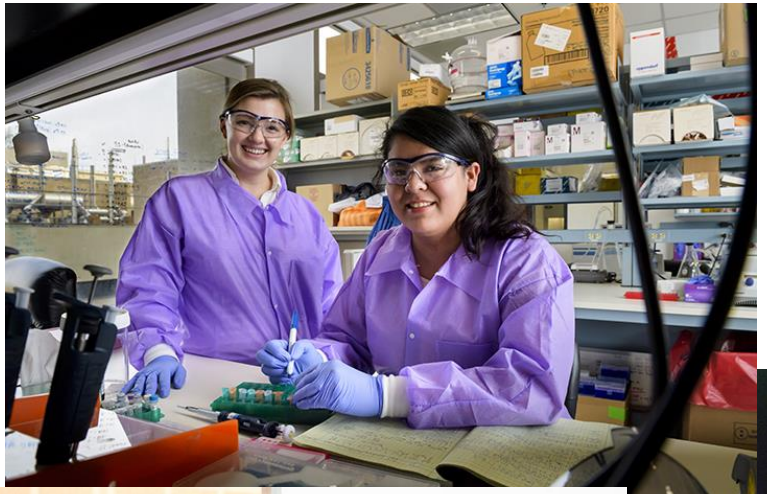
HHSC DSRIP Statewide Learning Collaborative 2019

Technical Assistance:

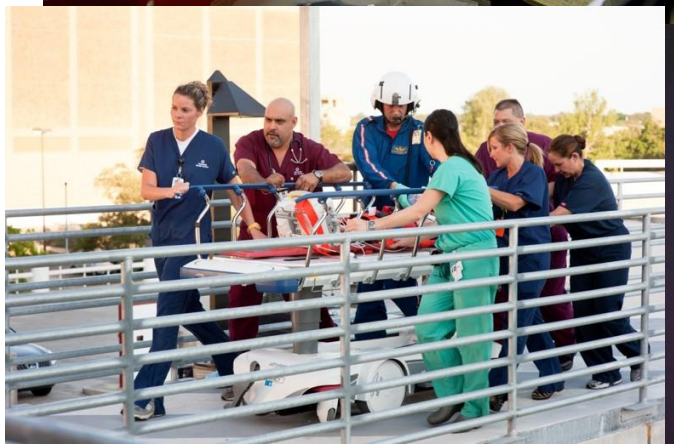
VBP/APM Strategies for Effectiveness in Texas Medicaid

Maureen Milligan, PhD, MA, MPAff, President and CEO, Teaching Hospitals of Texas

- **Cliff Fullerton, MD, MS,** President and Chief Population Health Officer, Baylor Scott & White Quality Alliance and Baylor Scott & White Health
- **Sharyl Jeffries,** Vice President, Provider Performance/Customer Experience, Superior HealthPlan
- **Frank Dominguez, MA,** President & CEO, El Paso Health



TEACHING HOSPITALS of TEXAS



Teaching Hospitals of Texas

support access to care for all with a special emphasis on vulnerable populations; provide and coordinate essential community health services such as trauma and disaster management; and prepare for tomorrow by training healthcare providers and supporting health research and healthcare transformation.

VBP/APM Strategies for Effectiveness in Texas Medicaid

"Working with Medicaid HMOs on Value-Based Programs"

TEACHING HOSPITALS of TEXAS

Frank J. Dominguez is the President and CEO of El Paso Health

Frank J. Dominguez is the President and CEO of El Paso Health, the only El Paso operated non-profit health maintenance organization (HMO) in the Borderplex region. Mr. Dominguez oversees a team of more than 145 El Pasoans who serve over 98,000 Members across the organization's various health plans. Those segments include Medicaid, CHIP, Preferred Administrators (Third Party Administration), and Health Care Options. Over twenty years of experience in the managed care industry has provided Mr. Dominguez with an extensive background in government health care programs and third-party administration operations. He is focused on creating and developing innovative programs that directly improve members' access to high quality care and outcomes. Of note, El Paso Health has consistently performed in the top tier of HHSC quality performance metrics and since 2014 has been the membership market share leader for both the Medicaid and CHIP programs in the El Paso Service Delivery Area. Along with his extensive duties at El Paso Health, Mr. Dominguez also serves as Board Chairman of the Texas Association of Community Health Plans (TACHP), a Board Member of the Association for Community Affiliated Plans (ACAP); as Board Secretary for Paso Del Norte Health Information Exchange (HIE); and as Board Member of the Texas Association of Health Plans (TAHP).

TEACHING HOSPITALS of TEXAS

Cliff Fullerton, MD, MS | President and Chief Population Health Officer, Baylor Scott & White Quality Alliance, Baylor Scott & White Health

Dr. Cliff Fullerton is president of the Baylor Scott & White Quality Alliance (BSWQA), an accountable care organization affiliated with Baylor Scott & White Health, the largest not-for-profit health system in Texas. He also serves as the health system's chief population health officer. As president of BSWQA, Dr. Fullerton oversees a network of clinical providers and facilities focused on improving quality, managing the health of patient populations, and reducing the overall cost of care. He is a board-certified family physician. Previously, Dr. Fullerton served as chief medical officer for BSWQA. In addition to his role as CMO, he became senior vice president and chief population officer for Baylor Scott & White Health after the 2013 merger between Baylor Health Care System and Scott & White Healthcare. During that time, he started the health system's Institute of Chronic Disease and Care Redesign. He assumed the role of president of BSWQA in July 2015. Dr. Fullerton has served in many leadership roles throughout his career, including within Baylor Health Care System, HealthTexas Provider Network (HTPN) and Baylor Scott & White Quality Alliance. He has been extensively involved with HTPN, serving as chief quality officer and president of his practice, Family Medical Center at Garland/North Garland. Dr. Fullerton earned his medical degree at the University of Texas Southwestern Medical School. He completed his internship at UT Southwestern Medical School/Parkland Memorial Hospital in Dallas, and his residency in family medicine at University of Oklahoma Health Science Center in Oklahoma City. He earned a master's degree in Health Care Management from the University of Texas at Dallas.

Sharyl Jeffries serves as the Vice President of Provider Performance and Customer Experience of Centene's Texas subsidiary, Superior HealthPlan

Sharyl Jeffries has more than 24 years of experience in managed health care. She currently serves as the Vice President of Provider Performance and Customer Experience Centene's Texas subsidiary, Superior HealthPlan (Superior). In her role, Ms. Jeffries manages internal and external process improvement utilizing Lean Six Sigma, value based contracting and provider incentives, and improving quality care through initiatives and provider education and partnerships. Since joining Superior in 2015, Ms. Jeffries has spearheaded quality accreditation initiatives, including implementing member and provider satisfaction task forces consisting of representation from all departments to improve the customer experience. Prior to transferring to Superior HealthPlan, Ms. Jeffries was with Centene Corporation since 2008 as the Sr. Director of Accreditation, responsible for achieving NCQA accreditation for all Centene health plans. Before her tenure at Centene, Ms. Jeffries was the Vice President of Quality Solutions for 10 years at MHNet, a behavioral health managed care organization. Ms. Jeffries graduated from the University of Utah with a Bachelor of Science degree in Economics. She is a certified Six Sigma Black Belt.

