2023 PCP QIP Updates

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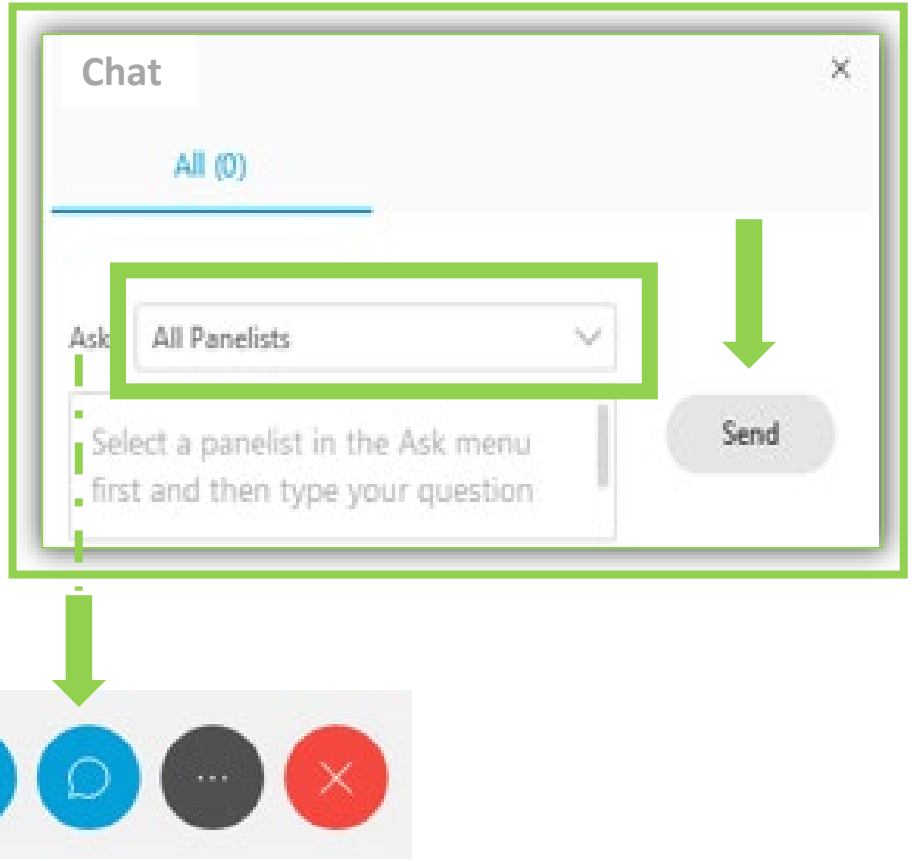
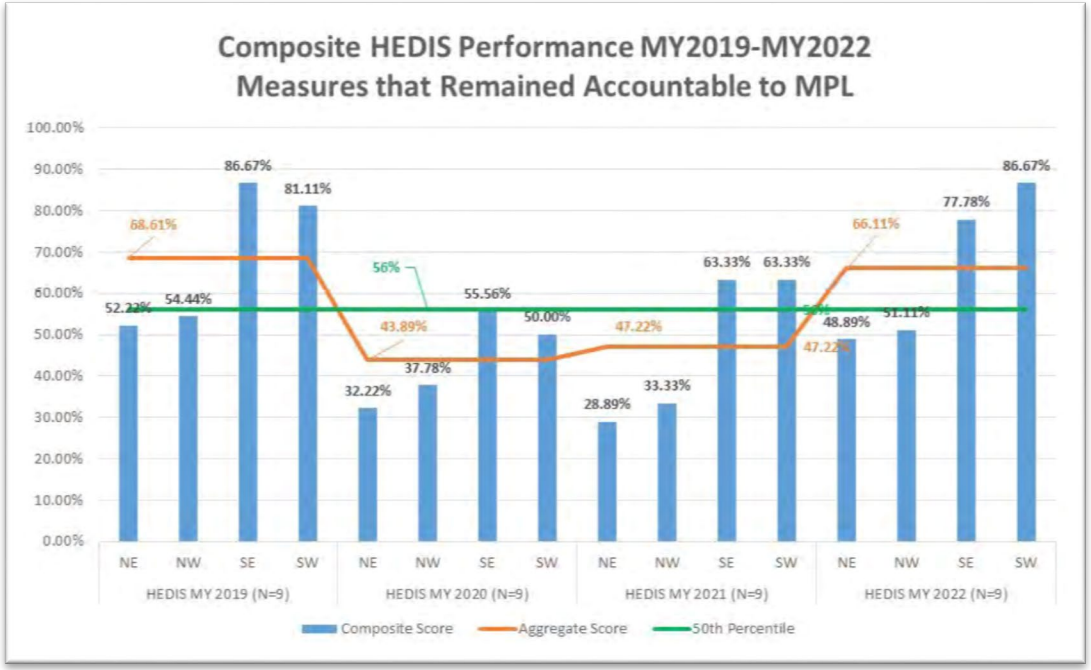
Webinar Instructions

- This webinar will be recorded.
- All participants have been muted to eliminate any possible noise interference/distraction.
- Time is put aside for questions at the end of the webinar.
- If you have a question, please type your question in the CHAT BOX, and address to “ALL PANELISTS.”



