RHP-1 Learning Collaborative & Stakeholder Update
September 8, 2020
Question & Answer Log

Myers and Stauffer Audits

1. **When should we know if Myers & Stauffer has completed their notification for information?**
   Each audit is specific to the performing providers. The Anchor will not be notified if Myers and Stauffer is requesting or will be requesting more information from a performing provider; however, the Anchor is notified in summary format the status of audits. Round 1a is completed and Round 1b is near completion.

2. **When should we know what Myers & Stauffer wants in Round 2 audits?**
   Round 2 notices will be sent beginning in September 2020.

Amerigroup (Alternate Payment Models)

1. **How are the quality measures identified for the contractual shared risk contracts?**
   Quality measures are a mix of patient attribution and total eligible for the selected quality measures. The health plan also considers what measures are at risk and applies those. It is typically 4-8 measures in the agreement.

2. **Are they universal or specific to the patients being served?**
   It is generally based on the membership impacted and the panel makeup. Someone with more adults will have a different mix than a primarily pediatric population.

3. **Under your payment systems is there a PPM and then shared savings?**
   The health plan does provide care coordination fees for providers participating in shared savings or shared risk outside of the enterprise programs.

4. **Do your systems integrate with EPIC EHR?**

   Yes, the tools provided integrated with several software packages.

5. **In your experience with providers, have providers had to make a significant investment in terms of EMR changes in order to make sure that appropriate quality data is being captured for reporting for their contractual arrangement?**
   Not typically. Amerigroup support practices with robust reporting for quality. In addition, the Health Plan can integrate into most EMRs saving the provider from having to do a chart review. Providers participating in our PQIP and Essentials programs also have free access to best in class resources that gives providers up-to-date, comprehensive, clinical information regarding the care rendered to patients. Our Provider Care Management System provides meaningful and actionable information that supports the proactive management of patients. This tool identifies patient-specific preventive screening needs, stratifies patient populations based on risk and prevalence of chronic conditions, and reports when and why your patients visit the ER.

6. **If providers want to know how they are performing, can they request those reports from the Care Management System independently of having a performance-based contact in place?**
Scorecards for cost and quality are available in the provided platforms.

7. **Do you have a value-based program for commercial, Medicare, and Medicaid providers?**
No, Amerigroup does not have a commercial product. Commercial programs are supported by Anthem.

8. **What percentage of your value-based contracts are with Medicaid providers?**

Approximately 61% of our membership is enrolled with APM providers. The following is a breakdown of the provider practices currently engaged in an APM programs:

PQIP	*87 practices (group and/or individual practices)*
Essentials	*153 practices (group and/or /individual practices)*
Shared Savings	*5 IPAs /Groups*
Risk	*1 Group*

Carol- we collect and track APMs at the group level, so I have to do a little more research to give you a definitive % of our Medicaid providers enrolled in APM programs. I hope the information supplied provides some insight into the scope of our APM program participation.

~~9.~~ **Are there program options for providers with less than 250 members?**

Yes, providers with less than 250 members may participate in an APM by aligning with an engaged IPA.

10. **How do providers get engaged with the programs?**
Enterprise APM programs like PQIP and Essential operate on a calendar year. Amerigroup typically recruits providers that meet program eligibility requirements in the 4th quarter of the year, prior to the new January 1 –December 31 Program Year. Amerigroup is actively preparing for recruiting providers for the 2021 program year. For standalone contracts they begin on January 1st or July 1st. If providers are not engaged, resources are provided to assist the provider in improving performance.

11. **How can a provider assure accuracy of attributed members?**
Amerigroup runs a loyalty report to identify patients that have not seen a provider in one year. The Amerigroup Provider Manual provides guidance on the management of non-compliant members. Reference page 174, ***Section 10.20 Noncompliant Amerigroup Members*** *An excerpt from the provider manual and corresponding Amerigroup Advocate Form is attached. Amerigroup relies on the provider to report incidences of no call, no show.*

https://providers.amerigroup.com/ProviderDocuments/TXTX_CAID_ProviderManual.pdf*.*

DSRIP DY11 Transition

1. **Do you think anything will need legislative approval post DSRIP level?**
   Yes, I expect the Legislature will be engaged in post-DSRIP discussions in the next session. Medicaid has formal processes they must follow to develop new policies, waivers, reimbursement methodologies, etc.

October DY9 Reporting – COVID Exceptions

1. **To clarify, can we choose per measure which exceptions we want to use if we don't use DY9 performance?**
   You will select based on the measure if it is 10 or more providers. You will need to run your DY 9 data to determine which exception option is best for each provider.

2. **What is the DY9 achievement goal?**
   This information has not been provided by HHSC yet.

October DY9 Reporting – Category B

1. **Do we include audio only services in the MLIU count?**
   It depends on the measure specification as well as the exceptions for telehealth services. I assume the question relates to telehealth services, not phone calls. Telehealth services are approved for some measures.

United Healthcare (Alternative Payment Models)

1. **Are there any MCO exceptions related to COVID-19?**
   Not at this time. There are very specific opinions related to the COVID-19 impact. UHC has wondered if some arrangements are realistic. UHC is advocating with state regulatory agencies. The industry is moving towards value-based care. The MCOs will be penalized for not meeting outcomes; however, it is expected that their will be some change.

2. **How is the 25% APM requirement met?**
   This requirement is evaluated looking at the total program, such as STAR Kids, STAR+PLUS, etc.. and across service areas.

3. **Is the 25% APM, just the Medicaid and dual-eligible populations?**
   The 25% APM is based on the Medicaid clients identified by program (STAR Kids, STAR+PLUS, STAR. There are some dual-eligible individuals counted such as a STAR+PLUS member.

4. **Is the 25% APM applicable to Medicare and commercial populations?**
   No, it is not applicable.

5. **Are there any options for providers who do not have 1000 members?**
   Yes, there are two other programs, basic primary care and clinical integration. The primary care incentive is 100 members.

6. **What is the process for providers who want to enroll into incentive programs?**
   For UHC, a provider eligibility list is generated multiple times a year. However, if a provider has some specific ideas on how they want to work with UHC, they can contact UHC directly.

General Questions

1. **Is there any way that HHSC can do a push notification to DSRIP Providers when a new document is posted to the bulletin?**
   Anchor will pass this suggestion on the HHSC Waiver Team.