Baylor Scott & White HEALTH

Value of Community Health Workers

Cliff Fullerton, M.D., M.S.

September 5, 2019

Changing Healthcare For The Better™

BSWH Community Health Worker Timeline

2008

1 CHW Diabetes Education

2009:

3+ CHWs Diabetes Equity Project

2010-2011:

10 CHWs Community Care Navigation

2011:

Positions created

- CHW I
- CHW II

2014:

30 CHWs

CHW Council Developed

2015 -2018:

100+ CHWs

- CHW in training
- CHW Supervisor
- CHW Manager

2019:

100+ CHWs

- In ACO
- Practices, hospitals, clinics

Community Health Workers in Baylor Community Care

Began in 2008 through a Merck Foundation Grant

1:1 Chronic diseases education:

- Improvement in diabetes control (Hba1c reduced by 1.4%)
- Improvement in self reported ability to manage disease and quality of life score
- Observed reduction in inpatient hospital encounters in the year following patient enrollment (0.18 vs. 0.08, p<.0001)

Community Health Workers in Baylor Community Care

Community Care Navigation:

- Community health worker bridges the transition for high-risk patients from the hospital to medical home. Started in 2010.
- Connection rates for new patients: 64.3% in 14 days, 75.3% in 60 days
- 50% reduction in readmissions as compared with usual care (Irving Impact Study)
- CHW-Led home visits for high-risk patients – improvement in HbA1c: 1.3%

Current State – CHWs In BCC:

- Integrated care team approach – Meeting DSRIP metrics
- CHWs function in chronic disease education, pharmacy services (pharmacy techs), hospital/health system navigation

Innovative Care Team for Medicare Patients

Through a Deerbrook Charitable Trust Fund

Purpose:

- Implement a care model that includes Community Health Workers (CHWs), Licensed Clinical Social Workers, Pharmacists and pharmacy technicians to provide the highest quality care, great patient experience at the lowest cost for the highest-risk Medicare beneficiaries

Community Health Workers:

- CHWs > 50 years of age
  - Serve as trusted peer for patients
  - Embedded in clinics with the highest number of Medicare beneficiaries

Quality Measures - Centricity vs Epic

(Deerbrook Eligible, Continuous Patients)

Measures		Jul 2014 - June 2015 (Baseline)	Jul 2015 - Jun 2016 (Centricity)	Jul 2016 - Sept 2016 (Centricity)	Oct 2016 - Dec 2016 (Epic Baseline)	Jan 2017 – Dec 2017 (Epic)	Jan 2018 - Dec 2018	Jan 2019 - Mar 2019
Screening for Clinical Depression and Follow-up Plan	*Target*	-	*45%*	*45.5%*	-	*63%*	*64.3%*	*64.3%*
	Actual	43.7%	47.0%	48.1%	60.8%	81.1%	82.7%	85.5%
Medication Reconciliation	*Target*		*92%*	*92.5%*	-	*83%*	*84%*	*84.6%*
	Actual	90.5%	93.0%	92.6%	82.3%	85.5%	85.2%	87.8%

Continuously enrolled patients seeing an HTPN primary care provider, age 50 and older.
** Updated identification of patients with aspirin allergy, on anti-coagulant

Report run date: April 12, 2019
Data Sources: HTPN Data Warehouse, Epic Data Warehouse & BSWQA Data Warehouse

Quality Measures
(Deerbrook Eligible, Continuous Patients)

Measures		Jul 2014 - June 2015 (Baseline)	Jul 2015 - Jun 2016	Jul 2016 - Jun 2017	Jul 2017 - Jun 2018	Jul 2018 - Dec 2018	Jan 2018 - Mar 2019
Diabetes: A1C in Poor Control (<9%)	*Target*	-	*13%*	*12%*	*11%*	*10%*	*10%*
	Actual	13.5%	12.5%	10.4%	8.9%	8.5%	8.1%
Vascular Disease: On Aspirin	*Target*		*91%*	*93%*	*95%*	*97%*	*97%*
	Actual	89.3%	88.5%	88.3%	88.0%	89.2%	87% / 96.2%

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Wellness, Cost and Efficiency Measures

(Deerbrook Eligible, Continuous Patients)

Measures		Jan 2015 - Dec 2015 (Baseline)	Jan 2016 - Dec 2016	Jan 2017 - Dec 2017	Jan 2018 - Dec 2018	Jan 2019 - Mar 2019
Wellness Visits Completed	*Target*	-	*64.6%*	*65.9%*	*67.2%*	*67.2%*
	Actual	60.9%	63.7%	71.7%	77.4%	79.2%
Cost Per Member Per Year	*Target **		*$9,574*	*$9,551*	*$9,622*	*$9,622*
	Actual	$9,550	$10,041	$10,438	$10,656	$10,838
ED Visits / 1,000	*Target*		*400*	*392*	*384*	*384*
	Actual	393	418	418	418	428
Admissions / 1,000	*Target*	-	*242*	*237*	*232*	*232*
	Actual	237	254	272	250	261
Readmission Rate / 1,000	*Target*	-	*122*	*120*	*118*	*118*
	Actual	104	128	134	118	113

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Adherence to Annual Wellness Visit Impact on Quality Measures (Deerbrook Eligible, Continuous Patients)

Measure	With Wellness Visit	No Wellness Visit
Blood Pressure Control	87.7%	83.2%
Breast Cancer Screening	79.4%	61.1%
Colorectal Cancer Screening	87.8%	78.6%
Diabetic Eye Exam	72.6%	53.5%
A1c in control	82.7%	68.1%
Cholesterol Medication Adherence	84.7%	80.8%
Plan All-Cause Readmission	13.0%	16.9%

Lessons Learned

- CHWs 50 years of age well received by patients as trusted peers
- CHW certification curriculum not sufficient to prepare CHWs to be in a clinical primary care setting
- The right people working together function safely in rapidly changing environments
- Conduct provider practice/clinic readiness to embed CHWs in practice
- Practices with engaged physician champions and administrators are thriving
- Time it takes to embed CHWs in the practices

Value Based Programs: Superior HealthPlan's Perspective

3/24/2020

Superior HealthPlan

Statewide Presence. Superior employs more than 3,500 Texans in 8 offices across the state. *CNC = 5,200 employees and 11 total offices including affiliates.*

Industry Leader. As the largest Medicaid health plan in the state, Superior serves more than 1.2 million members across 11 different products in all 254 counties.

