

Transcript for Quality & Population Health: Advanced Medical Homes: Incentives Plan

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5:30-6:30

Presenters:

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Carol Stanley

It's 5:30. Let's get started. Good evening, everyone, and thank you for participating in today's quality and Population Health Webinar featuring advanced medical homes incentive plans. I'm Carol Stanley, North Carolina AHEC's Medicaid transformation manager and your host for tonight's webinar. The webinar is part of a series of informational sessions produced by NC Medicaid and NC AHEC to support providers across the state with Medicaid managed care. We have some great panelists from the NC Medicaid health plans NC Medicaid and NC AHEC. So I'll be brief with some reminders for successful viewing and listening experience. You can adjust the size of the slides on your screen by clicking on the gray bar just to the right of the slide and dragging, dragging it to either side of your screen so you can make it bigger or smaller and see the speaker as well. You can also adjust your video settings to hide people who aren't speaking. Click the View button on the top of your screen and select side by side with the speaker. everyone other than our presenters is already muted. Le Crosby will run through the agenda that I'll put pull it up just so you'll know what we are covering. We've learned in the past that the presenters will often address participant questions during their presentation. So please allow the topic to be covered before submitting your question in the q&a box. All of the NC Medicaid health plans have representatives monitoring the q&a box for response. Please know that our goal is to respond to as many questions as possible during the webinar. However, if your question is not answered during the webinar, please contact the appropriate health plan tomorrow for your informational needs. tonight's webinar slides are on the NC AHEC website, and we'll put a link to them in the q&a box. Within a day or two. The recording and written transcript will be on the NC AHEC website as well. Kelly I'm turning this over to you to kick us off.

Kelly Crosbie

Awesome. Thank you so much, Carol. Hi, everyone. It's Kelly Crosbie from North Carolina Medicaid. I'm the Chief Quality Officer and I'm joined tonight by a bunch of really brilliant folks here we're going to

talk all about events Medical Home quality, so really excited about that. I'm on the Medicaid side we've got Taylor Zublena and she's our Associate Director for quality management and Sam Thompson, who's our Associate Director for program evaluation. We've got lots of folks from North Carolina a heck you of course know Carol Stanley, hopefully all of you know Monique Mackey is going to be talking about a heck programs and then we've got wonderful staff, really brilliant staff from the PHPs great partners here to talk about the Hmh incentive programs at their particular plan and how you can get more information. So the next slide will tell us a little bit about the agenda tonight I'll do a quick overview the vision for North Carolina quality and the timeline for quality. Taylor's going to talk about the advanced medical home quality program and share some rates with you. We'll talk about standard playing quality measures rates and targets. Sam's going to talk about the data strategy and vision for advanced medical homes. And the plans we'll talk about their incentive plans in the support they're going to provide you for the AMH incentive programs. And then AHEC members will talk about AHEC practice support. We'll have some time for q&a, as Carol mentioned. So I'm just going to remind folks a wee bit about the North Carolina, the quality vision for North Carolina Medicaid. So we want to have a data driven we said this many times before head data driven outcomes based continuous quality improvement process. And as for all of Medicaid, that's Medicaid director standard plans or behavioral health, IDD tailor plans, and we have a roadmap. We really want to have broader awareness of quality we want to focus more and more outcomes over the years. And we very much want to promote health equity. So in our first contract year, we we've tried very hard to establish our quality vision, and we've set some early benchmarks for quality measures. We've deployed our quality strategy and we are collecting measures and we've also provided hopefully the field but certainly our health plans with historical data on quality here in North Carolina Medicaid, as well as some preliminary benchmarks. In contract you too will continue to to calculate a quality measures but plans will start to calculate their own quality measures and they'll share this with us. We'll start to assess those measures in plan performance and start to think about potential areas for plan quality withholds in year three and beyond. And we'll update our health equity benchmarks and they'll be fine they they could very well be plan specific. In contracts, here's three to five we really hope to streamline our quality measures and reporting. So we want to have a really fine set that mean the most to us. We want to increase the role of outcomes in our quality program. So more and more moving away from process measures. Into a finer, smaller group of outcomes based measures. We absolutely want to start using our health equity benchmarks to promote health equity in the program. The next slide just talks about the timeline. You've seen this before. And it's a really opportune time to be talking about quality because we're about to launch the first measurement year for our standard plans. So you know that standard plans launched in July of 2021. But we'll start measuring the quality year for plans in January of 2022. So you see the measurement cycles for the plans. They do span contract years. And starting in plan year three and beyond. We will begin to implement our withhold program based upon the data that we're seeing where we're seeing disparities where we're seeing room for improvement but this is our this is the timeline that we've shared. I'm going to turn things over to Taylor now and she's going to talk specifically about advanced medical home quality. Thanks, Taylor.

