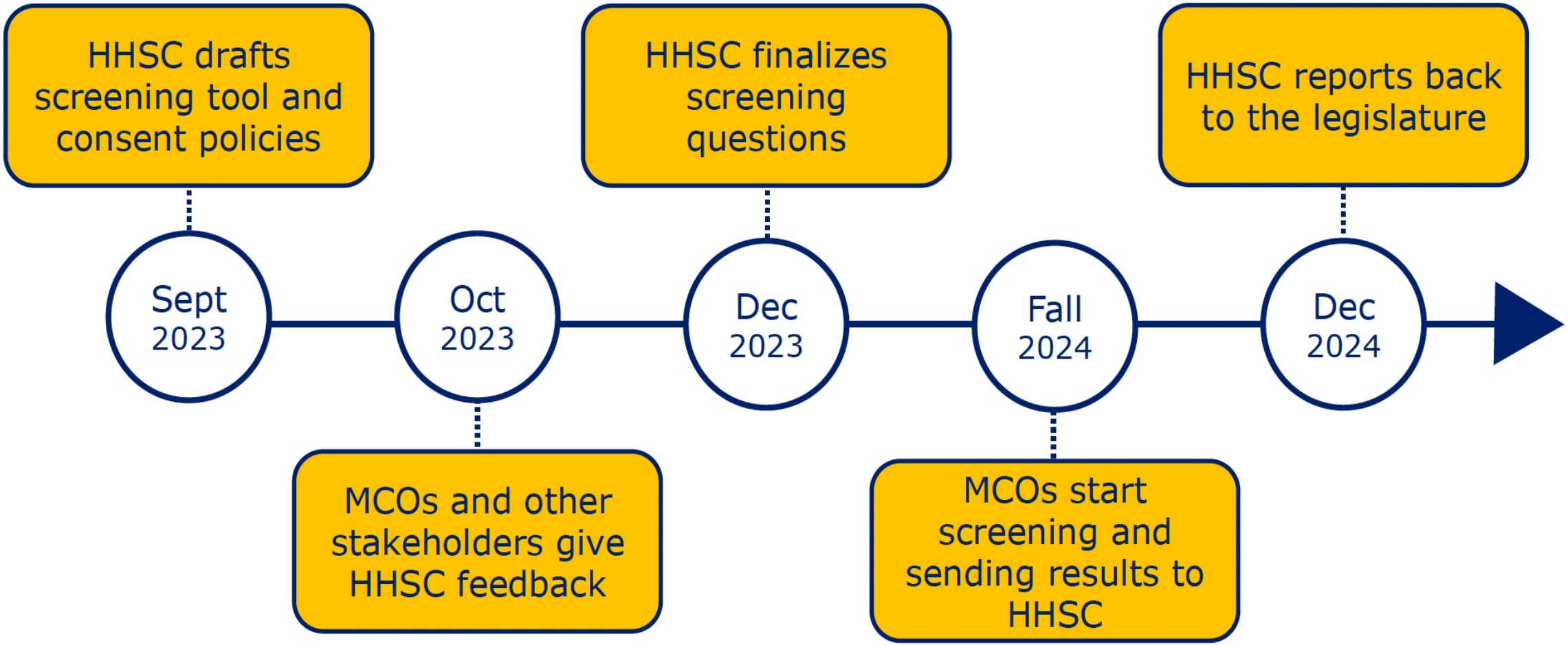
MCOs and Thriving Texas Families Organizations

MCOs coordinate and connect to services

Results sent to HHSC

Timeline for HB1575 Nonmedical Screening

TEXAS Health and Human Services



State Directed Payment Programs

TEXAS Health and Human Services

- New NMDOH measures approved by CMS for SFY 2024
- Reporting begins in October 2023
- The results are public and submitted to CMS

CHIRP, RAPPS, & DPP BHS

- Participating hospitals, Rural Health Clinics, & Community Mental Health Centers
- Questions about a participants NMDOH screening implementation status

TIPPS

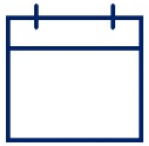
- Participating physician groups
- Rates of food insecurity screening and follow up planning

STAR+PLUS Social Needs Screening Requirements

TEXAS Health and Human Services

MCO screening for health-related social needs

Provider training on health-related social needs screening and community-based resources



Effective September 2024

Action Plan Progress

A) Data infrastructure

B) Coordinate services

C) Policies and programs

D) Support collaboration

Contact Info

Non-Medical Drivers of Health Action Plan

Medicaid & CHIP Services
Delivery System Quality & Innovation Team
DSQI@HHS.texas.gov

TEXAS Health and Human Services

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Health and Human Services

Alternative Payment Models Framework

September 20, 2023

APM Background

Phase I	
Value-based payment with APMS	2012

Phase II	
Contractual APM Targets	2017/2018

Phase III	
APM Performance Framework	UMCC – 2022; Data Tool Jan ‘24

APM-Performance Framework Principles

- Promote options and flexibility that align with HHSC priorities
- Increase adoption of Accountable APMs
- Provide credit for collaboration
- Broaden activities included in APMs
- Foster MCO and provider relations for successful APMs

APM Performance Framework Domains

- Flexibility for MCOs to advance value-based strategies and initiatives, while maintaining alignment with the HCP-LAN
- APM Performance Frameworks for STAR/CHIP, STAR+PLUS, and STAR Kids programs
- MCOs earn points across five APM Domains over four years:
  1. Achievement levels
  2. Quality Performance
  3. APM Priorities
  4. APM Pilots/Initiatives
  5. APM Support

APM-PF Domains One & Two

1 APM Achievement Level

- Maintain current APM achievement levels (Overall and Risk-based)
- Increase accountable (including Risk-based) APMs
- Increase incentive dollars paid through APMs

2 Quality Performance

- Exceptional or High performance on Performance Indicator Dashboard measures
- Based on Rider 20 (2022-23 General Appropriations Act) Benchmarks for MCOs Report*

*https://www.hhs.texas.gov/sites/default/files/documents/benchmarks-managed-care-organizations-aug-2022.pdf

APM-PF Domain Three

3 APM Priorities

- Rural or Non-metro providers
- Non-medical Drivers of Health (NMDOH)
- Primary and Behavioral Health Integration
- Medication Therapy Management
- Reduce Preventable Emergency Department Visits

APM-PF Domain Four

4 APM Pilots/Initiatives

- Maternal (or Primary) Care Medical Home Models
- Home and Community-based Services (HCBS) Workforce and Meaningful Measures
- Behavioral Health Evidenced Based Practice (EBP)
- Comprehensive Health Homes for Integrated Care (CHIC) Kids Pilot
- Transitions from pediatric to adult services for individuals with complex medical needs
- Other pilot in collaboration with HHSC and providers to test an innovative payment/care model

APM-PF Domain Five

5 APM Support

- APM Strategic Plan/Roadmap and annual updates
- APM Evaluations
- APM Learning and awareness with Providers
- APM Performance Reports to Providers
- APM Data Sharing with Providers

Accountable Care Curve measurement track definitions*

Measurement Tracks	Description/Definition
Payment Reform	Informs development and adoption of models and contracts that enable organizations to move from fee for service (FFS) to performance-based payment (LAN APM Framework Category 3A) and ultimately, two-sided risk arrangements (LAN APM Framework Category 3B and 4)
Quality	Informs development and use of measures that enhance patient experience to drive high- quality, high-value care for all
Health Equity Advancements	Informs development and alignment of initiatives designed to reduce health disparities by working with community-based organizations (CBOs) and other partners to collect, measure, and report on related outcomes
Data and Infrastructure	Informs development and alignment of technical components to enable sharing and receiving of timely healthcare-relevant data, including adoption of interoperable data exchanges
Multi-Stakeholder Alignment and Design	Encourages collective use of promising practices and other industry standards to promote collaboration and partnerships that advance accountable care, whether at the local, regional, state, and/or national levels

* HCPLAN_Accountable_Care_Curve_User_Guide.pdf (hcp-lan.org)

Major Decision Points

- Definition of Accountable Care
- APM contracts with Community Based Organizations
- Structure of Data Collection Tool
  - Rural and Non-metro APMs
  - Priorities and Pilots – check boxes
  - Tabs for Provider Engagement and APM Evaluation
- STAR and CHIP Reporting (separate or together?)
- Point requirements
  - Annual benchmarks
  - Options for crediting “year over year” improvement
  - MCOs new to a program or with a substantial change in service areas

Data Collection Tool
"Existing APM Data_MCO/DMO" Tab – left side

TEXAS Health and Human Services

MCO Existing Alternative Payment Model - Data Collection Tool

Back to Instructions

The purpose of this document is to enable HHSC to assess and measure over time MCO-Provider Alternative Payment Models. Please populate the worksheets per instructions provided. Please enter requested data below. Where applicable, use the drop down list to select your response (click on the cell and a drop down menu arrow will appear). Where more than one selection is needed, please use the next row to enter data where applicable. The Comment field can be used for any clarification.

Reporting Period | MCO Name

APM Description				Program Type (Enter "Y")					Persons Impacted by the APM		Payments Allowable and Made to Providers ($)			
#	Name of APM Related Intervention Program	APM Framework Category** (see footnote)	Rural or Non-Metro APMs	STAR	STAR+ PLUS	STAR Health	STAR Kids	CHIP	Provider-Service Type	Estimated Number of Unique Members Impacted by the APM Model	Payments Made to Participating Providers in the Reporting Period Without Incentives / Disincentives ($)	Incentives Paid and Disincentives Applied to Participating Providers in the Reporting Period ($)	Total Amount of Incentives / Disincentives Allowable under APM ($)	Total Payments Made to Participating Providers in the Reporting Period ($)
1														$ -
2														$ -
3														$ -
4														$ -

Data Collection Tool
"Existing APM Data MCO/DMO" Tab – right side

MCO Name														
Summary of Expenses														
Total MCO Medical and Pharmacy Expenses			Difference (HHSC to calculate)		Overall APM (HHSC to calculate)					Risk Based APM (HHSC to calculate)				
Program Type	MCO to enter	FSR (HHSC to enter)	Number	Percentage	Claims/APM Payments	Incentives / Disincentives	Total	% MCO	% FSR	Claims/APM Payments	Incentives / Disincentives	Total	% MCO	% FSR
STAR														
STAR+PLUS														
STAR Health														
STAR Kids														
CHIP														

Performance Measurement		Miscellaneous		APM Priorities					APM Related Pilots					APM Support				
Steward for Performance Measures Utilized	Performance Measures Utilized	Incentives / Disincentives Calculation ~~Evaluation~~ Schedule	Notes	Engage Rural or Non-metro Providers	Address Non-Medical Drivers of Health (DOH)	Promote Primary and Behavioral Health Integration	Medication Therapy Management	Reduce Preventable Emergency Department Visits	Maternal Medical Home Model	Comprehensive Health Home	Behavioral Health Evidenced Based Practice (EBP) Pilot	Home & Community Based Services	Other Pilot Authorized by HHSC to Test an Innovative Payment/Care Model	APM Plan/Roadmap and Annual Updates	APM Evaluation	APM Learning and Awareness with Providers	APM Performance Reports to Providers	APM Data Sharing with Providers

TEXAS
Health and Human Services

DISCUSSION?