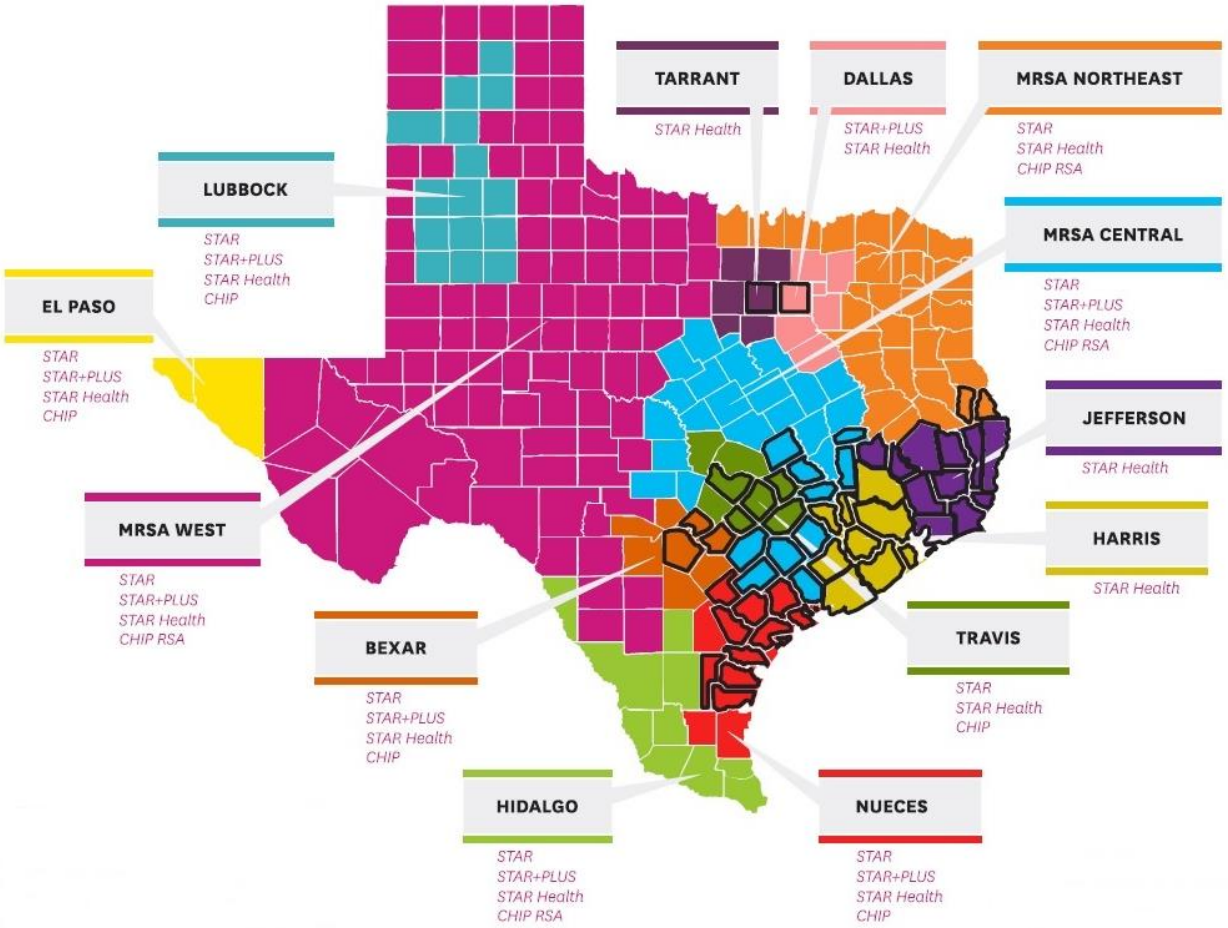
Quality. Superior is among the top-rated Medicaid plans in Texas, earning a score of 3.5 on a 5.0 scale on the National Committee for Quality Assurance (NCQA) Medicaid Health Insurance Plan Ratings 2018-2019.

Member Satisfaction. According to a 2017 survey, 93% of members said they were satisfied with customer service and 91% were happy with the health plan as a whole.

Large Provider Network. Superior manages a network of more than 64,000 providers in more than 90,000 locations.

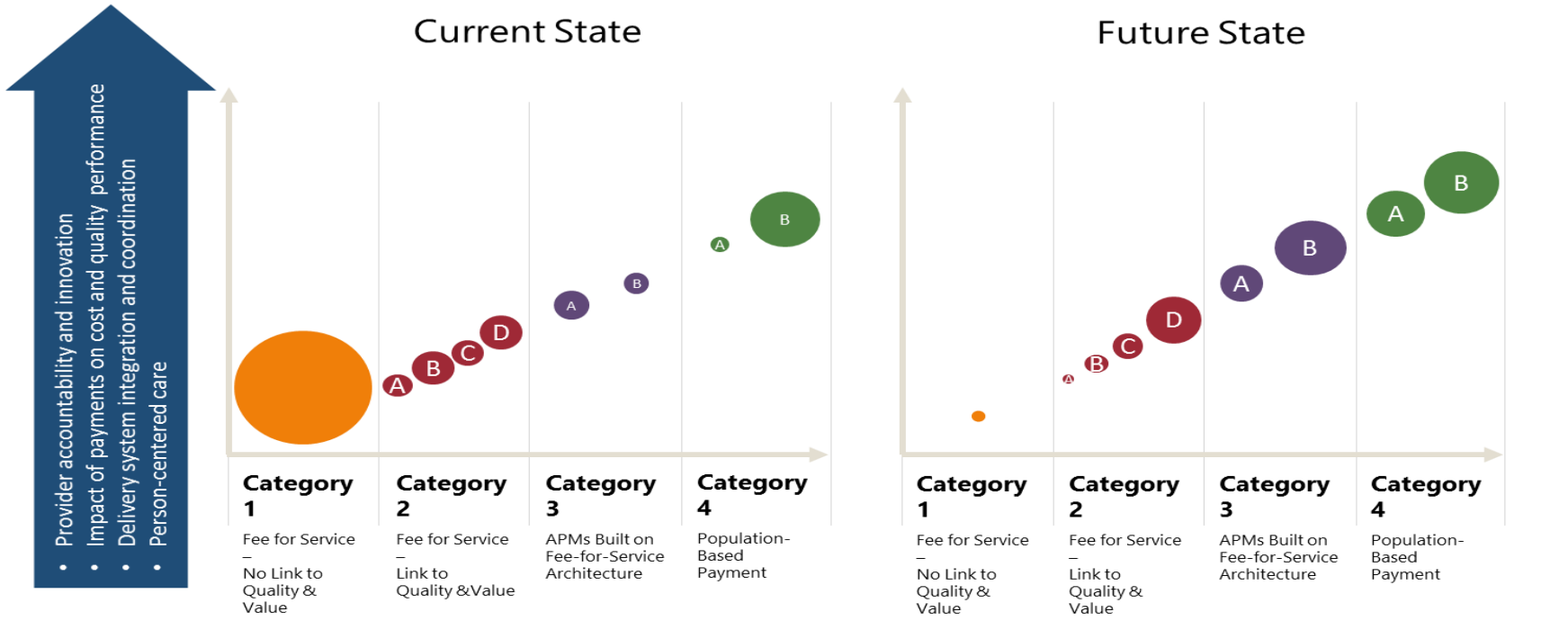
Active Local Involvement. In 2017, Superior and its employees donated nearly $1 million to organizations that support members and individuals from low-income families and neighborhoods.

