Overview of HEDIS Measures and Quality Care Plus (QCP) Program

2021 Annual Review

PartnerUp Health Partners Plans HPP

Agenda

- Opening remarks
- HEDIS Review
- Closing Care Gaps
- Health Equity
- Tools and Resources Overview
- Suggestions for Success and Feedback
- Q&A

- **Presented by:**
  - Chi Dang
  - Valerie McEvoy
  - Dr. Merleen Harris-Williams MBA, MD
  - Terry McKeever MS, BSN, RN
- **Facilitator:**
  - Lisa Mallory

Health Effectiveness Data Information Set (HEDIS) and the Quality Care Plus (QCP) Program

- HEDIS is a group of measures that allow health plans to measure how well they are doing taking care of their members.
  - There are 90 HEDIS measures that look at many different areas of care received from a health care practitioner.
- Some of the HEDIS measures are measures in HPP's QCP program.
- A few of the HEDIS measures can manifest as care gaps for your patients.
- All HEDIS measures that contribute to the QCP ratings can be submitted electronically via claims with the proper code usage – this is the preferred method of closing care gaps.

Closing Care Gaps

- HPP may also be able to assist in closing care gaps by performing medical record review (MRR), but this is only available for certain measures such as:
  - Cancer screenings
    - Breast (Medicaid and Medicare)
    - Colorectal (Medicare)
  - Comprehensive Diabetic Care (Medicaid and Medicare)
    - Diabetic Eye Exam
    - HbA1c Control
  - Child and Adolescent Well care visits (Medicaid and CHIP)
  - Lead screening in children (Medicaid and CHIP)
  - Immunizations (Medicaid and CHIP)
    - Childhood
    - Adolescent

Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)

- This measure looks at members that are 40 years old and older with a new diagnosis of COPD or newly active COPD, who received appropriate spirometry testing to confirm diagnosis.
- Are practices using Incentive Spirometry (IS) testing for their patients with a new diagnosis of COPD?
  - Yes
  - No
- What are some of the barriers to performing IS at the practice site?

HPP's Health Equity Strategy

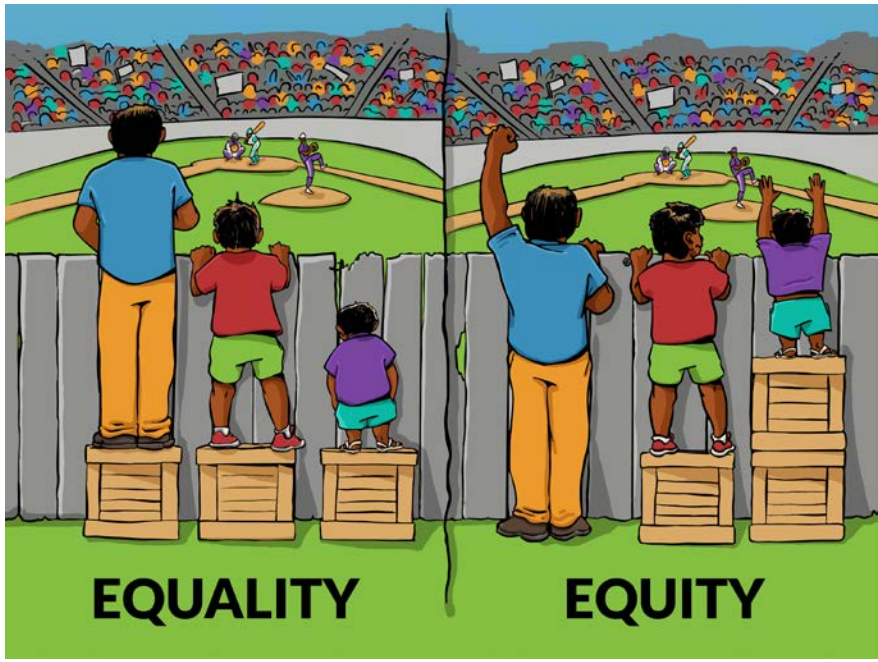
PartnerUp Health Partners Plans HPP

Overview of HPP's Health Equity Strategy

- 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."
- The life expectancy of a baby born in Pennsylvania is strongly tied to zip code. A newborn in certain census tracts of North Philadelphia has a life expectancy of 63 years, when just a couple miles to the south, newborns are expected to live to 86.

