Improving Quality and Utilization of Infant Well-Child Visits

Recorded September 10, 2021

Alyssa Bosold:

Hello everyone, and welcome to the second webinar in the Infant Well-Child Visit Learning Collaborative series titled "Improving Quality and Utilization of Infant Well-Child Visits." Before we begin, I want to cover a few housekeeping items.

Next slide, please.

All participants logged in to 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" drop-down 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 then describe your technical question or issue.

I also want to let everyone know that this webinar is being recorded. On the next slide, you'll see that the recording, slides, and transcript from the webinar will be posted on the www.Medicaid.gov Infant Well-Child Visit Landing Page. The link is on the slide here, and we will also share it for you through the Chat.

On the next slide, I'll review our webinar agenda.

We'll begin our webinar today with some welcoming remarks and an overview of our objectives from Deirdra Stockmann at CMS. From there, my colleague at Mathematica, Jodi Anthony, will provide an overview of the Maternal and Infant Health initiative. You will then hear from Glory Dole, the Compliance Section Manager in the Medicaid Programs Division in the state of Washington. She'll be followed by Dr. William Golden, the Medical Director for Arkansas Medicaid. Jodi will then facilitate a Q&A discussion, and I will wrap up the webinar with some announcements and next steps.

So now I will turn it over to Deirdra for the welcoming remarks.

Deirdra Stockmann:

Thank you so much, Alyssa.

Hello, everyone. My name is Deirdra Stockmann. I'm Acting Deputy Director of the Division of Quality and Health Outcomes at the Center for Medicaid and CHIP Services at CMS. I'm very pleased to welcome all of you to the second webinar in our Infant Well-Child Learning Collaborative series.

This learning collaborative is one of our several quality improvement initiatives at the Center for Medicaid and CHIP Services. The goal of all our quality improvement work is to support State Medicaid and CHIP agencies and their partners, including other State agencies, health plans, providers, and advocates to drive measurable improvement in quality of care and health outcomes for Medicaid and CHIP beneficiaries.

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The goal of the Infant Well-Child Visit Learning Collaborative is to help states improve the rate or utilization and quality of well-child visits for infants. As you all know, the first year of a baby's life is a

critical time to engage families in care and to assess and address the health needs of some of our youngest beneficiaries.

So the purpose of today's webinar is to offer considerations and strategies for improving the use and quality of infant well-child care in different delivery systems. Today we'll hear about effective approaches both in the managed care environment and in the fee-for-service patient-centered medical home model. While the delivery systems differ, you'll see that each State Medicaid agency was able to affect improvements in infant well-child visit quality and use.

So we hope that their experiences that they'll share today will provide some tangible steps that other states can adapt in your own unique delivery systems. So, with that, I'll turn it over to Jodi.

Jodi Anthony:

Thanks, Deirdra.

Next slide, please.

I'll also offer my welcome, and welcome back to those who joined the first webinar in the series. I just want to tell you a little bit more about the collaborative. It is one of three focus areas that CMS is undertaking as part of its Maternal and Infant Health initiative. This initiative is a multiyear one informed by an expert work group. I recognize that this figure is a little busy, but it demonstrates the initiative's framework; and I'd like to highlight a few important elements.

First, the expert work group 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 health outcomes throughout the childbearing years, as well as infant early childhood outcomes.

Next slide, please.

The second element I would like to highlight are the focus areas on the left-hand side. This Infant Well-Child collaborative focuses on strategies to increase use and quality of well-child visits, indicated by the red star. In addition, we've already begun a collaborative for the middle focus area, "Strategies To Increase Use and Quality of Postpartum Care"; and in about 6 months we'll begin a third collaborative to address the focus area at the top, "Strategies to Decrease Cesarean Births for Women with Low-Risk Pregnancies."

Next slide.

The third element I'd like to emphasize is the section on Infant and Maternal Outcomes for this collaborative. Research has demonstrated that by increasing use and quality of well-child care, there is an increase in immunizations, breastfeeding, parental knowledge on injury prevention, and fewer injury-related emergency department visits. There are benefits for the parent too, such as screening for depression and the social determinants of health.

Next slide.

