# *Pay for Performance*

## *Joint Medicaid Oversight Committee*

***Testimony by***
***Dr. Craig Thiele, Chief Medical Officer***

***May 18, 2017***





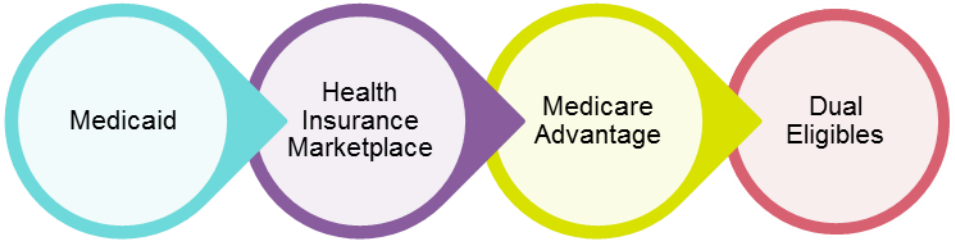
CareSource

# *Our* MISSION

*To make a lasting difference in our members' lives by improving their health and well-being.*

## CARESOURCE

- A nonprofit health plan and national leader in Managed Care
- 27-year history of serving the low-income populations across multiple states and insurance products
- Currently serving over 1.5 million members in Kentucky, Ohio, Indiana, West Virginia
- Preparing to serve Indiana and Georgia Medicaid members in 2017




**1.6M**
members

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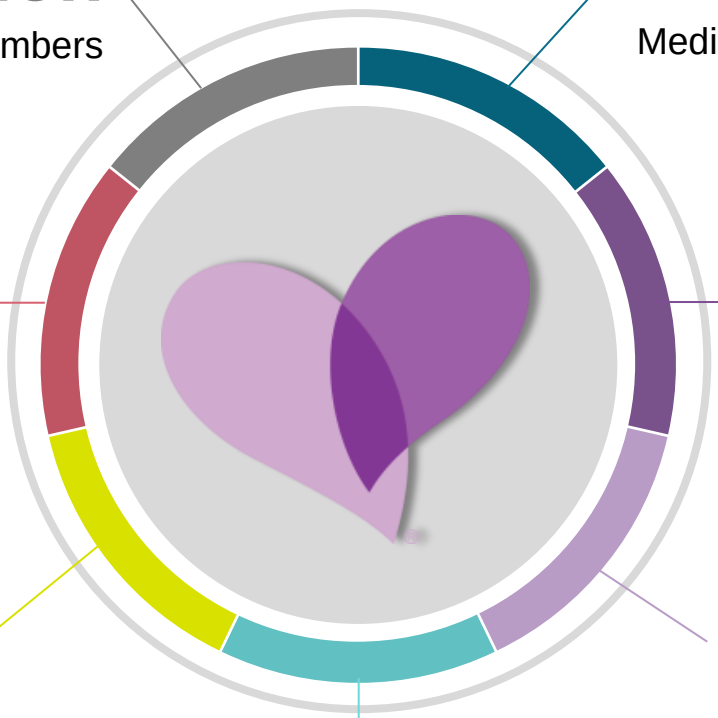
# *Medicaid Snapshot*

OHIO



**1.3 million**
Members

**303k**
Medicaid Expansion Members

**54%**
Market Share

**68%**
of Enrollees are Families

**60%**
Voluntary Enrollment

**44%** Male
**56%** Female

Average Age
**22.9**





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# *Ohio Medicaid Pay for Performance Measures*

# *Medicaid Quality Measures*

- Adolescent Well Care Visits
- Controlling High Blood Pressure
- Prenatal Care – Timeliness of Care
- Post Partum Care
- Diabetes: HcA1c
- Follow-up After Hospitalization for Mental Illness – 7 Days