HPP's Health Equity Strategy

- HPP undergoes a population health assessment annually that includes multiple data sources to better understand the characteristic needs, to 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.



HPP's Health Equity Strategy

- The Health Equity Committee provides leadership and oversight of workgroups for specific health equity initiatives developed to address identified health disparities.
- Updates are provided to a larger multidisciplinary group, the Quality Improvement Committee (QIC), on a monthly basis for additional idea generations.
- Provider and/or member focus groups and surveys are leveraged to characterize and/or meet the need/resources for community champions/partnership.

HPP Medicaid Membership Demographics
January – December 2020

Age Group	Members	Percent
Age 2 to 19	107,067	40.43%
Age 20+	157,733	59.57%
Total	***264,800***	***100%***

Race/Ethnicity	Members	Percent
BLACK	112,944	42.65%
HISPANIC	73,646	27.81%
WHITE	47,992	18.12%
OTHER	18,350	6.93%
ASIAN OR PACIFIC ISLANDER	11,868	4.48%
AMERICAN INDIAN	1	0.00%
Total	***264,800***	***100%***

HPP Medicaid Membership Demographics
January – December 2020

Gender	Members	Percent
Female	144,182	54.45%
Male	120,618	45.55%

Member Language	Members	Percent
ENGLISH	213,904	80.78%
SPANISH	25,922	9.79%
OTHER	18,687	7.06%
RUSSIAN	1,514	0.57%
VIETNAMESE	879	0.33%
ARABIC	737	0.28%
CHINESE (MANDARIN)	637	0.24%
CAMBODIAN	304	0.11%
BENGALI	219	0.08%
UZBEK	214	0.08%

HPP Medicaid Membership Demographics

Top 10 Member Zip Codes

Zip Code	Neighborhood	Members	Percent
19134	PORT RICHMOND	20,109	7.59%
19124	FRANKFORD	20,062	7.57%
19140	NORTH PHILA	17,676	6.67%
19120	OLNEY	16,419	6.20%
19149	NORTHEAST PHILA	11,292	4.26%
19133	NORTH PHILA	9,699	3.66%
19132	NORTH PHILA	9,140	3.45%
19111	NORTHEAST PHILA	8,837	3.34%
19135	NORTHEAST PHILA	7,452	2.81%
19144	GERMANTOWN	6,968	2.63%
19143	WEST PHILA	6,610	2.50%

HPP Health Equity Strategy

- Specific programs are in place to help address African American Health Disparities among measures including:
  - Uncontrolled Diabetes
  - Well Child Visit (W15)
  - Prenatal Care
  - Controlling High Blood Pressure

Quality Improvement Programs, Resources, and Activities

PartnerUp Health Partners Plans HPP

Key Quality Programs

HPP is committed to improving and maintaining our performance in the following programs:

Program	Description	Impact	2020 Results
Provider Pay-for Performance (QCP Program)	QCP is HPP's primary care physician incentive program that offers financial incentives to providers for select performance measures.	All	345 provider sites were rewarded
Patient-Centered Medical Home (PCMH)	A model of care program that enhances & facilitates care coordination.	Medicaid	80 sites that cover 44% of membership
NCQA Plan Rating	Plans are rated based on a scale from 0-5 based on a combination of clinical, quality, and member satisfaction results.	Medicaid	4.5 Plan Rating
NCQA Accreditation	Evaluates how well a health plan performs based on standards set by NCQA.	Medicaid	Commendable Status
NCQA Multicultural Distinction	Identifies plans that lead the market in providing culturally and linguistically sensitive services, and work to reduce health care disparities.	Medicaid	Awarded
DHS MCO P4P Program	Measures HPP for meeting HEDIS benchmarks and/or improvement from previous year.	Medicaid	High Performer
CMS Stars Program	Health plans are rated by CMS based on a five-star scale on a set of 48 measures.	Medicare	3.5 Stars Rating

Key Priority Measures

HPP has defined our 2021 measure level priorities based on historical performance and programs' goals and impact.

