**Roundtable Minutes: Presentation/Discussion/Q&A**

**Welcome and Introductions**

The roundtable kicked off with a welcome from host, Bluebonnet Trails Community Services, and then standard introductions and roll call coordinated by the Anchor Teams. The TAMHSC Anchor Teams provided a recap of regional alignment efforts to date, then turned the floor over to Ms. Angie Parks, Senior Quality Director, and Ms. Rachana Patwa (via phone), DSRIP Coordinator, for United Healthcare.

Brief notes and Q&A from Ms. Parks’ presentation and the open discussion forum are highlighted below.

**Recap of Regional DSRIP/MCO Alignment Efforts to Date**

* MCO Introduction/Cohorts
	+ August 2015 – Started discussion with MCOs and what P4P metrics they were using
	+ December 2015 – Talking about MCO’s areas of interest
	+ February 2016 – Matrix, started connecting dots between DSRIP and MCOs
* Joint Managed Care Forum
	+ March 2016 – Anchors presented where we thought there might be cross between DSRIP and MCO’s interest
* Joint Learning Collaborative: MCO Panel
	+ July 2016 – MCO panel and heard message from MCOs

**United Healthcare Spotlight**

* Last meeting with Regions 8 and 17 (July 2016 LC event with MCO panel) left questions, United is interested in working with DSRIP. What projects are going on? Where is there an intersection with MCO and DSRIP? Need to find the best fit.
* State has rescinded the P4Q program for MCOs; no good way to pay under this program. Being reformed/revamped at state level. MCOs no longer have a specific list of P4Q measures at the moment.
* Of Interest to MCOs:
	+ “Gaps in care” – quality buzzword will hear a lot;
	+ Reduction of unnecessary care – common with many DSRIP projects;
	+ Healthy start for children is always something MCOs are committed to;
	+ Care in alternative settings (home, etc.) is an interest but payment is a challenge; and
	+ Person-centered approach – integration between behavioral, physical, etc.
	+ Social Determinants – not something billable by Medicaid but MCOs really starting to look at; take more notice – STAR PLUS clients (service coordination/social needs).
* MCOs do need program data to be able to assess working with a provider, however:
	+ Not just a number threshold or minimum; also look holistically – is it an area w/issues they want to address, e.g., area they know has high PPE rates; and
	+ They can reach out to other MCOs to either make argument as a group about what services are needed (add as covered in managed care) and/or to MCOs they know are looking into those types of services even if it is something United is not looking at.
* Calling something a “Pilot” makes it easier to get started, it is seen as a trial run.
* Does the project address things we know we have issues with such as readmissions or access to care?
* Is there a chance that other MCOs can collaborate? Something that increases efficiency and benefits multiple MCOs?
* If you’re not a participating provider in the MCOs network, it is tough to work an agreement out:
	+ Intra-presentation Q – Williamson Cities & County Health District (WCCHD): As a health district, we do not fit as a contracted provider. Any thoughts of how to expand that umbrella so that we are able to work with MCOs?
	+ A – United: We would have to look at licensing you as an ancillary provider. If the provider isn’t a type that fits in the credentialing list, they can contract with them. DSRIP projects don’t always fit in a category, but you would need a Medicaid provider ID. It would have to be case-by-case, something that we tried to work through. Have to also consider legal barriers, too, with HIPAA.
* What is the ROI for the MCO? Need to be able to show effectiveness preferably at the MCO level (member or payer level data); love to see data for MCO population; need to show the program is effective.
* If a provider has trouble pulling that data, United may be able work with provider and work backward to extrapolate the data.
* Sustainability – they also want to know sustainability of the DSRIP services for 2017 and beyond. What is the provider’s plan for maintaining services? Need to understand the path and know longevity before working to provide those services to their members.
* If working together, could expect legal review of the project and Letter of Agreement (LOA) to begin sharing, exploring, and implementing pilot.
	+ Monthly JOCs (Joint Operating Committee) meetings would be key – check-ups to see if there are issues or discuss anything that needs to be addressed including project goals, needs of both parties.