Taylor Zublena

Thank you, Kelly. Good evening, everyone. We can move to the next slide please. And this slide is something that you're probably seen before but wanted to provide refreshes, we're talking about the

advanced medical home measure set and how that's incorporated and a subset from our standard plan. Measure set for accountability and how that folds again into the measures that we calculate and measure across Medicaid overall. So North Carolina, North Carolina Medicaid counts calculates an expansive and comprehensive set of quality measures to assess, monitor and evaluate access to and utilization of care for the beneficiaries we serve in order to evaluate their health and health outcomes as well as their experience of care and measures are sourced from nationally recognized and standardized sources such as HEDIS, by NCQA and other measures in alignment with the CMS adult child core behavioral health and maternal health core sets. So the standard plans and tailor plans are accountable. For performance on a subset of our calculated measures, which were selected by and determined annually thereafter by internal and external stakeholders to provide the department with an overview of structure processes and outcomes for quality of life care and health for beneficiaries at the plan. Provider and member level, where feasible and appropriate. And as a subset of the standard claim measures that the department calculated. The department calculated set of measures, there's an intentional alignment to standard measures that are indicative of quality and utilization of care that are relevant and actionable at the Advanced Medical Home level. So shown as a measure set here in the bottom right Amh measure set. If we can move to the next slide please we'll take a closer look at what the measures are included in that set. The quality and performance improvement within the advanced medical homes are incentivized through these measures which are centered standardized across all plans to support quality and health outcomes for both children and adults. These incentives are required to be offered to tier three ages or advanced medical homes by the standard plans and are optional as an offer to tiers one and two, as determined by the standard plan. Which we'll hear more about this evening. As each of the plans outline their incentives plan and structure. As these measures are a subset of the Standard Plan measure set the standard plan baseline rate meaning the rate that the plans are accountable for improving are pulled from North Carolina Medicaid statewide performance rate for 2019 and determine the improvement target that the plans was reached during the calendar year 2022 measurement period and we'll look at those targets a little bit later in the slides as well. So measures in the Advanced Medical Home measure set focus on primary care relevance to specific wellness and preventative care, screening and intervention, appropriate intervention, chronic condition management and utilization of care plans and events medical homes are able to choose from any and all of these measures to improve and use and value based arrangements and incentives. Next slide please. And so if we move on to the next slide, just wanted to give a refresher as well to show the measure mechanics that we've outlined as far as policy and expectations. So before we move into the baseline rates and targets I wanted to refresh from prior webinars and policy expectations the quality improvement standards and publications or manuals to reference for Medicaid and prevent strategy overall. So each thing or plan must improve at least 5% relative improvement for all standard plan measures year over year with an additional focus on health equity. All standard plan measures will be stratified according to race, ethnicity, age, primary language, disability status and geography. If there's a relative difference if there's one that exists within a comparison group to a reference group, such as black to white or black to overall population rates, then the plan must reduce the disparity to less than 10% relative difference for at least two years. For future evolution the department will evaluate annually and modify the benchmarks as needed to address evolution of these measures that statewide and nationally as well as through evaluation of year over year performance by region or by plan or group to maintain or adapt the strategy if needed. Next slide please.

For the advance medical home measures here are statewide historical rates including the baseline year of 2019 and you'll see national medians in the 2022 measurement year target some measures which are highlighted in yellow at the bottom of the screen do not have a 2019 baseline due to changes either in the measure by the measure steward or data availability in the 2019 measurement Year, which utilize clinical data that Sam will cover in just a few moments. Rates you do see show the expected improvement target for health plans for the calendar year 2022 measurement period. Significant improvements have been made and will continue through data access and availability to measure these core areas of care and health which will improve with data reporting, sharing and health information exchange which I'll hand over to Sam Thompson, our Associate Director for program evaluation and Medicaid.

