Health Partners Plans Quality Initiatives, Opportunities and Resources

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Introductions

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Agenda

- Quality Hot Topics
- Medication Adherence
- HPP's Vendor & Community Partnerships
- Addressing Health Disparities
- Provider Incentive Programs
  - QCP 2023 Key Changes
- Reporting and Available Resources

Quality Hot Topics

- **Remote Patient Monitoring**
  - New policy effective September 14, 2022, that allows for providers to be reimbursed for remote treatment and management of patients using devices that collect essential physiologic data.
  - To be eligible for reimbursement, providers must submit an RPM Approval Form to HPP.
  - The full policy can be accessed at HPPlans.com/Policy Bulletins.

- **Blood Pressure Cuff Benefits**
  - Medicaid and Medicare members have benefits for a blood pressure cuff.
  - HPP recently updated our BP cuff order form to make it easier for providers to order multiple cuffs at once. Find the new order form at HPPlans.com/cuff

- **Tobacco Cessation Counseling (TCC)**
  - As of July 1, 2022, providers must be certified by the DOH as a Tobacco Cessation Provider (TCP) in order to provide and receive reimbursement for TCC services (via CPT codes 99406/99407).
  - To become certified, providers must complete the DOH “Every Smoker, Every Time” online training and “Pre-approved Tobacco Cessation Registry Application”, be approved by DOH as a TCP provider, and apply for a PROMISe Number as a TCP from DHS.
  - DOH training, application and contact information can be found at: https://www.health.pa.gov/topics/programs/tobacco/Pages/Registry.aspx

- **Diabetes Management**
  - A1c POC Testing: Policy effective January 1, 2022, that reimburses providers up to 4 times per calendar year for POC A1c testing in the office setting to diagnose or manage diabetes. The equipment in use must be an FDA-approved device.
  - Retinal Eye Screening: New policy effective December 9, 2022, allowing digital retinopathy screening codes 92228 and 92229, in addition to 92227 and fundus photography (92250), eligible for reimbursement one time per calendar year. Certain criteria, including that the test must be performed by a PCP, optometrist or ophthalmologist, must be met. The full policy can be accessed at HPPlans.com/Policy Bulletins.

Improving Medication Adherence

- **Medicare member rewards available!**
- **Medication management support**
  - Switch to 90-day prescriptions
  - Offer delivery/mail order
- **HomeFree Pharmacy**
  - Monthly pill pack delivery and home visit from a RN/LPN/pharmacy tech to review meds, perform med rec, partner with providers to address prescription issues or needs, and provide monthly reminder outreach calls.
- **ExactCare Pharmacy**
  - Pilot program for Medicaid members on 8+ maintenance medications to switch their pharmacy to ExactCare.
  - ExactCare offers medication delivery, blister packaging and refill reminder calls to help members remain compliant.
- **CVS Simple Dose**
  - Allows members to receive a 30-day supply via USPS or pick up at their local CVS Pharmacy.

2023 Activity	Plan	Eligibility Criteria	Action Needed to Earn	Reward
Comprehensive Medication Review (CMR)	DSNP only	Medicare members eligible for a CMR under HPP's Medication Therapy Management (MTM) Program	Complete a CMR with HPP's MTM vendor	$15
Cholesterol Medication	DSNP only	MTM-eligible Medicare members 18 years or older with high cholesterol who have been prescribed cholesterol medications, and completed a CMR	Fill a 30-day, 60-day, or 90-day supply of a prescribed cholesterol medication, max $120 a year	$10-$120*
Diabetes Medication	DSNP only	MTM-eligible Medicare members 18 years or older with diabetes who have been prescribed oral diabetes medications, and completed a CMR	Fill a 30-day, 60-day, or 90-day supply of a prescribed oral diabetes medication, max $120 a year	$10-$120*
Hypertension Medication	DSNP only	MTM-eligible Medicare members 18 years or older with hypertension who have been prescribed blood pressure medications, and completed a CMR	Fill a 30-day, 60-day, or 90-day supply of a prescribed blood pressure medication, max $120 a year	$10-$120*