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Jimmy.Blanton@hhs.texas.gov

TACHC Clinically Integrated Network

Presented by Franchella Jennett,
TACHC CIN Executive Director

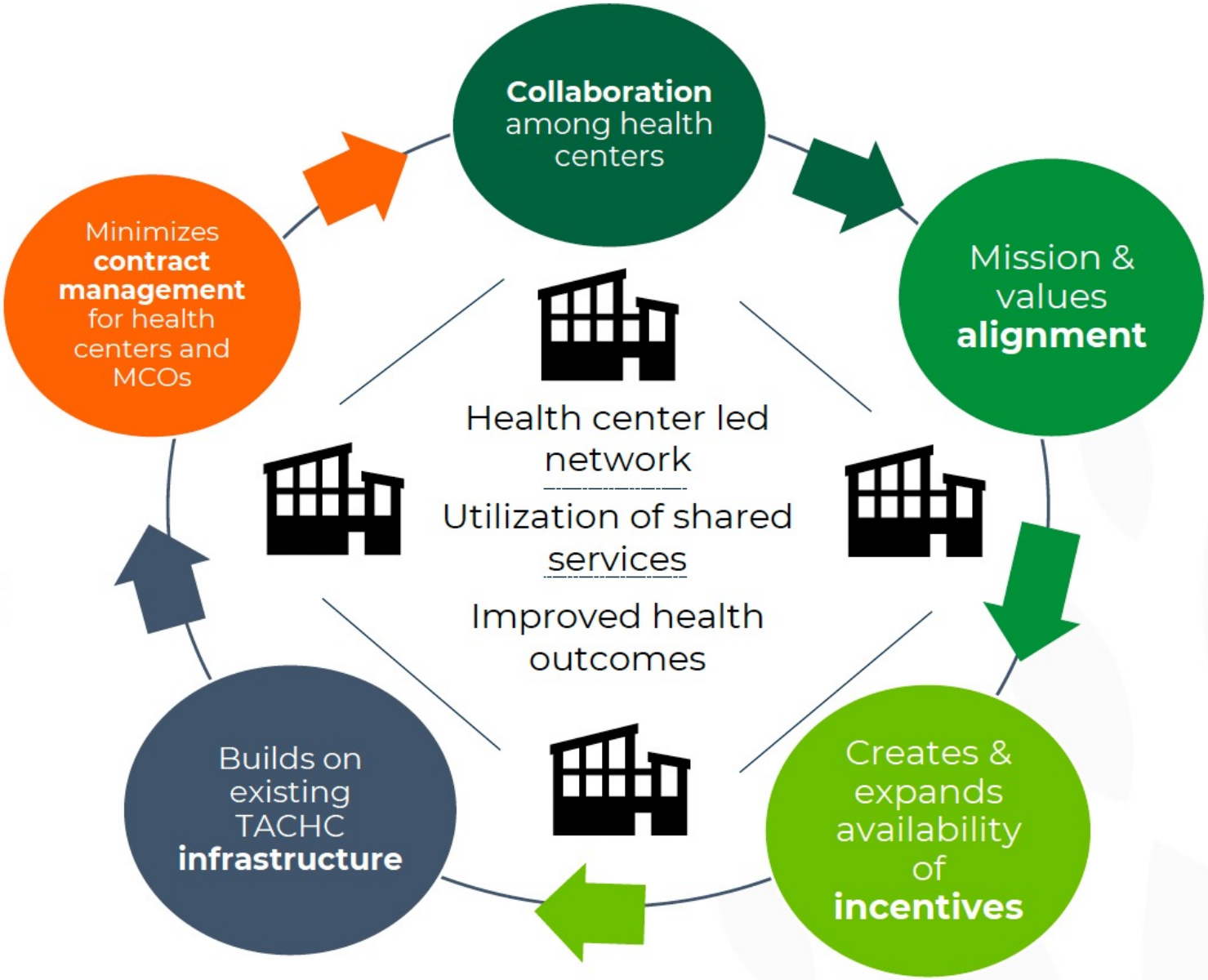
TACHC's Strategic Pillars

Background

- In 2022, the Texas Association of Community Health Centers (TACHC) conducted a study, supported by national public health consulting firm John Snow International (JSI) to explore options for improving Health Center participation in value-based payment plans with health insurers.
- The primary finding of this study was that a Clinically Integrated Network (or “CIN”) comprised of Texas Health Centers would be the most effective way to assist Health Centers in achieving these goals.
- In late 2022, the TACHC Board voted to move forward with the CIN.

Texas FQHC Value Based Care Engagement

TACHC Clinically Integrated Network, LLC



Health Centers, Stronger Together

QualityAxis

Our progress

April 2023
Engaged with consulting partners on the work

May 2023
Established CIN legal entity

Hired Executive Director

June 2023
Deployed Participation Agreements to Centers

June-July 2023
Facilitated educational sessions on CIN

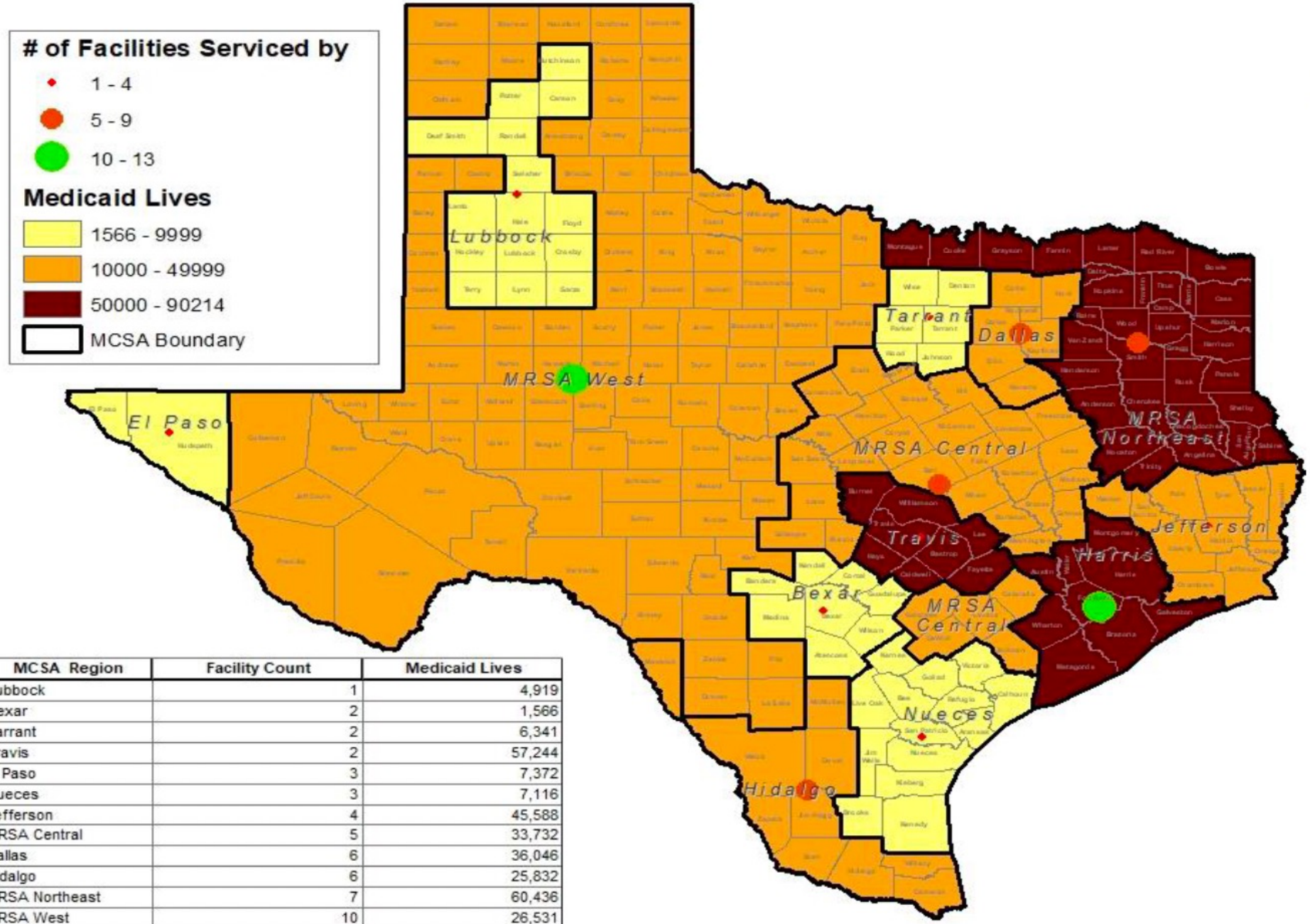
September 2023
1st Board of Managers Meeting

