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### Disclosure Statement

We do have a relevant financial relationship with commercial interest whose products or services relate to the content of the educational presentation.

Company: Moda Health, Inc./EOCCO/Summit Health

To ensure independence and balance of content, current conflicts of interest were resolved by basing recommendations on structured review for best evidence.







### Learning Objectives

After this session, attendees should be able to:

- 1. Review the importance of incentive measures and quality programs.
- 2. Summarize EOCCO and Summit Health's 2022 quality measure performance.
- 3. Summarize EOCCO and Summit Health's current 2023 quality initiatives.



### Agenda

Statewide CCO Metrics Program

2022 EOCCO Measure Performance

2023 EOCCO Quality Initiatives

Overview of Medicare STARS Program

2022 Summit Health Performance

2023 Summit Quality Initiatives

What's Next for Quality?









## Statewide CCO Metrics Program





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### **CCO Incentive Measure Program**

- ➤ OHA Committee selects measures and targets each year to show how well coordinated care organizations (CCOs):
  - Improve care
  - Make quality care accessible
  - Eliminate health disparities
  - Curb the cost of health care
- Measures can be based on claims, EHR, or chart review data

- CCOs are awarded quality pool funds based on annual performance
- > EOCCO uses quality funds for:
  - Quality bonus payments to providers
  - Enhanced PCPCH payments
  - Community Benefit Initiative Reinvestment (CBIR) grants



### 2022 Incentive Measures

#### **Claims Based Measures**

- 1. Child Immunization Status Combo 3
- Health Assessments for Children in DHS custody
- 3. Immunizations for Adolescents\*
- Initiation and Engagement of Substance Use Disorder Treatment
- 5. Oral Evaluation for Adults with Diabetes
- 6. Preventive Dental Visits Ages 1-14\*
- 7. Well-child Visits Ages 3-6\*

#### **Chart Review Measures**

- 8. Timeliness of Postpartum Care
- Meaningful Language Access to Culturally Responsive Health Care Services\*
- System-Level Social-Emotional Health\*

#### **Clinical Quality Measures**

- 11. Depression Screening and Follow-up
- 12. Diabetes HbA1c Poor Control
- 13. Cigarette Smoking Prevalence\*
- 14. SBIRT