Thank You

- Quality of care that Partnership members receive largely depends on efforts at the Primary Care Site level
- Partnership HEDIS results indicate a substantial recovery, post COVID – major remaining gaps are pediatric measures: well child visits and vaccinations



Agenda

- Update on equity adjustment methodology
- Special focus on acuity adjustment
- Specifications changes for ECDS measure

Equity Adjustment Methodology

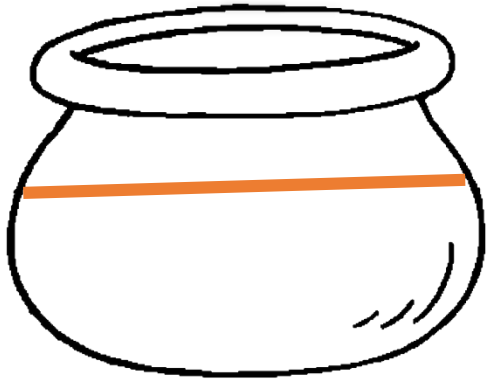
- **Why Equity Adjust?**
- **Big Picture**
- **Components of Adjustment**
- **Timelines**

Why Equity Adjust the QIP?

- Previously, dollars going into the pool for the PCP QIP were only dependent on assigned Partnership patients with primary Medi-Cal coverage
  - There was no adjustment in payment amount for the complexity of the patient, the degree of socio-demographic stress, the difficulty in recruiting high quality staff, or the baseline resources of the PCP
- Equity adjustment is intended to make the PCP QIP payment fairer, while not reducing motivation to strive for high quality

Basic Principles Approved for 2023 Equity Adjustment

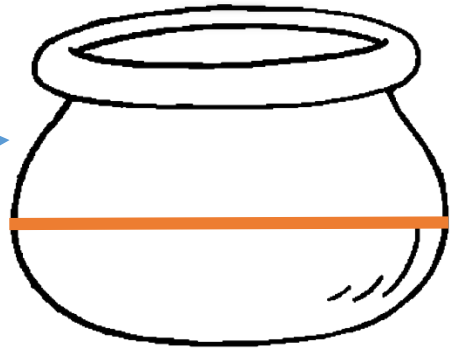
- Adjust the dollars at stake, starting at a minimum amount of $4 PMPM, increasing depending on adjustments



Multiplied by the score on Core Measure Set (0-100%)

- No adjustment for target thresholds or measures

- The amount earned will still depend on quality of care provided.



Previous Method of Allocating Dollars to Pool

- Dollars available for PCP QIP was set at $9.25 PMPM for members capitated or assigned to a PCP
- Of this amount in 2022, 62% of funds were earned (weighted average), or about $5.75 PMPM

Process Used to Determine Adjustment Methods

- Goals:
  - Fairness
  - Simplicity
  - Understandability
- Incentivize discretionary energy to improve quality metrics and avoid unintended negative consequences
- Stakeholder input of early ideas, last year
- Using actual data to test validity of options
- Structured to **not** have an overall increase in total PCP QIP budget
- Take into account new DHCS rate methodology
- 2023 is a pilot year; we will modify in future based on what we learn

Rate Methodology Changes for Medi-Cal Managed Care

- Rates will be adjusted based on estimated patient acuity, as calculated from encounter claims data
- Substantial new quality withholdings for patient experience/clinical quality
  - Year 1 – 0.5% withhold on PHC revenue
  - Year 2 – 1% withhold on PHC revenue
  - DHCS will increase withhold annually thereafter
  - Eight of ten withhold measures are in the PCP QIP

Components of Upward Adjustments Summary

- Gateway
  - Must have at least 100 assigned members as of December 1, 2023
- Core adjustments
  1. Site difficulty in recruiting PCP physicians
  2. Socio-demographic risk, at patient level, rolled up to PCP site level
  3. Lower than average baseline per visit resources available to PCP
  4. Acuity of patient panel
- Disaster Adjustment
  - Site closed and unusable due to external factor, such as fire, earthquake, flood, etc. for at least five consecutive days in the year

Relative Weight of Core Adjustments

Percentage Weight	Equity Adjustment Factor
20%	Difficulty in Recruiting PCPs (2 components)
20%	Socio-demographic risk factors
20%	Below average resources
40%	Acuity adjustment