Superior HealthPlan



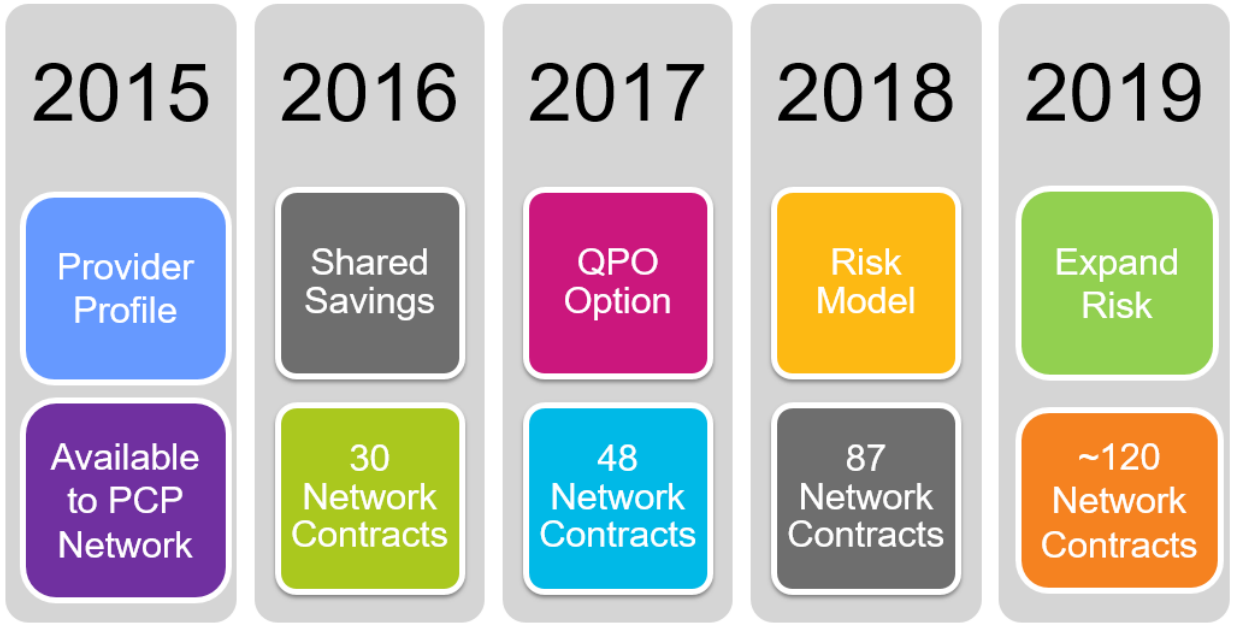
- STAR – TANF
- STAR+PLUS – ABD
- STAR+PLUS MMP – Dual Eligible
- STAR Health – Foster Care
- STAR Kids – Disabled Children
- CHIP – Children
- Ambetter – Marketplace
- Allwell – Medicare D-SNP and MAPD

APM Goals – State Contractual



2018	2019	2020	2021
>25% on APM	> 31.25% on APM	>39% on APM	>50% on APM
>10% Risk	>12.5% Risk	>16% Risk	>25% Risk

Superior's APM Progression



Program Year	Participating Provider Networks	% Achieving Savings	% Achieving Incentive	Attributed Members	VIS Change
2016	30 (66 TINS)	60%	90%	106,763	73% Overall Average Improvement 14.9 Percentile Points Improvement
2017	47 (244 TINS)	60%	70%	244,114	60% Improved VIS
2018	87 (302 TINS)	49%	59%	490,456	47% Improved VIS 14% Overall Average Improvement

Superior 2019 Programs

- Value Based Total Cost of Care Program (VBP)
  - Minimal Risk, HEDIS Bonus, Primary Offering
  - Reduce Preventable Events, Population Health Management
- Shared Savings Program
  - Upside Only, Reduced Incentive, HEDIS Bonus
- Pay for Quality Programs
  - Primary Care – HEDIS Measures, Small/Developing Providers
  - Behavioral Health Programs - Reduce PPR, HEDIS
  - Chronic Conditions – BTE Diabetes and Asthma - PPE, HEDIS
  - LTSS Programs – PPE, HEDIS, Visit Compliance
  - LTSS Model of Excellence – PPV, EVV Documentation and Maintenance, Attendant Continuity and Satisfaction
  - STAR Health 3-in-30 Incentive
  - Clinical Documentation/Closing Care Gaps

