Quality Improvement Webinar Series:
Adolescent and Pediatric Measures

June 23, 2020

Health Partners Plans HPP

Agenda

- Opening remarks
- Overview of pediatric & adolescent measures
- Discuss 2020+ quality measure changes
- Overview of the value proposition for providers
- Review 2019 pediatric “missed opportunities”
- Discuss resources & strategies to improve performance
- Q&A

HEDIS Pediatric & Adolescent Measures

Preventive Care

- **Annual Dental Visit***
- **Childhood Immunization Status***
- Chlamydia Screening in Women
- **Immunizations for Adolescents***
- **Lead Screening in Children***
- Non-Recommended Cervical Cancer Screening in Adolescent Females
- **Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents***

Behavioral Health

- Depression Remission or Response for Adolescents and Adults
- Depression Screening and Follow-Up for Adolescents and Adults
- Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence
- **Follow-Up After Emergency Department Visit for Mental Illness***
- **Follow-Up Care for Children Prescribed ADHD Medication***
- Metabolic Monitoring for Children and Adolescents on Antipsychotics
- **Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics***
- Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults

Access/Availability to Care

- **Adolescent Well-Care Visits****
- **Children and Adolescents' Access to Primary Care Practitioners***
- Contraceptive care - all women age 15-20
- Contraceptive care - postpartum women 15-20
- **Developmental Screening in the first Three Years of Life***
- Follow-Up After High-Intensity Care for Substance Use Disorder
- Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment
- Pharmacotherapy for Opioid Use Disorder
- **Well-Child Visits in the First 15 Months of Life****
- **Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life****

Management of Conditions

- **Ambulatory Care - ED Visits****
- Appropriate Testing for Pharyngitis
- Appropriate Treatment for Upper Respiratory Infection
- **Asthma Medication Ratio***
- Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis
- **Medication Management for People With Asthma***
- **Reducing Preventable Readmission***

*** QCP measures**
*** Measures with new telehealth guidelines**

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2020 Quality Measure Changes

NCQA has announced changes that impact pediatric quality measures. This will increase the number of members in your QCP measure denominators.

Changes to Well Visit measures:

1

Well-Child Visits in the First 15 Months of Life

Members **0-15 months** who had **six** well visits before turning **15 months**

Expanded population to include members 15-30 months

2

Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life

Members **age 3-6** who had a well-child visit during the measurement year.

Expanded population to include members ages 7-21

Adolescent Well-Care Visits

Members **age 12–21** who had a well-care visit during the measurement year.

Combined with W34

Well-Child Visits in the First 30 Months of Life

- Members **0-15 months** who had **six** well-child visits by their **15-month birthday**.
- Members **15-30 months** who had **two** well-child visits by their **30-month birthday**.

Child and Adolescent Well-Care Visits

Members **age 3-21** who had a well-child visit during the measurement year.

Measures being retired:

3

Medication Management for People With Asthma (MMA)

Members age 5-64 with persistent asthma who were adherent to 75% of their asthma medication during the measurement year.

→

Asthma Medication Ratio (AMR)

Members age 5-64 with persistent asthma who had a .50 ratio of controller medications to total asthma medications during the year.

Changes will take effect starting with the 2021 QCP measurement period.

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Providers' Value Proposition

Evolving care delivery and incentive models tied around quality programs have become critical to our provider organizations' success.

Financial Incentive: QCP Financial Opportunity

	Per Member Per Month (PMPM) Payment			
	Tier 1	Tier 2	Tier 3	Tier 4
Medicaid Total	$3.00	$5.65	$11.50	$16.75
CHIP Total	$2.70	$5.15	$9.05	$13.55
Total PMPM	**$5.70**	**$10.80**	**$20.55**	**$30.30**

Operational Opportunity

- Growth Opportunity
- Reduced Abrasion
- Inclusion in Programs
- Improved Clinical Impact

Summary of CY2019 "Missed Opportunities" for Peds

Annually, HPP evaluates and shares data to identify missed opportunities for our providers. This is defined as pediatric/adolescent members who were seen by their provider but care gaps were left open.