**Open Discussion/Q&A**

* Q - (Seton Highland Lakes): As an MCO, have you heard anything with the new administration? ACA & managed care?
	+ A – (United): We haven’t gotten any info at this point. No reason to believe funding will change drastically. We will just have to wait and see.
* Q – (Bluebonnet Trails Community Services): Social determinants – What would be impactful for you to see regarding social determinants? What are MCOs looking for?
	+ A – (United): Example – Housing project – bringing us information on what the difference is once they were housed. How it affected medical costs? What their satisfaction level is? Some are subjective, some are more objective like their medical cost change. Interested in success stories. Medication adherence/cost ratio before and after, etc. Case studies are good, track at population or individual level. If you don’t have data (ex., LMHA may not have med costs), MCO can look at their claims data with a patient roster.
* Q – (Bluebonnet Trails Community Services): We don’t have access to medical data? How can we show change in medical costs?
	+ A – (United): We are able to look at claims data, if you know you have patients we are covering and see holes in the data you can provide, reach out and we may have it.
* Q – (Bluebonnet Trails Community Services): Is it important to break out by product line?
	+ A – (United): Yes, that would be helpful.
* Q – (Bluebonnet Trails Community Services): For clarification, one of the first steps should be to build a case study and then step two would be to quantify money amount, then third present & share with MCOs?
	+ A – (United): Yes, Identify touch points. Track touch points & decrease in utilization. Show us the impact and “feel good stories.”
* Q – (Anchor Teams) How do MCOs define super utilizers? Is there a standard or does it differ between MCOs?
	+ A – (United): Every MCO has their own criteria/definition. There are no numbers that HHSC has given to define super utilizers. We look at who is using the most resources. It is a mixture of amount of money and number of encounters.
* Q – (Anchor Teams): Would it makes sense for providers doing similar projects to get together and come to MCO for preliminary conversation?
	+ A – (United): I think there is definitely benefit in having those preliminary conversations.
* Q – (Texas A&M Evidence-Based Program): Can you describe what a contract with an MCO might look like?
	+ A – (United): If not a contracted provider, some sort of letter of agreement, something to cover legal (HIPAA) and a non-disclosure.
* Q – (Texas A&M Evidence-Based Program): What would payment look like?
	+ A – (United): It really depends; many ways to set up - monthly, quarterly; contract provider; claims, vendors, invoice.
* Q – (Bluebonnet Trails Community Services): Did the MCOs get a copy of sustainability template questions from HHSC?
	+ A – (Anchor Teams): Not sure if they have, we can give feedback to HHSC to send that out to MCOs.
	+ A – (United): That would be good, there is a disconnect. Providers coming to us has been very helpful.
* Q – (TriCounty Services): We have a high percentage of low income/uninsured. Could you identify high utilizers that you serve that could work with us?
	+ A – (United): If contracted, then – yes - we may be able to work out something, would need to go through legal. There is a possibility where your project is just the seed to build more with our members.
* Q – (Bluebonnet Trails Community Services): We have felt hesitation from MCOs waiting for extension information.
	+ A – (United): From my perspective, it is good to move forward and have conversations, look toward the future. It is important for providers to show effectiveness data. There is some hesitation, worried about sustainability of DSRIP and the waiver – agreeing to make services available to members and then those services disappear.

**Wrap-Up and Action Steps**

Brief Overview of HHSC Value-Based Payment and Quality Improvement Advisory Committee shared by Ms. Parks (a voting member of the committee)

* Early stages of development, has only met twice.
* Purpose is to look and see at how we can roll out and improve VBP.
* Tasked with writing report about status of VBP in Texas and expansion (due 11/1/2018).
* Considering how we work together to improve quality of care for Medicaid population.
* Meetings are open to the public.
* More information available on HHSC website here: <https://hhs.texas.gov/about-hhs/leadership/advisory-committees/value-based-payment-quality-improvement-advisory-committee>.

**Upcoming Events/Reminders**

* + 1. **February 16, 2017** – RHP 8 & 17 Joint Bimonthly LC Call
		2. **March 22, 2017** – First DY6 RHP 8 & 17 Joint Learning Collaborative Event (Georgetown)