# Jefferson Health Plans
# Quality Initiatives, Opportunities and Resources

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# Introductions

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# Objectives

- Quality Hot Topics
- Medication Adherence
- Jefferson Health Plans' Vendor & Community Partnerships
- Provider Incentive Programs
  - QCP 2024 Key Changes
- HEDIS Measures, Reporting and Available Resources
  - Controlling Hypertension
  - Diabetic Measures
  - Well Visits
- New Provider Best Practice Sharing Series

# Quality Hot Topics

# Quality Hot Topics

- **Blood Pressure Cuff Benefits**
  - We recently simplified ordering a BP cuff for all LOBs.
  - To order a cuff, members must be 18 years of age or older OR pregnant.
  - Find the new order form here: https://www.healthpartnersplans.com/providers/resources/form-and-supply-requests -

- **Asthma Medication Ratio – Flovent HFA and Diskus Discontinued**
  - GSK discontinued manufacturing Flovent HFA and Diskus as of 12/31/23 for members with asthma. We will continue to cover these drugs until supplies run out. Once supplies are depleted, members will need to be switched to a preferred alternative.

| Preferred Alternatives |
| --- |
| Arnuity Ellipta |
| Asmanex HFA |
| Asmanex Twisthaler |
| Budesonide 0.25 mg/2 ml, 0.5 mg/2 ml |
| Pulmicort Respule |
| Pulmicort Flexhaler |
| Qvar Redihaler |
| Arnuity Ellipta |

# Quality Hot Topics

- **Annual Wellness Visits (AWVs)**
  - The AWV is a preventive care visit covered by Medicare. The visit helps collect valuable health information like personal and family health history, a list of patients' current care team members, and their medications list, and it also serves as a time to complete important health screenings.
  - The visit is free to your patients, helps with early disease detection and prevention, maximizes patients' wellness, and can help delay long-term care.
  - For providers, this visit can help improve your quality performance in QCP by addressing care gaps.
  - New code added this year for SDOH.
    - G0136 – Administration of a standardized, evidence-based social determinants of health risk assessment tool, 5 to 15 minutes.
    - The AWV can be an optional community health integration initiating visit when the provider identifies any unmet SDOH needs that prevent the patient from doing the recommended personalized prevention plan.
    - This code should be submitted after a positive screening is completed along with any corresponding ICD-10 codes.
    - Cannot be completed/submitted for the Welcome to Medicare visits (G0402).
  - For additional information, please reference our AWV Provider Fact Sheet: https://www.healthpartnersplans.com/media/100881358/awv-provider-fact-sheet.pdf -

# Medication Adherence

# Improving Medication Adherence

- **Medicare member rewards are available!** Learn more at 2024 Member Rewards Programs

**Only DSNP members eligible for the Medication Therapy Management Program (MTM) can earn Part D rewards.**
**Maximum Reward Value = $195**

**Comprehensive Med Review (CMR) $15**
Who? MTM-Eligible DSNP Members
How? Complete a CMR with HPP's MTM vendor (SinfoniaRx). CMR must be completed to become eligible for any med adherence rewards.

**Cholesterol Medication $5 - $60** ★
Who? MTM-Eligible DSNP Members
How? After completing a CMR*, earn $5 per month for a 30-day fill of your medication. Up to $60 for the year.

**Hypertension Medication $5 - $60** ★
Who? MTM-Eligible DSNP Members
How? After completing a CMR*, earn $5 per month for a 30-day fill of your medication. Up to $60 for the year.

**Diabetes Medication $5 - $60** ★
Who? MTM-Eligible DSNP Members
How? After completing a CMR*, earn $5 per month for a 30-day fill of your medication. Up to $60 for the year.

# Improving Medication Adherence

- **Medication management support**
  - Delivery is available by local pharmacies
  - Mail order through CVS Caremark Mail Order Pharmacy
  - Med synchronization is an option
  - For Medicare, switching to 90 or **100-day supply** prescriptions is an option at participating network pharmacies
  - For Medicare, Tier 6 covers Select Care Drugs at $0 copay through all coverage phases, including the coverage gap
    - Includes generic STARs medications plus 3 brand medications Januvia, Jardiance, and Trulicity
- **Pharmacy partners (including Centennial, Cambria, Coordinated Care Network (CCN), Philadelphia Pharmacy, Friendly Pharmacy)**
  - Services: Cycle fills/med sync, medication packaging/blister packing/pill boxes, and delivery
- **CVS Simple Dose**
  - One simple white box of pre-sorted prescription packs contains a 30-day supply of medication
  - Each pack is clearly labeled morning, midday, evening and/or bedtime
  - Allows members to receive a 30-day supply via USPS or pick up at a CVS Pharmacy
  - CVS Simple Dose offers 30-day supply only