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# CareSource P4P Strategy

Meet the People
Where they Are

## Quality Outcomes Strategy

**VALUE BASED REIMBURSEMENT**
Hospitals, CMHCs, FQHCs, Physicians, Nursing Homes

**CAPTIVE AUDIENCES**
@School, Upon Discharge, @the Doctors office, @Pharmacy (MTM), @Home

**MANAGED CARE COLLABORATION**
Infant Mortality, @School, HIE

**ACCOUNTABILITY**
Financial and Membership Assignment with the Managed Care Plans

**LIFE SERVICES**
Social Determinant Drivers (Food, Housing, Employment, Healthcare)

**DATA**
Accelerate the sharing of medical records for the purpose of improving health





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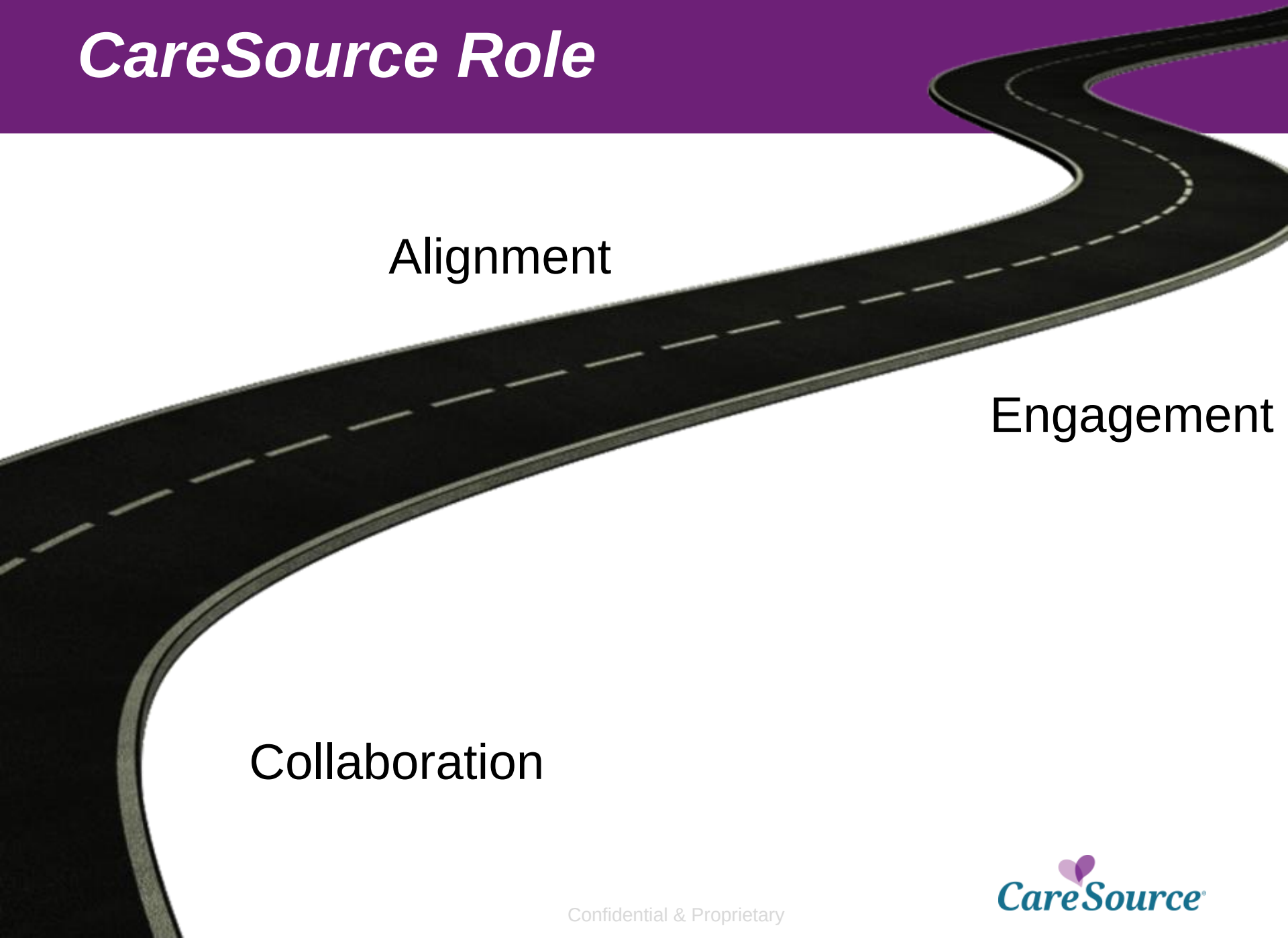
# *CareSource Role*



