

## Using Payment, Policy, and Partnerships to Improve Infant Well-Child Care

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### Alyssa Bosold:

Housekeeping items. All participants logged into this webinar have been muted for the best sound quality possible. We welcome audience questions throughout today's webinar through the Q&A window located at the bottom right corner of your screen. To send a question or comment related to the webinar, please highlight All Panelists and click Send in the Ask dropdown list. We will address as many questions as possible during today's webinar.

If you have any technical issues, please also use the Q&A window. Please select Host in the Ask dropdown menu and describe your technical question. Lastly, we want to let everyone know that this meeting is being recorded. Now I'd like to turn it over to Jodi Anthony from Mathematica to kick us off. Jodi, you have now the floor.

### Jodi Anthony:

Thanks, Alyssa. Next slide, please. Here's our agenda for today. We're going to hear from Kristen Zycherman at CMS and myself about the purpose of this initiative. We'll then spend the majority of time hearing from David Kelley, the Chief Medical Officer at Pennsylvania Medicaid, and Denbigh Shelton, program specialist with the Texas Health and Human Services Commission. We plan to have time at the end for questions and then we'll wrap up with next steps. Next slide, please.

Today, we intend to share more about the CMS Maternal and Infant Health Initiative, including why we are focused on infant well-child care, and offer considerations for strategies to improve the use and quality of infant well-child care. You'll also learn about how Pennsylvania and Texas utilize a mix of payment, policy, and partnerships to effect improvements. And with that, I'll turn it over to Kristen Zycherman from CMS.

### Kristen Zycherman:

Thank you, Jodi. On behalf of CMS, I want to thank all of you for joining us. I know you're all busy and we appreciate so many of you taking the time to partner with us on this important work. As a bit of background – oh, sorry, next slide. As a bit of background, CMS launched the Maternal and Infant Health Initiative, or MIHI, in July 2014 in order to improve access to and quality of care for pregnant and postpartum people and their infants. Five years into the MIHI and in light of increasing rates of maternal and infant mortality and morbidity, CMS identified a need to take stock of the progress of the MIHI and to chart a course for the next five years.

To inform CMS in this process, another expert workgroup was convened, representing a variety of stakeholders, with the aims of eliminating preventable maternal mortality and severe maternal morbidity and inequities, and to reduce the infant mortality rate as well as inequities in infant mortality. The workgroup helped to identify and prioritize three areas of focus where Medicaid and CHIP have a significant opportunity to influence change through technical assistance. These included increasing the use and quality of postpartum care visits, increasing the use and quality of well-child visits for infants zero to 15 months, and to decrease the rate of cesarean births in low-risk pregnancies.

The expert workgroup emphasized the need for a comprehensive life course approach to maternal and infant health, one that recognizes the importance of the mother-infant dyad as well as the interconnectedness of the focus areas and how they affect both maternal and infant health outcomes throughout the childbearing years as well as infancy and early childhood. Next slide, please.

Fast forward two years from the workgroup recommendations and our world has changed. However, the COVID-19 public health emergency has further emphasized the importance of high-quality comprehensive well-child and preventative care that is accessible to all people. In addition, it is essential that we undertake efforts and encourage catching up on missed care due to the pandemic. We know that states are already focusing on this and examples of these efforts include using and sharing data for family outreach, partnering with other sectors and providers, and addressing systemic barriers. Next slide, please.

With that, I am excited to kick off our Infant Well-Child Visit Learning Collaborative. We will hold two additional webinars. The second focuses on improving the use and quality of infant well-child visits in different state delivery systems and the third which will describe models of care that drive improvements in infant well-child visits, including home visiting and patient-centered medical homes. The webinar series will then be followed by an action-oriented affinity group beginning in October. Thank you again for tuning in and we hope many of you will continue to join us. Back to you, Jodi.

### Jodi Anthony:

Thanks, Kristen. So, why focus on infant well-child visits in Medicaid and CHIP? Next slide. So, as most of you know, the American Academy of Pediatrics, through the Bright Futures Periodicity Schedule, recommends six well-child visits by the time a child is 12 months old. These comprehensive visits are extremely beneficial to both the child and parents. Particularly, they allow the child to receive the preventive services that they need, such as immunizations and lead, hearing, and vision screening. The visits also track growth and development and provide an opportunity for a referral to specialized care if needed. In addition, routine well-child visits allow the establishment of a relationship between a parent and provider, and provides support to parents, especially new parents. This includes screening for parental depression, help with breastfeeding, and opportunity for parents to share concerns and parental education. This routine interaction can reduce emergency room usage. Next slide.