Vendor & Community Partnerships

Vendor	Description
CareNet	Medicaid and CHIP member outreach for care gap closure: W15, Asthma Med Ratio, Dental, Child and Adolescent Well Visits.
Healthy Measures	In-home lab vendor and event support to perform testing for A1c, Kidney, DRE, lead and FOBT.
Quest HealthConnect	In-home member bone density scans (osteoporosis management in women).
BioIQ	In-home kit mailing for A1c and FOBT.
Magellan RX	Outreach to Medicare members, provider and/or pharmacy for medication adherence and statin use in persons with diabetes.
Tabula Rasa	Completes comprehensive medication reviews (CMRs) or targeted medication reviews (TMRs) for Medicare members that qualify for the MTM program

+ Partnerships with the Temple Mobile Health van, Jefferson Mobile Mammography van and the St. Chris Dental van.

Addressing Health Disparities

According to the CDC, health equity is achieved when every person can “attain his or her full health potential” and no one is “disadvantaged from achieving this potential because of social position or other socially determined circumstances.”

Each year, HPP undergoes a population health assessment that includes multiple data sources that help identify and address the needs of our membership. Information is categorized by age, race, language, gender, county, ZIP codes, disabilities, chronic conditions, Social Determinants of Health (SDOH), etc.

Addressing Health Disparities

HPP's Goals

1. To identify specific measures and associated initiatives that will further HPP's work related to health disparities
2. To collaborate with our internal Health Disparities Workgroup
3. To maintain HPP's NCQA Health Equity Accreditation status

Focus Measures

A1c Control, CBP, Child and Adolescent Well-Care Visits, Prenatal Care, Postpartum Care

2023 Initiatives

- QCP bonus for achieving Tier 4 for African American members
- Health events or block scheduling – member outreach list based on zip code or race/ethnicity
- Incentives offered at health events
- Recipe book and other culturally appropriate resources available
- SDOH resources based on need of community or population

Are you doing anything to address disparities at your practice? Let us know!
We welcome working together to improve the health outcomes of our members.

Addressing Health Disparities: A1c control

Measure Intent

- The percentage of members 18-75 years old with diabetes, both type 1 and 2, whose hemoglobin A1c was maintained at the following levels during the measurement year:
  - A1c Control < 8.0%
  - A1c Poor Control > 9.0%
- Members are identified as being diabetic by claims/encounter data and pharmacy data.
- Reporting is stratified by race and total, and ethnicity and total.
- Exclusions for this measure: members in hospice or who are using hospice services.
- Hybrid measure: Both medical record review and claims data can be used to satisfy this measure.

Medical Record

- Date of HgA1c
- Result of HgA1c
- Lab result slip
- Documentation of Point of Care (POC) testing with date and signature
- Documentation in the progress note; note must be dated and signed

Best Practices

- Outreach to patients who have are diabetic and haven't had a recent A1c.
- Outreach to patients whose last HgA1c was elevated >9.0%

Addressing Health Disparities: Controlling Blood Pressure

Measure intent:

- The percentage of members 18-85 years old who had a diagnosis of hypertension (HTN) and whose blood pressure is well controlled, <140/90, during the measurement year.
- Must be the most recent blood pressure documented in the measurement year.
- Reporting is stratified by race and total, and ethnicity and total.
- Exclusions for this measure: members in hospice or who are using hospice services, members pregnant during the measurement year and members with end-stage renal disease (ESRD).
- Hybrid measure: Both medical record review and claims data can be used to satisfy this measure.

Medical Record:

- BP must be taken during and outpatient visit.
  - No inpatient or ED visits can be used.
- Can use a member reported BP if documented in the outpatient medical record, dated and signed by the provider.
- Documentation in the progress note; note must be dated and signed.