Adult Population

- **Breast Cancer Screening * ***
- **Care of Older Adults * ***
- Cervical Cancer Screening
- Chlamydia Screening
- **Colorectal Cancer Screening * ***
- **Controlling High Blood Pressure * * ***
- **Diabetes – Eye Exam * ***
- **Diabetes – Blood Sugar Controlled * ***
- **Kidney Health Evaluation for Patients with Diabetes ***
- **Medication Adherence for Cholesterol ***
- **Medication Adherence for Hypertension ***
- **Medication Adherence for Oral Diabetes ***
- **Medication Reconciliation Post Discharge ***
- Osteoporosis Management *
- **Plan All Cause Readmission ***
- Postpartum Care *
- Prenatal Care in the First Trimester *
- Reducing Preventable Readmissions

Adult & Pediatric Population

- **Ambulatory Care – ED visits ***
- **Asthma Medication Ratio * ***

Pediatric Population

- **Annual Dental Visit ***
- **Child and Adolescent Well-Care Visits * ***
- **Developmental Screening in the First Three Years of Life ***
- **Lead Screening in Children ***
- **Well-Child Visits for Age 0 to 15 Months * ***
- **Well-Child Visits for Age 15 Months–30 Months * ***

***QCP Measures**
***Measures with telehealth allowance in the identification/exclusion of condition**
***Measures with telehealth visits allowed**
New NCQA Measures

Providers' Value Proposition

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

Financial Incentive: QCP Financial Opportunities

Per Member Per Month (PMPM) Payment				
	Tier 1	**Tier 2**	**Tier 3**	**Tier 4**
Medicare Total	$6.25	$11.25	$21.00	$28.50
Medicaid Total	$6.85	$11.75	$21.25	$30.25
CHIP Total	$3.30	$5.95	$9.50	$13.55
Total PMPM	**$16.40**	**$28.95**	**$51.75**	**$72.30**

Operational Opportunities

Growth	No-show Reduction	Abrasion Reduction
Increased Efficiency	Program Inclusion	Clinical Impact Improvement

Summary of CY2020 “Missed Opportunities”

Annually, HPP evaluates and shares data to identify missed opportunities for our providers. These “missed opportunities” are defined as members who were seen, but care gaps were left open.

Overall HPP Performance

Total # of members with gaps	Average # of visits to assigned PCP	# of members with 3+ visits with assigned PCP	Total # of gaps identified as missed opportunity
57,694	2.33	17,007	81,433

Total # of gaps identified as missed opportunity	Total # of easy gaps	Total # of medium gaps	Total# of hard gaps
81433	15,144	51,670	14,619

Total # of QCP gaps left open	Total # of MCO P4P gaps left open	Total # of Stars gaps left open
65,866	42,885	10,410

57k members were seen an average of **2.3** times and had **81k** gaps left open.

19% of gaps were considered easy gaps, **63%** were medium and **18%** were considered hard.

Provider revenue generating opportunities left on the table.

Negatively impacts HPP’s funding opportunities.

Provider Tools and Resources

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

Resource	Description	Frequency
QCP Manual	Includes an overview of measures, best practices, codes for compliance and payout opportunities.	Annually
Webinars	Cover various topics to help you provide the best outcomes for your patients.	Ad-hoc
Reporting/Data	HPP can provide your practice with reports to help with population health management, quality improvement activities, and utilization management.	Ad-hoc
NaviNet 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.	Varies
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
Aunt Bertha	Web-based platform that allows you to identify, refer and track referrals to community-based organizations (CBOs) for members that screen positive for social determinants of health.	Ongoing
Network Account Managers	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

Current HPP Quality Improvement Activities

HPP often partners with provider and community organizations to further drive quality improvement and improve access and member engagement.

Appointment Scheduling

HPP conducts outreach calls (internally and using vendors) to members to schedule appointments for all priority measures.

Educational Mailings

HPP conducts member mailings to educate on the importance of screenings and mails screening kits (e.g., FOBT) to increase outcomes.

Health Screening Event Partnerships

HPP partners with practice sites on block scheduling events for select measures and partners with the Fox Chase mobile van to conduct mammogram screening events.

Quality Programs

Baby Partners, tobacco cessation, diabetes prevention, and CX training programs have been created to help support our providers.

In-Home Services

HPP partners with various vendors to conduct in-home visits for members for well visits, diabetes testing, and other critical services.

Member Incentive Program

HPP offers a member incentive program for Medicare (reloadable gift card) and Medicaid (points to be used in a catalog) members for completing key health screenings.

These initiatives only highlight <u>some</u> of the opportunities offered to our network.


Questions?