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

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”
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).
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.
Value of Community Health Workers

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

September 5, 2019
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)

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Screening for Clinical Depression and Follow-up Plan</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Target</td>
<td>-</td>
<td>45%</td>
<td>45.5%</td>
<td>-</td>
<td>63%</td>
<td>64.3%</td>
<td>64.3%</td>
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<tr>
<td>Actual</td>
<td>43.7%</td>
<td>47.0%</td>
<td>48.1%</td>
<td>60.8%</td>
<td>81.1%</td>
<td>82.7%</td>
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<tr>
<td>Medication Reconciliation</td>
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<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Target</td>
<td>92%</td>
<td>92.5%</td>
<td>-</td>
<td>83%</td>
<td>84%</td>
<td>84%</td>
<td>84.6%</td>
</tr>
<tr>
<td>Actual</td>
<td>90.5%</td>
<td>93.0%</td>
<td>92.6%</td>
<td>82.3%</td>
<td>85.5%</td>
<td>85.2%</td>
<td>87.8%</td>
</tr>
</tbody>
</table>

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

Report run date: April 12, 2019
Data Sources: HTPN Data Warehouse, Epic Data Warehouse & BSWQA Data Warehouse
# Quality Measures
(Deerbrook Eligible, Continuous Patients)

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Diabetes: A1C in Poor Control (&lt;9%)</strong></td>
<td><strong>Target</strong></td>
<td>13%</td>
<td>12%</td>
<td>11%</td>
<td>10%</td>
<td>10%</td>
</tr>
<tr>
<td>Actual</td>
<td>13.5%</td>
<td>12.5%</td>
<td>10.4%</td>
<td>8.9%</td>
<td>8.5%</td>
<td>8.1%</td>
</tr>
<tr>
<td><strong>Vascular Disease: On Aspirin</strong></td>
<td><strong>Target</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Actual</td>
<td>89.3%</td>
<td>88.5%</td>
<td>88.3%</td>
<td>88.0%</td>
<td>89.2%</td>
<td>96.2%</td>
</tr>
</tbody>
</table>

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
# Wellness, Cost and Efficiency Measures
(Deerbrook Eligible, Continuous Patients)

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Wellness Visits Completed</strong></td>
<td>Target: -</td>
<td>64.6%</td>
<td>65.9%</td>
<td>67.2%</td>
<td>67.2%</td>
</tr>
<tr>
<td>Actual</td>
<td>60.9%</td>
<td>63.7%</td>
<td>71.7%</td>
<td>77.4%</td>
<td>79.2%</td>
</tr>
<tr>
<td><strong>Cost Per Member Per Year</strong></td>
<td>Target: $9,574</td>
<td>$9,551</td>
<td>$9,622</td>
<td>$9,622</td>
<td>$9,622</td>
</tr>
<tr>
<td>Actual</td>
<td>$9,550</td>
<td>$10,041</td>
<td>$10,438</td>
<td>$10,656</td>
<td>$10,838</td>
</tr>
<tr>
<td><strong>ED Visits / 1,000</strong></td>
<td>Target: 400</td>
<td>392</td>
<td>384</td>
<td>384</td>
<td>384</td>
</tr>
<tr>
<td>Actual</td>
<td>393</td>
<td>418</td>
<td>418</td>
<td>418</td>
<td>428</td>
</tr>
<tr>
<td><strong>Admissions / 1,000</strong></td>
<td>Target: -</td>
<td>242</td>
<td>237</td>
<td>232</td>
<td>232</td>
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<tr>
<td>Actual</td>
<td>237</td>
<td>254</td>
<td>272</td>
<td>250</td>
<td>261</td>
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<tr>
<td><strong>Readmission Rate / 1,000</strong></td>
<td>Target: -</td>
<td>122</td>
<td>120</td>
<td>118</td>
<td>118</td>
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<tr>
<td>Actual</td>
<td>104</td>
<td>128</td>
<td>134</td>
<td>118</td>
<td>113</td>
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</table>

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

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

<table>
<thead>
<tr>
<th>Category 1</th>
<th>Category 2</th>
<th>Category 3</th>
<th>Category 4</th>
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</thead>
<tbody>
<tr>
<td>Fee for Service</td>
<td>Fee for Service</td>
<td>APMs Built on Fee-for-Service Architecture</td>
<td>Population-Based Payment</td>
</tr>
<tr>
<td>No Link to Quality &amp; Value</td>
<td>Link to Quality &amp; Value</td>
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<td></td>
</tr>
</tbody>
</table>