TACHC Clinically Integrated Network

48
Participants

1 Million+
UDS Lives

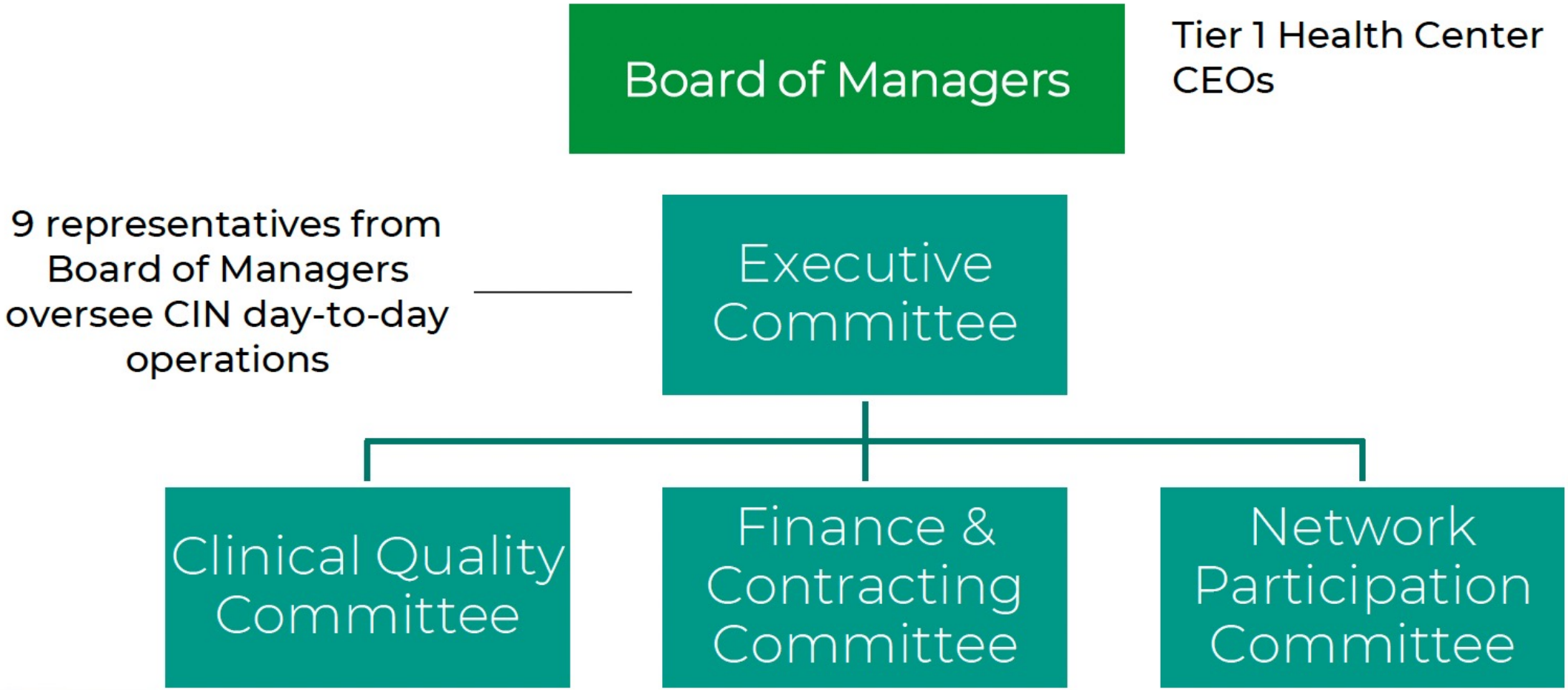
Strong interest among health centers



CIN Participants' Medicaid Lives by Managed Care Region

MCSA Region	Facility Count	Medicaid Lives
Lubbock	1	4,919
Bexar	2	1,566
Tarrant	2	6,341
Travis	2	57,244
El Paso	3	7,372
Nueces	3	7,116
Jefferson	4	45,588
MRSA Central	5	33,732
Dallas	6	36,046
Hidalgo	6	25,832
MRSA Northeast	7	60,436
MRSA West	10	26,531
Harris	13	90,214

TACHC CIN Governance



Alignment and Synergy

TACHC
TEXAS ASSOCIATION OF COMMUNITY HEALTH CENTERS

TACHC CIN

- Value Based Care Contracting
- Shared Services
- Azara DRVS

Management Agreement

TACHC PCA

- Policy & Advocacy
- Health Center Operations
- Outreach and Enrollment
- Training & Technical Assistance
- PCMH
- Workforce Development
- Risk Management
- Data Analytics
- Quality & Performance Improvement
- Azara DRVS
- HCCN
- UniteUs

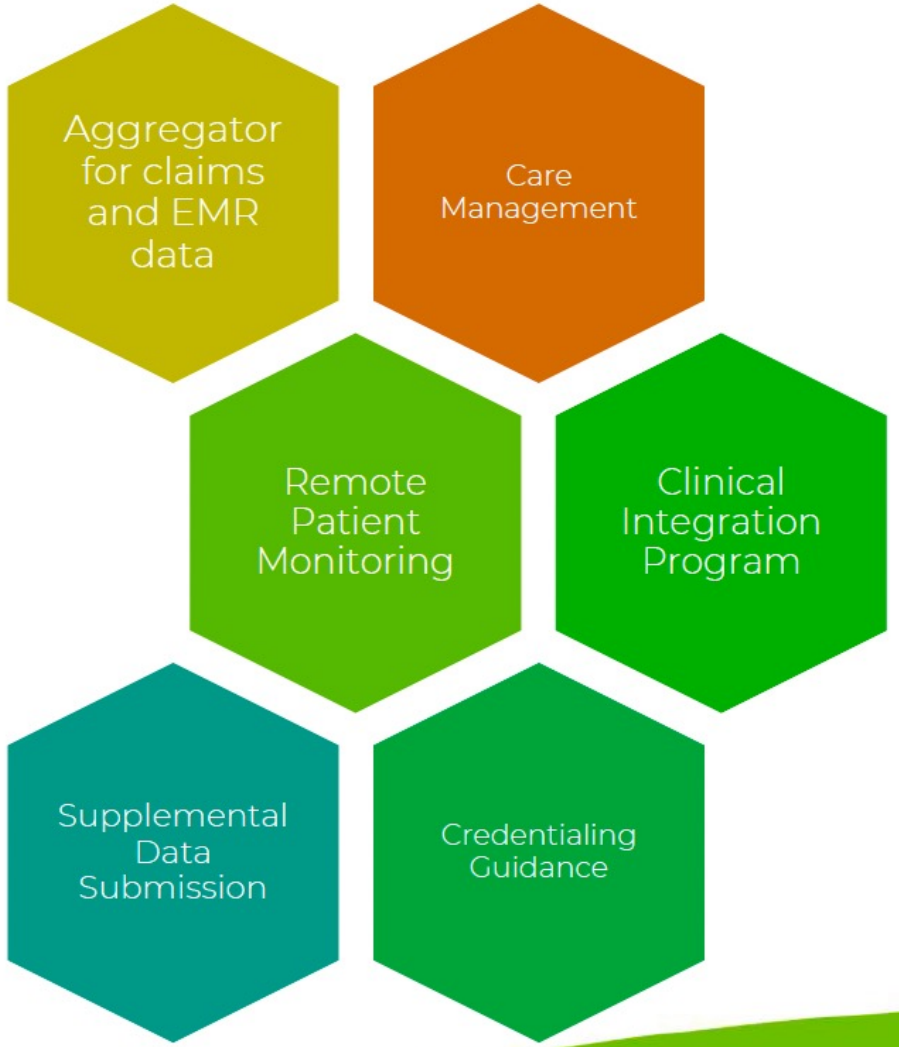
Alignment

- HCCN
- Training & Technical Assistance
- Quality Axis
- Azara DRVS
- UniteUs

Alignment

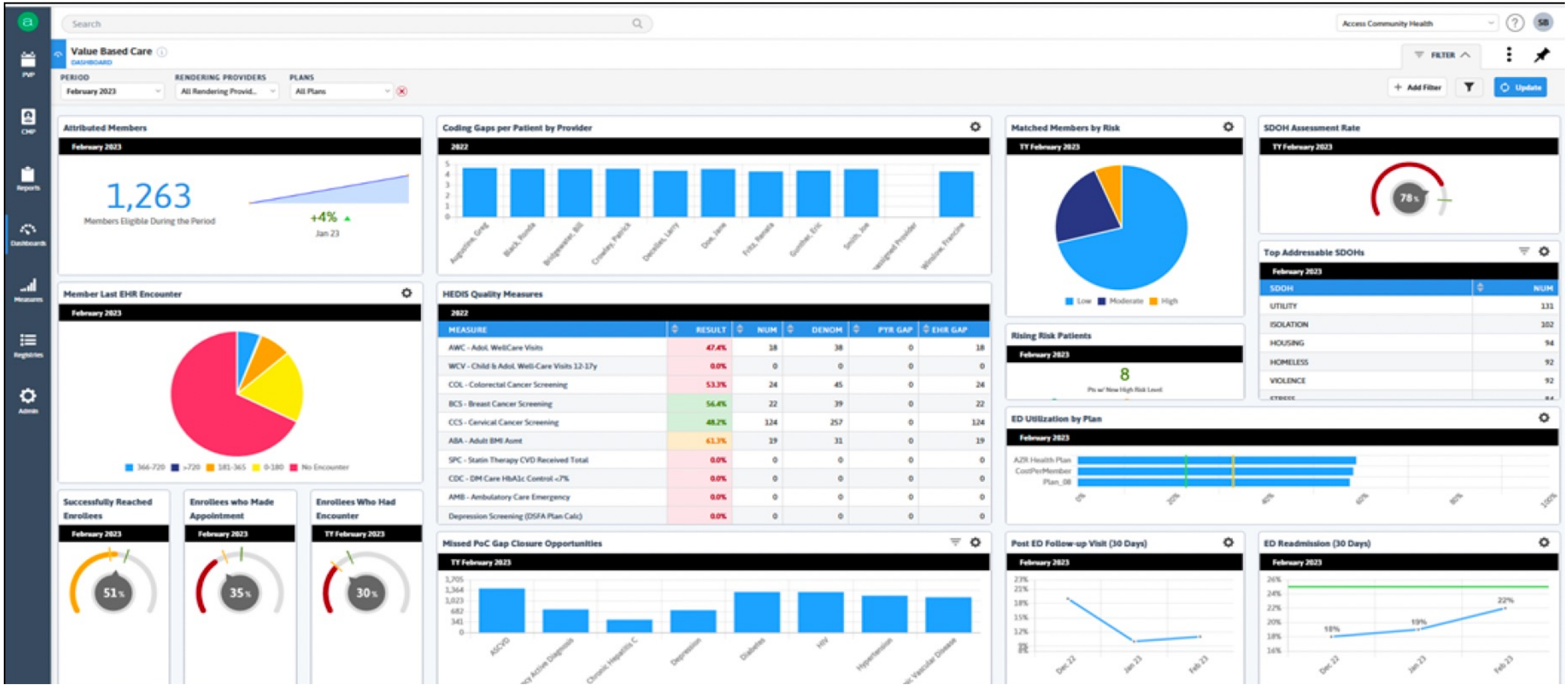
TACHC CIN Strategy

- Leverages existing infrastructure in health centers
- Successful pilots demonstrating improved health outcomes
- Open to delegation or infrastructure investment