Difficulty in Recruiting PCPs

- Several options have been evaluated, including using point of care survey.
- Final plan for this year:
  - Half points (10% out of 20%) awarded if PCP site is in a frontier area, as defined by Level two Frontier and Remote areas by the U.S. Economic Research Service (Dept. of Agriculture)
  - Half points (10% out of 20%) awarded based on 2022 ratio of PCPs/population of the county where the PCP is located – incentive amount differs for each county

Socio-Demographic Risk Factors

- Member addresses are used to determine census tract of residence
- Using census-tract level data from the Healthy Places Index, each patient will be given a socio-demographic risk score
- This will be rolled up at the site level to determine an overall average site level sociodemographic risk score
- Extra dollars in the PCP QIP will be added at the site level, depending on the rolled-up sociodemographic risk score for that site

Adjusting for Low Available Resources

- Similar to a tax credit for low income households
- Per visit resources available to practices are calculated based an several data sources
- No adjustment for sites with per-visit resources greater than the 50th percentile
- Maximum adjustment for sites in the lowest 10th percentile of per-visit resources
- Sites in between these ranges will have partial payments calculated

Acuity Adjustment

- High Level Overview
- Rationale
- Key Messages
- Further Education

Acuity Adjustment
High Level Overview

- Weighted more heavily (40% of total) to encourage immediate attention to this
- Calculated based on claims data received, which in turn depends on
    1. How severely and chronically ill the patient is
    2. How much the patient sought care
    3. How well the provider captured all relevant diagnosis codes
- The latter two factors can be improved upon with discretionary clinician attention, systems of support, and education on billing processes

Acuity Adjustment
Two Components

- Half of points (20% out of 40%) will be awarded based on the aid code-adjusted average number of diagnosis codes per encounter submitted by the provider
- The other half of points (20% out of 40%) will be awarded based on the percentage of assigned patients who are seen at least once in the measurement year
- For both measures, an upper target threshold (above which the maximum dollars are allocated) and lower baseline threshold (below which no dollars are allocated) will be established. In between these values, increased acuity scores will lead to a higher supplemental equity PMPM amount being added. Providers may also be eligible for payment based on improvement.

Rationale I

- The actual methodology that DHCS will be using for acuity adjustment is not finalized
- The previous methodology used by the state had some flawed actuarial assumptions
  - Need to adjust for proportion of patients with different Aid Codes, whose disease burden is known to be different
- There is no generally accepted standard of adjustment of acuity based on the workload of the PCP, but financial acuity adjustments are widely used as a surrogate.

Rationale II

- Two key drivers/associations of acuity levels, with other factors being constant are:
  - Average number of diagnoses per claim
  - Number of assigned patients with at least one encounter
- These numbers are easily calculated both by the health plan and by PCPs
- These measures are easy to convey to clinical staff, making interventions and dashboards easier to develop
- This methodology will be analyzed and adjustments made for future years (weighting of diagnosis codes)

Key Messages for Providers: Diagnosis Codes

- If time allows in a visit, review and update the patient's problem list
  - If a previous problem is addressed at a visit, document the medical decision-making or counseling provided on that problem and
  - Include it on the list of diagnoses that were covered at that clinical visit (to be sent in with the claim)
- If a patient has complications of a chronic condition, include the complications in the diagnosis list, not just the underlying chronic condition

Key Messages for Care Teams: Percent of Patients Seen

- All in-person and virtual visits count
- Denominator for this measure is patients who were seen in the prior year or the current year – this removes patients that have never been seen or never want to be seen.
- However, don't give up on patients who haven't been seen in a while. Bringing in a long-lost patient will count for numerator and denominator, boosting the score
- Assuming that on their prior visit, their contact information was updated, the PCP is more likely to be able to reach this population
- First outreach to those who need an annual visit anyway are children up to age 20, and those with diabetes, hypertension, asthma, and other chronic diseases.

Additional Education on Acuity Measures

- PHC will offer a recorded lunchtime webinar for clinicians and finance/billing/office staff (Late September or early October)
- In the meantime, please share the prior two slides of “Key Messages”

Estimated Site PMPM

- In the next few weeks, we will distribute an example PMPM for each PCP site, using 2021 or 2022 data, depending on the measure
  - These will be sent to parent organizations with at least one site greater than 100 members assigned
- These will be distributed to parent organizations, to assist with budgeting and to be a baseline for the acuity measure, which is amenable to change due to coding behavior
- The final adjustment factors for the 2023 measurement year will be based upon updated data, the most recent available – Estimated date of final calculation March 2024
- We recommend immediately focusing energy on improving acuity adjustment by improving diagnosis code capture and bringing in patients who are not being seen

ECDS Measure Adjustment

- Background
- Why Changes?
- Current Specs
- Changes in Specs
- Webinar

ECDS Measure Update Background

- The Electronic Clinical Data Systems (ECDS) measure is a unit of service measure in the current QIP
  - The measure requires submission of a report of data extracted from your electronic health record for use in calculating several HEDIS quality measure rates

- NCQA is striving to move all quality measures away from hybrid methodology to electronically captured data
  - Some electronic feeds are more established, like vaccination and radiology data
  - Others are more complex with little or no claim codes available to capture such as alcohol screening and depression measures

Why Are Changes Needed?