### 2022 Performance

14 incentive measures total



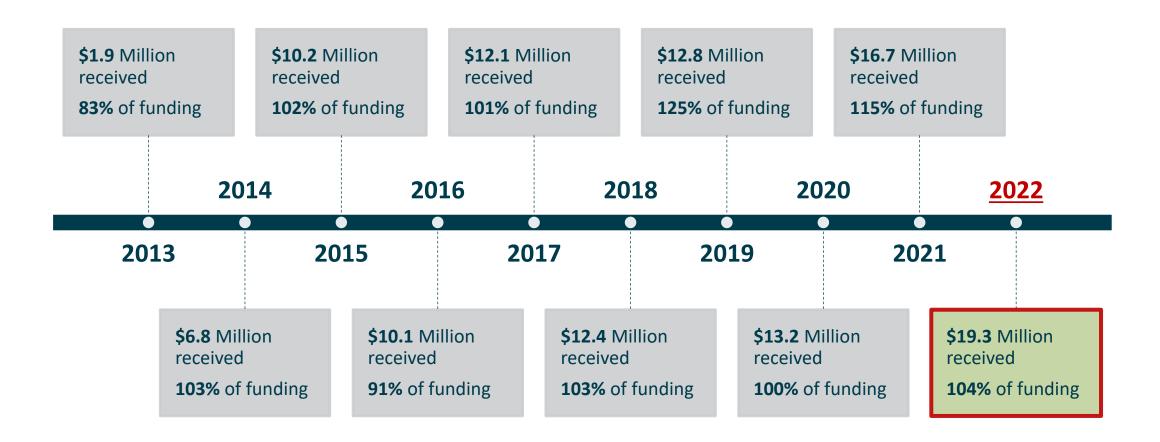
11 of 14 (75%) targets achieved



100% of Quality
Pool funds
received

| Incentive Measure                  | 2022 Target   | 2022 Final<br>Rate | Performance |
|------------------------------------|---------------|--------------------|-------------|
| Childhood Immunizations            | 66.3%         | 65.5%              | 8           |
| DHS                                | 90.0%         | 90.4%              | •           |
| Immunizations for Adolescents      | 36.9%         | 36.5%              | 8           |
| IET: Initiation                    | 36.5%         | 38.5%              | •           |
| IET: Engagement                    | 12.6%         | 14.9%              |             |
| Oral Eval for Adults with Diabetes | 20.4%         | 23.0%              | •           |
| Preventive Dental Services: 1-5    | 43.1%         | 48.2%              | •           |
| Preventive Dental Services: 6-14   | 52.0%         | 64.8%              |             |
| Well Child Visits                  | 64.0%         | 64.6%              | •           |
| Postpartum Care                    | 71.5%         | 72.4%              | •           |
| Language Access                    | Hybrid Report | Reported           | •           |
| Social Emotional Health            | Report Only   | Reported           | <b>Ø</b>    |
| Depression Screening               | 58.8%         | 65.8%              | •           |
| Diabetes HbA1c Poor Control        | 31.5%         | 21.3%              | •           |
| Cigarette Smoking Prevalence       | 25.0%         | 21.3%              | <b>Ø</b>    |
| SBIRT - Rate 1                     | 59.7%         | 51.4%              | 8           |
| SBIRT - Rate 2                     | 29.7%         | 28.8%              |             |

### 2013 – 2022 Quality Pool Funds





### 2022 Quality Pool Funds Distribution









### 2023 Incentive Measures

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#### **Chart Review Measures**

- 8. Timeliness of Postpartum Care\*
- Meaningful Language Access to Culturally Responsive Health Care Services
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- 11. SDoH: Social Needs Screening & Referral

#### **Clinical Quality Measures**

- 12. Depression Screening and Follow-up
- 13. Diabetes HbA1c Poor Control
- 14. Cigarette Smoking Prevalence
- 15. SBIRT

New measure for MY 2023 \*2023 Challenge Pool Metric



### 2023 Challenge Pool Measures



- Immunizations for Adolescents
  - Partnership with LPHAs to gather out-of-state shot records
  - Outreach to parents of members due for vaccines
- Well-Child Visits for Ages 3-6
  - Amazon gift card incentive program
  - Outreach to parents of members due for visits





- ❖ Preventive Dental Services for Ages 1-5 & 6-14
  - CCO-sponsored First Tooth trainings for PCP clinics
  - Collaboration with DCOs for member outreach and offsite dental services
- Timeliness of Postpartum Care
  - Cribs for Kids program
  - Continued partnership with THWs and doulas





### SDoH: Social Needs Screening and Referral

- ❖ New measure meant to support CCOs, providers, and other agencies in implementing robust social needs screening and referral processes
- Focus on food security, housing, and transportation
- ❖ 2022 & 2023 efforts:
  - Interdisciplinary CCO workgroup to develop measure policies and engage stakeholders
  - Survey all contracted providers on screening & referral practices
  - Review current screening tools in use
  - Creation of CBO/agency inventory and identification of resource gaps









### SDoH: Social Needs Screening and Referral

#### 2023

- Report-only year for CCOs
- Measure workgroup convened
- Focus on "must-pass"
   elements: SDOH
   screening policies,
   surveying providers on
   screening processes, CBO
   resource inventory,
   establishing agency
   agreements

#### 2024

- Report-only year for CCOs
- Work with providers on screening, documentation, & referral workflows
- Develop process to ingest and use REALD data

#### 2025

- CCO Report and Hybrid Sample Measurement
- Hybrid sample will
   measure percent of
   members who were
   screened at least once
   during measurement year
   for housing, good and
   transportation needs
   using an OHA-approved
   screening tool







