2024 HAP Best Practice Incentive Program

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Agenda

Welcome

Vision and Changes

Measures

Questions

Next Steps

Health Alliance Plan Vision for Partnering with you on Holistic Support of our Population

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Commercial and Medicare

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Incentive Program Changes

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Program Changes (Commercial and Medicare):

- Removed the following measures
  - None
- Added the following measures
  - Osteoporosis Management (Medicare only)
- Added the following Medicare measures as display-only
  - Kidney Evaluation for Patients with Diabetes
  - Plan All Cause Readmissions
- Focus Measures are set at the 90th percentile for Commercial and 5.0 Star Cut Point for Medicare

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2024 Best Practice Incentive Program: Medicare and Commercial

2024 HAP Best Practice Incentive Program

	Commercial Target	Commercial Payout (PMPM)	Medicare Target	Medicare Payout (PMPM)
Composite Score	75%	x.xx	4.0	x.xx
SDoH Z codes submitted for % population	2%	.xx	2.5%	.xx
MiHIN Use Cases: ACRS, HD, ADT, PPQC and CCDA	Compliant	.xx	Compliant	.xx
Focus Quality Measures	Target		Target	
Controlling High Blood Pressure	74%	.xx	82%	.xx
HbA1c Control for Patients with Diabetes Commercial: A1c < 8 Medicare: A1c <= 9.0%	69%	.xx	87%	.xx
Utilization Measures: Reward only if composite score > 50% (Commercial) or 3.0 (Medicare).				
Avoidable ED visits / 1000	80	.xx	130	.xx

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Quality Measures - Commercial

Quality Measure Table: Commercial

HAP Commercial Measures	Target
Hypertension: Controlling High BP	60%
HbA1c Control for Patients with Diabetes HbA1c < 8%	59%
Breast Cancer Screening	71%
Cervical Cancer Screening	74%
Colorectal Cancer Screening	63%
Child and Adolescent Well Visit	57%
Eye Exam for Patients with Diabetes	49%
Statin Therapy for CVD	83%
Well-child Visits (0-15 Months)	82%
Well-child Visits (15-30 Months)	88%

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Quality Measures - Medicare

Quality Measure Table: Medicare

2024 HAP Medicare Measures	Wt	Two Stars	Three Stars	Four Stars	Five Stars
Outcomes					
Controlling High Blood Pressure	3	58%	68%	74%	82%
HbA1c Control for Patients with Diabetes HbA1c <= 9%	3	58%	72%	80%	87%
Med. Adherence for Cholesterol	3	82%	86%	88%	91%
Med. Adherence for Diabetes	3	80%	84%	88%	90%
Med. Adherence for Hypertension	3	82%	86%	89%	91%
Process					
Breast Cancer Screening	1	52%	63%	71%	79%
Colorectal Cancer Screening	1	50%	61%	71%	80%
Eye Exam for Patients with Diabetes	1	52%	65%	73%	81%
Osteoporosis Management in Women w/ Fracture	1	29%	42%	55%	71%
Statin Therapy for CVD	1	79%	84%	86%	90%
Statin Use for Persons with Diabetes	1	81%	86%	88%	92%
Transitions of Care - Med Rec Post Discharge	1	38%	52%	68%	82%
Display-only					
Follow-up after ED Visit for Patients with Multiple Chronic Conditions	Display	44%	53%	60%	68%
Kidney Health Evaluation for Patients with Diabetes	Display				
Plan All Cause Readmissions	Display	13%	11%	10%	8%
Transitions of Care - Patient Engagement	Display				

Utilization Measures: Commercial and Medicare

Utilization Measure Table

Provider Organizations are rewarded if Avoidable ED Visits meets the target **and** the Composite Score > 50% (Commercial) or 3.0 (Medicare).

Measure	Commercial Target	Medicare Target
Avoidable ED Visits	80	130

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Composite Score: Commercial and Medicaid

$$\text{Composite Score} = \frac{\#\ \text{eligible measures meeting the target}}{\text{The total number of eligible measures}}$$

- Measures are eligible to be scored if the denominator is 10 or greater.
- A minimum of 51% of measures must be scored to obtain a composite score.
- The target is set at the 50th percentile for both Commercial and Medicaid.

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HAP CareSource™

Medicaid/MMP

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Incentive Program Changes

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Program Changes (Medicaid/MI Health Link):

- Added the following measures:
  - Childhood Immunizations (Combo 3)
  - Lead Screening for Children
  - Adolescent Immunizations (Combo 2)

- Moved the following from display to incentivized:
  - Timeliness of Prenatal Care
  - Postpartum Care

- Removed the following measures:
  - None

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HAP CareSource 2024 Medicaid/MMP Incentive Program

Provider Organization Incentives	Target	Payout (PMPM)
Eligibility: Provider organizations with a minimum of 100 HAP CareSource Medicaid and/or MI Health Link members can request to participate		
Composite Score	75%+ 60%-74% Below 60%	$0.xx $0.xx $0.00
SDoH Z codes submitted for % population	1.5%	$0.xx
Care Management Codes for % population	2%	$x.xx
MiHIN Use Cases: ACRS, HD, ADT, PPQC and CCDA	Compliant	$x.xx
Focus Measures		
Adult Access to Preventive Care 20 - 44	70%	$0.xx
Adult Access to Preventive Care 45 - 64	80%	$0.xx
Adult Access to Preventive Care 65+	80%	$0.xx
Child and Adolescent Well Visits	48%	$0.xx
Well Child Visits 0 – 15 months	58%	$0.xx
Well Child Visits 15-30 months	67%	$0.xx
Provider Incentives	**Target**	**Payout**
Adult Access to Care 20-44	79%	$xx per member in numerator if target is met
PCMH Certification	2024 PCMH certification	$0.xx PMPM
Health Risk Assessment (HRA)		$xx per HRA

HAP CareSource Quality Measures

Quality Measures Table

2024 Medicaid/MI Health Link Measures	Target
Adolescent Immunizations (Combo 2)	34%
Adult Access to Preventive Care 20 - 44	70%
Adult Access to Preventive Care 45 - 64	80%
Adult Access to Preventive Care 65+	80%
Breast Cancer Screening	52%
Child and Adolescent Well Visit	48%
Diabetes Eye Exam	52%
HbA1C Control for Patients with Diabetes HbA1C <8%	52%
Hypertension: Controlling High BP	61%
Lead Screening in Children	63%
Postpartum Care	78%
Timeliness of Prenatal Care	84%
Well-child visits (0-15 Months)	58%
Well-child visits (15-30 Months)	67%

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Care Management Codes

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Partnering with you on Care Management and SDoH

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- HAP per medical policy supports Care Management codes as covered codes without need for prior authorization – **for Medicare Advantage Individual and Medicaid they are covered at <u>no cost share</u> to the member**
- <u>Examples of Care Management include:</u>
  - Transitional Care Management (TCM)
  - Advanced Care Planning (ACP)
  - General Behavioral Health Integration Care Management (BHI)
  - Psychiatric Collaborative Care Management (PCCM)
  - Chronic Care Management (CCM)
  - Principle Care Management (PCM)
  - Care Coordination Management
- Although not separately billable – HAP strongly encourages screening and code capture for social determinant - **SDoH Z-codes** as part of regular clinical or care management encounters

Questions?

Thank You