Overall HPP performance

Total # of members with gap	Average # of visits to assigned PCP	# of members with 3+ visits with assigned PCP	Total # of gaps identified as missed opportunity
23,426	2.07	5,907	27,661

23k *members were seen an average of* ***2.1*** *times and had* ***27k*** *gaps left open.*

Total # of gaps identified as missed opportunity	Total # of Easy Gaps	Total # of Medium Gaps	Total # of Hard Gaps
27,661	5,698	19,933	2,030

21% *of gaps were considered easy gaps,* ***72%*** *were medium and* ***7%*** *were considered hard.*

Total # of QCP Gaps left open	Total # of MCO P4P Gaps left open
27,661	22,306

Revenue generating opportunities left on the table.

Negatively impacts HPP's funding opportunities.

Missed Opportunity Example: Based on 2019 MY

This example further illustrates the importance of maximizing each opportunity.

Background:

- Independent pediatric practice with average panel size of **1,400** members
- **465** members in their Adolescent Well-Care Visits (12-21y) measure

Medicaid	Benchmarks				PMPM			
Measure	Tier 1	Tier 2	Tier 3	Tier 4	Tier 1	Tier 2	Tier 3	Tier 4
Adolescent Well-Care Visits	52.00%	60.00%	66.00%	76.50%	$0.25	$0.50	$1.00	$1.50

Source: 2019 QCP Manual

What happened:

1. Reached measure rate of **65.16%**
2. Reached Tier 2 QCP Payment and earned **$0.50 PMPM**
3. For 2020, the practice is earning **$710** per month or **$8,520** per year on the measure.

What could have happened:

1. HPP identified **32** "Missed Opportunities" for this measure in 2019.
2. **Missed financial opportunity:**
   - → **2** out of the 32 members would have resulted in an additional **+$0.50 PMPM** payout
   - → Total payout of **$1,420** per month or **$17,040** per year on this measure alone instead.

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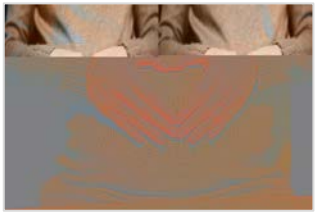
Care Management Resources

HPP's Clinical Programs activities focus on both long and short term goals for members who may require assistance coordinating their care.



- **Baby Partners**: Care coordination for prenatal and postpartum members up to 84 days post delivery. No age restrictions.
- **Healthy Kids**: Provide disease education, reminders and assistance in obtaining important preventive services (EPSDT). Under 21 for Medicaid and under 19 for CHIP members.
- **Special Needs Unit**: Assistance for children who have identified special needs and need assistance with coordination of care or access issues, and serves as a link between members, practitioners, agencies and community services. No age restrictions.
- **Clinical Connections**: Provide follow up post-acute inpatient hospitalization to promote compliance with PCP follow up appointments and access to care. No age restrictions.
- **Care Coordination**: Provide care coordination along with disease education, behavioral health coordination and connection to Community Resources for members with multiple co-morbidities. 21 years and older.

Contact the Clinical Connections team to refer any patients for care coordination services at 215-845-4797 or clinicalconnectionteam@hpplans.com.

Recommendation for Success

HPP recommends taking the following actions to improve your performance on quality measures.

Opportunity	Levers
Increase knowledge of measure requirements and root cause of missed opportunities	• Educate members and providers/staff on the services and messaging required for compliance. • Review your missed opportunities and design corrective action plans and/or lessons learned documents that can be shared with your teams.
Increase delivery of HEDIS-related medical services	• Schedule well visits all year long. • Prioritize the measures and ensure workflow can support. • Leverage existing opportunities/visits (where applicable). • Create and deploy interventions to improve rates. • Leverage your MCO's member incentives to encourage members. • Create mechanisms to pro-actively identify and close care gaps.
Increase capture/sharing of evidence that screenings/services were delivered	• Maximize coding accuracy for screenings/services. • Leverage all codes allowed (e.g., CPT II codes). • Discuss EMR/data sharing opportunities.

QUESTIONS?

Thank you for your participation!

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