Azara Sample Health Center Dashboard

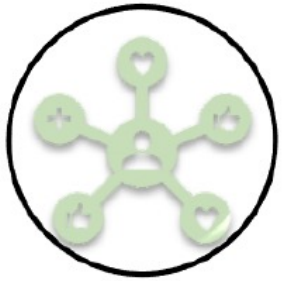
TACHC
TEXAS ASSOCIATION OF COMMUNITY HEALTH CENTERS



2024 Value Based Care Goals

TACHC
TEXAS ASSOCIATION OF COMMUNITY HEALTH CENTERS

Establish a standard quality measure set (based on HEDIS) for the network

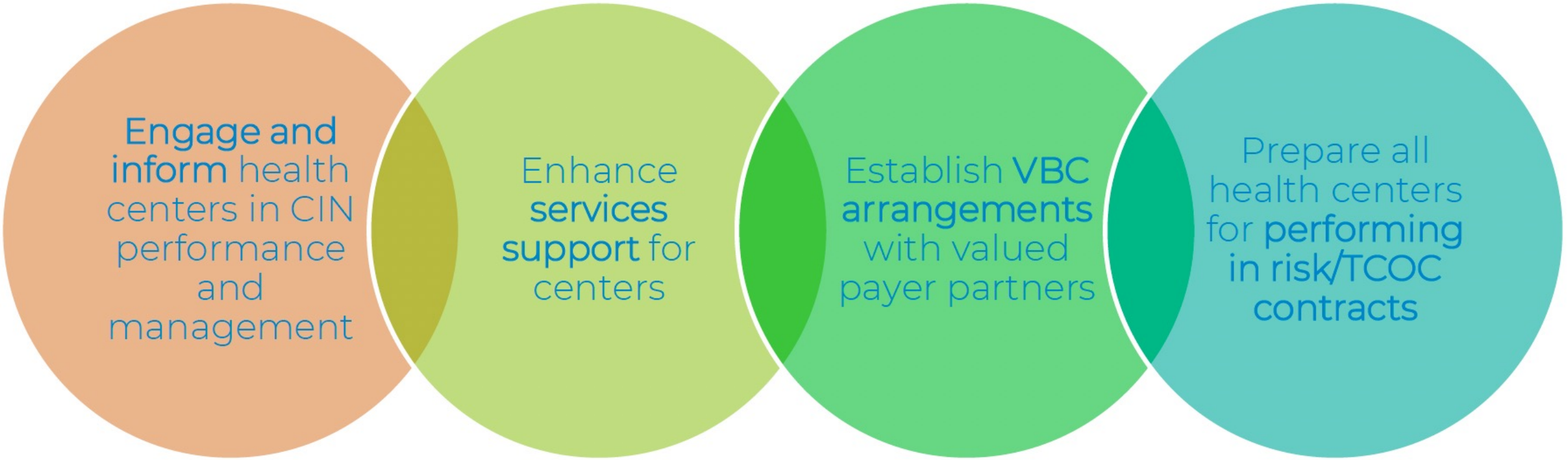


Deploy SDoH standard screening questions and Z code initiative

Demonstrate success in value based care arrangements for the network

Organizational Priorities

TACHC
TEXAS ASSOCIATION OF COMMUNITY HEALTH CENTERS



Collaboration

- **January 1st 2024** agreement desired
- Medicaid **priority** and open to other lines of business
- Evaluating various **alternative payment arrangements** and care coordination support
- Health plan provides **historical claims data** monthly and accepts submissions of supplemental data
- TACHC CIN will support health centers with data analytics, practice transformation, and **performance opportunity improvement**
- TACHC CIN will deliver improved outcomes and help deploy **enhanced care models** for health centers

TORCH CLINICALLY INTEGRATED NETWORK

Why/How We Got Here

What We Want to Achieve Together

Where We Want To Go

WE ARE BETTER

TOGETHER

John Henderson – President/CEO, TORCH | 4.20.23

Drivers of Change

WE KNOW

- Rural health orgs serve ~1/3 people in the U.S. and are **foundations of rural economies**, w/ RHCs as **vital primary care access points**
- There's significant **under-performance** and **variation** → many are at **existential risk**

EVIDENCE

- All vectors of change point to a new imperative based on **value**, **outcomes** and **patient XP** → **reward** prevention & efficiency
- **Health equity** has **strategic** *and* **moral** importance → drives VBC formulation

IMPERATIVE

- **Future is about Health**, not just healthcare → perpetuating the status quo likely is a failed strategy
- Requires value-creation focus, value-driven capabilities to achieve high-value health

Implications & Strategic Options

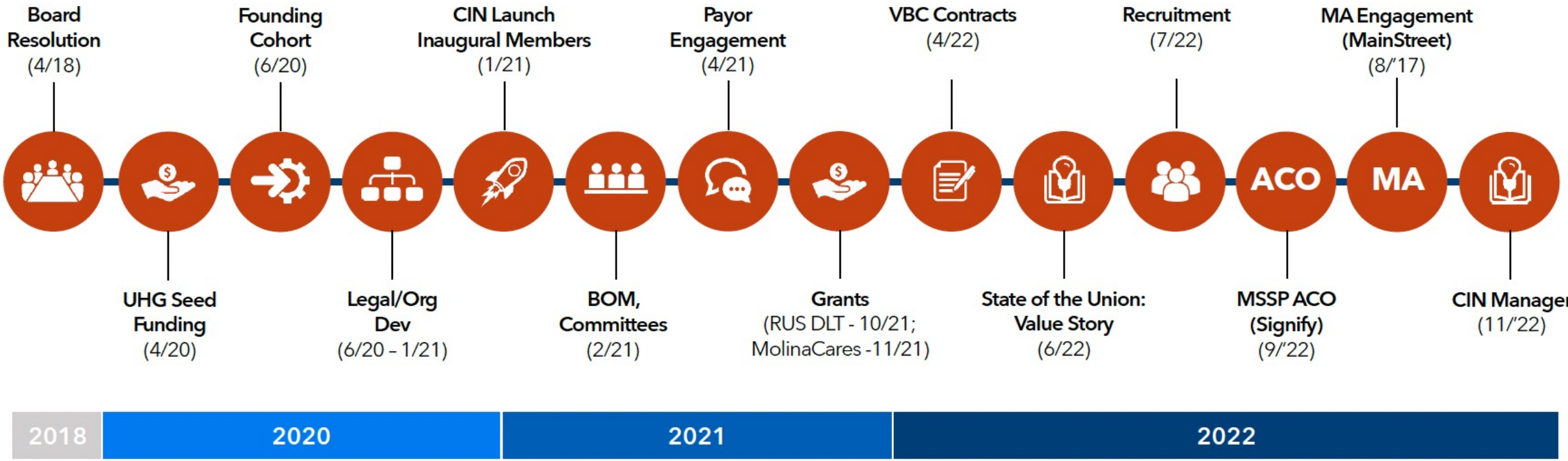
1. **Integration** → **Leverage**
   - **Actuarial ballast (CLs)**
   - **Provider network**
   - **Geographic reach**
2. **MAP** → **Loss of autonomy**
3. **Step-down** → **REH (Anson, Crosbyton, Marlin, St. Marks, San Augustine)**
4. **Closure**

TORCH CLINICAL INTEGRATED NETWORK

PURPOSE

- To create a **high performing statewide network of aligned healthcare providers** to engage in clinical and financial integration programs; specifically, to participate in joint VBC/PHM initiatives and enable innovative methods for sharing contractual risk among Participants
- **Launched in January 202**
- Active **value-based contracts** with United Healthcare, Amerigroup, and Aetna and participating in **Medicare Shared Savings Program** and **Medicare Advantage**

TORCH CIN - How We Got Here



TORCH CIN Guiding Principles

TORCH CIN is a platform for new opportunities, coordination and support not available to individual facilities

Better Together

Reimagine Rural Care

Think beyond the norm and innovate to achieve sustainable, high-value independent and local care delivery to meet rural community's healthcare needs

CIN contracting supports economic sustainability for rural healthcare providers

Financial Sustainability

Appropriate Pacing

Begin with proper short-term goals and early wins with continued focus on our long-term vision

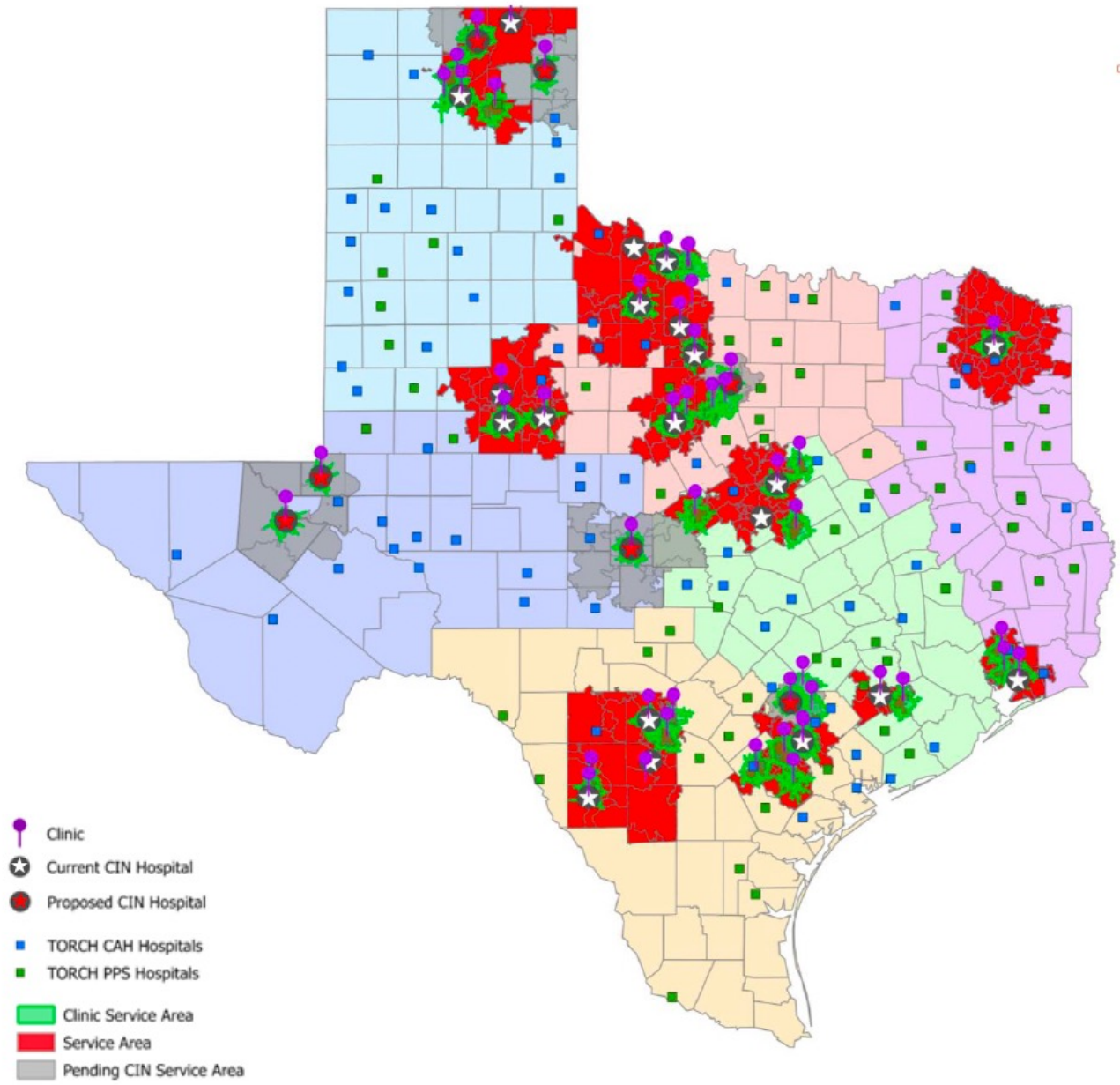
Prioritize contracts and partnerships streamlined processes and efficient administration