- A detailed review of data files submitted last year found a number of issues that made the data not usable for the Partnership HEDIS project
  - Changes made to spreadsheet template
  - Manual manipulation of data
  - Validation timeline was too short
  - Key supporting documentation needed by NCQA was not required
- As a result, only 10% of submitted data was usable
- Need to make changes to current specifications to correct these issues

Previous Specifications

Thresholds

Incentive can be achieved by participating in Electronic Clinical Data System (ECDS) implementation by the end of the measurement year.

$5,000 per Parent Organization for either:

1. Submitting a test file by **November 15, 2023** followed by the final file run between **January 8, 2024 and January 29, 2024**
2. For sites that previously submitted an initial file: Submitting monthly 2023 ECDS file starting no later than **June 2023**.

Measure Requirements

Participation to include data collection of the following clinical components for all PHC members within your organization.

1. Attention-deficit/hyperactivity disorder (ADHD)
2. Breast Cancer Screening (BCS)
3. Alcohol Screening and Counseling (11 years and older)
4. Depression Screening

High Level Changes

- Reduction in number of measures to be reported
- Requirements for payment include additional steps
- Timelines to be adjusted
- Higher payment level for successful submission

Reduced List of Measures

- Depression measures
  - Five ECDS measures are all covered in on report)
- Alcohol screening measure
- Breast cancer screening and ADHD measures will no longer be included as little new information was found with these measures

New List of Requirements

- **No manual manipulation of data!**
  - If errors are found in data output, the underlying computer code must be fixed, NOT the data output
  - NCQA audit rule
- In addition to data submission, a ECDS roadmap document must be submitted
  - A template/sample will be distributed
- Additional requirements listed with the timeline

New ECDS Timelines

- Generate Electronic Clinical Data System (ECDS) output using updated 2023 specifications and submit as a test file no later than **October 15, 2023** via Secure File Transfer Protocol (sFTP)
- Submit draft of ECDS roadmap to PHC by **October 15, 2023**
- Any corrections to the data to be completed by **November 1, 2023**
- Both data test file and ECDS roadmap are accepted by the Partnership HEDIS team by **November 1, 2023**
- Cooperation with Partnership HEDIS team Primary Source Verification which may be between **November 1, 2023 and January 31, 2024**
- Submit final data file – using the exact programming used for the test file – via sFTP between **January 7, 2024 and January 14, 2024**

Payment Adjustments

- $10K per parent organization for sites with no support from their EMR vendor, and thus need to use an outside vendor to extract the data
- $5K for parent organization whose EMR vendor generates the report for ECDS data submission
- Note: if EMR vendor charges more than $5K per site to generate reports, notify the QIP team for a possible exception to allow higher payment
- The payment will only be made if the Partnership HEDIS and IT team is able to accept and ingest **both** a test file in the autumn of 2023 and the final year end file in January of 2024

ECDS Measure Support

- Partnership will post updated sample SQL code that can be adapted to extract data from ECW and NextGen on the eReports section of the Partnership website
- OCHIN Epic Uses should submit request for ECDS report; OCHIN is aware and says they will coordinate these requests.
- The code has minor changes from last year
  - The value sets are updated and include various California specific codes
  - The Excel templates are formatted to prevent accidental changing of key fields
- Additionally, excel reporting templates, value sets, and a template roadmap will also be on eReports

Webinar: ECDS Updates

Date: September 11, 2023

Time: 11:45 am – 12:45 pm

Topics:

- Introduction to HEDIS
- Coding / File Layout
- Overview of the ROADMAP
- Audit Process / Timeline
- Defining Primary Source Verification (PSV)

Registration: Register with this link – https://partnershiphp.webex.com/partnershiphp/j.php?MTID=m54ad155450af33dd3716b4c0bfc6d681

Other News

Health Equity Practice Transformation Grants

Funding: $700M initiative

Goal: to improve primary care for Medi-Cal recipients by:

- Advancing health equity
- Reducing COVID-19 care disparities
- Investing in up-stream care models to address health and wellness
- Fund practice transformation

Very short turnaround between full grant description and grant application submission deadline

Preparing for EPT - BJS

WHAT TO DO NOW:

email PracticeTransformation@partnershiphp.org
TODAY for eligibility criteria and next steps

Questions