So how can Medicaid agencies support the use and quality of infant well-child visits? Our team assessed the peer and grey literature, combed state websites, and spoke with several states. From this process, we identified high-leverage strategies that state Medicaid agencies and their partners can employ including:

- Aligning payment to support high-quality well-child visits and reduce disparities
- Using data to drive improvements
- Cultivating cross-sector, provider, and beneficiary partnerships

Leveraging quality improvement tools

Today you'll learn about patient-centered medical home models of care, value-based payment strategies, how data were used to drive improvements, and the critical partnerships – including with families –that informed quality initiatives.

Next slide.

Just as a reminder, this learning collaborative includes a webinar series open to everyone that provides examples of these strategies in state settings; and then in September we begin the action-oriented affinity group where state Medicaid agencies can build, test, and scale these strategies for their unique environments.

In the first webinar in the series, we heard from Medicaid colleagues in Texas and Pennsylvania who described their use of managed care contract requirements and incentives; data monitoring; and performance improvement projects. In addition to today's webinar, I just want to give a plug for the third webinar where representatives from North Carolina, Michigan, and Oregon will describe their models of care and partnerships including pediatric medical homes, home visiting, and partnering with Title V.

With that, I will hand it over to Glory Dole.

Glory Dole:

Next slide.

Great, thank you.

Thank you for having me here today. My name is Glory Dole. I'm a nurse, and I'm the Compliance Section Manager at the Washington State Health Care Authority. My team focuses on Medicaid Managed Care. We ensure that the managed care organizations, the MCOs, are compliant with the contract that they have with the Health Care Authority to deliver Medicaid services.

Today I'm going to discuss some of the strategies the Washington State Health Care Authority uses to improve infant and child health. I'll discuss strategies the Healthcare Authority is focused on specifically with our state Medicaid MCOs.

I also want to be sure to give credit to my team, and particularly Teresa Cooper, who is here today. She's our subject matter expert in this area. She's been working for years to improve infant and child health in our state, and I want to make sure I recognized her.

Next slide, please.

In this presentation, I'm going to tell you about the Health Care Authority, HCA; Washington Apple Health; value-based purchasing; performance improvement projects; and the collaborative PIP for the Well-Child Visit measure.

Next.

About HCA, briefly, the Health Care Authority is the largest health care purchaser in Washington State. We purchase health care for more than 2.5 million Washingtonians; and that includes Medicaid, public employees, and school employees.

Next.

A closer look at Washington Apple Health – there are over two million Medicaid enrollees. The vast majority, or 85%, are in Managed Care. We contract with five MCOs across the state. We also integrated physical and behavioral health; and with the expansion of the Affordable Care Act in 2014, we added more than 650,000 newly-eligible adults by the end of 2020. So that's a glimpse at Washington Apple Health.

Next slide.

VBP, Value-Based Purchasing – the Health Care Authority implemented VBP to incentivize health plans to purchase health care in a different way, using value-based payments to providers. This is a strategy used to basically improve the quality and value of health care services that a person receives. VBP ensures health plans and health care providers are accountable for providing high-quality, high-value care and a satisfying patient experience. VBP rewards providers for the quality of health care rather than just the volume of patients that they see. This is different than paying a set amount of dollars for a specific service.

Next.

Each year, the Health Care Authority reviews VBP quality measures that the Agency is focused on improving. Here's the list of measures that were selected to impact infant and child health in 2020:

Prenatal care

Postpartum care

Well-child visits

And children's access to primary care

In 2021, we added the measure Prenatal and Postpartum Care, PPC. So that's an overview of the measures that we look at.

Next.

Another strategy to improve infant health is through performance improvement projects, or PIPs. For years, Health Care Authority has been focusing on improving infant and child health through managed care strategies. Looking back to 2015, Health Care Authority explored ways to improve immunization and well-child visit rates and focused on PIP requirements to do that. The Health Care Authority required additional PIPs for rates below the national 75th percentile for well-child visits or childhood immunization performance measures.

The result is that a variety of PIPS across our state were developed by the MCOs, and there was a varying level of success.

Next.

Due to continued low statewide performance in well-child visit rates, the Health Care Authority decided to make a coordinated statewide effort. In 2018, the collaborative well-child PIP replaced the individual MCO PIPs. All five MCOs are required to participate in this collaborative. The Department of Health is contracted to facilitate the group, and the collaborative PIP actually continues today. We've seen a lot of positive impact on the measures.

Next.

You can see here a significant measure improvement in childhood immunization status, Combo 2 specifically on this screen, since the PIPs requirement started with a *notable* improvement after the statewide collaborative effort began.

Next slide.