Alignment

Engagement

Collaboration



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# TRANSFORMING *Care*

***Care4U*** is a game-changing, holistic population health model. Through tailored care plans, CareSource can address the needs with the greatest impact for each individual member. The model fully integrates our commitment to Primary Care & Prevention, Care Management, Behavioral Health and Life Services, promoting health and wellness across the ***entire continuum*** of the population we serve.

**CareSource continues to lead health care in an innovative, new direction.**





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# Care4U

We focus on our members' *health* and *socioeconomic* needs.

**No matter where our members are in their stage of wellness, we have services and supports for them.**

### CARE MANAGEMENT
One-on-one attention to support health needs

### DISEASE MANAGEMENT
Assistance managing issues like diabetes, asthma, high blood pressure or high cholesterol

### TOBACCO CESSATION
Health coaching from a Certified Tobacco Treatment Specialist

### WOMEN & CHILDREN'S HEALTH
Pre-pregnancy and pregnancy programs plus support for young children

### BEHAVIORAL HEALTH
Mental health and substance use services and resources

### WELLNESS
Online wellness tool to learn about health topics

### HEALTH RISK ASSESSMENT
Clarity on personal health and wellness including physical, mental and social health





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# *Medicaid Opportunities*

| Measure | Opportunity |
|---|---|
| Adolescent Well-Care | • Require Well Child Check-ups for School:<br>• Managed Care and Health Partners provide and pay for them |
| Controlling High Blood Pressure | • Requires medical records and must contain both diagnosis and compliant blood pressure:<br>• Health Information Exchange and Health Partner Coding Education and Compliance |
| Comprehensive Diabetes Care, HbA1c Poor Control >9% | • Requires lab results:<br>• Data needed from labs, provider EHR systems |
| | |
| Follow-up After Hospitalization for Mental Illness – 7 Days | • Outdated Coding and Appointment Availability:<br>• Anticipate significant improvements with Behavioral Health Carve-In |
| Prenatal Care – Timeliness of Care | • Infant Mortality Collaboration |
| Postpartum Care | • Captive Audience and Health Partner Collaboration |