Relieve Administrative Burden

TORCH CIN Participants

27 Hospitals | **51** Clinics

1. Bayside Community Hospital
2. Cogdell Memorial Hospital
3. Coryell Health
4. Cuero Region Hospital
5. Dimmit Regional Hospital
6. Electra Memorial Hospital
7. Eastland Memorial Hospital
8. Frio Regional Hospital
9. Golden Plans Community Hospital
10. Goodall-Witcher Hospital
11. Graham Regional Medical Center
12. Hamilton Regional Hospital
13. Haskell Memorial Hospital
14. Medina Regional Hospital
15. Mitchell County Hospital
16. Ochiltree General Hospital
17. Olney-Hamilton Hospital
18. Otto Kaiser Memorial Hospital
19. Parkview Hospital
20. Pecos County Memorial Hospital
21. Rice Medical Center
22. Rolling Planins
23. Seymour Hospital
24. Stonewall Memorial Hospital
25. Titus Regional Medical Center
26. Tyler County Hospital
27. Wilbarger General Hospital



As of March 2023

Leverage – Actuarial Ballast & Network Essentiality

Network Essentiality

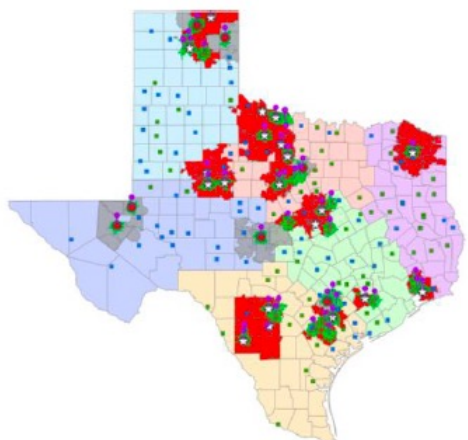
- 20 HSP
- 35 Clinics
- +287 1° Providers
- 553 Beds
- 8789 Discharges

Attribution

- >716k Mkt Pop[1]
- >264k Lives

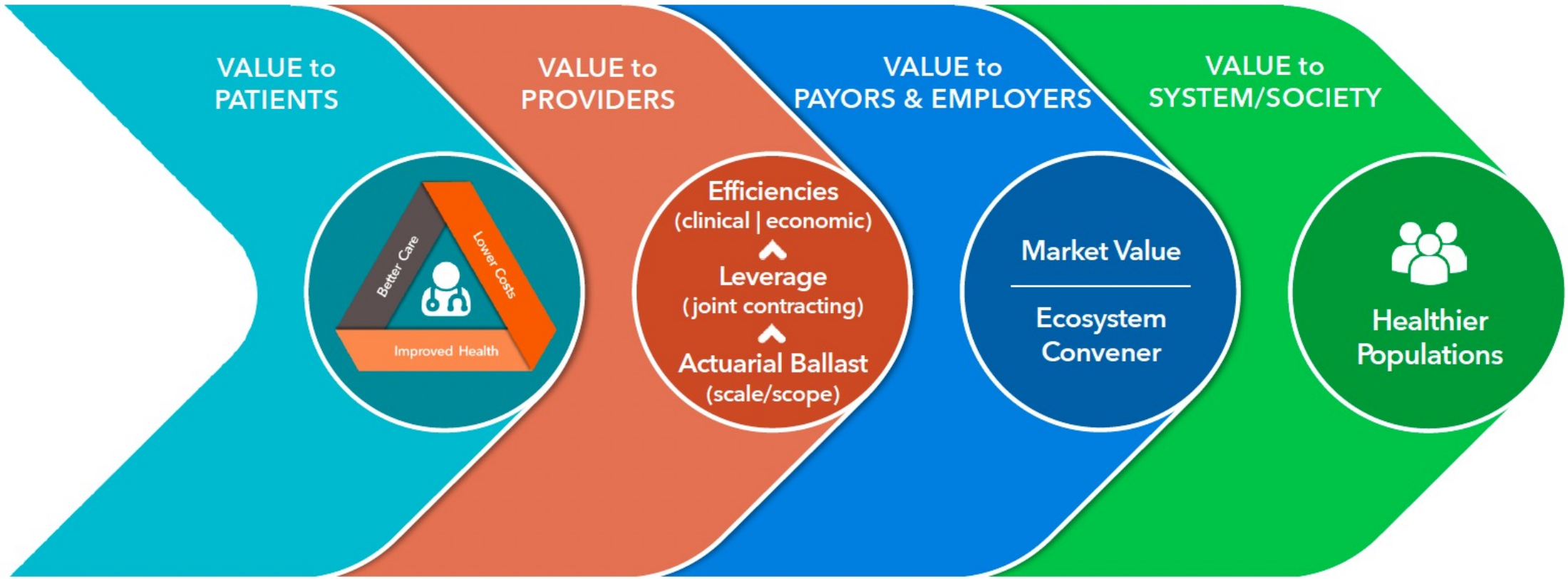
- Commercial: 89,814
- Medicaid: 81,754
- Medicare: 59,674
- MA: 32,917

Geographic Coverage



[1]Population in the markets (by ZIP codes) served by the hospitals (calculation: SA2020pop*OPmktshare)

Benefits to All

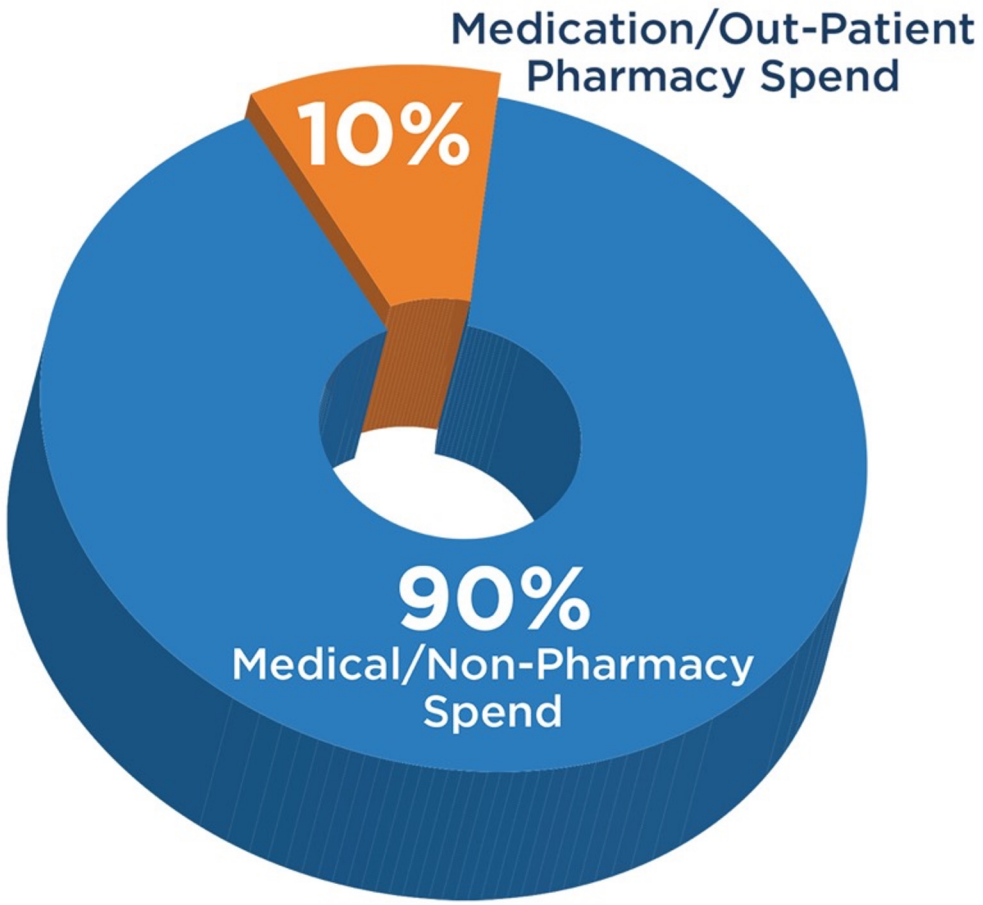



LOVE OAK
PHARMACY
Ben McNabb, PharmD


LOVE OAK
PHARMACY • MEDICAL
TEXAS
LOVEOAK

Introducing CPESN® Networks

Healthcare Spend in America



CPESN

EXPECT MORE

America's First Accountable Pharmacy Organization

- Lower Blood Pressure
- Lower HgA1C
- Decrease ER Visits and Hospitalizations
- Lower the Total Cost of Care
- Improve Health Awareness
- Improve Employee Productivity

CPESN

EXPECT MORE

America's First Accountable Pharmacy Organization

- 5th Largest Pharmacy Organization in the U.S.
- Reach Patients in the Local Community
  - Presence at 2M doorsteps every month
  - Reach >83% of Americans via hand-delivery to the home
- Single Signature Contracting
- Standardized Clinical Data Collection

CPESN

EXPECT MORE

America's First Accountable Pharmacy Organization

- Longstanding, Local Roots in the Community
- Local Relationships with Patients and Other Providers
- Locally-Delivered Patient Care Services
- Engage High-Risk Patients 35 Times a Year*