However, we know that some children enrolled in Medicaid and CHIP did not receive the recommended well-child visits. This slide shows the differences in delivery of care by payor, with commercial HMOs and PPOs performing better than Medicaid Managed Care. Next slide.

The Well-Child in the First 15 Months of Life Quality Measure has been on the Medicaid and CHIP Child Core Set since it was started in 2010. This core set measure is called the W15, although it will soon be an element of the W30, which has two sub-measures, one from zero to 15 months and one from 16 to 30 months. Other core set measures build off of these well-child visits, including the childhood immunization status and developmental screening. In addition, well-child visits are included in the mandatory annual EPSDT reporting through the form CMS416, which also includes blood level screening tests and oral health services. This map shows that within the Medicaid and CHIP population, in federal fiscal year 2019, 48 states reported a median of 64 percent of children in Medicaid or CHIP who received six or more well-child visits in the first 15 months of life. Next slide.

Missing well-child visits has consequences for infant and parental health. It puts children at risk for disease from missed immunizations and other preventive care. In addition, it can lead to delayed identification of developmental concerns. It also lessens or removes a tremendous support for parents, particularly mothers. So, honing in on immunizations with this slide, we see that about 70 percent of U.S. children are up to date on immunizations by 24 months, with disparities by race and ethnicity. Next slide.

Here we have some data to suggest that, overall, there has been a reduction in the percent of children receiving vaccinations because of COVID-19. The dark line is for 2020, which is about nine percent fewer vaccinations for children under age two. Next slide.

So, what can be done? There are several high-leverage strategies that state Medicaid agencies and their partners can employ. First is to align payment to support high-quality well-child visits and reduce disparities. Examples of this includes supporting patient-centered medical home models of care, screening and referral that address the social determinants of health, and using community health workers and home visitors.

We can also use data to drive improvements. We can document and monitor disparities in well-child visit rates by race, language, geography, and other relevant factors. We can identify children not receiving well-child visits, uncover barriers, provide assistance to their families, and publicly report progress over time on stratified well-child visit rates. Third, we can cultivate cross-sector provider and beneficiary partnerships. This includes creating a common vision and goals with state and local public health departments, WIC, and Title V—some of which you'll hear about today but certainly in the other subsequent webinars—and sharing data to identify and serve children.

Last but not least is to leverage the already existing quality improvement tools, including the quality strategy external quality review recommendations, and things like collaborative PIPs. So, with all that said, I know that we are all interested in how to make improvements in this area and learn from efforts that have been undertaken. Therefore, I'd like to introduce our first presenter, Dr. David Kelley, who will present on Pennsylvania's efforts to improve use in quality of infant well-child visits. Dr. Kelley.

### David Kelley:

Thank you, Jodi. And appreciate the opportunity to share some of the programs that we've put in place here in Pennsylvania, really leveraging payment policy and partnerships to improve well care. Next slide, please.

So, quickly, I'll just give a brief background on Pennsylvania Medicaid. We'll talk about our focus on quality measures and how we use those measures to incent both our managed care plans as well as incent our providers. And then I'll talk also about some of the partnerships that we've formed and, lastly, finish up with talking about our Maternal Infant Home Visitation Program. Next slide.

So, a quick overview of Pennsylvania Medicaid. We have over 2.9 million individuals, 1.1 million of them are children. And as a program, we pay for over 50,000 deliveries per year. We have a mandatory managed care model. We've been doing managed care for over 20 years. And children under 21, including dual-eligibles, are mandatorily placed into our HealthChoices Program. We have eight physical health managed care plans that operate in up to five various zones across the state. Each of those MCOs must have a special needs unit that is focused on participants with special needs, and especially children with special needs. We're a carveout state, so we have five behavioral health managed care organizations. Increasingly from a quality and value strategy, we're focused more and more on value-based purchasing models. Next slide, please.

This slide is very busy, but I'll just say that on the very – on the left-hand column, you see there are five models, pay for performance, patient-centered medical home, shared savings, bundled payments, and full risk and accountable care organizations. We're actually in year four of our value-based arrangement. So, 50 percent of dollars that go out the door are supposed to be involved in value-based arrangements and preferably those in shared savings bundled payments and full risk. But I'll talk today about some of our programs that include paid performance. I'll talk about our patient-centered medical home program a little bit and how many of them have moved into a shared savings model. And I'll talk a little bit about our bundled payments. But this value-based strategy really drives a lot of what we're trying to accomplish. But

all throughout these various payment models we're paying very close attention to the quality of care. Next slide.