Sam Thompson

Thanks. So yeah, I'm going to share with you sort of our strategy for working with clinical data in the Health Information Exchange to advance medical homes are committed to us to use various data sources up to eight from the PHPs but also from other clinical entities to support population health, and we have a sort of all the criteria here but I've highlighted the ones coming from the Health Information change, but just to go through quickly. All ages need to have beneficiary assignment data can eat screening data, miss scoring, and quality measure performance limit. Obviously that last part has been talked about a lot today. But tier three practices also have to receive encounter data from the PHPs and user we get into the clinical data from information exchange. They need to receive ADT information that doesn't necessarily have to come from NC Health Connex, but it would be recommended. Obviously, those those credits would also be interested in cost data but it's not required. Also, all ages are encouraged to access clinical and other population health information from mental health connects data for NC CARE 360 and data sharing with with with patients so we you know, our strategy for making this happen. This is more the is ever evolving. We continue to update our plans based on new programs like the innovative CARE for Kids project, but also we are moving towards sort of a future state where we're working more and more to exchange data through hubs like information exchange to take me to the next slide. Um, and as you all probably know, all providers that that are that are carved out on the deadline was pushed out, but the expectation is that they're submitting data to the Health Information Exchange by the first day of 2023. So in just over a year, I am pasted on different provider subgroups and the expectations related to them here and but again, all those expectations fall on January 1 2023. Canadian the next slide please. So I'm learning our work with the Health Information Exchange. NC Medicaid has a lot going on but for quality and population health. We're focused in particular on three different work streams. We've worked with the prepaid health plans and CCNC to identify a set of priority data elements that we need the HIE to be sending to us at least monthly in the early part of next year. We'll use this to monitor population health and for essential quality measurement. And we'll look at that in a minute. Also and deeply related is that we want to work with health information exchange to ensure that that data that is that we received from it are of high enough quality to use for quality measurement and population health. And that will involve working with the PHPs and providers to ensure that the data are entered completely inconsistently. And then lastly, in an effort to ensure that the data that providers push into the Health Information Exchange aren't altered and look exactly like the data that come out the other side that we might use that might be part of those primary data elements. We're working with them to implement NCQA is a data aggregator validation program at

which will validate the inputs. And so next slide, please. So here's an example of some of the clinical data we need from the Health Information Exchange to produce the quality measures that we committed to for CMS and public facing out but in work for the plants. So, for the comprehensive diabetes care, we need pharmacological and lab data for controlling high blood pressure. We need vital signs data and you know, it may go without saying but I do want to underline none of these data are available to us in claims.

To measure screening for depression and follow up we need pharmacotherapy data lab data and follow up data. For weight assessment and counseling we BMI and clinical data and for HIV viral load suppression. We need diagnosis and lab data and for many of these we have commitments to CMS to predict to next slide please. And here's a look at those priority data elements I mentioned earlier. We went round and round with HIE and PHPs to identify specific data elements, some of which we were confident are already in good shape and we'll be receiving students on which mean significant work on you know examples of much of what are in pretty good shape we believe are certainly the new get demographic factors and things like blood pressure, things like depression screening, we don't need a lot of work in terms of how we read them and whether we can make sense of them and give you just a second to take a look at what we'll be pulling in starting to one of next year. Next slide please. And now I'm handing it off to the prepaid health plans to talk about the incentives and support they provide the AMH's and I believe healthy blue is going to kick things off.

Harrell

That is correct. Greetings everyone. This is Harrell here from Healthy blue. My colleague and I, Sam Maria will now share a brief summary of the quality incentives and value based program support we offer to our network providers, programs that are designed to support and align with North Carolina's quality vision and continuous improvement strategy. Healthy blue's value based program strategy highlights our commitment to expanding participation in population based payment models. Since the beginning of managed care lines, our health plan has been collecting various data to establish quality performance benchmarks and targets aimed at improving key performance measures and outcomes across various healthcare domains. As we move into the next phase of the implementation, healthy blue will launch a suite of performance incentive programs that encompasses the full spectrum of the lamb framework and categories that transcend just primary care. So programs focused on improving outcomes in other domains such as maternity health, behavioral health. And long term care will also be made available by program year 2023. Next slide please.

Sam

Hey, everyone. Thank you Harrell for passing it on. Healthy blue strategy and support journey has been fascinating. innovating and game changing. We focused on high touch high impact outreach dedicated to the programmatic lift. already made support model is designed and equipped to meet our providers where they are helping to identify and implement strategies to increase health care providers operational capacity and overall efficacy. Healthy blues engagement with providers thus far has been

largely centered around reinforcing delegated care management. The requirements there and such as timely data exchanges, the risk assessment and coordination of member care transitions. I am happy to share that healthy Blue has experienced 100% provider engagement seems lofty but pretty cool. Zero performance issues even cooler. Healthy blue attributes this to the strategically planned engagement with all assigned provider accounts and all contracted entities prior to launch. This takes us back to the glide path timeframes and healthy blue does believe that providers can support quality performance monitoring by getting connected to the HIE as we just heard a few slides ago by the other sim. Healthy blue will be in sharing monthly care gap reports with ah program participants through availability starting q1 of 22 so upcoming and our dedicated field support staff will be providing quarterly quality performance scorecards for target measures as well. Next slide please. And here on this slide you see ability right at the top in the rest of the list are a bunch of helpful resources. Please take some time taking a look and if you have any questions or need assistance, just want to shoot the breeze about some of the content please contact your Account contact that you probably already been in touch with. Thank you very much and I will transition to our peer at WellCare