Best Practices:

- If an initial blood pressure is high (>140/90), retake the BP before the patient leaves your office.
- Outreach to patients who haven't had a recent appointment; allow for in person, virtual and telephonic visits.
- Order the patient a BP cuff as discussed earlier in this presentation.
- Educate members on the importance of taking medications, and healthy lifestyles.

Addressing Health Disparities: Child and Adolescent Well-Care Visits

Measures and intent:

- Well Child Visits in the First 30 Months of Life (W30):
  - Well-Child Visits in the first 15 Month: Expectation six (6) or more well-child visits on or before the child's 15-month birthday.
  - Well-Child Visits for age 15 Months to 30 Months: Expectation two (2) or more well-child visits after the child's 15-month birthday but before the child's 30-month birthday.
- Child and Adolescent Well Care Visits (WCV)
  - Children and Adolescents between the ages of 3-21 years who had at least one comprehensive well-care visit with a PCP or OB/GYN practitioner during the measurement year
- This measure is administrative only; no chart review is done for these measures.
- Reporting is stratified by race and total, and ethnicity and total.

Best Practices:

- Well visit components can be completed during sick visits and include physical exam, developmental screening and anticipatory guidance.
- Check HP Connect (provider portal) to identify patients that need well visits.
- Target family members that are in the same household.
- Partner with HPP to hold block scheduling events.

Addressing Health Disparities: Prenatal and Postpartum Care (PPC)

Measure intent:

- The percentage of deliveries on or between October 8 of the year prior to the measurement year and October 7 of the measurement year, this measure consist of two sub-measures:
  - Timeliness of Prenatal Care: The percentage of deliveries that received a prenatal care visit in the first trimester.
  - Postpartum Care: The percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery not including the day of discharge.
- Hybrid measure: Both medical record review and claims data can be used to satisfy this measure.
- Reporting is stratified by race and total, and ethnicity and total.

Medical Record: May be a PCP; OB/GYN or other prenatal care practitioner

- Prenatal Care: Diagnosis of pregnancy must be present; LMP or EDD; basic OB exam.
- Postpartum Care: Notation of postpartum care; depression screening; pelvic exam or exam of weight, BP, breasts and abdomen.
- All documentation must be dated and signed.
- ONAF may be used as a supporting document for progress notes/flowsheets, but the progress notes/flowsheets must contain the needed information, dated and signed

Best Practices:

- Educate staff to schedule visits in the needed time frame.
- Educate patients on the importance or prenatal and postpartum care.
- Schedule appointments for the next visit while the patient is in the office.
- Call or text appointment reminders.

Addressing Health Disparities: Colorectal Cancer Screening (COL)

Measure Intent:

- The percentage of members 45-75 years of age who had appropriate screening for colorectal cancer.
- Reporting is stratified by race and total, and ethnicity and total.
- Exclusions: members in hospice or who are using hospice services, members who have had colorectal cancer.
- Hybrid measure: Both medical record review and claims data can be used to satisfy this measure.
- Screening methods:
  - FOBT in the measurement year.
  - Flexible sigmoidoscopy during the measurement year or four years prior.
  - Colonoscopy during the measurement year or nine years prior.
  - CT colonography during the measurement year or four years prior.
  - Stool DNA (sDNA) with FIT test during the measurement year or two years prior.

Medical Record:

- Progress note dated and signed with documentation of colorectal cancer screening.
- Procedure note dated and signed.
- Lab or pathology results dated and signed.

Best Practices:

- Check HP Connect (provider portal) to identify patients that need colorectal cancer screening.
- Provide at-home FOBT colorectal cancer screening kits for use in patients' homes.
- Educate your patients about the importance of screening and early detection.

Provider Incentive Programs

Provider Pay-for-Performance (QCP) Program (All LOBs)

QCP is HPP's primary care physician incentive program that offers financial incentives to providers for select performance measures.