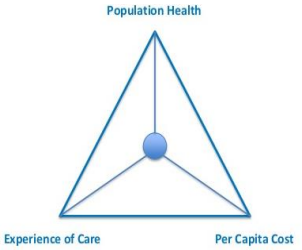
# *Partnering with Health Partners*

# Partnering for Success

## Integration

**VBR Arrangements**

## Triple Aim




Managed Care and Health Partners Working Together

**Achieves a common platform, goals, and strategies with our Health Partners through:**

Shared Quality and Population Health Management Goals

Shared initiatives to enhance patient/member experience

Shared financial and savings goals





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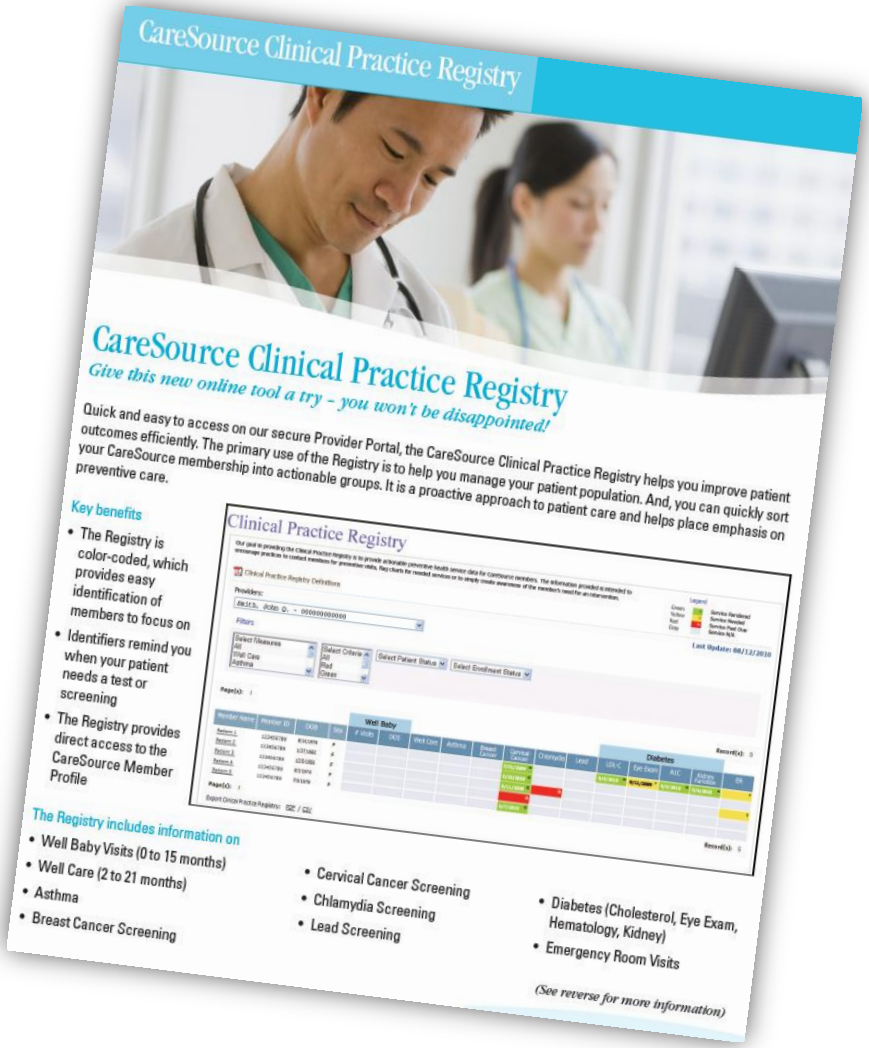
# Partnering with Providers

The CareSource Clinical Practice Registry (CPR) is a feature on the CareSource Provider Portal. This registry offers providers a working list of their members and associated gaps in care.