- For additional information related to medication adherence, including a list of pharmacies that offer delivery, please follow this link: Medication Management - **https://www.healthpartnersplans.com/providers/quality-and-population-health/medication-management**

# Jefferson Health Plans' Vendor & Community Partnerships

# 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, CBP, Lead and FOBT |
| **Inovalon** | In-home member bone density scans (osteoporosis mgmt. in women), Vaccine outreach program via mailings (HPV, Covid, Flu, Tdap, Meningitis) |
| **Let's Get Checked** | In-home kit mailing for A1c and FOBT |
| **Clark Resources** | Outreach calls to pediatric members ages 2-14 years to schedule annual dental appointments. |
| **Magellan RX** | Medicare member, provider and/or pharmacy outreach for medication adherence and statin use in persons with diabetes |
| **Outcomes MTM** | Completes comprehensive medication reviews (CMRs) or targeted medication reviews (TMRs) for Medicare members that qualify for the MTM program |
| **ExactCare Pharmacy** | Aid Medicaid members who are on 6+ medications with mailing prescriptions to their home, blister packaging, and med sync |

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

# Provider Incentive Programs

# Provider Incentive Programs

- **Provider Pay-for-Performance (QCP) Program (All LOBs)**
  - QCP is Jefferson Health Plans' 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. 2023 well-child visit incentive).

# Provider Incentive Programs

## QCP 2024 Key Changes:

1. **Eligibility Requirement:** Providers will continue to be required to see at least 25% of paneled JHP *Medicaid* Members during the 2024 measurement year in order to earn any incentive dollars
   - No impact to Medicare or CHIP LOBs
   - We plan to increase this eligibility requirement to 30% for measurement year 2025.
2. **Measure Denominator Minimum**: Increase the minimum number of Members in the individual measure's denominator from 20 to 30 members for all lines of business.
3. **New Improvement Incentive Opportunity:** Effective for the 2024 measurement period, providers will be eligible to earn a $0.05 PMPM incentive payment if they improve their baseline rate by 5% for each of the below five measures:
   - Child and Adolescent Well-Care Visits (Total)
   - Controlling Blood Pressure
   - Developmental Screening in the First Three Years of Life
   - Glycemic Status Assessment for Patients with Diabetes
   - Lead Screening in Children
   - Practices must have qualified for QCP during the previous measurement period (MY2023).
4. **PCMH Bonus Removed:** Greater emphasis on quality measures within PCMH program
5. **HOS Bonus Removed**

# HEDIS Measures, Reporting and Available Resources

# Reporting & Available Resources

**Jefferson Health Plans has many tools and resources available to our provider organizations.**

| Resource | Description | Frequency |
|---|---|---|
| **Network Market Managers (NMMs)** | Your main point of contact who can help support your practices, review reports with you and connect you to the right resources within Jefferson Health Plans. | Ongoing |
| **QCP Manual** | Includes an overview of measures, best practices, codes for compliance and payout opportunities. | Annually |
| **HealthTrio 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 |
| **Webinars** | Cover various topics to help you provide the best outcomes for your patients. | Ad-Hoc |
| **Reporting/Data** | Jefferson Health Plans can provide your practice with reports to help with population health management, quality improvement activities, and utilization management. | Ad-Hoc |
| **Coding Education** | Jefferson Health Plans' Clinical Risk Assessment team provides education on appropriate coding and documentation. | Ongoing |
| **Data Sharing** | Jefferson Health Plans' data and quality team can work with you to capture supplemental data from your EMR or to gain access to your EMR. | Ongoing |
| **Provider Webpage** | Jefferson Health Plans continues to add and update resources for providers on our Provider Webpage! Visit the **Quality and Population Health** - https://www.healthpartnersplans.com/providers/quality-and-population-health and **HEDIS Hints** - https://www.healthpartnersplans.com/providers/quality-and-population-health/hedis-hints pages now for helpful tips and education on key quality measures! | Ongoing |

# Reporting & Available Resources

## Request your 2023 Missed Opportunities Report!

This report provides a list of members seen in 2023 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 Jefferson Health Plans (e.g. MCO P4P and Stars)

| 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 |
|---|---|---|---|
| 52,098 | 1.57 | 6674 | 85,788 |

2022 Report

| Total # of Easy Gaps | Total # of Medium Gaps | Total# of Hard Gaps | Total # of QCP Gaps | Total # of P4P Gaps (Medicaid) | Total # of STAR Gaps (Medicare) |
|---|---|---|---|---|---|
| 4,431 | 70,890 | 10,467 | 66,673 | 47,214 | 9,390 |

# 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 did not have a well visit in 2023.

- **Goal:** Use this outreach list to contact members that are due for their well visit and haven't been seen in 12+ months.