Fran Johnson

Good evening everyone. My name is Fran Johnson and I am the Senior Director of Quality Improvement for Wellcare of North Carolina. I appreciate the opportunity to speak for even though it's just a few minutes on provider incentive programs data exchange and also some key contacts. I just got a couple of slides and I'm going to turn it over to Charlene King from our team who's going to speak to provide a resources. So if you'll go to the next slide so with regard to incentive programs WellCare North Carolina plans to implement two provider incentive programs in 2020 to one being an AMH program with a quality the other being a more traditional if you will program rewarding individuals for care gap closure for individual characters closure. So in other words, if you close X care gaps, you receive X dollars. And we will share the specifics of these programs as soon as possible as soon as they get through the approvable approval process. And note at this time these reports will be distributed via either on the FTP site if we had that with you or via email. So I mentioned data exchange or EMR file fees. We've had some great collaborative efforts to date and I look forward to some more conversations. Um it's been my experience that when a data exchange program is implemented, and it's up and running, provider quality results improved greatly. So it's typically well worth the effort of implementation for the long, long term game. And of course it goes without saying accurate coding billing the HIE are also keys to care gap closure and six outcomes for our members and patients as well. So right now, we will continue and begin with some discussions with various providers on that data exchange for that EMR file fee program. This will include discussions around our process, sharing your program description and templates, testing, identifying key individuals so we can have an ongoing relationship and troubleshoot when needed. So like I said, we've started a lot of those conversations and this is typically a larger as it sees, because it does take some resources to get it up and going but we look forward to more collaboration. And on that note, Nate is the point of contact for this program. Nathan is our Director of healthcare analytics here at WellCare, North Carolina, and he would be the person that would get the ball rolling as far as that EMR file feed program. And then speaking of contacts, we have quality practice advisors who are boots on the ground nurses that work with providers on anything quality in order to enhance our outcomes, member outcomes, your outcomes. They're here to assist you in any way possible. Because again, we want to maximize our results. And for that contact if you drink most

everyone knows who their quality practice advisor is but if you do not. Michelle Menten is our Director of Quality Improvement and she would be your contact to get to introduce to your PPA as we call it. So at this time, I'm going to hand it over to Charlene King from our provider relations department chatting.

Charlene King

Good evening. My name is Charlene King. I'm a provider relations manager for wealthcare I'm going to talk a little bit about the resources available for well care providers. Providers have access to a variety of easy to use reference materials on our website without the use of a user ID or password. That is called our public portal. The information on our website is the most up to date, and it includes covered benefits provider bulletins and reference guides related to claims authorizations and electronic funds transfer. The provider manual is available on the public portal as well as clinical practice guidelines and clinical coverage guidelines. Our quick reference guide can be found there it's a great tool. It provides contact information for specific departments and authorization information provider dispute appeals and grievance information as well as providers support services on nature. Additional services and resources can also be found on our secure Provider Portal. It does require registration a user ID and password to act and providers are able to check eligibility for the fit and copayment information. They can get an inpatient log the admit discharge and transfer report for their members that can request authorizations submit claims, perform payment query status that can get the preferred drug listings and provider newsletters on a secure portal. The provider overview and resources can be found@www.behr.com Who would select North Carolina providers and then Medicaid. In addition to those resources, we have associates that assist providers in achieving high quality practice status. These regionally based network performance advisors OJOCs these are our large provider groups and hospitals. They review performance metrics and identify opportunities to improve overall success and performance through providers under value based arrangements. We also have a general email box that's dedicated to provider relations. The contact that email address is on the screen it's SMNorthCarolinaprovider relations@wellcare.com. If providers are not sure who to contact for assistance at well, they can send an email to that box which is monitored daily. AmeriHealth is up next on the agenda so I'm going to turn it over to them. Thank you very much.