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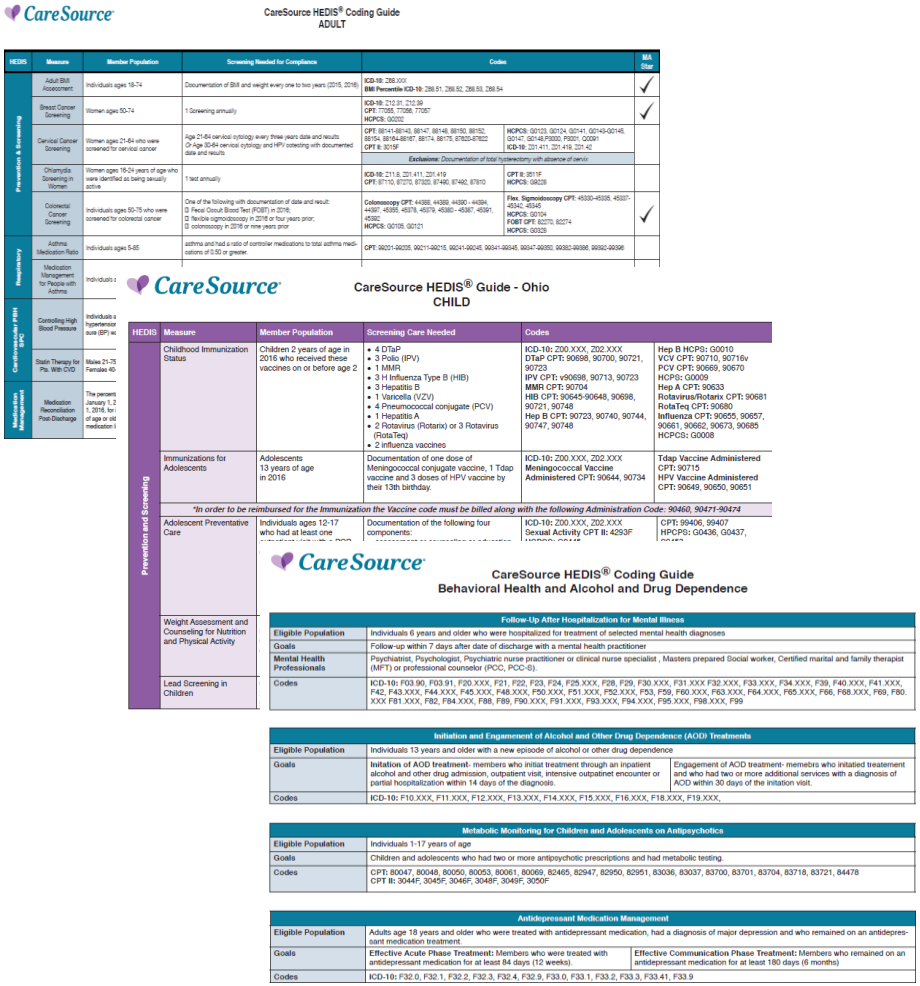
# Partnering with Providers

Coding guides are intended to assist the provider with understanding of quality measures and associated codes



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CareSource HEDIS® Coding Guide
ADULT

| HEDIS | Measure | Member Population | Screening Needed for Compliance | Codes | MA Star |
|---|---|---|---|---|---|
| Prevention & Screening | Adult BMI Assessment | Individuals ages 18-74 | Documentation of BMI and weight every one to two years (2015, 2016) | **ICD-10:** Z68.XXX<br>**BMI Percentile ICD-10:** Z68.51, Z68.52, Z68.53, Z68.54 | ✓ |
| | Breast Cancer Screening | Women ages 50-74 | 1 Screening annually | **ICD-10:** Z12.31, Z12.39<br>**CPT:** 77055, 77056, 77057<br>**HCPCS:** G0202 | ✓ |
| | Cervical Cancer Screening | Women ages 21-64 who were screened for cervical cancer | Age 21-64 cervical cytology every three years date and results<br>Or Age 30-64 cervical cytology and HPV cotesting with documented date and results | **CPT:** 88141-88148, 88147, 88148, 88150, 88152, 88154, 88164-88167, 88174, 88175, 87620-87622<br>**CPT II:** 3019F<br>**HCPCS:** G0123, G0124, G0141, G0143-G0145, G0147, G0148-P3000, P3001, Q0091<br>**ICD-10:** Z01.411, Z01.419, Z01.42<br>***Exclusions:*** *Documentation of total hysterectomy with absence of cervix* | |
| | Chlamydia Screening in Women | Women ages 16-24 years of age who were identified as being sexually active | 1 test annually | **ICD-10:** Z11.8, Z01.411, Z01.419<br>**CPT:** 87110, 87270, 87320, 87490, 87492, 87810<br>**CPT II:** 3511F<br>**HCPCS:** G9228 | |
| | Colorectal Cancer Screening | Individuals ages 50-75 who were screened for colorectal cancer | One of the following with documentation of date and result:<br>☐ Fecal Occult Blood Test (FOBT) in 2016;<br>☐ flexible sigmoidoscopy in 2016 or four years prior;<br>☐ colonoscopy in 2016 or nine years prior | **Colonoscopy CPT:** 44388, 44389, 44390 - 44394, 44397, 45355, 45378, 45379, 45380 - 45387, 45391, 45392<br>**HCPCS:** G0105, G0121<br>**Flex. Sigmoidoscopy CPT:** 45330-45335, 45337-45342, 45345<br>**HCPCS:** G0104<br>**FOBT CPT:** 82270, 82274<br>**HCPCS:** G0328 | ✓ |
| Respiratory | Asthma Medication Ratio | Individuals ages 5-85 | asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater. | **CPT:** 99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99382-99386, 99392-99396 | |
| | Medication Management for People with Asthma | Individuals | | | |
| Cardiovascular PHM Measures | Controlling High Blood Pressure | Individuals a hypertensior sure (BP) w | | | |
| | Statin Therapy for Pts. With CVD | Males 21-75<br>Females 40- | | | |
| Medication Reconciliation Post-Discharge | Medication Reconciliation Post-Discharge | The percent<br>January 1, 2<br>1, 2016, for<br>of age or old<br>medication | | | |