For the Combo 10 immunization, you see improvement as well, particularly when the statewide collaborative began.

Next.

Compared to national Medicaid percentages, well-child visits in the first 15 months of life is performing above the 58th percentile; and it remains stable. This continues to be an important area to prioritize.

Next.

The collaborative PIP work group has shown a lot of success, and I want to walk you through some of the interventions and the pilot projects that we've done.

Next.

First pilot, the MCOs partnered with clinics. The MCOs chose clinics that had at least 150 patients in the age range assigned to the MCO and who also saw that the well-child rates needed improvement. So we chose those clinics based on that criteria. A monetary incentive was provided to the clinic, and there were a variety of clinics that were chosen – one tribal clinic, two federally-qualified health centers, and two private clinics.

In this pilot, they focus on reconciliation, which is to find patients who had not had a well visit or were overdue for one, and to find patients registered to the clinic but just have never been seen.

Next.

Interventions for Pilot 1 included focusing on patients that were overdue, ensuring the provider list of patients was reconciled, ensuring that providers knew who and how many patients they were responsible for, and helping clinic staff understand the performance measures related to infant and child health – a lot of interaction with MCO and claims.

Next.

In Pilot 1 Lessons and Observations, we found that it was difficult to match records. We found it was better to assign patients to a specific clinic rather than a specific provider. Patients don't always go to their assigned clinic, this was another observation, and we found that warm handoffs between MCOs and clinics were effective.

Next slide.

Other lessons are that patients received care, but they didn't always return for their well-child exams; it was better to schedule the next appointment at the time of check-in; and clinics added and dropped lists of patients to the panel each month. Those were the observations.

Next.

Here we see some of the positive outcomes of the pilot. Four clinics improved their well-child visit rates for three- to six-year-olds, and two clinics increased by at least 8%.

Next.

Parent focus groups are another aspect of the pilot. These groups were held to find out about barriers to care. Themes we heard from the parents included: there is a perceived stigma of having Medicaid; work and school schedules didn't allow time for the appointment; language and cultural differences made an impact; the appointments were too short; and hidden costs, like transportation and childcare.

Next.

In response to this feedback, lessons learned included that it's helpful to give parents a checklist of the screening procedures; offer for parents to ask questions before and in between visits; train office staff on better communication about insurance status; provide materials in language of choice; and add weekend or evening appointments.

Next.

That's Pilot 1 and the second pilot we did with the collaborative PIP focused on adolescent well-child visits. The goals of Pilot 2 included: to reconcile the patient list, and it also had the clinics contact the patient twice. If the clinics were unable to reach the patient, then the MCOs would attempt to contact them. That was Pilot No. 2.

Next.

Pilot No. 3, through 2019, the primary goal was to spread the impact and share lessons learned from earlier pilots, built one from another, building on lessons learned. This was the most successful of the pilots. In the clinics that participated in the pilot, we saw an almost 10% increase in well-child visits.

Next.

Pilot 3 also started social media campaigns and offered trainings to clinics.

Next.

Pilot 4 – this pilot focused on Statewide Children's Health Promotion initiative projects. It focused on children with chronic conditions. It focused on more social media, and they worked on a common form for patients to request changing their PCP.

Next.

So those are the four pilot projects. Here you see the before and after results. They show the impact of the pilots, and the bottom line is that rates improved.

Next.

In 2020, we saw challenges related to the COVID pandemic. For example, in-person visits decreased. By the end of 2020, well-child in-person visits started to pick back up. We had precautions in place, such as separate times in waiting rooms for well children and sick children; but 2020 was a challenging year for this measure.

Next.

In 2020, the Collaborative Work Group decided to focus on Spokane County, which is in the eastern part of our state. The work group partnered with Child Care Aware. That's a community organization. They have contacts in early learning and childcare centers. With them, they gave out more than 4,000 educational flyers to parents in at least four languages throughout the county. After this initiative, county well-visit rates for all the age groups were more than 11% higher than the statewide combined rate. This is a very effective, community-focused promotion that we did in 2020.

Next.

This table shows the last three years and the trends of the W15 – the well-child measure for the first 15 months of life – in these measures, and the measurement years 2018, 2019, and 2020, the final rate that you see is 54.1% D4.05, the final HEDIS rate. This is estimated right now, and that's because this is the rate that was reported by each MCO. We'll get the final audited results later. They haven't been released yet. That will determine what the final rate is, but this gives us a ballpark of what to expect. Again, in this rate, we see the impacts of COVID.