This just shows you the five different regions of Pennsylvania and our HealthChoices program. Next slide. As I mentioned, we're very focused on the pediatric quality measures. And these measures, I have them listed here, the well-child visits in the first 15 months, or you'll hear me use the term WCV-15; lead screening; developmental screening. And I include annual dental visits because, in our program, we're encouraging, when that first tooth erupts, that there should be a preventive dental visit. I've shared with you kind of our trended three-year results for all of those measures. And from 2018 to 2020, we've been able to show significant improvement in all four of these. So, we're happy about that. Towards the end, I'll talk about how our performance in these key measures really helps to drive a lot of the programs that we've put into place. Next slide.

So, one of the things that we do through our managed care contracts, with each of our managed care plans, we have an aligned incentive program that involves two percent of capitation and it's 200-and-some million dollars across all of our plans. So, it's not a small chunk of change. And that revenue is split between 12 measures. We use NCQA benchmark payments. We split those 12 measures into benchmark payments and incremental improvement payments. We also penalize our plans if they don't reach the NCQA 50th percentile. And all of those measures that I mentioned, the well-child visit 15, lead screening, developmental screening, and annual dental visit, those are all part of this pay-for-performance or incentive program with our managed care plans.

In addition to that structure that's laid out, we developed what we call perinatal infant bundle where, if our plans perform at either the NCQA 75th or 90th percentile for all three measures—prenatal care, postpartum care, and well-child visit 15—they actually get and earn additional dollars. A new component that we just added in this past year is what I call our well-child visit 15 equity payment. This is based on incremental improvement from calendar year 2020 to calendar year 2021. And basically, what we're doing is we are measuring – we have known for many years, we've measured by, race and ethnicity, all of those measures that I've mentioned above, and we know that there's an equity gap. We know that there's about a four-percent absolute difference statewide between Black African American children and well-child visits in the first 15 months of life, versus all others. So, part of what we wanted to do is we want to close that equity gap. So, we actually have placed this extra incentive in the Managed Care Incentive Program. Next slide.

Likewise, we want to align our programs. So, our provider incentives actually mirror the same measures, the MCO incentive program. Again, you can see the measures listed. So, each of those providers have the ability to earn extra dollars based on their practice's performance across these measures. What we added recently, in 2021, was a new maternity care bundle incentive program. Again, the focus of today's talk is on infant – improving the quality of care for infants. But we always – in our program, we're always looking at that dyad and that relationship.

And what we did, and I'll say that some of our obstetricians didn't necessarily like this, but we included a specific reward for obstetricians to coordinate that handoff to their pediatric colleagues. So, we're actually, as part of that bundle, we're measuring the well-child visits in the first 15 months. Again, we think that this is really vital that we get our obstetrical and pediatric communities working as closely together as possible.

The new maternity care bundle also requires and rewards for screening of moms for social determinants of health. We think that any quality improvement effort looking at mom and/or baby really needs to be looking at social determinants of health to really understand any barriers to access or to the quality of healthcare. What's really key is that we have our MCOs annually assess the provider programs, pay-for-performance programs, and they have to annually submit revisions. Another – to align incentives for some of the quality measures, our MCOs have the ability to do participant incentives. And, again, they all have to be approved by our department before the managed care plans to put those incentives in place.

For instance, a health plan can provide a baby carriage or a child infant seat if mom has completed a postpartum visit and they're getting in for a well-child visit, or there can be a gift card for getting those six well-child visits. So, that's an example of how some of our plans include participant incentives. Next slide.

So, another essential part of our program is really having provider partnerships. We have a perinatal quality collaborative, and, again, I mention this because, in that collaborative, we include both obstetrical and NICU health systems and those providers statewide. So, we have our OBs, you know, meeting and interacting with our NICU and pediatric providers. Again, the PQC is really focused on screening and treating pregnant women with opioid use disorder, treatment of substance-exposed infants, and reducing maternal/infant mortality. So, there's a huge focus, again, on the maternal dyad – maternal-child dyad. We also have them focus on well-child visits in the first 15 months again, especially for those high-risk infants. Some of the data that we looked at showed that many of these substance-exposed infants and NICU babies, believe it or not, they don't necessarily get in for all of their visits, even when we exclude those that have had a very long NICU stay.

Another program that we've developed is the Patient-Centered Medical Home Program. We have over 1,000 practices. Here, again, we're focused on incenting those very same quality measures. So, again, we're trying to align both MCO provider and participant incentives. In this program as well, we require annual screening for the social determinants of health. And then they place their claim Z codes to identify some of those social determinant needs. So, in the patient-centered medical home, again, a really huge focus on especially children with high needs, special needs and high-end needs, to really better coordinate their care. And, again, they get enhanced payments as participants of that patient-centered medical home.