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CareSource HEDIS® Guide - Ohio
CHILD

| HEDIS | Measure | Member Population | Screening Care Needed | Codes | |
|---|---|---|---|---|---|
| Prevention and Screening | Childhood Immunization Status | Children 2 years of age in 2016 who received these vaccines on or before age 2 | • 4 DTaP<br>• 3 Polio (IPV)<br>• 1 MMR<br>• 3 H Influenza Type B (HIB)<br>• 3 Hepatitis B<br>• 1 Varicella (VZV)<br>• 4 Pneumococcal conjugate (PCV)<br>• 1 Hepatitis A<br>• 2 Rotavirus (Rotarix) or 3 Rotavirus (RotaTeq)<br>• 2 influenza vaccines | **ICD-10:** Z00.XXX, Z02.XXX<br>**DTaP CPT:** 90698, 90700, 90721, 90723<br>**IPV CPT:** v90698, 90713, 90723<br>**MMR CPT:** 90704<br>**HIB CPT:** 90645-90648, 90698, 90721, 90748<br>**Hep B CPT:** 90723, 90740, 90744, 90747, 90748 | **Hep B HCPS:** G0010<br>**VCV CPT:** 90710, 90716v<br>**PCV CPT:** 90669, 90670<br>**HCPS:** G0009<br>**Hep A CPT:** 90633<br>**Rotavirus/Rotarix CPT:** 90681<br>**RotaTeq CPT:** 90680<br>**Influenza CPT:** 90655, 90657, 90661, 90662, 90673, 90685<br>**HCPCS:** G0008 |
| | Immunizations for Adolescents | Adolescents 13 years of age in 2016 | Documentation of one dose of Meningococcal conjugate vaccine, 1 Tdap vaccine and 3 doses of HPV vaccine by their 13th birthday. | **ICD-10:** Z00.XXX, Z02.XXX<br>**Meningococcal Vaccine Administered CPT:** 90644, 90734 | **Tdap Vaccine Administered CPT:** 90715<br>**HPV Vaccine Administered CPT:** 90649, 90650, 90651 |
| | **In order to be reimbursed for the Immunization the Vaccine code must be billed along with the following Administration Code: 90460, 90471-90474* | | | | |
| | Adolescent Preventative Care | Individuals ages 12-17 who had at least one | Documentation of the following four components: | **ICD-10:** Z00.XXX, Z02.XXX<br>**Sexual Activity CPT II:** 4293F | **CPT:** 99406, 99407<br>**HPCPS:** G0436, G0437, |
| | Weight Assessment and Counseling for Nutrition and Physical Activity | | | | |
| | Lead Screening in Children | | | | |