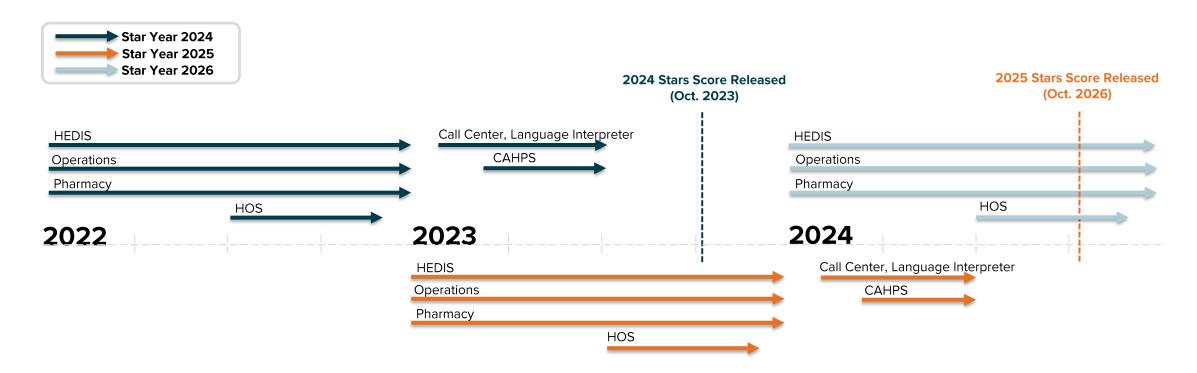
### Objectives of Medicare Stars Program

- The Centers for Medicare and Medicaid Services (CMS) developed the Medicare Stars Rating System to:
  - Provide quality and performance information to Medicare beneficiaries to assist them in choosing their health and drug plan
  - Incentivize health plans to improve member health and experience through a performance-based rating system
- Health plans receive a 1 to 5 Star Rating (5 being the highest) each year based on 40 individual measures related to member experience, health outcomes, and operations



### Medicare Stars Program

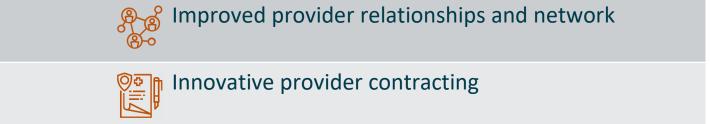
• Star Ratings activities and measurement follow a continuous two-year cycle, where Measurement Year (MY) 2023 = Star Year (SY) 2025





### Star Ratings Impact

| Patient   | Provider                     | Health Plan                            |
|---|------------------------------|--|
| Better care and health management                                   | Increased incentive payments | Growth in revenue and membership       |
| Improved benefits, lower premiums, and lower out-of pocket expenses | -                            | Increased member loyalty and retention |
| Positive patie  |                              |  |
| Improved pat  |                              |  |









### Summit Health Incentive Program

- Summit Health providers are eligible to participate in the Medicare Advantage Primary Care
  Incentive Program (MAPCIP) that rewards PCPs for meeting set thresholds for quality measure
  gap closures
- Summit Health selects measures and targets each year based on CMS measure priorities, Summit Health population needs, and recommendations from the Summit Health Clinic Advisory Panel
- Access to Care Incentive Payment (ACIP) is a performance-based payment based on members
  having completed an annual physical and/or annual wellness visit
- Care Gap Incentive Payment (CGIP) is a performance-based payment based on annual performance on quality measures, patient experience of care measures and/or utilization measures
  - Breast Cancer Screening
  - Colorectal Cancer Screening
  - Controlling High Blood Pressure
  - Diabetes Care HbA1c Poor Control (≥9%)
  - Statin Therapy for Patients with Diabetes
  - Statin Therapy for Patients with Cardiovascular Disease
  - Transitions of Care Patient Engagement after Inpatient Discharge