**Current State**

- 2018: >25% on APM
- 2019: >31.25% on APM
- 2020: >39% on APM
- 2021: >50% on APM

**Future State**

- 2018: >10% Risk
- 2019: >12.5% Risk
- 2020: >16% Risk
- 2021: >25% Risk
## Superior’s APM Progression

<table>
<thead>
<tr>
<th>Program Year</th>
<th>Participating Provider Networks</th>
<th>% Achieving Savings</th>
<th>% Achieving Incentive</th>
<th>Attributed Members</th>
<th>VIS Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>30 (66 TINS)</td>
<td>60%</td>
<td>90%</td>
<td>106,763</td>
<td>73% Overall Average Improvement 14.9 Percentile Points Improvement</td>
</tr>
<tr>
<td>2017</td>
<td>47 (244 TINS)</td>
<td>60%</td>
<td>70%</td>
<td>244,114</td>
<td>60% Improved VIS</td>
</tr>
<tr>
<td>2018</td>
<td>87 (302 TINS)</td>
<td>49%</td>
<td>59%</td>
<td>490,456</td>
<td>47% Improved VIS 14% Overall Average Improvement</td>
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</table>
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 with 13.96% fewer PPV/1,000 mm.
- 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/100,000 mm.
- 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)
Maximize Transparency

Improve Population Health Management

Utilize Predictive Models Data

Reduce Preventable Events

Total Cost of Care

<table>
<thead>
<tr>
<th>Key Performance Measure</th>
<th>Actual (Jan-Oct 11/07)</th>
<th>Program (FY2 11/07-11/11)</th>
<th>Var %</th>
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</thead>
<tbody>
<tr>
<td>Variance from Budget (PMH 6)</td>
<td>56X</td>
<td>(34.20)</td>
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<tr>
<td>All Allowed (PMH 6)</td>
<td>896.40</td>
<td>900.83</td>
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<tr>
<td>Variance 3P Allowed (PMH 6)</td>
<td>N/A</td>
<td>5.00</td>
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<tr>
<td>Variance OP Allowed (PMH 6)</td>
<td>N/A</td>
<td>(32.64)</td>
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<tr>
<td>Variance PM Allowed (PMH 6)</td>
<td>N/A</td>
<td>6.71</td>
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<tr>
<td>Variance Dk Allowed (PMH 6)</td>
<td>N/A</td>
<td>(22.07)</td>
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High Needs Individuals

<table>
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<tr>
<th>Key Performance Measure</th>
<th>Actual (Jan-Oct 12/07-11/11)</th>
<th>Program (FY2 11/07-11/11)</th>
<th>Var %</th>
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<tbody>
<tr>
<td>Persistant High Needs Individuals</td>
<td>40</td>
<td>Member List</td>
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<tr>
<td>Emerging High Needs Individuals - Severe</td>
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<td>Member List</td>
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<tr>
<td>Emerging High Needs Individuals - High</td>
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<td>Member List</td>
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<tr>
<td>Emerging High Needs Individuals - Moderate</td>
<td>5</td>
<td>Member List</td>
<td></td>
</tr>
<tr>
<td>Emerging High Needs Individuals - Low</td>
<td>19</td>
<td>Member List</td>
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Potentially Preventable Events

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<tr>
<th>Key Performance Measure</th>
<th>Actual (Jan-Oct 12/07-11/11)</th>
<th>Program (FY2 11/07-11/11)</th>
<th>Var %</th>
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<tr>
<td>Allowed Preventable (PMH 6)</td>
<td>630.07</td>
<td>630.17</td>
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<tr>
<td>Varences PPA Admit PMPY</td>
<td>0.8</td>
<td>0.9 Member List</td>
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<td>Varences PPA Admits PMPY</td>
<td>(0.1)</td>
<td>0.1 Member List</td>
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<tr>
<td>Varences PPV Visits PMPY</td>
<td>(12.1)</td>
<td>(16.0) Member List</td>
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<tr>
<td>Varences PPV PPM</td>
<td>(61.8)</td>
<td>(74.0) Member List</td>
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Utilization