Next.

This is an example of outreach materials. Two other flyers were created for young child and middle child. They were translated into languages such as Spanish, Russian, Vietnamese, and distributed in the community.

Next.

This is an example of social media messages posted on Facebook in 2021. They focus on things like free health checkups, how to schedule an appointment, and information like that, focusing on social media platforms.

Next.

2021 and beyond – where do we go from here? Well, analysis of 2020 results correlate with what we hear from providers. Starting in April of 2020, well-child visits for children and adolescents decreased dramatically. Even with telehealth appointments, there was still dramatic decrease. The data indicates that in 2020, we lost some of the gains that we made in preceding years. In all age groups, the decrease in rates of well-child visits was significant; and that's what we saw across the board.

The Spring 2021 Clinic project focuses on educating clinics about the change in children's well-child visit measures. In addition, this year, MCOs are doubling down, working with schools, childcare, Head Start, and parents statewide to promote well exams; continuing to reach out to clinics; and working in the community to promote the well-child visits. There's lots of focus on making up the lost gains that we saw because of COVID in 2020.

Next.

What we learned through the collaborative well-child PIP is that it's possible to raise rates of well-child visits and immunizations. It's possible to do this by making sure providers know the population of patients they're responsible for; collaborating with different agencies; facilitating providers to learn from each other; outreaching to patients and their families in creative and ever-changing ways – really listening to them and responding to that feedback – and ongoing analysis to improve quality.

We've seen that value-based purchasing, performance improvement projects, and specifically the collaborative PIP were all effective strategies to increase infant and child health through managed care.

Next.

Thank you. If you have questions, you're welcome to e-mail me at the e-mail address you see on the slide: glory.dole@HCA.wa.gov. If there's time, I can take questions now.

Jodi Anthony:

Glory, I think we'll move on. We'll take questions at the end. Maybe we can move on now to Bill Golden from Arkansas. Thank you very much.

William Golden:

Thank you.

Good afternoon, and there we are. Thank you for joining us this afternoon. It looks like I'm unmuted. We can move on forward.

I'll tell you a little story about what we've been doing in Arkansas. Arkansas Medicaid has been a PCCM for years, really *not* a managed care state. That has given us an enormous claims warehouse. We've done electronic claims for many years; and we've been using it for quality improvement projects, data analysis, policy reform for a good 20-25 years. I work with contractors and statisticians who are familiar with our dataset over many years, so they know our idiosyncratic codes and how the data actually works.

We were one of the first – we were the *only* state for a while in the South who did Medicaid expansion with a private option. So those patients went – mostly adults – to commercial payers, and our children remained in the traditional Medicaid. We basically provide insurance for close to 65%-70% of children in the state.

In about 2013-2014, we did multipayer payment reform with the other commercial payers. We did episodes of care. We had a CMMI Implementation grant. We have a whole other day,beer and peanuts

about episodes of care. But we launched a patient-centered medical home in 2014, which is really the crux of a lot of what we're going to talk about today.

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You can see when we started the PCMH program in 2014, we had hoped to get 40%-50% of eligible Medicaid patients, adults and kids, in the program; but our first year, we had close to 80% of eligible patients involved. As time went along, we had maintained about 85% of eligible Medicaid clients in a patient-centered medical home, which now has 215 practices and almost 900 PCPs. These numbers continued into 2020.

Patients are assigned for PCMH. They have to get referrals and so forth to get care. So everyone knows on their panels the patients go there – the primary care location; and the doctors and clinics and nurse practitioners know who they are accountable for.

Next slide.

This is an old slide, but it gives you a sense of how the program was established in 2014, which is interesting. We told folks that they would get an extra PMPM on top of their PCCM dollars, and we called that an investment in their practice. It wasn't just new money to be in the program, but we expected them to do things in exchange.

We also set up some bonus money so that if they performed well in terms of total cost of care – which we no longer use, we now do different incentive plans – they could get substantial bonus and checks. But the key thing was that, in the beginning, the PMPMs were tied to certain performance activities that they had to achieve to get the dollars.

Next slide.

So what kind of things did they do? Well, we told them they had to have an EMR. Interesting, they had to have 24/7 live voice access to their care. I jokingly tell people that if I retire tomorrow, I can put on my CV that I eliminated answering machines in rural Arkansas in a period of two years, which was a much greater lift than one might think at the time.