Then, lastly, I'm going to talk about our Maternal Infant Home Visitation Program. This was implemented in 2021 with community-based providers through our managed care contract. Next slide. Again, many of you are familiar with home visitation programs. One of the things that – again, we're very focused on really improving maternal and infant health outcomes, reducing mortality. So, we're very focused on the dyad of the entire family. We are making these visits available not just for first-time parents but also for parents/caregivers of infants that have been identified as having additional risk factors. Quite honestly, if any parent/caregiver raises their hand and says, "You know what, I need these home visits," they can request those home visits and those needs are met. The services need to be made available in the prenatal period but also through the child's first 18 months of life. Next slide.

We have a focus on visiting programs that include licensed and non-licensed staff. We really want to be focused on evidence-based programs, but we are very interested in those that may not be perfectly evidence-based but allow for licensed and non-licensed staff to be very, very engaged in an evidence-informed program. The home visitors really must have ongoing training and supervision, and really have to have knowledge about the resources in the families' community and be able to link them to those needed services that have been identified. Next slide.

Again, these are just some of the activities that are supposed to occur. Not a lot of surprises here but, again, a huge emphasis on both maternal and infant health, healthy child development, child safety, perinatal health, childcare, again with a focus on identifying and mitigating social determinants of health. Next slide.

And we really want to be able to strengthen the family so that there's self-sufficiency. There's a big focus in our program on screening the caregiver for depression and anxiety or substance use disorder to get them the services that they need so that that maternal-child-infant dyad is very much so intact and healthy. We're very focused, again, on postpartum depression screenings and especially addressing behavioral healthcare needs and whole person care. Then the last two bullets, again, go back to those quality measures and really being able to increase the quality of care for our well-child visits and EPSDT appointments. Last but not least, we're really focused on increasing plans of safe care for all infants.

Again, we want to do this in a non-judgmental way, and we want to make sure that mom and baby get the services that they so much need, and all of the social support that they need and deserve. Next slide.

So, in conclusion, in Pennsylvania, we really try to use our MCO contracts to drive quality improvement for infants. Actually, just about everything that I talked about is included in our MCO contract with our managed care organizations. That includes, again, MCO incentives, provider incentives, participant incentives. And, again, the key here is to really align those incentives. Secondly, we want to be able to, from a policy standpoint, establish really great health provider and community-based programs that are partnering with us. Included in that are our Perinatal Quality Collaborative, patient-centered medical home, and the community-based organizations that are involved in maternal health and home visitation programs.

So, again, our focus really is to improve the quality of care that's rendered but really with a focus and a lens on equity, and focusing also on the social determinants of health. Obviously, what's always very important is to be able to evaluate the performance of programs. I think earlier on I showed the slide that indeed showed how some of this quality metrics continued year after year to improve. I believe that's the end of my comments. Next slide. I'm going to turn it over to Denbigh Shelton. She's from the Texas Health and Human Services Commission. Denbigh, over to you.

### Denbigh Shelton:

Thank you so much, David. I appreciate that. Hello everyone. I'm Denbigh Shelton and I work for the Texas Health and Human Services Commission in the Medicaid Managed Care Quality Assurance area. Texas is primarily a managed care state. Approximately 95 percent of our Medicaid members are in managed care, and CHIP is fully managed care as well. We serve over four million members in Medicaid, and just over 250,000 of those are infants that are under one year old. So, that represents about five percent of our enrolled population.

We have several managed care programs targeting different populations. And most of our infants are in what we call our STAR program, which is our largest Medicaid managed care program, and it's primarily for healthy children and pregnant women. We have 17 managed care organizations, three dental maintenance organizations. We actually have dental care carved out, and we have separate contracts with dental maintenance organizations. And we have 13 service areas throughout the State of Texas. So, that winds up being a lot of different data points as we're looking at our various quality measures. Next slide, please.

I'm going to just really hone in on this primary measure of infant care, which is the six or more well-child visits in the first 15 months of life. So, this chart just shows that our Medicaid child rates – it shows our Medicaid child rates that we report for the annual CMS core measures as compared to the national average, the HEDIS 50th percentile for the most recent five-year period. The most current year data we have right now is 2019. It also shows how we sort of rank relative to other states reporting the CMS core measure.