CPESN

EXPECT MORE

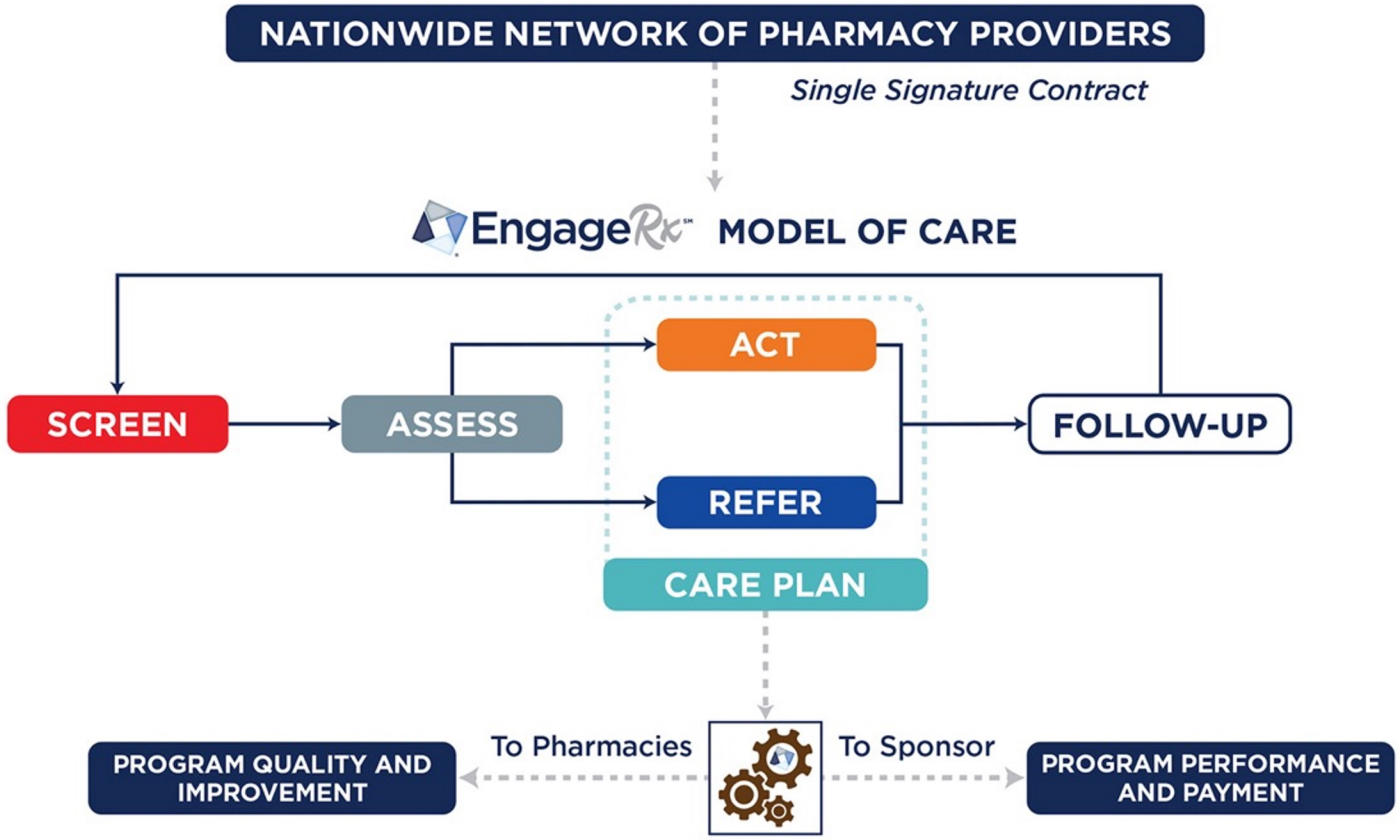
America's First Accountable Pharmacy Organization

- Clinically Integrated
- Performance-Based
- Willing to be Held Accountable
- A "Pharmacy Provider" Network - Contract Directly with the Provider of Patient Care

CPESN

EXPECT MORE

CPESN Pharmacies Provide Enhanced Patient Care Services That Go Far Beyond Medication Dispensing



All CPESN Pharmacies Provide Consistent, Systematic Care Across Locations

EngageRx℠ SERVICES

EngageSync℠

Medication Synchronization

Care Synchronization

- *Patient Care Synchronization*

Advanced Care Synchronization

EngageRx℠

Adherence Packaging

Care Management

Hand Delivery to the Home

Medication Reconciliation

Transitions of Care

Engage℠

Clinical Trial Recruitment

Screenings

- *A1C Reporting and/or Gap Closure*
- *Asthma Control Test*
- *BP Reporting and/or Gap Closure*
- *COPD Assessment*
- *General Anxiety Disorder-7 (GAD-7)*
- *Health Risk Assessment*
- *Patient Health Questionnaire-9 (PHQ-9)*
- *SDoH with or w/out referral*

EngageDM℠

Asthma/COPD Management

Behavioral Health Supports

- *Depression*
- *Anxiety*

Diabetes Management

Hypertension Management

Opioid Use Supports

- *Opioid Management*
- *Opioid Use Disorder Supports*

Tobacco Cessation

CPESN®

EXPECT MORE

CPESN® Pharmacies – Cost Savings & Results

Cost of Medication Non-Adherence[1]

HgA1C

Diabetes **$5,100/YR**

Hypertension **$5,800/YR**

Care Team Collaboration[3]

Care Teams

3 to 1 ROI

Medicaid generated $3 in savings for every $1 spent

Asthma Cost Savings[6]

$1,955/YR

ED Visits ↓ from 10% to 1.3%

Hospitalizations ↓ from 4% to 2%

Social Determinants of Health[18]

10%

Annual cost savings of $2,443 per member

Quality Measures[13]

HgA1C

22% MORE

Patients achieved A1C < 9%

Transitions of Care[9]

8 to 1 ROI

in Pharmacist Services

A performance analysis of CCNC primary care practices with integrated community-based pharmacy supports.[21]

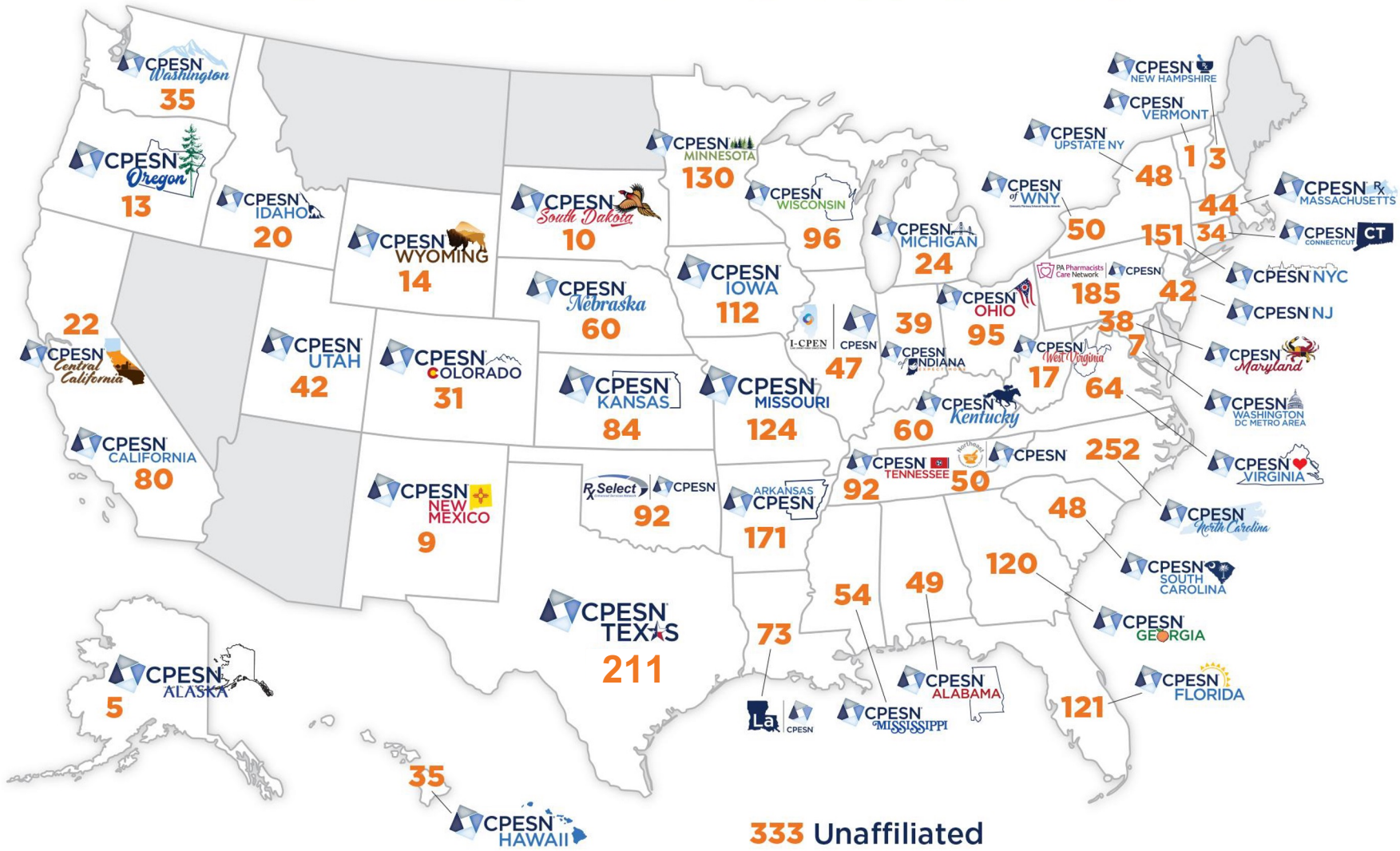
CPESN®

EXPECT MORE

CPESN USA – Growth and Scale

- 3,500 participating pharmacies
- >83% of the U.S. population covered through hand delivery to the home
- Provide 2.5 Million hand deliveries to patients every month (over 28 Million each year)
- 48 CPESN® Networks in 43 different states
  - See map on next slide
- 30 networks have elected their own representative to the decision-making Board of Managers who govern CPESN® USA
- Data from August 2023