We also had them designate high-priority beneficiaries, a whole variety of patient-centeredness, in order to be a PCMH. But now that the program is well-established, these activities that they had to achieve to get the PMPMs, and keep them, are basically baked into the system. They're now basically part of the routine.

Next slide.

Which gets into how we're now using measures. Obviously if you want to use the measures, you have to have effective analytics. You want to drive culture change, particularly how to use data and how to transform clinical activities. We are now using these measures tied to incentives, and the incentives are connected in three different buckets, if you will.

The first incentive was for excellent performance. In the beginning, as I said, was the total cost of care; but now it's two other performance metrics – emergency room utilization, hospitalization rates – and we actually now have a bonus plan for adolescent wellness visits, because that straddles adult and pediatric care.

The second bucket, or the second use of the measures, is what we call "achieving average performance." That we call a tollbooth. These are quality measures that basically look at state average performance from a previous year. The practices, or the PCMHs, have to achieve average performance for that past year in order to qualify to be considered for the excellent performance bonus money. So there's no direct dollars involved with achieving these tollbooth measures, but they basically qualify people to be eligible for the big-dollar bonus money.

Then in the last two or three years, we took on something that we were kind of hesitant to do. We actually started to set minimum performance measures, which is to say that now that they were established and achieved their medical wholeness, if you will – their patient-centered attributes – we threatened to take away the PMPM dollars if they didn't achieve some minimal clinical performance. And when I mean minimal, I really mean going after the low performers or the folks who are outliers compared to the average PCMH. I'll show you what the impact was on implementing this change.

Next slide.

So here's an example of the bonus money dollars. This is for emergency room utilization. You can see the upper 10% get the big dollars, and the upper 35% get some other dollars. Basically, we set this from year to year on a normative basis.

Next slide, please. Oops, we're stuck...see where we are here.

Okay, so – nope, go back one slide. Thank you. There we go. So this – nope, one more slide back, sorry.

There we go, thank you.

So this is the performance for calendar year 2017 for well-child infant visits. We were targeting at that time five or more visits. I understand that's not the national standard, it's six; but our performance was sufficiently problematic that we were trying to target something that we could see on people's horizons. You can see that only 63% of PCMHs achieved five or more visits. We had this long tail, and this was pretty static. We actually did academic visits, academic detailing. We had a national pre-K program ten years earlier. I have to tell you, the five or more visits curve really didn't change much over the years.

Next slide.

We decided to look at the laggards. Here were people who were doing zero or one well-child visit in the course of a year – I mean really low rates of performance. We had *five* PCMHs you can see here that had 20% of the infants with zero or one well-child visit in the calendar year 2017. So we said, "Okay, folks," we basically said, "If you can't get above 20%, zero or one, we will very likely take away your PMPMs, your basic core support money for being a medical home. So you basically need to do better in order to be considered a medical home for the dollars."

Not only were we targeting these low folks, but we set the rest of the curve on notice that we were going to start look at low performance. What happened?

Next slide.

In 2018, all of a sudden we had nine that were above 15%. So we moved the curve. You can see the curve began moving starkly to the left. We started getting rid of the outliers. So we said, "Okay, for calendar year 2020, you have to have less than 15% of your infants have zero or one visit,"

Next slide.

In calendar year 2019, one PCMH had more than 12% zero or one. That's quite a change over a period of two years. So what happened to the other measure?

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This is where it gets interesting. In 2017, here's the static slide. Twenty-three medical homes had fewer than 50% of their children have five or more visits.

Next slide.

A year later, nine had fewer than 50% of five or more visits. You can see that the average for the state went from 63% to 69%. And next year... – next slide –2019, five PCMHs had less than 50% well-child visits of five or more; and the state average hits now at 75%, which means we moved the state average

of five or more visits about 20% in two years. The only major change we've had in the operations was to go after the laggards and threaten the PMPMs.

Now, I will say just like what happened in Washington State, 2020 was disruptive; and we did have backsliding in our well-child visits. I will say that it's interesting that the infant visits and infant immunizations took less of a hit than the three to five visits and the adolescent visits. Indeed, when you look at overall utilization, parents were bringing in infants; but acute care visits for colds, ER visits, asthma, etcetera for three- to five-year-olds went down across the board. The good news is our immunization rates did not suffer terribly in infants. We did better on measle shots than we expected. The older child booster measles vaccine was much more problematic.