## Hypertensive/Diabetic Member Report

**Description:** Missed opportunities report for members who are diabetic and hypertensive, were engaged in care throughout 2023 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.

# Controlling Blood Pressure

- **HEDIS Measure Intent:**
  - The percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled (<140/90mm Hg) during the measurement year.
  - This is a hybrid measure.  A HEDIS hybrid measure can be submitted via claim or found in a medical record.
- **Medical Record Documentation:**
  - BP must be taken during an 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 retake the BP before the patient leaves your office.
  - Order the patient a BP cuff to allow for home monitoring.
  - Outreach to patients who haven't had a recent appointment; allow for in person, virtual and telephonic visits.
  - Educate members on the importance of taking medications, and healthy lifestyles
  - Add CPT2 codes to claim or automate the addition of CPT2 codes in your EMR.

# Diabetic Measures

- The former diabetes measure Comprehensive Diabetic Care (CDC) has been separated into three separate measures.
- All are hybrid measure and can be submitted via claim or found in a medical record.
- Blood Pressure Control for Patients with Diabetes (BPD):
  - The percentage of members 18–75 years of age with diabetes (types 1 and 2) whose blood pressure (BP) was adequately controlled (<140/90 mm Hg) during the measurement year.
  - **Medical Record:**
    - BP must be taken during an 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 retake the BP before the patient leaves your office.
    - Order the patient a BP cuff to allow for home monitoring.
    - Outreach to patients who haven't had a recent appointment; allow for in person, virtual and telephonic visits.
    - Educate members on the importance of taking medications, and healthy lifestyles
    - Add CPT2 codes to claim or automate the addition of CPT2 codes in your EMR.

# Diabetic Measures

- Hemoglobin A1c Control for Patients with Diabetes (HBD)
  - The percentage of members 18–75 years of age with diabetes (types 1 and 2) whose hemoglobin A1c (HbA1c) was at the following levels during the measurement year:
    - HbA1c control (<8.0%).
    - HbA1c poor control (>9.0%).
  - **Medical Record:**
    - Date **and** Result of HgA1c
    - Lab result slip
    - Documentation of POC testing with test date and result
    - Documentation in the progress note; note must be dated and signed
  - **Best Practices:**
    - Outreach to patients that are diabetic and haven't had a recent HgA1c.
    - Outreach to patients who's last HgA1c was >9.0%
    - Add CPT2 codes to claim or automate the addition of CPT2 codes in your EMR.

# Diabetic Measures

- Eye Exam for Patients with Diabetes (EED)
  - The percentage of members 18–75 years of age with diabetes (types 1 and 2) who had a retina exam.
    - A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement year.
    - • A negative retinal or dilated exam (negative for retinopathy) by an eye care professional (optometrist or ophthalmologist) in the year prior to the measurement year.
  - **Medical Record:**
    - A note or letter prepared by an ophthalmologist, optometrist, PCP or other health care professional indicating that an ophthalmoscopic exam was completed by an eye care professional (optometrist or ophthalmologist), the **date** when the procedure was performed and the **results**.
    - A chart or photograph indicating the date when the fundus photography was performed and one of the following:
      - Evidence that an eye care professional (optometrist or ophthalmologist) reviewed the results.
      - Evidence results were read by a qualified reading center that operates under the direction of a medical director who is a retinal specialist.
      - Evidence results were read by a system that provides an artificial intelligence (AI) interpretation.
  - **Best Practices:**
    - Educate members on the importance of annual eye exam
    - Hypertensive retinopathy counts toward diabetic retinopathy screening
    - Utilize CPT2 or automate CPT2 codes in your EMR to indicate if eye exam has positive or negative findings.

# Well 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-old who had at least one comprehensive well care visit with a PCP or OB/GYN partitioner during the measurement year.
  - This measure is administrative only – No chart review is done for these measures
- **Best Practices:**
  - Well visits can be completed during sick visits.
  - Check your portal to identify patients that need well visits
  - Target family members that are in the same household
  - Partner with Jefferson Health Plans to hold block scheduling events
  - Implement a recall system to call patients back when schedules open or remind members to call back X weeks or months before they are due for their next appointment.

# Introducing our Provider Best Practice Sharing Series!

- Jefferson Health Plans is implementing a new quarterly provider-led best practice sharing series this year.
- These lunch-time meetings will each spotlight an innovative initiative that your provider peers have implemented, ranging from topics like well child visit block scheduling to medication adherence texting campaigns.
- We hope to schedule our first presentation in Q2 and will share details when we have them.

**We hope you join us!**

# Contact information

# QUESTIONS?

- Valerie Van Buren: vmcevoy@jeffersonhealthplans.com
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