One Model Does Not Fit All

The Right Fit for the Right Provider

Multiple Key Factors to Success

Outcomes through Provider Clinical Engagement

PPV

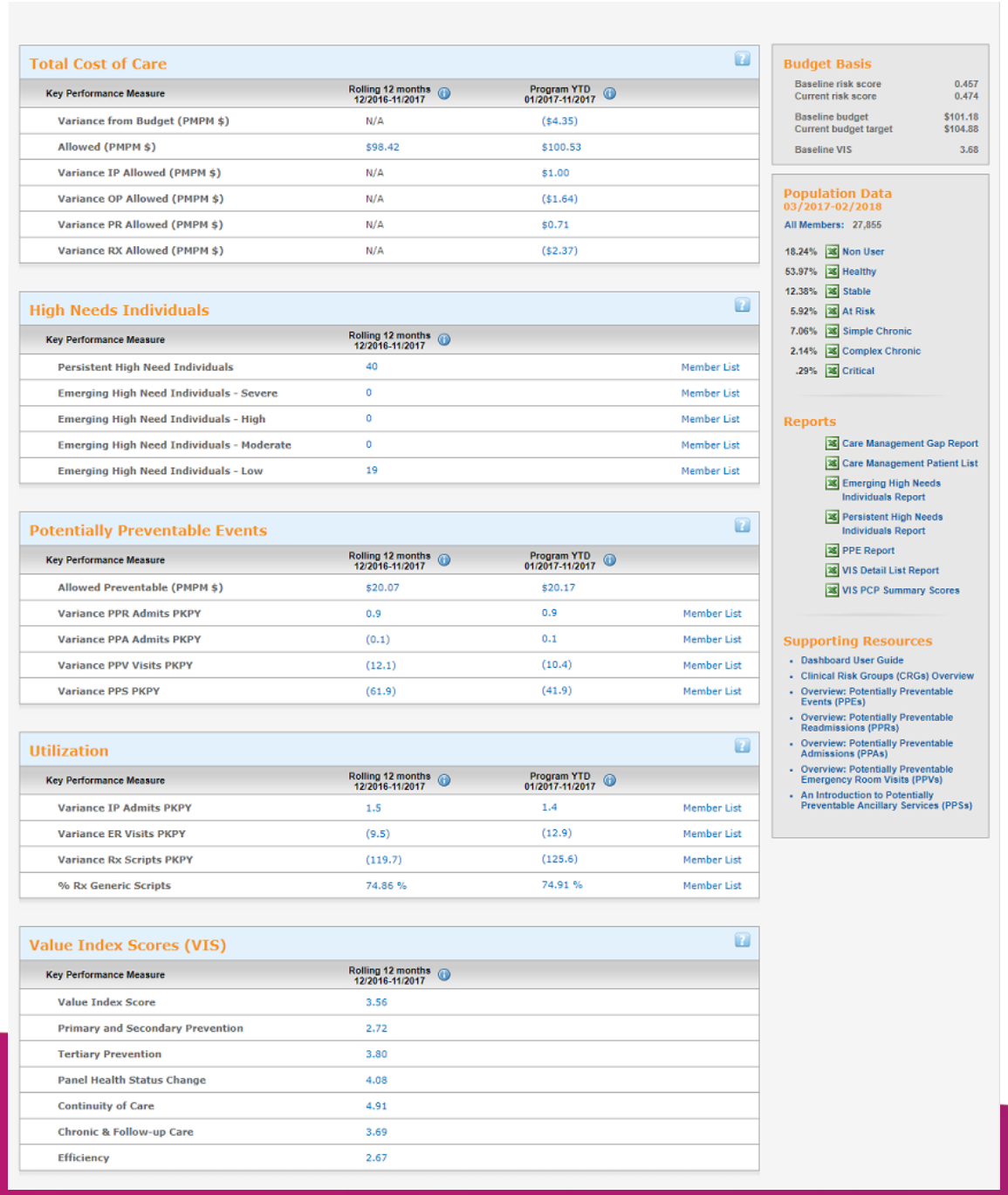
- 2018 Shared Savings/Shared Risk (SS/SR) providers performed significantly better than other providers with13.96% fewer PPV/1,000mm.
- The PPV Variance for SS/SR attributed members is -1.9910 per 1,000 member months vs 2.2142 per 1,000 member months.

PPA

- 2018 SS/SR providers performed significantly better than other providers with 26.29% fewer PPA/100,000mm.
- The PPA Variance for SS/SR attributed members is -3.4265 per 100,000 member months vs 4.8789 per 100,000 member months.

HEDIS

- SS/SR providers achieved higher HEDIS measure scores than other providers.
- Preventive visits are more compliant (CCS, AWC, W15, W34, CIS-10).
- Appropriate treatment improved (URI, CWP, ADD, CDC)



Total Cost of Care

Key Performance Measure	Rolling 12 months 12/2016-11/2017	Program YTD 01/2017-11/2017
Variance from Budget (PMPM $)	N/A	($4.35)
Allowed (PMPM $)	$98.42	$100.53
Variance IP Allowed (PMPM $)	N/A	$1.00
Variance OP Allowed (PMPM $)	N/A	($1.64)
Variance PR Allowed (PMPM $)	N/A	$0.71
Variance RX Allowed (PMPM $)	N/A	($2.37)

High Needs Individuals

Key Performance Measure	Rolling 12 months 12/2016-11/2017	
Persistent High Need Individuals	40	Member List
Emerging High Need Individuals - Severe	0	Member List
Emerging High Need Individuals - High	0	Member List
Emerging High Need Individuals - Moderate	0	Member List
Emerging High Need Individuals - Low	19	Member List

Potentially Preventable Events

Key Performance Measure	Rolling 12 months 12/2016-11/2017	Program YTD 01/2017-11/2017	
Allowed Preventable (PMPM $)	$20.07	$20.17	
Variance PPR Admits PKPY	0.9	0.9	Member List
Variance PPA Admits PKPY	(0.1)	0.1	Member List
Variance PPV Visits PKPY	(12.1)	(10.4)	Member List
Variance PPS PKPY	(61.9)	(41.9)	Member List

Utilization

Key Performance Measure	Rolling 12 months 12/2016-11/2017	Program YTD 01/2017-11/2017	
Variance IP Admits PKPY	1.5	1.4	Member List
Variance ER Visits PKPY	(9.5)	(12.9)	Member List
Variance Rx Scripts PKPY	(119.7)	(125.6)	Member List
% Rx Generic Scripts	74.86 %	74.91 %	Member List

Value Index Scores (VIS)

Key Performance Measure	Rolling 12 months 12/2016-11/2017
Value Index Score	3.56
Primary and Secondary Prevention	2.72
Tertiary Prevention	3.80
Panel Health Status Change	4.08
Continuity of Care	4.91
Chronic & Follow-up Care	3.69
Efficiency	2.67

Budget Basis

Baseline risk score	0.457
Current risk score	0.474
Baseline budget	$101.18
Current budget target	$104.88
Baseline VIS	3.68

Population Data

03/2017-02/2018

All Members: 27,855

18.24%	Non User
53.97%	Healthy
12.38%	Stable
5.92%	At Risk
7.06%	Simple Chronic
2.14%	Complex Chronic
.29%	Critical

Reports

- Care Management Gap Report
- Care Management Patient List
- Emerging High Needs Individuals Report
- Persistent High Needs Individuals Report
- PPE Report
- VIS Detail List Report
- VIS PCP Summary Scores

Supporting Resources

- Dashboard User Guide
- Clinical Risk Groups (CRGs) Overview
- Overview: Potentially Preventable Events (PPEs)
- Overview: Potentially Preventable Readmissions (PPRs)
- Overview: Potentially Preventable Admissions (PPAs)
- Overview: Potentially Preventable Emergency Room Visits (PPVs)
- An Introduction to Potentially Preventable Ancillary Services (PPSs)

superior healthplan™

Maximize Transparency

Improve Population Health Management

Utilize Predictive Models Data

Reduce Preventable Events

3M Value Index Score

Domain	What it evaluates	Measures used
Primary and secondary prevention	Screening for early detection or prevention of disease	• Breast cancer screening • Colorectal cancer screening • Well child visits for infants • Well child visits for children 3-6 years
Tertiary prevention	How well a provider manages patients' urgent health issues	• Potentially preventable admissions* • Potentially preventable ED visits*
Panel health status change	How well a provider manages patients whose chronic conditions progress from one time period to another	• Chronic complexity status jumpers* • Chronic severity jumpers*
Chronic and follow-up care	How well a provider delivers post hospitalization care and engagement	• Potentially preventable readmissions* • Post-discharge follow-up • 3 chronic care visits
Continuity	The concentration and consistency of patient visits	• PCP visit • Continuity of care index*
Efficiency	How resourceful a provider is when prescribing drugs and ordering ancillary services	• Potentially preventable services* • Generic prescribing*
*Risk adjusted		

Potentially Preventable Events

Potentially preventable events are encounters, which could be prevented, that lead to unnecessary services and cost or contribute to poor quality of care.