Because of this improvement in these numbers, for 2022 we're going to now set the standard instead of having five or more visits, we're making it six; and we're moving the target lower to give them credit for the fact that we are now adding another visit for expectations. For our laggard target, we're going to make it zero or two visits to be at risk for losing PMPMs.

Next slide.

So what are some of the lessons here? Well, you could say that this actually follows behavioral economics, where very often the risk of a loss has more impact than the value of a small gain. I think we've seen that threatening people with a loss of something they had changed behavior much more dramatically than the potential for being part of a small gain.

Next slide.

So this is our philosophy of the PCMH program. This is just one piece of how we use measures and try to improve care, but basically have had programs and measures in place and measurements, which have stretched the providers to provide feedback which modified requirements and analytics. By the way, all of these practices now have a very substantial practice report card that gets updated monthly; and many of them use this as a gamechanger to drive their own practice management style, and their practice managers use this report card on a regular basis.

We then support practice transformation. We then push the practices a bit more. We have a whole new cycle of dialog to how to improve care and make sure our data analytics are appropriate and are supportive in pushing for achievable goals and implementation.

Here's my e-mail if you have questions. Again, thank you for listening. I hope this is useful for your program.

Jodi Anthony:

Thank you, Dr. Golden.

We are now going to open it up to questions. Just as a reminder – next slide – this is how you submit a question. You put it into the Q&A and select "All Panelists" in the "Ask" menu. Type your question, and it will come up in my little Q&A box; and I will read it aloud.

While people are doing that, I will start with a couple of questions that are already in the queue. The first one is to Dr. Golden: "*How big are the bonus or incentives that doctors get? As a follow-up, do PAs or nurse practitioners get bonuses as well?"*

William Golden:

The bonus dollars in the beginning were a percentage of the shared savings, that's a whole other discussion about the complexity of maintaining that kind of a total-cost-of-care program; so we have moved away from that. Essentially, there is about a $12 million to $13 million pool, which is split among those three or four measures that we have, which we call focus measures. The top 10% get the biggest

share of that dollars, and then the top 35% get a smaller share. So it is a $12 million to $13 million pool, so the checks can get pretty substantial on a per-member basis, depending on the size of the practice.

At this time, the PAs and nurse practitioners are not eligible to be PCPs in our program. That will change in 2022. However, I will say that the practices that have gotten some of these big checks have been very creative in how the dollars are spread around. In fact, we heard stories that some practices gave bonus checks to front desk clerks, who were absolutely shocked that their doctors and practices gave them the extra money; but they were told by their practices that they were essential components of reaching out to patients, getting patients to understand the system, and engaging patients in becoming a part of a patient-centered program.

So, every practice can do their own thing; but in very many of these practices, it's considered a team effort. Jobs have been redesigned. Nurses and PAs have been re-empowered, and dollars have been shared across all levels of a team.

Jodi Anthony:

Great, thank you.

The next question is for Glory: *Some of the particular pilots in the PIPS focused on older children or toddlers. What lessons learned from those PIPS would you change or would you test specifically for the zero- to 15-month infants, and what might you test that might be new*?

Glory Dole:

Thank you for that question. I think one of the most effective things that we saw were really the engagement with the clinics, the engagement with parents, training, education, and those kinds of things. We saw effective change across the age groups with those lessons learned. We actually have fairly good infant rates, and we have been concentrating on the 3- to 11-year-olds because that's where we see a great need.

The prenatal and postpartum VBPs should have a positive impact on infant rates as well. That was one additional thing that we did this year. So those are some of the efforts and focus and lessons learned that we've had through the pilot projects and other PIPS and things that we can focus on.

Jodi Anthony:

Great.

Okay, so this question is actually for both of you; but let me start with you, Glory: *In what ways, if at all, are you tracking disparities and implementing efforts to push plans to close racial and ethnic disparities?*

Why don't I start with you, Glory; and then I'll ask Bill to respond to the same question.

Glory Dole:

Thank you, and I really appreciate that question. One of the things that the Health Care Authority has done in the past year is we actually hired a health equity person to coordinate all of the health equity activities that the Agency is doing and have a coordinated strategy that really focuses on health equity, diversity, equity, and inclusion.

There are lots of different activities across the Agency; and this person is able to get us focused, get a strategy around it, and see where we need to go in the future. Been able to implement, just within the Agency, already a focused website that is in alignment with the Office of Equity and Inclusion that our governor has put in place this year. We're able to do a lot of internal training. We are able to get this health equity focus in our interactions and meetings and contracts with the managed care organizations.