We saw an improvement of 12 percentage points on this measure, from 54 percent in 2015 to 66 percent in 2019. During that same period, the national average did improve by eight percentage points, from 60 percent in 2015 to 68 percent in 2019. You can see we have a little dip in 2019. We're not entirely sure why that is. It could be that this measure has been what we call a hybrid measure, so it has involved medical record review. Some of our managed care organizations report they had some challenges obtaining medical records since they were doing that right at the start of the pandemic. So, we're not sure if that's the cause or maybe if there's something else going on, but I think we'll probably know more as we get our 2020 data in. Next slide, please.

Okay. In addition to six or more well-child visits in the first 15 months of life, some of the other measures that CMS mentioned in their introduction included developmental screenings in the first three years of life



and childhood immunization status, so that's did members receive their immunizations by age two, the recommended immunization. So, we also do monitor and report on those measures, including as part of the CMS core measure set. As you can see, we're above the median in both of those measures. Next slide, please.

Okay. I want to just talk a little bit now about some of the initiatives we've implemented to try and improve our rates of infant well-care and tell you a little bit about what we've been doing there. Next slide, please. One of the ways in which we've tried to promote this issue is by having our managed care organizations do performance improvement projects. So, in Texas Medicaid, our – I'm just going to call them PIPs for short – we require each MCO to have two-year performance improvement projects, so two-year PIPs. So, the PIPs that were implemented in 2017 and 2018 by the managed care organizations, there were 20 across ten MCOs. So, it was the same ten MCOs implementing the PIP on well-child visits in the first two months of life for both their STAR populations and their CHIP populations. We do require them to have two PIPs per program at all times. So, that winds up being a lot of PIPs in all.

So, there were four MCOs that collaborated on a PIP for improving well-child visit rates in the first 15 months of life. That was, we thought, a great idea. The idea of the collaborative PIPs is we want the MCOs to work together to sort of align initiatives. We think that that can lead to more significant improvements in certain areas of care. So, we were pleased to see that collaboration.

Out of the 20 PIPs that were done on this topic, there were four of those PIPs that demonstrated sustained improvement. And we consider that statistically significant improvement over the course of two consecutive measurement periods. So, the interventions that were used in those PIPs that showed sustained improvement were provider and member education. That's probably a pretty common intervention. Having a home health care coordinator reach out to the family after delivery to try and set up those well-child visits and answer questions, convey the importance of them, maybe help them find a provider, if needed, that kind of thing. New mom kits, so including a diaper bag, baby items, and, with that, resources on the importance of well visits, on parenting and infant health and those kinds of things. Breastfeeding support and home wellness visits after delivery and talking about well-baby care during those visits, and then also provider surveys and focus groups to help the MCOs better understand the barriers or how they can assist providers in helping ensure that the infants are getting their well visits. Okay. Next slide, please.

Thank you. Another initiative that we've put a lot of work into is our Medicaid Pay-for-Quality Program. So, what that is is we hold three percent of the MCO's capitation at risk, meaning we pay it all up front, but we reserve the right to recoup money based on their performance on a set of quality measures. We also can reward them if they do well on those quality measures. We select a small number of quality measures for them to focus on, usually around four or so in this case. For measurement years 2018 and 2019, we assigned .75 percent of their capitation to their performance on this six or more well-child visits in the first 15 months of life. So, they could lose up to .75 percent of their capitation or they could earn above and beyond their capitation for that measure.

We evaluate them in two ways. One being their performance against benchmarks, so relative to kind of the national benchmarks, the HEDIS percentiles. And then we also evaluate their improvement or decline over their own prior year performance. So, those are the two ways in which they could earn or lose capitation. On this measure, 12 out of our 16 STAR MCOs improved in 2018. So, we were really pleased to see that. We felt like that was wonderful results. Then in 2019 that wasn't as significant of an improvement but eight out of the 16 improved on that measure the following year. So, we're pleased to see that, and we think that that's helping to improve our overall rates for the program. Next slide, please.

All right. Another thing that we do are what we call MCO Report Cards. It's very similar to the new quality rating system that CMS is going to be requiring states, but we've been doing this since actually 2014. And we produce essentially STAR ratings for each managed care organization in each service area, for each

program. So, that winds up being 62 unique report cards because there are multiple managed care organizations in each service area.

The report cards are an effort to increase public transparency and help members select a managed care organization. So, these report cards are included in – during the enrollment process, they're given to our members and our hope is that they're using them to assist in their selection of a managed care organization. The W15 measure is one of the measures we use in our we call it STAR Child Report Card. We do one for adults that has a different set of measures in it.

The report cards – individual measures are essentially scored and then grouped into three different domains, so experience with a doctor or health plan, staying healthy, controlling chronic disease, things like that. And then each service area in each program receives STAR ratings for the different performance domains. These are updated annually, and they're provided in both English and Spanish. The W15 measure has been on the STAR Child Report Cards every single year that we've produced them.