PPV	PPR	PPA	PPC
•Potentially preventable **emergency room visit** •Emergency treatment for a condition that could have been treated or prevented by a physician or other health care provider in a nonemergency setting.	•Potentially preventable **hospital readmission** •A return hospitalization, within a set time, that might have resulted from problems in care during a previous hospital stay or from deficiencies in a post-hospital discharge follow-up.	•Potentially preventable **hospital admission** •A hospital admission or long-term care (LTC) facility stay that might have been reasonably prevented with adequate access to ambulatory care or health care coordination.	•Potentially preventable **complication** •A harmful event or negative outcome, such as an infection or surgical complication, that occurs after a hospital admission or an LTC facility stay and might have resulted from care, lack of care or treatment during the admission or stay.

El Paso Health

HEALTH PLANS FOR EL PASOANS. BY EL PASOANS.

DSRIP Statewide Learning Collaborative
VBP/APM Strategies for Effectiveness in Medicaid

September 5, 2019

Our **Mission**

To build relationships with our Members, Providers, and Partners that strengthen the delivery of healthcare in our community and promotes access to quality healthcare for children, families, and individuals.

Our **Vision**

We will be the region's trusted community health plan.

An affiliated and private, IRS-qualified nonprofit Texas corporation

- Incorporated in **April 1996** by University Medical Center, El Paso (UMC)
- Licensed Health Maintenance Organization (HMO) since **October 2000**
- Governed by a separate and independent Board of Directors appointed by UMC Board of Managers

Operations

- Over **92,000 members** across all lines of business (CHIP, STAR/Medicaid, HCO, TPA)
- **Over 135** full-time employees
- Healthcare network of approximately **1,500 physicians** and ancillary providers
- Annual revenue of over **$190 million**

EPH Business Standards

Serve as a Trusted Partner

- Business model emphasis on HHSC goals and objectives
- Collaborative innovation with Providers
- Local Provider Relations Representatives
- Key MCO functions performed in-house (i.e. medical management, claims payment, case management)
- Provider payments issued twice a week

Provide Access to High Quality Health Care

- APMs focused on Member care and cost-containment efforts
- Established Provider network
- Innovative telemedicine programs

Deliver Person-Centered Customer Service

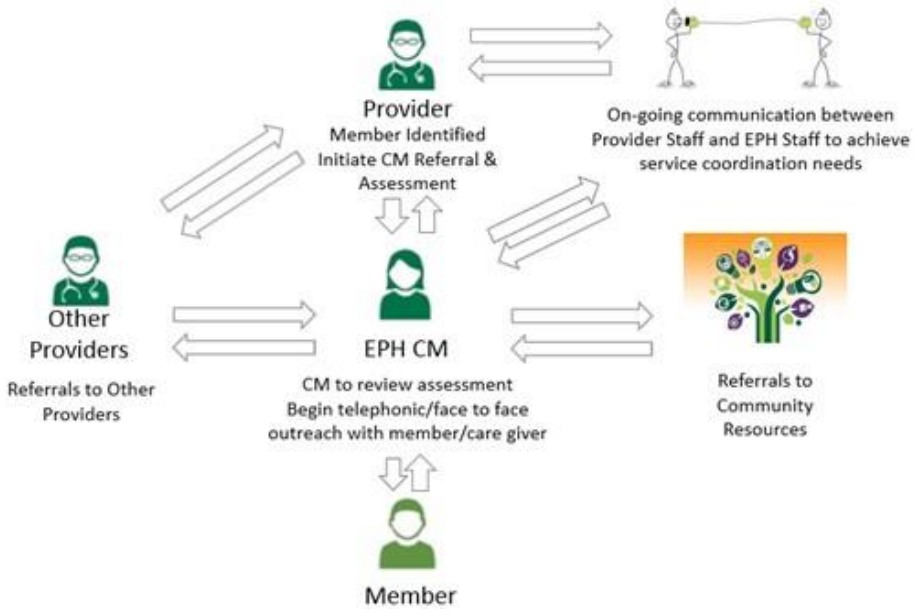
- Prioritize Member needs
- Walk-in visits welcomed
- Home visits with Members

Integrated Care Philosophy

Integrated Service Model

Integrated Care Program

- Holistic integration of medical, behavioral, social and pharmacy information to promote optimal health outcomes for members.
- Clinical staff from El Paso Health and the Provider's office form a care integration team consisting of the following individuals:
  - Primary Care Provider
  - Nurse Practitioners
  - EPH Medical Director and Associate Medical Director
  - EPH Psychiatrist
  - EPH Nurses
  - EPH Social Workers
  - EPH Promotoras