The annual report that we put out every year that demonstrates and shows how well the MCOs, the managed care organizations, are doing in terms of their performance -- there is a big effort to include social determinants of health, racial and ethnic disparities, and getting better data around that. We have implemented several work groups to try to understand this better. In Washington, we see that the data – we have problems with it because of very low numerator/denominator issues, where the pool is just not very large. So getting better data, having better focus on how – we need better data– how to get it and having really focused work groups on that.

We are working directly with our external quality review organization for them to research what best practices other states are doing around getting better data around these disparities. It's a constant part and integration of our system.

One thing that I would like to highlight as well from Washington State is we're putting health equity focus into all of our job descriptions. This year during our annual evaluation period, we're rewriting every single job description to include an integration of health equity focus into every person who's employed at the Health Care Authority.

So there are tons of efforts and things that the State is doing around health equity – not just around infants and children, but I think that the global effort definitely impacted this specific area as well. So those are the things that I would say about health equity and what we're doing there.

Jodi Anthony:

Great, thank you, Glory.

Can I pose the same question to you, Dr. Golden?

William Golden:

Yeah, I'll tell you kind of an apocryphal story. Ten years ago or so someone from AHRQ gave me a call and said, "Gee, we have an annual quality report and we have an annual disparity report. You guys look great in terms of disparities in X,Y,Z."

And I said, "Well, yes, and no."

He said, "What do you mean?"

I said, "Well, the reason why our disparity looks so good, and our lack of disparities, is because our white population gets equally bad care; and we are way below average." So we have equal opportunities for questionable care sometimes in terms of care gaps. So it was interesting how it gets spotty. We do get some data, and we do run it; and it really is variable.

We just did some data analysis on our expansion population, and white women are getting less breast and cervical cancer screening than black women. Black patients are getting less substance treatments than white patients. It really is variable depending on the topic. So we are working on them on a per-topic basis, but also many of the other issues that come across in terms of disparities get into many of the social functions of the Department of Human Services well beyond just the clinical provisions of care.

I will say though that in terms of clinical disparities, it's not quite as obvious perhaps in some regions; but we are working in care gaps throughout the system. Very often they are equal opportunity care gaps.

Jodi Anthony:

Okay, let's see...lots of questions here.

Let me ask you, Bill, about *what are some of the activities that you've heard from the providers about what has been effective for them to improve the number of well-child visits for this population?*

William Golden:

Yeah, obviously medical homes here – we've been going on now eight or nine years. We were a CPC state, a CPC+ state. There had been webinars; there had been coaching teams; there had been regional meetings, regional group sharing. It's really become a community of primary care, patient-centered medical home entities, and they have been truly sharing with each other and presenting to each other. So it's really been quite a transformation in the state; and I think the culture of primary care has been massively improved by being part of CPC+, CPC, and Medicaid and commercial medical home programs.

Jodi Anthony:

Great. I think a follow-on question is: *What processes do you have to involve the practicing community in setting the requirements and expectations?*

William Golden:

Yes, when we put the minimum performance and we had a legislative mandating advisory group come in. They're kind of the squeaky wheels of the practicing community if you will. We outlined for them what was a little bit of trepidation that we could threaten to take away PMPMs for minimum performance. They looked at our numbers. They looked at what we were targeting. They looked at us and said, "Well, you know, if those folks in those outlier status numbers can't do better than that, they shouldn't be in the program."

So these folks were actually saying, "Hey, we're doing the work. We should expect people to get with the team and do something to earn their dollars.

We just had a webinar today outlining next year's metrics. We also have a regular advisory group, which we call the Strategic Advisory Panel, that meets Wednesday mornings at 7:30 a.m. in the morning. We meet about every other month. There's about 80 people on the call, but about 15 people are the designated advisors; and that's where we suggest new ideas. They are able to raise issues and problems or questions about our data.

Excuse me, someone wants to sell me insurance here.

It actually is a good dialog and keeps everybody in the loop, both about problems in the program as well as potential new opportunities for changing the program for the better.

Jodi Anthony:

Great.

Okay, a question for Glory. This is coming back to your engagement of parents. Somebody wanted to know how you engage parents for the focus groups.