Then in 2020, we started using the report card ratings as part of a value-based enrollment initiative. So, when a member does not select a managed care organization, there's a default methodology that just automatically enrolls them in a managed care organization. So, we've embarked on trying to include value-based components in that default enrollment methodology and these report card scores are one of the factors that we use for that. So, in essence, a plan with higher quality will have more – a higher proportion of members default enrolled to them. Okay. Next slide, please.

Okay. We also have really enhanced our public reporting. So, we have what we call the Texas Healthcare Learning Collaborative Portal, or THLC Portal for short. And that's primarily used by us, managed care organizations, and other stakeholders just to track healthcare quality data for Texas Medicaid and CHIP programs. And almost all of the data is available to the public, with some additional information that requires a login. But some of our – the featured information that we have include medical quality of care data. We have a data downloader so that folks can download data from the portal into their own kind of analysis. We have dental quality of care, CMS core measure data, our survey measure data we added this past year, which we're really excited about. We use three potentially preventable events measures. We have the data on those measures posted here, including trends. We also have performance indicator dashboards which we use to evaluate the health plans. We also have a pay-for-quality performance dashboard where you can go in and see all the results of our pay-for-quality program. And then we also have folders of resources which we mostly use to make resources readily available to our health plans. We use this resource all the time. And the W15, soon to be W30 measure, is one of the many that is posed in the Medical Quality of Care Data Section, and it allows you to look at each MCO's rates for that measure, trending data year for year, how it compared to national benchmarks, how each service area compares to one another because there is regional variation and so forth.

What we don't have, unfortunately, right now is some of the data stratification that we have on a lot of our other measures. So, most of the measures on our quality-of-care dashboard are stratified by service area, sex, race, and health status, but because the W15 measure has been calculated by record review and we allow our MCOs to calculate those, they do the record collection and report their NCQA-audited rates to us. We are not able to do the same kind of stratification that we have on other measures. So, one of the things we are excited about with the change to the W30 measure is that it's also now going to be administrative only. So, we will be able to have that stratification on this measure going forward and we think that may help us identify some potential disparities there, if there are any. So, those are some of the many initiatives that we have that we've been incorporating this measure into to try and improve infant health outcomes. Okay. Next slide.

So, these are just – I'm sure the slides will be shared after, if they haven't already. So, there's just a link to that, Texas Healthcare Learning Collaborative Portal, if any of you are interested to dig deeper. And our external quality review organization is the one who manages that website for us. And then we also



have a webpage – a Medicaid and CHIP Quality and Efficiency Improvement webpage, and that has tons of information on our various initiatives, ones I've discussed here as well as several others that we are working on and implementing to try and improve the quality of care in Texas. I think that's it. Next slide I think is just the thank you slide with my contact information. Certainly, any questions today we'll do our best to answer, but if you want to reach out for any reason or have any follow-up questions after the webinar, this is how you can. Thank you. I'm going to hand it back over to CMS.

**Jodi Anthony:**

Thanks, Denbigh. And thanks, David, too. Okay. So, now we're going to move into questions. And just as a reminder – next slide, please – you can use the Q&A function to submit questions or comments. And what you do is submit it to 'all panelists' in the ask menu and then I can read it out loud. Just so you know, only the presentation team will be able to see your questions and comments. So, we have a couple in queue. Let me start off with one for Dr. Kelley. That is, what is the percent of MCO payment penalty for not hitting the 50th percentile?

**David Kelley:**

So, each measure is – there's a dollar value attributed to each measure. So, overall, the program is two percent of capitation that's split in benchmark and incremental improvement. So, when you divide that by 12, the penalty, if they don't hit the 50th percentile, is the dollar amount that – it's equal to, I believe, the dollar amount if they hit the 75th percentile. So, it's a significant penalty. It gets their attention, let's put it that way.

And I'll just say that when we started the incentive program, we did not have any penalties. And over time, we moved towards this approach that if you're not hitting the 50th percentile, we're then going to penalize you. Again, we've been doing managed care for over 20 years and we probably did not add penalties until maybe seven or eight years ago. So, just have to be judicious when you do add those penalties, but I guess I can do the quick math, but that gives you an idea. All the penalties per measure are going to be at least six figures. So, it's enough of a penalty to get their attention.

**Jodi Anthony:**

Thank you. And I will answer a question that we've already received a few, which is, will this presentation and transcript be available? And yes, indeed, we will – in just a week or so, we will be posting it on the Infant Well-Child Care landing page on Medicaid.gov. Okay. I have a question for Denbigh. Denbigh, what impact has COVID had on these initiatives?