Pam

Thank you Charlene for the introduction. Hello, everyone. I am the Director of Quality Management for Amerihealth Caritas North Carolina for this first slide. We've outlined the three years moving forward for 2021. The only program that we have right now that is underway is our gaps in care payment program. This is an interim program that outlines closing care gaps by each of our providers. They get paid a certain fixed amount and that will be paid out to them early next year as they close some of the gaps for our members. This program is only for 2021 for 2022 our provider network management team along with our value based team will be working with the providers on the pay for performance value based arrangements. And this includes our Huey P program for the EMHs and those metrics that are embedded in the QET program. We'll also be working with the providers and the tier one and tier twos, other HEDIS measures and those metrics and will continue to address the gaps in care if we as we move forward. If there are any other value based program arrangements for providers, this work will begin

during 2022 as well and our providers can run their contracts for their metrics or they can reach out to our AmeriHealth account executive to get details around those value based payments and moving into 2023. We will continue that same work addressing our value based payment arrangement. Our pay for performance measures, our QE programs, and then we'll be kind of morphing into any kind of other reports that addresses opportunities for improvement and potentially any corrective action plans that we might want to develop. This work will be identified and we'll be working with a team of folks including quality and the provider network account executive to be able to address those opportunities

Pam

Any other improvement strategies that might be ad hoc around our performance improvement tests, and other programs that we identify and roll out throughout the year. Next slide please.

Our organization provides performance feedback in many different ways. This includes but obviously is not going to be limited to the work that our population health management team does as they perform outreaches to the AMH's tier threes in a sense, we're also be providing feedback through our provider newsletter, in any other quality work, that work that goes around our improvement for metrics, either through our corrective action plans and provide a report cards as we roll those out. assistance can also be obtained through our practice transformation team will also be providing feedback through our joint operation committee meetings with our larger health systems. And then finally, the work that can be done through the never net portal which is our provider portal. This portal really is our source of truth, as well as where our providers can close their gaps. They can download reports around their member panels, look at their status of claims, as well as provide feedback through different contacts as well. Never not really needs to have a sign in you need to be engaged in never net as well as also accessing our provider webpage which also has a number of resources for our providers and finally, I just like to put a little plug in that the provider manual that we provide through the orientation process also has a number of good resources for our providers. And that includes our provider support plan, and other documents that will help identify resources that they might be able to to use. Next slide please. And not to not to be a little repetitive here, but as the other health plans have indicated, data exchange is being done through many different avenues through the HIE through internal data files that we will be sharing, both with our providers as well as DHB. Any provider report, any dashboard access report, or NCQA data sharing for accreditation processes and then any other state or accrediting body reports that may be ad hoc potentially through the North Carolina immunization registry in our local health departments and other other stakeholders as well. Next slide, please. So what we've currently find working well for AmeriHealth care tasked with our contracting process, our closing of gaps for the first six months. That launch has done very well. And we're very pleased with the engagement that we've been getting to date. And then we are showing a lot of high level interest in our value based programs with many questions being funneled through to our value based teams. areas that we really need help from from the providers is a little bit of better engagement and accessing our provider website as well as our Provider Portal nav and net. Also the engagement that we need around data exchanges. We're doing some end to end testing. We also would like to get the HIE data exchange process up from operationalize and then making sure that providers review their orientation manuals and the resources that we have in that manual and other resources that we have also embedded on the website. And the next slide please. As the other plants I've provided links to our resources. So for the provider portal, we

have the sign up link to be able to access an --net provider portal as well as the logon page once you have that access identify. I also provided a web link to our provider manual as well. As the Provider Web page and the forms that we have listed out on our webpage. I have the general AmeriHealth care attack web provider webpage and our clinical policy link for that next page. Next slide please. And finally, I've provided a list of our contacts. And so I've provided everything from Population Health Management all the way to our chief medical officer at the local level. You can you can reach out to them for any questions or concerns that you might have. And finally, I'd like to introduce United Director of Quality my counterpart Laurie Jones Smith for the next presentation.

Laurie Jones Smith

Thank you. Thank you, Pam. I appreciate that. Good evening, everybody. I'm going to spend the next few minutes talking about United Health Care provider support and incentives. Primary Care Provider incentive or PCPI is the standard provider incentive program offered by United Healthcare to all eligible Hmh providers in all tiers. This program is a pay for performance model based on allowable age quality measures. Other value based arrangements are negotiated on a case by case basis with providers. United Healthcare provides patient care opportunity reports or what you may have heard reference to as P core. These are located on the provider.com website. The P cores are utilized for access to access for looking at your quality measures and viewing quality metrics for gap closure opportunities on a on a monthly basis. We've been hosting provider clinical leadership meetings to discuss clinical quality information, including but not limited to the quality metrics, care gaps and improvement opportunities. We've also started to engage providers on how best to obtain clinical data to satisfy performance measures. We see this process occurring in somewhat of a tiered approach, primary, secondary and tertiary with primary being claims registry data and as you've heard the HIE data when we have this available, secondary is electronic health record feeds and continuity of care documents, cc days, and then tertiary would be that chart review based method. So what's going well, from our standpoint, claims ingestion is going very well for performance measure identification, and we also have a very high degree of provider engagement. The biggest opportunity we see is HIE data exchange and I guess you've heard that that's kind of been saying throughout the evening. What we're asking from our providers to do to support all of these processes is first to continue to access UHC provider portal and view your patient care opportunity reports. on a routine basis. Continue to actively participate with us in clinical leadership meetings. Work with us on strategy and action planning for quality improvement activities and continue to support and facilitate the processes needed to ensure the EHR connections. For additional information on the lower right hand side of the screen, you'll find that we've provided some links from UHC provider.com, where you can find a number of helpful resources. Next slide please.