Integrated Care Program

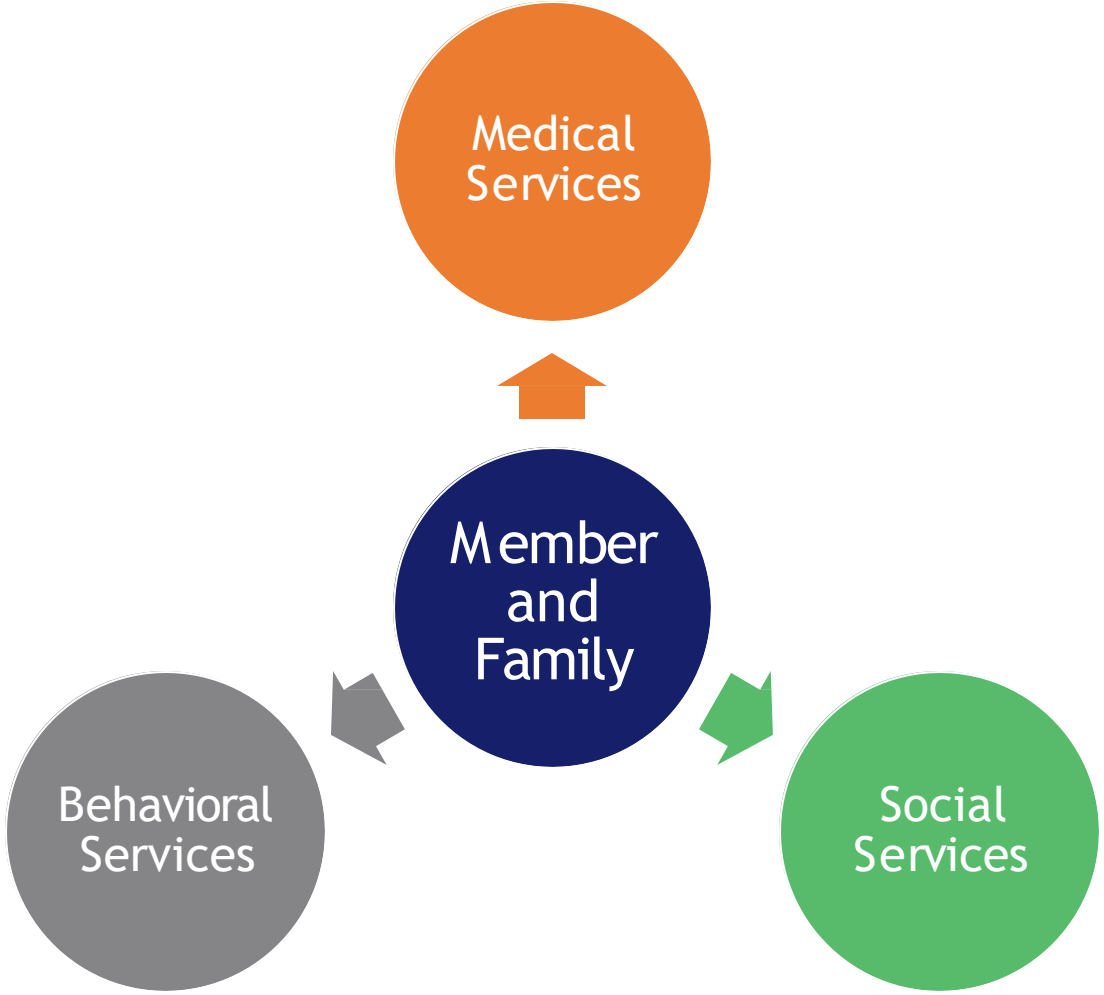
Integration of primary care and behavioral health care is achieved through the following:

- Comprehensive assessments that address the mental health, medical, social, health literacy, employment, and environmental needs of the member
- Person centered, interdisciplinary care plan with the member, their legally authorized representative/guardian and natural support system
- Appropriate referrals to community based organizations, specialty providers and acute care services
- Risk and barrier identification that impacts treatment and successful completion of the service plan
- Coordination of information sharing among the providers who are providing services to the member
- Authorization initiation by the EPH Care Coordination team to expedite the process for services that require prior authorization
- Education to the member, their guardian, natural support system and providers about the care management process
- Monitoring that services are rendered and documenting progress

Member Engagement

EPH team assess the following:

- Access to medical care
- Assistance with pharmacy needs
- School involvement
- Education regarding diagnosis
- Socio-economic situation
- Emotional needs



Provider Engagement

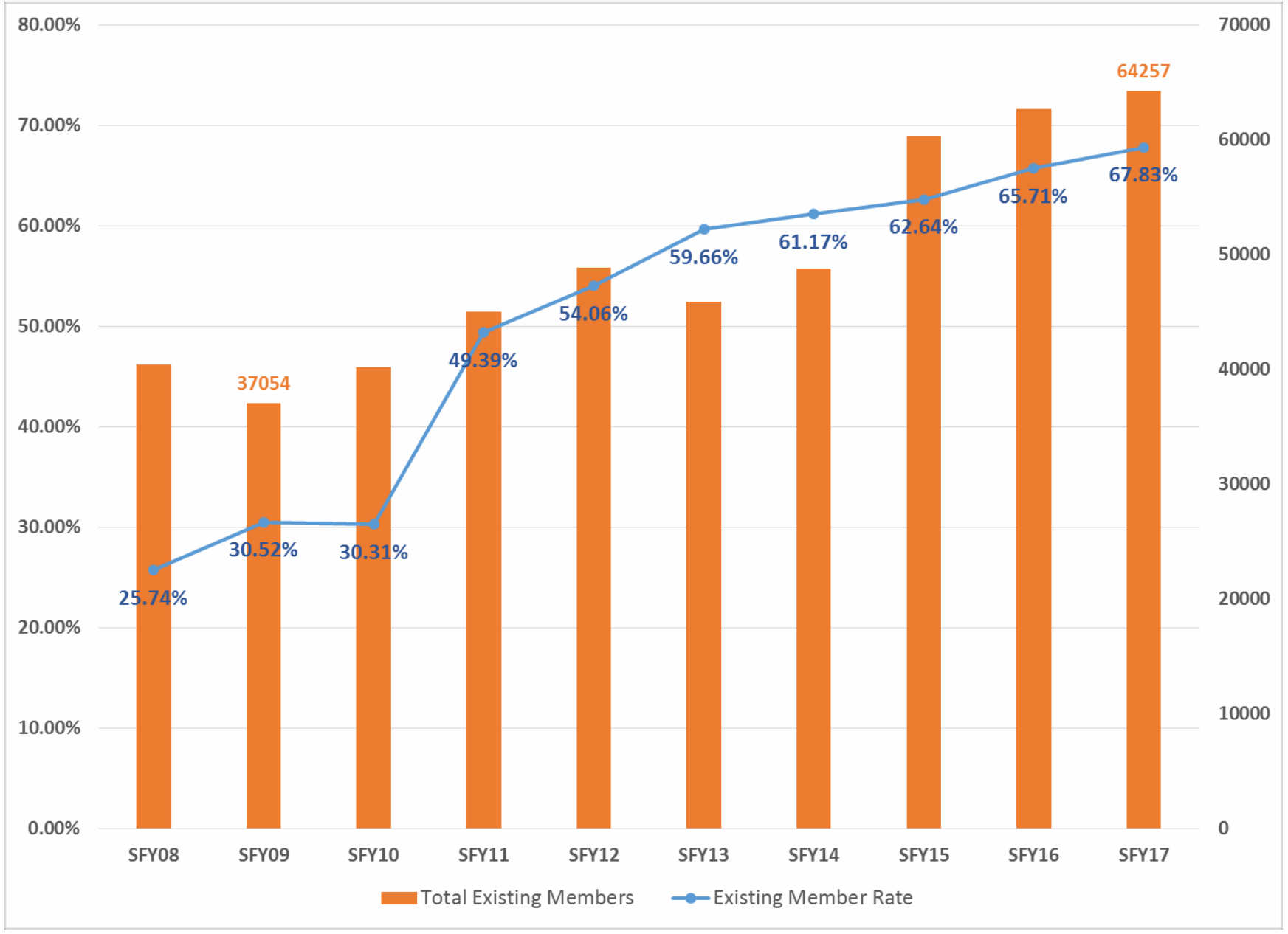
- High touch engagement with participating providers
  - Identify a Quality Liaison
- Specific review of the data and metrics
  - Meaningful comparisons
- Continual assessment of provider attitude and motivation for advancing APMs
  - Annual meeting with providers
- APM development considers individual physician progress and patient population