**Denbigh Shelton:**

Well, it's had quite a – well, honestly, we're not quite sure yet. We think it's going to have a fairly significant impact on them. We did have to suspend, for example, our medical pay-for-quality program in 2020, but we have not received our final calendar year 2020 data yet on our quality measures. We did get our preliminary data and it showed some pretty dramatic changes in a lot of our measures that probably are not entirely attributable to just MCO performance. So, we're going to be monitoring that going forward. Of course, now we're in year two of COVID and we haven't really figured out what all the impacts are yet, but we do know that it makes it very hard to evaluate the managed care plans on their quality performance because sometimes it's difficult to sort out what is within their control and what is not within their control. So, it is creating a real challenge for us to continue to pursue some of these initiatives.

**Jodi Anthony:**

Thanks. And in sort of a follow-up question that's related that I'll ask to both of you from one of the participants is, are there plans to support telehealth or hybrid visits to increase access? Denbigh, why don't you start and then I'll ask Dr. Kelley to respond?

### Denbigh Shelton:

Yeah, so it's interesting in that we had been wanting to expand telehealth before COVID, and COVID just sort of fast-tracked all those efforts. And I think there is a real desire to keep a lot of the flexibilities around making telehealth available now that – you know, as we move forward even after the pandemic. So, that's sort of in process for us. I honestly am not certain about the infant well-care visits and a telehealth option. I can take that back to my team and find out if that's something that's being considered. But more broadly, in terms of telehealth, I think there will be more options going forward. Again, I don't know specific to infant well-care. I think there's a lot of in-person things that need to happen with that, immunizations, physical exams, and so forth. But, yeah, generally, we are moving toward more telehealth options.

### Jodi Anthony:

Thanks. David?

### David Kelley:

Actually, I think the well-child visits, for NCQA, they do accept telemedicine visits. In Pennsylvania, we do accept telemedicine visits for well-child visits, as well as for some dental preventive visits. And we really have pushed during the pandemic the use of telemedicine where we've gone from probably about 50,000 telemedicine visits a year to over 700,000 televisits per year. And there are a whole host of NCQA measures that have allowed telemedicine visits to count for those particular quality metrics. So, that is – you know, it's certainly just one of the challenges related to the COVID pandemic.

And from a quality-of-care measurements standpoint where we've had to make some changes and some flexibilities, NCQA has supported that. Likewise, I think with our incentives that I've described and the effect of the pandemic all throughout, that there's incremental improvement from the prior year. So, we're waiting to see how much effect the pandemic is going to have on that incremental improvement component. We also can be looking at the benchmarking components. We're guesstimating that some of those benchmarks, nationally, may go down as well. So, the pandemic has definitely made it a challenge in some of our incentive programs.

### Jodi Anthony:

Okay. Thank you.

### Denbigh Shelton:

If I may, sorry to interrupt but I did get clarification that we really only allow telehealth for well-child visits for children two years and older. So, at current time, we're not promoting telehealth for the infant well-care.

### Jodi Anthony:

Okay. Thank you. Okay. So, I have a couple of questions for David about some of the specifics. I'll start with, how is social determinants of health incorporated into your value-based payment strategy for Pennsylvania?

### David Kelley:

So, in our patient-centered medical home, which was one of our value-based strategies, we have made it a requirement that everyone in that practice who comes in for a visit should undergo a screening using a validated tool, looking at essential domains of social determinants of health. And we've provided coding guidance. I should have them memorized but I don't, but there are two codes that patient-centered medical homes are supposed to use for whether or not an individual was screened, and they screened

positive, and they screened and they screened negative. If they screen positive, we ask them then to put certain Z codes on their encounter forms or billing forms, and we've been able to collect data that way.

Patient-centered medical homes that participate in our program, and that's one of the activities that are required, they get enhanced payments either on a PMPM basis. They're also eligible for additional quality incentive payments. And then those practices are also – they can also be part of a gain share arrangement. Increasingly, those patient-centered medical homes are part of the gain share.

The maternity care bundle is a bundle package that mainly, you know, for our obstetricians and, again, that bundle rewards providers – it's a gain share arrangement. There's no downside to it. But based on, again, using those same codes, our obstetricians are asked to screen moms for social determinants of health using a validated tool and using those same codes and using Z codes. There are incentives built into and it's part of our MCO contract. There's an incentive – I call it a brownie point system, but there are additional points or rewards that can be obtained by actually doing that activity. But the patient-centered medical homes, we've have been doing that now for – since 2018. We've used the learning network to operationalize that with our patient-centered medical home learning network, to embed that into those practices. And we're just starting with the obstetrical community and we're going to be using our perinatal quality learning collaborative to get them up to speed and operationalizing as part of their workflow.