For clinical quality and provider support, we have dedicated teams to support various aspects of clinical quality. The health plan quality team establishes the overall quality strategy in alignment with the North Carolina Medicaid Managed Care Quality Strategy and identifies global performance opportunities. Our frontline team support the providers and the local health department's through oversight of performance metrics, facilitation of PI activities, education and incentives. So for any questions related to clinical quality and provider support, you can contact us at UHC-amh-support@uhc.com. Thank you for your attention this evening. And I'm going to hand it over to Jesse at CCH. Thank you,

Jesse Hardin

Thank you, Laurie. Good evening, everyone. My name is Jesse Hardin with Carolina complete health and I'll be talking to you tonight about our incentive programs and our provider engagement strategy. So to start with our provider engagement strategy, this is going to include a lot of education and support around quality and performance. So I wanted to start here with just a high level review of our approach to provider engagement each advanced medical home and help system has a dedicated provider engagement coordinator, which you can reach directly by phone or email and we have really found that having that direct line of communication is extremely helpful. We have a directory of our provider engagement team available on our website and when in doubt, feel free to email or call any one of us and we'll make sure that we have you set up with the right person. But provider engagement coordinators are going to and are currently providing education and support around the quality initiatives, the incentive programs the various performance improvement projects or pips, and more. And in addition, these provider facing teams they also support the operational teams in executing the Quality Strategy, interventions and improvement plans. Next slide please. Great so let's dive into our quality program and how you can access your performance feedback. So the quality management program with Carolina complete health really builds on the foundation from North Carolina's Medicaid strategy and also aligns with the state's Quality Management Program and quality measures. The goal of course really being to enhance the member and provider experience and engagement improve health outcomes. So as a first step, we successfully ingested and set up historical claims data along with all other files that are critical elements required to run those performance measure rates, including the data feeds from the North. Carolina immunization registry. And we can also work with our providers to set up EHR or supplemental data feeds for clinical data collection to help close those care gaps. So on the screen you see pictured is a an image of our provider portal. This is where you're going to find the quality dashboards. They've been disseminated through the provider portal. So if you have not yet registered for that we definitely encourage you to do so the link is listed on the screen here provider Carolina complete health.com You can click Create an account to get that started. And once you're verified in order to use the portal, you can go back to that login screen and on the welcome menu on the right hand side you'll click provider analytics and that is where you will see the screen on the right to get to your quality and pay for performance dashboards. So all advanced medical homes have quality care gap and measure reports available to them. And that's going to include all the priority measures. All the primary care practices are also part of our standard pay for performance program except those that are within practice entities that may be involved in a broad value. based payment arrangement. The standard p four P program is upside only and it aligns with the advanced medical home priority measure set and of course focuses on those preventative and screening services while promoting engagement with our members. The pay for performance program also of course provides financial incentives for closing the care gaps and achieving those improvement targets on the quality measures. And similarly the Value Based Payment Model is also aligned with the advanced medical home priority measures. So the quality and the standard p for p reports these are generated monthly and you can export them either in Excel or PDF as well as generate those number level detail reports. You can do this on your own through the portal but of course your provider engagement coordinator is here as a partner to help you do this. Our provider engagement teams are currently working with providers educating training supporting them with these tools and resources. And we're happy to provide some extra assistance and

support to review those care gaps and best practices for closing them, including those clinical practice guidelines.

On the next slide, we'll just show a few resources that are currently available. We continue to add to our library of tools and three new provider facing tools available to support you with the HEDIS and care gap specifically include a HEDIS measurement Year 2021 Quick Reference Guide, and adult measures pocket guide and a documentation tool for the preventative health counseling and education for pediatrics. So these are all available on our website currently and these are some resources that will give you some good tips and tricks around best practices with coding for example, as you guys are well aware in order to ensure those care gap closures. Those the coding is is definitely key for that and so that he does Quick Reference Guide in particular will be a great resource for that. But as we develop new tools and resources, be sure to check out our education and training page linked here. That's where we're going to post the latest offerings. And it'll also be helpful if you're receiving our monthly newsletters. They're always going to spotlight new tools and trainings available. So if you're not already receiving those, you can use the link listed on this screen to sign up for those communications. And we've also got all of our archived newsletters there as well for your reference. And that's all from us. I'll pass it over to Monique with AHEC thank you so much.