Patient-Centered Medical Home (PCMH) Program (Medicaid Only)

A model of care program that enhances & facilitates care coordination.

Ad Hoc Incentive Programs

Communicated to network via provider communications and your Provider Relations Representative (e.g., 2022 well-child visit incentive).

QCP 2023 Key Changes

- New eligibility requirement: Providers must see at least 25% of paneled HPP Medicaid members during the 2023 measurement year.
- Measure denominator increased to 20 members.
- Medicare measure benchmarks adjusted to align with CMS Medicare Stars Program.
- Member satisfaction penalty/reward removed.
- Measure Changes:
  - Added two-member satisfaction measures (one measure related to office staff and the other to providers) (Medicare & Medicaid)
  - Added Patient Engagement After Inpatient Discharge (Medicare)
  - Removed Rate of PCP/SP Visit within 7 Days Post-Hospital D/C (Medicaid)
  - Updated Plan All Cause Readmissions (Medicare & Medicaid) – HPP will now use the ratio of observed/expected readmissions

Reporting & Available Resources

HPP has many tools and resources available to our provider organizations.

Resource	Description	Frequency
Provider Relations Reps	Your main point of contact who can help support your practices, review reports with you and connect you to the right resources within HPP.	Ongoing
QCP Manual	Includes an overview of measures, best practices, codes for compliance and payout opportunities.	Annually
HP Connect Reports	Include membership data, eligibility reports, practice level reports, and gap-in-care (GIC) reports. Monthly site level report cards allow you to track your performance and opportunities.	Ongoing
Webinars	Cover various topics to help you provide the best outcomes for your patients.	Ongoing
Reporting/ Data	HPP can provide your practice with reports to help with population health management, quality improvement activities, and utilization management.	Ad-hoc
Coding Education	HPP's Clinical Risk Assessment team provides education on appropriate coding and documentation.	Ongoing
Data Sharing	HPP's data and quality team can work with you to capture supplemental data from your EMR or to gain access to your EMR.	Ongoing
Website	HPP recently added additional resources for providers on our Provider Webpage! Visit HPPlans.com/quality and HPPlans.com/HEDIS hints for helpful tips and education on key quality measures!	Ongoing

Reporting & Available Resources

Request your 2022 Missed Opportunities Report!

This report provides a list of members seen in 2022 with potential “missed opportunities,” in which they were seen by their attributed PCP/site, but care gaps were left open at year-end.

Gaps are broken down by level of difficulty (easy/medium/hard) and assessed by their impact both to providers (e.g., QCP) and HPP (e.g., MCO P4P and Stars).

2021 Report Summary

Total # of members with Gap	Average # of visits to assigned PCP (Including Telehealth)	# of members with 3+ visits with assigned PCP (Including Telehealth)	Total # of gaps identified as missed opportunity
64,451	2.71	22,953	92,736

Total # of Easy Gaps	Total # of Medium Gaps	Total# of Hard Gaps
2,874	73,693	16,169

Total # of QCP Gaps	Total # of P4P Gaps (Medicaid)	Total # of Stars Gaps (Medicare)
78,836	46,396	10,910

Reporting & Available Resources

Reminder that these ad hoc reports are available now to help you get a jump start on your care gap closure outreach efforts!

Well Child Visit Due Soon Report
Description: List of members that had a well child visit in January/February 2022 and are due again in January/February 2023. The date of the last well visit is included in the report for reference and there is a field to indicate the date of the last developmental screening.
Goal: Use this outreach list to contact members that are due for their well visit in the beginning of the year and attempt to complete a developmental screening if needed, billed under CPT code 96110.

Hypertensive/Diabetic Member Report
Description: Missed opportunities report for members who are diabetic and hypertensive, were engaged in care throughout 2022 but ended the year uncontrolled.
Goal: Use this outreach list to contact these members and schedule them for a visit to test their A1c and take a BP reading.

Contact Us

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Thank You!

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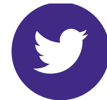
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