**Jodi Anthony:**

That's great. Thank you. Okay. Another question is about overcoming – getting administrative data during the first 60 days of life, since it's often paid under mom or direct through state, to support the well-child 30. Denbigh, can I ask you to field that one?

**Denbigh Shelton:**

I will do my best. I think that, you know, that hasn't been so much an issue for us, and I'm not really sure what it is about our systems that we haven't had that issue. What we had more of a challenge with is connecting mothers and babies, which, you know, obviously, as David talked about the dyad and how interconnected those two things are, I would say that's more where we've struggled a little bit. But we have not really had an issue. I think a lot of it is because we get, you know – everything sort of gets updated by the time we get to the point of calculating the W15 measure to where I don't think – we currently don't have that challenge. So, sorry I can't provide something more helpful.

**Jodi Anthony:**

Okay. And David, I don't know if there's anything you want to say about that particular question.

**David Kelley:**

I would say, likewise, it's not as big of an issue. Again, in managed care, we pay our managed care plans on every live birth. It's a bundled payment to our managed care plans. So, it's their responsibility to be able to identify mom and those live births and who they are, and those babies are then placed into the health plan. There is a little bit of a lag time. Sometimes it can be up to two weeks. But, again, the managed care plan is responsible. So, when you put that fiscal responsibility on them, they're pretty good at usually being able to identify the mom-baby dyad. And for purposes of getting those well-child visits in, it's less of an issue. And there are some exceptions to that with some complex kids that sometimes land in the NICU for long periods, but it has not been, in our experience anyway, that big of a barrier.

**Jodi Anthony:**

Okay. All right. Another question has come in for Pennsylvania, for you, Dr. Kelley, about sort of how the provider network or how do providers participate in home visiting programs, and sort of how does the reimbursement work?

### David Kelley:

So, within our contract within managed care, we have a section called community-based care management. It's a requirement for our managed care plans to actually contract with let's say community-based organizations that are evidence-informed or evidence-based. So, we have required them to use this community-based care management funding to do contracts and do those relationships. We've not set any – to my knowledge, I don't think we've set any fee schedules. Some of our plans have, you know, contracted with a nurse-family partnership and other programs. We have home – in Pennsylvania, happily, we have a whole host of community-based organizations that have been doing this type of activity for many years.

So, it is – we leave it up to the MCOs who get the contracts done and then they do have to report to us the number of visits that get done. In fact, we're developing incentives that looks at at least moms, babies getting two visits and then we're tying that to the well-child visits. So, we're actually in the middle of developing an incentive program for MCOs. And I will say that that was another challenge with COVID that I forgot, was that the whole home visit thing concept is much more difficult during a pandemic. So, you know, we did allow for some flexibilities there with some telemedicine or videoconferencing and other ways of communicating and doing those visits.

### Jodi Anthony:

Okay. So, we have a few more questions but we're out of time. So, I would just want to say, and Alyssa will talk about this, but we do have two more webinars. We will be talking more about partnerships and fee-for-service and screening for substance use, and all of the other really great questions that's come in. So, we really welcome you to join those subsequent presentations. And with that, I will turn it over quickly to Alyssa to describe our next steps.

### Alyssa Bosold:

Okay. Thank you, Jodi. On the next slide, I'd just like to remind everyone to visit the [Medicaid.gov](https://www.Medicaid.gov) Infant Well-Child Care landing page, which you'll see on this slide, for more information about our Infant Well-Child Visit Learning Collaborative, upcoming webinars, and our affinity group. On the next slide, you can just see that the landing page will include, as Jodi mentioned, information on our upcoming webinars. And you'll also find the transcript and recording from this webinar. You can also access more information about the upcoming affinity group, including the infant well-child visit affinity group fact sheet and expression of interest form. And if you are a state Medicaid agency interested in participating in the affinity group, you should complete your expression of interest form by September 30th at 8:00 P.M. Eastern Time.

On the next slide, just want to wrap up by saying thank you all for attending. As you exit the webinar, just remember to complete the evaluation which will show up in a separate browser. And if you have any questions or if we didn't have time to get to your question today, please feel free to email us at [MACQualityImprovement@mathematica-mpr.com](mailto:MACQualityImprovement@mathematica-mpr.com). So, thanks again everyone and have a great afternoon.