Monique Mackey

Speaking right now. Thank you. Good evening, everyone. I'm Monique Mackey and I'm the quality improvement manager for the North Carolina AHEC Practice Support Program. North Carolina. I have practice support coaches have been supporting North Carolina small independent primary care practices. Since 2008. First with improving outcomes and asthma and diabetes, and beginning in 2010, assisting North Carolina providers with becoming meaningful users of health information technology, followed by helping providers to be successful with CMSs QPP and next program we've also expanded the number of chronic diseases and conditions from which we can help practice improve outcomes for patients. From the start, we have assisted practices with meeting Aijaz triple aim of improving patient satisfaction and experience while improving clinical outcomes and reducing the per capita cost of care. This slide gives a brief overview of the many ways that we can support your practice. Next slide please. We have more than 30 coaches across the state who are available to work with you on your Hmh goals at no cost to you or your practice. Our coaches have strong backgrounds across the healthcare spectrum, with many having served as practice managers and or health information technology experts prior to coming to AHEC. This map outlines the non AHEC regions and will provide you with content tact information for our regional Practice Support team leads. Next slide please. There is no wrong door to get to one of our expert coaches. We can also be reached by email at back support and NC AHEC dotnet or you can learn more about us at our website. There's a link to that website here on this slide. Next slide please Nevin. The first link on this slide provides you with with quick access to all Medicaid managed care webinars. The second link will take you to a more in depth into more in depth information about the Medicaid Managed Care Quality Strategy. AHEC is here. We're happy to assist you. Back to you Carol.

Carol Stanley

Thanks so much, everybody. Great presentation. So we have your participants have any questions put please put those in the q&a box and you can also see some questions that have been answered. Sam Thompson, this is a comment that I believe you would like to respond to and I'm going to read it out for you. It would be nice to get all of our care grant gap information in one place. While it's appreciated that we can access the payers portal. We need to see all of our information in one place regardless of payer also would be great to have this without joining an ACO or CIN since they don't reflect all payers.

Sam Thompson

So I joke with Taylor offline that I think somebody from the Health Information Exchange planted this question but it's a bit futuristic. It's not something that's going to happen this year. But But what's being requested requires an information of salary because because nobody has all the information except for Medicaid and even we don't have all that. So it has to happen somewhere where the data are being aggregated. There is a vision CMS has a vision that place like the health information sets up data collection systems where the data cleaning up and pulls in encounters. Which are health information exchange already does and pose in the clinical data that from providers and produces quality measurement and other key key population health data and it's about two providers from their Medicaid is currently working on it sort of information system of the future and you know we, Taylor, Kelly, I other folks team as we understand what what we need to do to serve on folks like you will build that vision and eventually be able to serve that purpose. Unfortunately, that'll take a few years. But but that's how something like that would happen. And in the meantime, you can support that happening by submitting complete high quality data to the Health Information Exchange and getting acquainted with sort of bi directional use in terms of using the data that comes out of it.

Carol Stanley

Great, thanks so much, Sam. And I see that most of the other questions are currently being answered. And we do have one question that a general question for response and that is for patients who are non responsive to letters, calls or texts. Is there a way to move them off of that panel? I believe that would be for the Medicaid team.

So if a provider has patients on their panel who are just not having appointments, attending appointments, not responding to phone calls or anything any suggestions for the practice.

Jesse Hardin

Oh, this is Jesse with me Carolina complete health. Okay, I was gonna jump in just to speak to this on behalf of Carolina complete health in the process. We have mapped out for providers to support them with this, because we definitely understand that can get in the way of meeting your benchmarks and quality measures and care gaps and so I'll reply to the question in the chat as well but we have a policy

on our website around number reassignment. And basically it invites the provider to send an email with a bit of member information and the reason that you want to request reassignment and the first thing that will happen is our Member Services team is going to conduct outreach to that member to attempt to get them engaged to address any social determinants or other reasons why they may have trouble engaging with care to really wrap around them in that way. And then of course, if necessary, get them reassigned to a different primary care provider if that is needed. So I'll drop a link to that in our in the q&a. box for you. That'll help. Thank you. Thank you.