<table>
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<td>Variance IP Admit PMPY</td>
<td>1.5</td>
<td>1.4 Member List</td>
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<tr>
<td>Variance ER Visits PMPY</td>
<td>(0.2)</td>
<td>(0.0) Member List</td>
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<tr>
<td>Variance Rx Scripts PMPY</td>
<td>(21.7)</td>
<td>(25.6) Member List</td>
<td></td>
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<tr>
<td>% Rx-Genetic Script</td>
<td>76.2%</td>
<td>74.9% Member List</td>
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Value Index Scores (VIS)

<table>
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<tr>
<th>Key Performance Measure</th>
<th>Actual (Jan-Oct 12/07-11/11)</th>
<th>Program (FY2 11/07-11/11)</th>
<th>Var %</th>
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<tbody>
<tr>
<td>Value Index Score</td>
<td>2.05</td>
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<tr>
<td>Primary and Secondary Prevention</td>
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<tr>
<td>Tertiary Prevention</td>
<td>3.80</td>
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<tr>
<td>Forced Health Status Change</td>
<td>4.90</td>
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<tr>
<td>Continuity of Care</td>
<td>4.51</td>
<td></td>
<td></td>
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<tr>
<td>Chronic &amp; Follow-up Care</td>
<td>3.85</td>
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<tr>
<td>Efficiency</td>
<td>2.87</td>
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## 3M Value Index Score

<table>
<thead>
<tr>
<th>Domain</th>
<th>What it evaluates</th>
<th>Measures used</th>
</tr>
</thead>
</table>
| 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*  
• 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*  
• Potentially preventable readmissions*  
• Post-discharge follow-up  
• 3 chronic care visits            |
| Chronic and follow-up care | How well a provider delivers post hospitalization care and engagement            | • Potentially preventable services*  
• Generic prescribing*  
• PCP visit  
• Continuity of care index*        |
| Continuity               | The concentration and consistency of patient visits                              | • Potentially preventable services*  
• Generic prescribing*            |
| Efficiency               | How resourceful a provider is when prescribing drugs and ordering ancillary services | • Potentially preventable services*  
• Generic prescribing*  
• PCP visit  
• Continuity of care index*        |

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

**PPV**
- Potentially preventable emergency room visit
- Emergency treatment for a condition that could have been treated or prevented by a physician or other healthcare provider in a nonemergency setting.

**PPR**
- 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.

**PPA**
- 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.

**PPC**
- 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.
**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 Service Model

24-Hour Medical Advice Infoline

Local Mental Health Authority

Provider Community

El Paso Health

Telemedicine (coming October 2019)

PHIX - Health Information Exchange

UMC Clinics & Pharmacy
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

<table>
<thead>
<tr>
<th>Period</th>
<th>Minimum Overall APM Ratio</th>
<th>Minimum Risk-Based APM Ratio</th>
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</thead>
<tbody>
<tr>
<td>Year 1 (CY 2018)</td>
<td>&gt;= 25%</td>
<td>&gt;= 10%</td>
</tr>
<tr>
<td>Year 2 (CY 2019)</td>
<td>Year 1 Overall APM Ratio + 25%</td>
<td>Year 1 Risk-Based APM Ratio + 25%</td>
</tr>
<tr>
<td>Year 3 (CY 2020)</td>
<td>Year 2 Overall APM % + 25%</td>
<td>Year 2 Risk-Based APM % + 25%</td>
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<tr>
<td>Year 4 (CY 2021)</td>
<td>&gt;= 50%</td>
<td>&gt;= 25%</td>
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THSteps
Existing Member Rate by SFY
Measurement Year 2016 and 2017 HHSC Quality of Care Rankings & 2018 Preliminary Results

**CHIP**

<table>
<thead>
<tr>
<th>Measure</th>
<th>2016 Rate</th>
<th>2017 Rate</th>
<th>2016 Ranking</th>
<th>2017 Ranking</th>
<th>2018 Rate</th>
<th>P4Q Measure</th>
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<tbody>
<tr>
<td>AWC</td>
<td>81.51%</td>
<td>79.08%</td>
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<td>1st</td>
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<tr>
<td>WCC- BMI Screening</td>
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<td>WCC- Nutrition</td>
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<tr>
<td>WCC- Physical Activity</td>
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**STAR**

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<th>Measure</th>
<th>2016 Rate</th>
<th>2017 Rate</th>
<th>2016 Ranking</th>
<th>2017 Ranking</th>
<th>2018 Rate</th>
<th>P4Q Measure</th>
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<tr>
<td>WCC- Physical Activity</td>
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