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CareSource HEDIS® Coding Guide
Behavioral Health and Alcohol and Drug Dependence

| Follow-Up After Hospitalization for Mental Illness | |
|---|---|
| **Eligible Population** | Individuals 6 years and older who were hospitalized for treatment of selected mental health diagnoses |
| **Goals** | Follow-up within 7 days after date of discharge with a mental health practitioner |
| **Mental Health Professionals** | Psychiatrist, Psychologist, Psychiatric nurse practitioner or clinical nurse specialist , Masters prepared Social worker, Certified marital and family therapist (MFT) or professional counselor (POC, POC-S). |
| **Codes** | **ICD-10:** F03.90, F03.91, F20.XXX, F21, F22, F23, F24, F25.XXX, F28, F29, F30.XXX, F31.XXX F32.XXX, F33.XXX, F34.XXX, F39, F40.XXX, F41.XXX, F42, F43.XXX, F44.XXX, F45.XXX, F48.XXX, F50.XXX, F51.XXX, F52.XXX, F53, F59, F60.XXX, F63.XXX, F64.XXX, F65.XXX, F66, F68.XXX, F69, F80.XXX F81.XXX, F82, F84.XXX, F88, F89, F90.XXX, F91.XXX, F93.XXX, F94.XXX, F95.XXX, F98.XXX, F99 |

| Initiation and Engagement of Alcohol and Other Drug Dependence (AOD) Treatments | | |
|---|---|---|
| **Eligible Population** | Individuals 13 years and older with a new episode of alcohol or other drug dependence | |
| **Goals** | **Initation of AOD treatment**- members who initiat treatment through an inpatient alcohol and other drug admission, outpatient visit, intensive outpatinet encounter or partial hospitalization within 14 days of the diagnosis. | Engagement of AOD treatment- memebrs who initatied treatement and who had two or more additional services with a diagnosis of AOD within 30 days of the initation visit. |
| **Codes** | **ICD-10:** F10.XXX, F11.XXX, F12.XXX, F13.XXX, F14.XXX, F15.XXX, F16.XXX, F18.XXX, F19.XXX, | |

| Metabolic Monitoring for Children and Adolescents on Antipsychotics | |
|---|---|
| **Eligible Population** | Individuals 1-17 years of age |
| **Goals** | Children and adolescents who had two or more antipsychotic prescriptions and had metabolic testing. |
| **Codes** | **CPT:** 80047, 80048, 80050, 80053, 80061, 80069, 82465, 82947, 82950, 82951, 83036, 83037, 83700, 83701, 83704, 83718, 83721, 84478<br>**CPT II:** 3044F, 3045F, 3046F, 3048F, 3049F, 3050F |

| Antidepressant Medication Management | | |
|---|---|---|
| **Eligible Population** | Adults age 18 years and older who were treated with antidepressant medication, had a diagnosis of major depression and who remained on an antidepressant medication treatment. | |
| **Goals** | **Effective Acute Phase Treatment:** Members who were treated with antidepressant medication for at least 84 days (12 weeks). | **Effective Communication Phase Treatment:** Members who remained on an antidepressant medication for at least 180 days (6 months) |
| **Codes** | **ICD-10:** F32.0, F32.1, F32.2, F32.3, F32.4, F32.9, F33.0, F33.1, F33.2, F33.3, F33.41, F33.9 | |





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# Partnering with Providers

Clinical Practice Guideline fliers are shared with providers to inform and guide the care provided to CareSource members






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# *DATA*

# Connection to CliniSync

## Hospital Data:

- ADT (admission, discharge and transfer) alerts from 149 facilities:

## CareSource:

- Real-time feed of Emergency Room (ER) alerts to Care Management dashboard
- Pharmacy: Daily feed of discharge alerts to MTM vendor in order to complete medication reconciliation for members

## Lab Data from 3 facilities:

## CareSource:

- Real-time feed of lab data to Care Management dashboard
- HEDIS: Monthly lab data feed to HEDIS application