Glory Dole:

You know, that's a great question. I saw that in the Chat and was reaching out to folks who had been involved with this for years. We actually will need to get back to you on those details. We know there were a lot of really great community outreaches with the Department of Health and the MCOs. The specifics of exactly how they reached out – did they call them, did they cold call them, were there folks provided to them through the clinics – I don't exactly know the specific details of how they got that group together.

What we do know is that there was really great qualitative – asking questions and *really* great listening. That to me was the real take-home point. The logistics of how they got the group, we'll definitely have to follow up on those details. I don't actually know.

Jodi Anthony:

Okay, this is again a question for Bill. Let's see here…I think this question is getting to sort of the process for making this all come together: *Was there a contract amendment? What was the prep time for making*

the threat a real option? Can you just talk a little bit more about sort of the process that helped you get there and how others can adapt?

William Golden:

We started telegraphing it about six months before it went into effect, before the year the measurement went into effect. We let people know they were outliers. We tell people, and also this goes back to failure to – and remember that first slide about things they had to do to get the PMPMs, like have an EMR or get rid of answering machines. If they didn't achieve those elements, we threatened to take the money away, and we gave them six months to remediate.

Believe it or not, we did take away money. We just said, "This is a program. It's voluntary. You don't have to be in it. You're not kicked out of Medicaid, but you're not meeting the expectations of the program."

We're doing that with now these performance measures. If you fail a measure, we send you a notice saying, "We need a corrective action plan. We expect these numbers to get better. If we don't get the corrective actual plan, we'll stop the payments. If you don't achieve your numbers, we'll stop the payments." They're allowed to appeal and appeal their data. So there's all sorts of safeguards; but, yes, people do actually lose their dollars. Very often, it's practices that really just can't get their acts together.

Jodi Anthony:

Okay, so I think I only have time for one more question. I'm going to make it for you, Bill; and this is sort of a two-parter. It's about how the physician community has responded to the accountability measures. In particular, there is a question about whether there has been any sort of discussion or a suggestion to risk adjust some of the thresholds and targets for minimal performance.

William Golden:

The bonus money dollars, the normative stuff, *is* risk-adjusted. We will let people take one or two patients out of their pool for measurement. We do work with each practice in terms of if they want to appeal their numbers and why they have issues. So a lot of it is tailor-made. There's an open dialog. We want to make the program as fair as possible.

The fact that – I think I showed you the first or second slide – enrollment has been robust and remains robust. The primary care community has been *strongly* supportive of the program. They much prefer this over dealing with a managed care program. They had told their legislatures they like the PCMH Program. So it has, as I said, been transformative.

We try to maintain an open dialog, and we do respond to comments and questions. Now sometimes when people raise complaints and questions, they're right. They actually point things out that are problems with the system or problems in their local environments, and we work with them to try to overcome and to remedy those issues. So we have learned about local systems issues that we wouldn't have learned about otherwise. So we try to make this a collaborative process that I think the practicing community has been very appreciative of this engagement and this responsiveness.

Like for example with COVID, we rapidly implemented changes to the program to allow telehealth visits. That quick responsiveness actually helped keep many of these practices alive during some of the lean months in the early days of the COVID epidemic.

Jodi Anthony:

Great.

Well, this has been a fantastic conversation. We only have a couple minutes left, and we do have a couple of announcements and next steps. So I am going to first thank you, thank the presenters, but then turn it over to Alyssa.

Alyssa?

Alyssa Bosold:

Thank you, Jodi.

Next slide, please.

In closing, I'd just like to again remind everyone to visit the www.Medicaid.gov Infant Well-Child Care Landing Page which is displayed on this slide. You also have it in the Chat for more information about the Learning Collaborative's upcoming webinar and Affinity Group.

Next slide.

Again, as I mentioned, you'll find a transcript and recording from this webinar and the first webinar in our series on the Page, as well as information and registration links for our upcoming which are all listed here. You can access more information about the upcoming Affinity Group here, including the Affinity Group Fact Sheet and Expression of Interest form. If you're a state Medicaid agency interested in participating in the Affinity Group, you should complete an Expression of Interest form by September 30th at 8:00 p.m. Eastern Time.

Next slide.

Finally, I just wanted to say thank you all for attending. As you exit the webinar, please remember to complete the evaluation which should show up for you in a separate browser. If you have any questions or if we didn't have time to answer your question today, please e-mail us at MACQualityImprovement@mathematica-mpr.com.

Thanks again for your time and have a great afternoon, everyone.