Carol Stanley

Now I'm looking for other questions that are relevant to the topics specifically on performance incentives from the health plans. Here's a question that I'm going to go ahead and pitch it to the PHP is our provider relations meetings with the practices required or can a practice meet with you as needed? And I'll just mention it it's quite possible that the representatives from the health plans tonight are not representing the part of the health plan that could answer that question. So we welcome questions that are specific to performance incentives. Keeping an eye on the questions so I'll ask this question live. Is there a certain number of patients practices must have on their panels before the PHPs have to pay them for quality incentives? So that might be a question for the Medicaid team.

Unknown Speaker

Carol, this is -- from CCH. For CCH we do not require them to have a certain number of members. We have all primary care practices part of the incentive programs.

Carol Stanley

Would the other PHPs like to comment?

Unknown Speaker

Same for the others.

Carol Stanley

Okay. Healthy blue. Do you require a minimum number of patients on a practice panel for them to be eligible for incentives?

Harell

This is Harell from healthy blue. I did drop a response on a pain but essentially, I mean, giving the variation of programs that a lot of the PHPs offer us included. It's going to depend on what program they're participating in some do and some don't.

Carol Stanley

Okay, very good. Thank you.

Pam

Carol, this is Pam. I'll take a stab at the provider relations question. Okay. How differs Are they required to me and for Amerihealth you're not required to meet it? There's a little caveat to it. On the clinically integrated networks of ask that we go through a certain contact and then that they would then funnel information down for the joint operating committees for the larger health systems. People aren't required to come but it's nice that they can come so we can talk about opportunities on both sides of the table and how we can improve everything from communications to no to metrics.

Carol Stanley

Okay, very good. Thank you. Other questions? Got a few minutes left. So don't hold that specific to quality performance incentives. The health plans and Medicaid are monitoring the q&a box so please put your questions in there. Alright, I'm not seeing any more questions. Oh, hold on a minute.

Taylor Zublena

Carol, there's one that I saw in the chat that I just wanted to say it's a bit of jacent but relevant for what we're talking about. Do you have incentives for COVID vaccine administration rates in our practice or to the members and I want to just a reference of prior backwards chat that I can link within the chat as well. We're talking about the member incentives by each of the plans, as well as what's to come as far as provider incentives for vaccination rates. So I will put that within the chat but I wanted to address it.

Carol Stanley

Great. I'm glad you noticed that one. I think, isn't there may I think there's a matrix in the appendix of the slide deck to about that.

Taylor Zublena

I think it was removed so I'll put it in the back to the head web page. So make sure I answered it live to the point in the right direction.

Carol Stanley

Okay. Thanks, Taylor. And here's a question Is there a specific time frame in which the NC HIE, will be up and running and providing non claims based data, such as A1Cs so the to the PHP so that the practices can receive that data and communicate it back to the practice?

Sam Thompson

See, yeah, is up and running for this purpose. You can you can set up a bi directional exchange and get it right back into your EHR if your HR is set up to do so. Um, that's the intention those priority data elements we presented earlier. That's a set of data elements including A1C, that that DHB to mitigate the PHPs and some larger CINs to a CCNC will be receiving from Health Information Exchange based on on data submitted by providers. But there's also a tool called NC notify, which which will, if you've connected the HIE, not just pull data out into the health information exchange but push data back including things like A1C.

Carol Stanley

Okay. Thank you, Sam. And we've got a new question that's come in as well. Will there be incentives to primary care providers that integrate behavioral health into practice? With any of the health plans like to respond to that one. Okay, let's see.

Harell

I'm sorry, this is Harell from healthy blue. Okay. Well, in response to the second to last question about the incentive incentives for behavioral health. I did put a response I don't know why it doesn't seem to be showing up but ultimately, what I was explaining was for us to test the blue does offer Quality Incentive Programs for AMHs which are essentially primary care, but they also include behavioral health measures, in some, you know, a few behavioral health measures and those programs so let me know if that kind of answers what you're getting at.

Carol Stanley

Yeah, any other PHP like to comment if you're offering incentives at this point in time, or anywhere in the near future? To primary care providers who integrate behavioral health into their practice? Okay, um, let's see. I'm looking at this question I'm gonna defer to the Medicaid team.

Carol Stanley

I'm not sure about this question and then we have a couple of others so the individual who asked about behavioral health integration clarified that they were speaking of extra payment for integrating

psychiatry, psychology or therapists. I suspect there's more to come on that. So we are currently at 630 right on the dot and I'm going to go ahead and close things up for now and wish everybody a good evening and thank our fantastic panelists. For a good session. So long, everybody