DSRIP Partnership Opportunities

APM Ratios by Calendar Year

Period	Minimum Overall APM Ratio	Minimum Risk-Based APM Ratio
Year 1 (CY 2018)	>= 25%	>= 10%
Year 2 (CY 2019)	Year 1 Overall APM Ratio +25%	Year 1 Risk-Based APM Ratio +25%
Year 3 (CY 2020)	Year 2 Overall APM % + 25%	Year 2 Risk-Based APM % + 25%
Year 4 (CY 2021)	>= 50%	>= 25%

THSteps Existing Member Rate by SFY



Measurement Year 2016 and 2017 HHSC Quality of Care Rankings & 2018 Preliminary Results

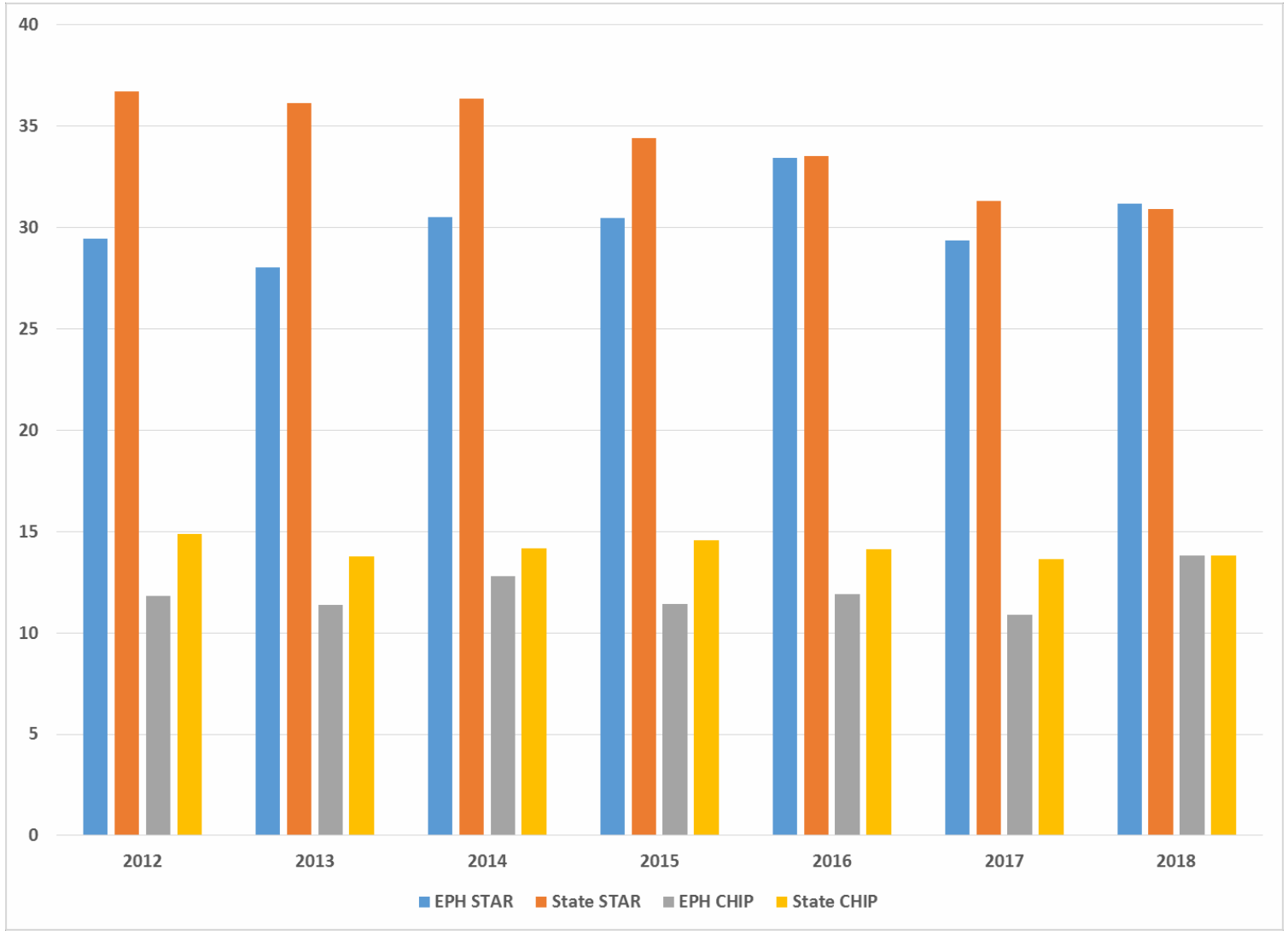
CHIP

Measure	2016 Rate	2017 Rate	2016 Ranking	2017 Ranking	2018 Rate	P4Q Measure
AWC	81.51%	79.08%	1st	1st	82.00%	Yes
W34	87.83%	87.35%	1st	2nd	86.13%	
WCC- BMI Screening	80.29%	83.94%	2nd	1st	79.32%	
WCC- Nutrition	80.29%	83.21%	1st	1st	83.45%	Yes
WCC- Physical Activity	74.70%	77.62%	1st	1st	80.05%	Yes
URI	87.85%	90.99%	8th	5th	90.66%	Yes
W15	67.89%	64.83%	4th	6th	69.42%	

STAR

Measure	2016 Rate	2017 Rate	2016 Ranking	2017 Ranking	2018 Rate	P4Q Measure
AWC	77.62%	81.75%	2nd	1st	81.51%	
W34	86.37%	88.81%	4th	2nd	87.35%	
WCC- BMI Screening	82.97%	85.40%	2nd	1st	81.08%	
WCC- Nutrition	85.89%	84.43%	1st	1st	82.09%	
WCC- Physical Activity	81.51%	77.62%	1st	1st	77.03%	
URI	90.79%	91.95%	5th	5th	92.78%	Yes
PPC- Prenatal	92.94%	87.59%	1st	4th	88.32%	Yes
PPC- Postpartum	65.94%	69.59%	11th	7th	73.97%	Yes
W15	55.72%	71.53%	13th	1st	71.53%	Yes

PPV Rates per 1000 Member Months – EPH vs State Averages



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