### 2022 Incentive Program and Stars Performance

Provider MAPCIP performance and incentive earnings for 2022 Measurement Year:

| Participating Providers | Providers that Earned a<br>Bonus | Overall Gap Closure Rate | Median Gap Closure Rate |  |  |
|-------------------------|----------------------------------|--------------------------|-------------------------|--|--|
| 25                      | 24                               | 64.6%                    | 67%                     |  |  |

Summit Health Stars performance of incentive measures for 2022 Measurement Year:

| Measure  | 2021 Score | 2021 Star | 2022 Score |  |  |
|--|------------|-----------|------------|--|--|
| Breast Cancer Screening  | 63%        | 3         | 65%        |  |  |
| Colorectal Cancer Screening  | 72%        | 4         | 69%        |  |  |
| Controlling High Blood Pressure                                    | 58%        | 2         | 56%        |  |  |
| Diabetes Care – HbA1c Poor Control (≥9%)                           | 70%        | 3         | 71%        |  |  |
| Statin Therapy for Patients with Diabetes                          | 83%        | 2         | 84%        |  |  |
| Statin Therapy for Patients with Cardiovascular Disease            | 94%        | 5         | 100%       |  |  |
| Transitions of Care – Patient Engagement after Inpatient Discharge | N/A        | N/A       | 60%        |  |  |







### Summit Health 2023 Quality Initiatives

|  | Jan   | Feb   | Mar             | Apr                          | May   | Jun                          | Jul | Aug      | Sep                       | Oct          | Nov         | Dec  |
|--|---|---|-----------------|------------------------------|-------|------------------------------|-----|----------|---------------------------|--------------|-------------|------|
| CMS  |   |   | CA              | AHPS Survey H                |       | Health Outcomes Survey (HOS) |     |          |                           |              |             |      |
|  |   |   |                 |                              |       |                              |     |          |                           | Annı         | ual Enrollr | ment |
| Provider   |   |   | Spring Training |                              |       |                              |     |          | Fa                        | all Training | gs          |      |
| Data sharing: Summit Provider Data Exchange, Arcadia, Novillus Care Ga |   |   |                 |                              |       |                              |     | Gap Man  | ap Management Application |              |             |      |
|  | Ongoing engagement with EOCCO/Summit QI team and monthly newsletters                              |   |                 |                              |       |                              |     |          |                           |              |             |      |
| CAHPS  | Pre-C   | AHPS  |                 | Off-Cycle Survey No Negative |       |                              |     |          |                           | gative Su    | rprise      |      |
| HEDIS  |   | Care  |                 |                              | Care  |                              |     | Care     |                           |              | Care        |      |
|  |   | Guide   |                 |                              | Guide |                              |     | Guide    |                           |              | Guide       |      |
| FIT and  |   |   |                 |                              |       |                              |     | A1c kits |                           |              |             |      |
|  |   | Ongoing targeted programs for PCR, TRC, OMW, Diabetes Management, |                 |                              |       |                              |     |          |                           |              |             |      |
|  | Chronic Kidney Disease Management, and general health coaching                                    |   |                 |                              |       |                              |     |          |                           |              |             |      |
| Pharmacy   | Ongoing targeted programs for Medication Adherence, Statin use, and Medication Therapy Management |   |                 |                              |       |                              |     |          |                           |              |             |      |











#### **EOCCO**

#### • <u>2024</u>

- Maintain 2023 measure set
- Focus on 2024 Challenge Pool measures: Well-Child Visits, Postpartum Care, Social-Emotional Health, Preventive Dental Services
- Sustain work on "upstream" measures and initiatives

#### • <u>2025</u>

 Improve cross-sector collaboration for integrated behavioral/dental/physical health measures

#### Summit

#### 2024

- Maintain the same quality incentive measures as prior year
- Increased emphasis on Annual Wellness Visits and Annual Physical Exam incentive and gap closure
- Provide training on appropriate assessment and coding for HCCs

#### • <u>2025</u>

- Incorporate incentives for patient experience and access to care
- Incorporate incentive for assessment of historical and suspected HCC gaps







# Thank You!