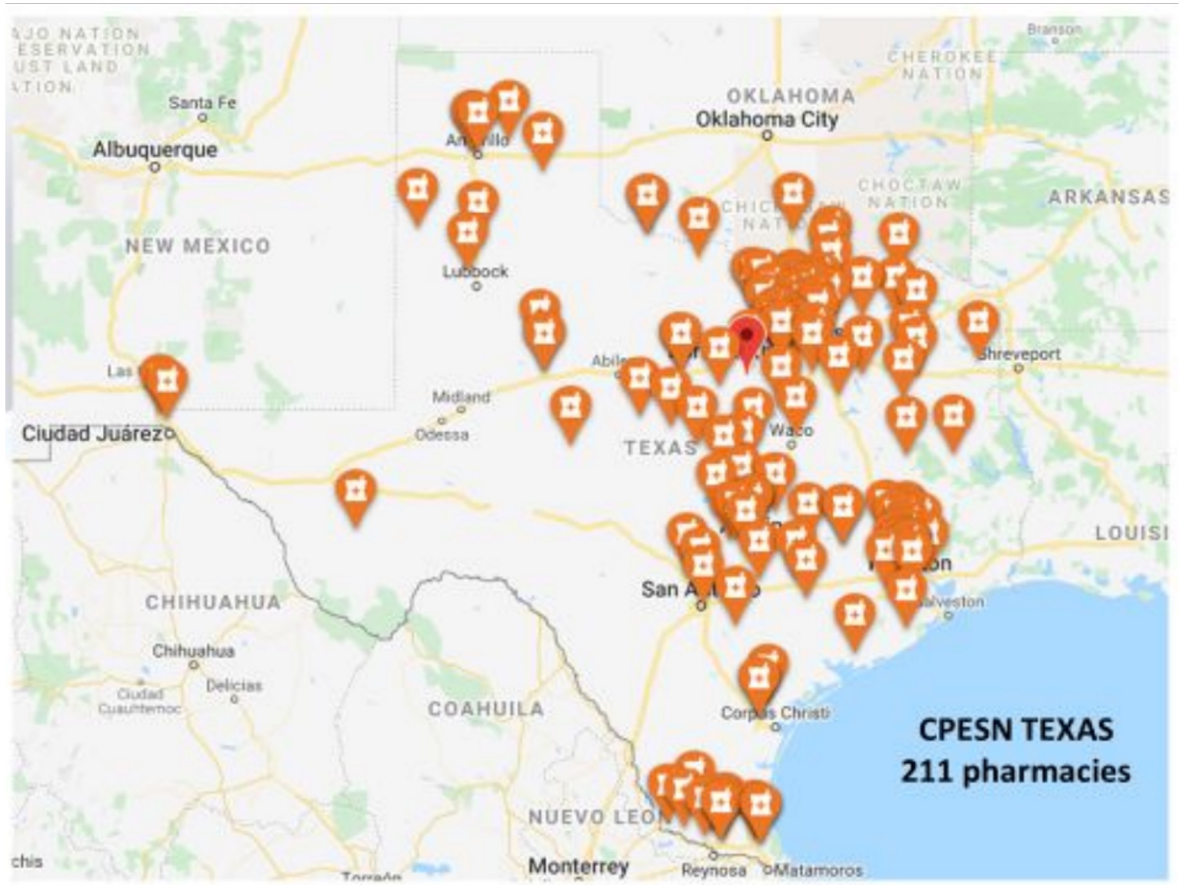
CPESN Networks



CPESN

EXPECT MORE

CPESN Texas



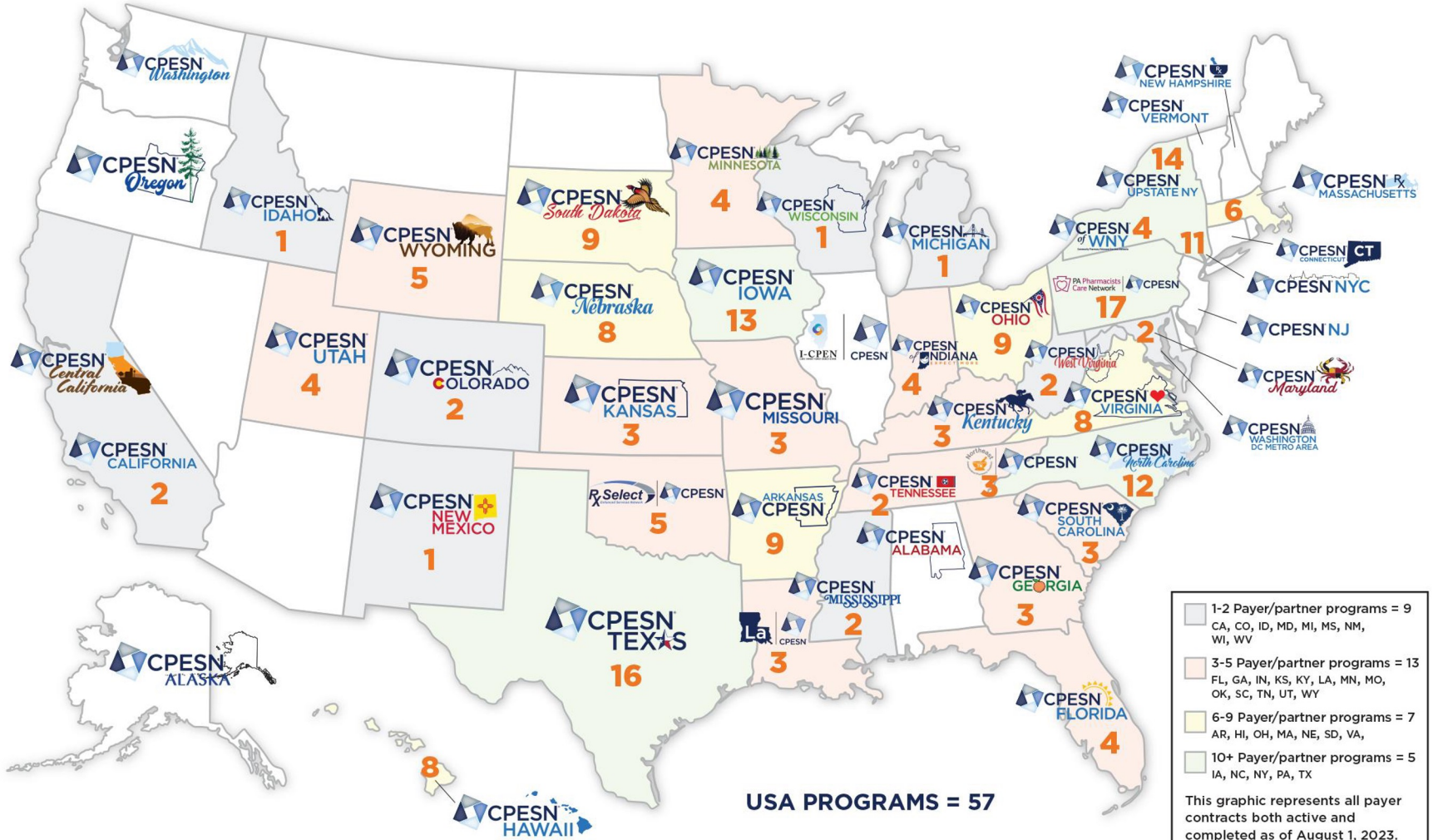
CPESN

EXPECT MORE

CPESN USA – Payers Success

- 249 national or local contracts have been signed, completed or active
- 38 (of our 48) networks have contracted with at least one payer to provide enhanced pharmacy services
- 11 Networks have 8-plus Contracts
- Every network that has reached network adequacy for population coverage has at least one payer contract to provide enhanced pharmacy services
- Data from August 2023

Total Payer Programs



CPESN

EXPECT MORE

Pharmacy Health Equity Case Study

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MCO Discussion

- Do you currently have any APMs that include some type of intervention to address NMDOH?
- Do you have any best practices to share or consider when implementing APMs that address NDMOH?
- What are the biggest barriers to developing and implementing NMDOH related APMs? What keeps you from implementing this type of APM if you haven't already?
- Is there additional flexibilities or guidance the plans need from HHSC to be more successful in implementing NMDOH related APMs?
- Are there any resources or topics that the Learning Collaborative could provide to help the plans be more successful in this area?

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Better care where it's needed most

National Context: Financing NMDOH Services through Medicaid Managed Care and Value-based Payment

Diana Crumley & Anna Spencer, CHCS

September 20, 2023

Made possible by the Episcopal Health Foundation, in partnership with Treaty Oak Strategies

Center for Health Care Strategies

Dedicated to strengthening the U.S. health care system to ensure better, more equitable outcomes, particularly for people served by Medicaid.

Together with our partners, our work advances:

- **Effective models for prevention and care delivery** that harness the field's best thinking and practices to meet critical needs.
- **Efficient solutions for policies and programs** that extend the finite resources available to improve the delivery of vital services and ensure that payment is tied to value.
- **Equitable outcomes for people** that improve the overall well-being of populations facing the greatest needs and health disparities.

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Agenda

- Federal Trends
- State Trends
- CHCS Activities
  - → New Publication
  - → New Workgroup

Federal trends

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Centers for Medicare & Medicaid Services Activities

- Screening for social risk factor measures or requirements embedded in:
  - → Hospital Inpatient Quality Reporting Program (mandatory in 2024)
  - → Merit-based Incentive Payment System (MIPS) (2023)
  - → Special Needs Plans Health Risk Assessments
  - → CY 24 Medicare Fee Schedule (Proposed)
  - → Accountable Care Organization Realizing Equity, Access, and Community Health (ACO REACH) Model
  - → States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model
  - → Making Care Primary (MCP) Model
- Early social risk adjustment approaches in ACO REACH, MCP, & AHEAD

State Trends:
New approaches to Medicaid-funded NMDOH services and partnerships with community-based organizations (CBOs)

Moving toward more standardization and coordination

California: Community Supports (a.k.a. *in lieu of* services) & Enhanced Care Management (ECM)

- Started in January 2022 (approved by CMS in December 2021)
- DHCS announced new changes to its programs after Year 1. DHCS is interested in adding **more standardization over time** to make the programs **more consistent** around the state and **mitigate administrative burden** on providers.
- DHCS developed a "cheat sheet" to outline where managed care plans have the **flexibility to design payment models that meet ECM and Community Support provider needs**.

North Carolina: Healthy Opportunities Pilots

- Started in March-June 2022 (approved by CMS in 2018)
- Creates relationships between Network Leads, Human Service Organizations (HSO), and Prepaid Health Plans (i.e., MCOs)
- Provides food, housing, transportation, and toxic stress/interpersonal violence services
- State has shared lessons learned, like the importance of:
  - → A “Bridge” Organization
  - → Data Exchange Platform
  - → Investment in HSO Participation & Onboarding

Ohio: New Managed Care Requirements

- MCO must **work collaboratively** with other MCOs to:
  - → Earn quality withholds (current focus: diabetes, birth/infant outcomes; past: COVID and health-related social needs)
  - → Maximize the collective impact of community reinvestment funding (required 3% of the 1.5% risk margin)
- Members who are pregnant who reside in a community served by a **qualified community hub** may be recommended to receive HUB pathway services.
  - → State included care management amounts under the delivery kick payment in six regions to account for the HUB contracting requirements (under “non-benefit costs.”)