## NCQA

- NCQA is emphasizing the importance of this type of data sharing

# *Connection to The Health Collaborative (THC)*

**2017 Target: Receive ADT** (admission, discharge and transfer) alerts from 6 facilities

**CareSource:**

- Real-time feed of Emergency Room (ER) alerts to Care Management dashboard
- Pharmacy: Daily feed of discharge alerts to MTM vendor in order to complete medication reconciliation for members

**2017 Target: Receive lab data from 7 facilities**

**CareSource:**

- Real-time feed of lab data to Care Management dashboard
- HEDIS: Monthly lab data feed to HEDIS application



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# *Appendix*

# Medicaid Clinical Programs

| P4P Measure | Programs |
|---|---|
| Controlling High Blood Pressure | • Participation in Hypertension Quality Improvement Projects (QIP)<br>• Partner with Community HUBs<br>• Provider Clinical Practice Registry – gaps in care<br>• Value Based Reimbursement |
| Comprehensive Diabetes Care - HbA1C | • Partnered with Community HUBs<br>• Partnered with Diabetes support group in Hancock County (Caughman Clinic Program)<br>• Provider Clinical Practice Registry – gaps in care<br>• Value Based Reimbursement |





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# Medicaid Clinical Programs

| P4P Measure | Programs |
|---|---|
| Prenatal and Postpartum Care: | • Statewide Infant Mortality Program<br>• Discharge planning<br>• Provider evidenced based care communication<br>• Provider Coding Guides<br>• Provider Clinical Practice Registry – gaps in care<br>• Value Based Reimbursement |
| **Follow-Up After Hospitalization for Mental Illness – 7 Day Follow-Up** | • Partnerships with Community Mental Health Centers<br>• Personalized discharge planning<br>• Imbedding staff into health partners<br>• Provider Clinical Practice Registry – gaps in care<br>• Value Based Reimbursement |
| Adolescent Well-Care Visits | • School based program partnerships with The Community Learning Center and over 40 schools<br>• Provider Clinical Practice Registry – gaps in care<br>• Provider Coding Guides<br>• Provider Clinical Practice Registry – gaps in care<br>• Value Based Reimbursement |





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# Partnering with Ohio Medicaid

- Targeted initiatives coordinated with all MCPs
- Childhood immunization requirements prior to the member's 2nd birthday
- Mandatory annual preventive health visits
- Well-child visit requirement for participation in sports (expand sports physicals)
- School Based Health Clinics
- CPC – Comprehensive Primary Care Initiative
- Infant Mortality Initiative





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# NCQA Electronic Clinical Data

NCQA is working with clinicians, system interoperability experts, NCQA-Certified EHR vendors, data analytic experts, NCQA-Certified auditors and other stakeholders to develop a clear framework using electronic clinical data.

NCQA is following three core principles to ensure that use electronic clinical data for HEDIS quality reporting will:

1. Support appropriate access to electronic health data across the entire care continuum
2. Emphasize a member-centered, team-based approach to quality health care services
3. Support a learning health system that encourages innovation

NCQA is reviewing existing administrative, hybrid and medical record HEDIS technical specifications to determine which could be re-engineered to utilize the wealth of data available in ECDS.

# *NCQA Electronic Clinical Data*

**Electronic health record (EHR).** Real-time, patient-centered records that make information available instantly and securely to authorized users. EHRs eligible for this category of ECDS reporting include any vendor certified by the NCQA Measure Certification program, the NCQA eMeasure Certification program or any system that meets the 2015 Edition Base Electronic Health Record (EHR) definition

**Health information exchange (HIE)/clinical registry.** HIEs and clinical registries eligible for this reporting category include state HIEs, immunization information systems (IIS), public health agency systems, regional HIEs (RHIO), Patient-Centered Data Homes™ or other registries developed for research or to support quality improvement and patient safety initiatives. Registries can be sponsored by a government agency, nonprofit organization, health care facility or private company, and decisions regarding use of the data in the registry are the responsibility of the registry's governing committee.