Arizona:
Housing & Health Opportunities (H20) Demonstration

- In Fall 2022, CMS approved Arizona's request to provide housing support services as part of an 1115 demonstration project. These services include **six months of transitional rent**.
- AHCCCS plans to procure a Third Party Administrator (TPA) to assist the State in administering H2O services, including:
  - → Recruitment, onboarding and training on **Medicaid enrollment for CBOs**
  - → Establishing and verifying member eligibility for H2O services
  - → Coordinating services between MCOs and H2O providers
  - → Developing a **streamlined process for H2O providers to bill AHCCCS**
- Individuals may be initially engaged by a street outreach team, their enrolled health plan, or through an existing AHCCCS provider who screens for needs.

New York State – 1115 Demonstration Proposal

- New York has a longstanding requirement for at least one NMDOH intervention and one CBO partnership in advanced VBP arrangements, but New York notes that:
  - → "Most interventions were **only for one social risk factor** for the entire arrangement, and **contracts were also relatively small** and contracted with **only one CBO**."
  - → "MCOs and CBOs cited **difficulties with contracting and creating a uniform referral system."**
  - → "Efforts need to be **coordinated on a larger and more comprehensive level** and **additional funding beyond plan premium** to ensure adequate investment and support from MCOs."
- New approach (not yet approved): **Social Determinants of Health Networks**, creating a single point of contracting for NMDOH interventions in VBP arrangements or with other providers

Washington State – 1115 Demonstration

- State can expand and encourage Medicaid payment for **community-based workforce through the managed care contract and care coordination accountabilities**, but:
  - → "Payment for these workers has been **largely limited to administrative expenditures and alternative payment models** due to perceived payment barriers and policy gaps."
- New approach: **Community Hubs** and **Native Hub**, managing health-related social needs services and relationships with CBOs
  - → MCOs will provide *in lieu of* services.
  - → Services will be available to FFS/Traditional Medicaid members, too.

Resources

- California: DHCS Cheat Sheet
- North Carolina: *A First Look: Highlights From North Carolina's Healthy Opportunities Pilots*
- Ohio: Managed Care Contract & Rate Development
- Arizona: Proposed 1115 Demonstration Protocol
- New York: 1115 Demonstration Proposal
- Washington State: 1115 Demonstration Proposal & Approval

Update on CHCS Activities

Report & Workgroup

Center for Health Care Strategies

Medicaid Managed Care NMDOH Learning Collaborative

September 20, 2023

DATA SHARING WORKGROUP

DATA SHARING WORKGROUP GOALS

- Review the data landscape for what is available with respect to NMDOH in Texas Medicaid (including how NMDOH data flows between MCOs, providers, and others).
- Attribution process for assignment of Medicaid enrollees to primary care providers (PCPs) and for MCO alternative payment models (APMs).
- Additional goals identified by the workgroup – e.g. the need for incentives.

Workgroup participants include providers (including FQHCs), MCOs, associations, philanthropies.

MEETING #1 – KEY TAKEAWAYS

- Start with HB 1575 for infrastructure development.
- Regional Community Information Exchange initiatives such as Connxus (Austin area) and Greater Houston HealthConnect could be a model to consider.
  - Explore the possibility to collect assessments at scale (such as in OK through HIE capabilities), transform to Z codes, submit to MCOs, and notify providers.
  - Consider an approach that is EHR-agnostic (such as planned with Connxus) that provides NMDOH information needed by providers, plans, CBOs, patients, etc. without disrupting their activities but also without having to manage integrations with each EHR, which can take a substantial amount of time and resources.
- Incentives are important for providers, CBOs and MCOs (such as implemented in Arizona Medicaid).

MEETING #2 – KEY TAKEAWAYS

Attribution – 2 issues:

- How beneficiaries get assigned/change PCPs
- How MCOs determine attribution for APMs

Potential topics for Learning Collaborative in 2024 focused on data sharing:

- Presentation from Dr. David Kendrick, CEO of MyHealth Access Network (OK's HIE) and/or Eliel Oliveira, Connxus
- NMDOH data flow – potential link to implementation plan for HB 1575
- Recommendations for improving attribution and patient engagement

NEXT STEPS

- Next Data Sharing Workgroup meeting will focus on NMDOH data flow
- MCO Learning Collaborative in 2024 focused on data sharing.

Food Insecurity Workgroup Goals

Develop a Standardized Referral Process

- Reach consensus on preferred Food Bank food insecurity services than can be executed by MCO and develop a standardized referral process.

Support Food Rx Pilot Program Alignment for Best Outcomes Validation

- Orchestrate alignment of Food Rx pilots on key measurement variables

Identify MCO Quality Metrics Recommendations for Measuring Food Insecurity

- Aggregate and rank

Meeting #2 – July 25th

Discussion Highlights

- Overview of existing quality measurement options
- Discussion on existing and potential quality options related to food insecurity
- Review of MCO quality metrics, including possible food insecurity impact

Other Key Discussion Points

- Rural vs. urban impact on food insecurity programs and outcome measures
- Cultural competency is critical to program and outcomes success
- Potential resources such as PRAPARE, In Lieu of Services (ILOS) is being piloted between MSDF & TCHP

Take Aways

- ➢ Assess best MCO Quality Metrics to measure food insecurity impact
- ➢ Aggregate and rank feedback
- ➢ Begin discussions on viable food bank services for food insecurity impact

Meeting #2 – August 24th

- Discussed Sub-Goal A.1 of HHSCs NMDOH Action Plan: Recommend a set of food insecurity and clinical quality measures for HHS, MCOs and providers to use for quality programs and evaluation purposes. Include measure specifications, screening tools, target populations, demographic stratifications, and other data elements.
- Review of existing P4Q metrics. Texas Incentives for Providers and Professional Services (TIPPS) food insecurity screening measures and Alternative Payment Methodology (APM).
- Discussed social vulnerability and how it provides a way to understand how the broader conditions in which people are born, live, work, and age can impact outcomes.

Next Steps – Food Insecurity

- Review MCO medical P4Q and identify the top 3-5 measures with the most potentially significant impact on food insecurity.
- Treaty Oak will conduct individual discussions with Food Banks and MCOs to do a deeper dive into data integrity/sharing and current referral processes.
- Following the individual discussions – a draft for a standardized referral process will be developed and presented to the food insecurity workgroup for feedback.
- Work on a Food Rx framework and metrics to measure success.

CHW Workgroup

Goals:

- Develop recommendations for HHSC to guide implementation of HB 1575
- Provide a SME group for HHSC to solicit information or request guidance on HB 1575 implementation
- Learn about CHWs and doulas and network with the various CHW and doula organizations
- Discuss CHW models and programs
- Support implementation of CHW programs

First Meeting:

- The CHW workgroup kicked off with a meeting with the MCOs to hear directly from them on recommendations related to implementation of HB 1575]
- The next meeting will be broader and include all other LC participants – HHSC, FQHCs, etc.
- The MCO workgroup plans to review existing CPW program policy

HB 1575 Implementation Recs

MCO Initial recommendations include:

- MCOs currently have screening questions integrated into their initial risk assessment and processes that are triggered based on how those questions are asked. It is really important that HHSC provides MCOs with the standardized questions but allows flexibility for the MCO to integrate into existing processes and not disrupt existing workflows.
- Health plans stress the importance of cultural sensitivity as a critical factor in effective screening and related outcomes.
- CPW today is predominately clinical today so it will be important to understand who and how to refer to CHWs and doulas – workgroup will provide program/medical policy recommendations including regarding assessment and service plan requirements.
- It will be important to ensure that referrals to CPW is not considered a duplication of Service Coordination.
- It is very important that HHSC finalize CHW and doula enrollment requirements and start provider enrollment in advance of the benefit going live. Also, extremely important that doulas and CHWs are giving extensive training and assistance with the enrollment process.

HB 113

- HB 113 directs HHSC to allow CHWs to be categorized as a Quality Improvement (QI) cost. It would allow more of these types of services to be counted in this QI category.
- HHSC previously released a QI cost guidance document that included a Q&A related to NMDOH.
- MCOs indicated they need HHSC to provide guidance around HB 113, potentially in the QI cost guidance document.

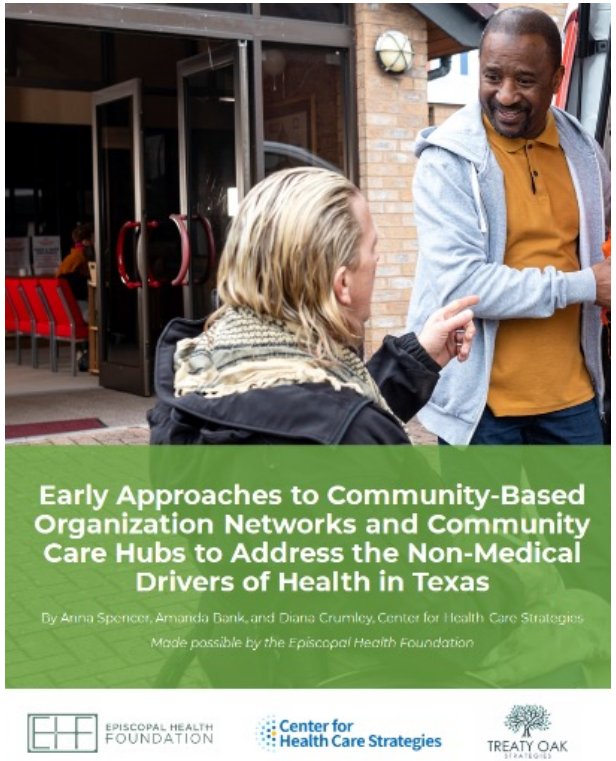
MCO Screening Questions

The MCOs were asked to provide their existing screening questions for TOS to do an analysis and provide HHSC with a crosswalk of questions, etc. We are still pending questions from 4 MCOs and will then provide final analysis to HHSC.

Findings:

- The number of questions asked ranges from 5 to 12. MCOs that asked more questions tended to include follow up questions – for example if an individual indicates a food insecurity there may be additional questions to get more specifics about that insecurity.
- All MCOs asked the same questions as follows:
  - Food insecurity – if members have accessed local resources and if there are concerns with running out of food.
  - Housing – do members have access to safe housing and what is their current housing situation. Many plans also asked about ability to pay for utilities.
  - Transportation – if they have access and are able to keep appointments, work etc.
  - Crime/violence – are they exposed to any (e.g., domestic, discrimination etc.)
  - Financial – any financial barriers including ability to pay for bills
  - Does the member currently access any community resources, what are resources that the member may need help accessing.

New Reports on Texas CBO and CBO Network Capacities to Engage with MCOs



MCO NMDOH LC will host a Virtual Webinar in October to learn about these report findings.

Thank you for attending!