



**PARTNERS**  
Improving Lives. Strengthening Communities.

# Provider Performance Reporting



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# Strategic Planning Goal: Improve Provider Performance

# PERFORMANCE SCORING METHODOLOGY



3/25/2019 3

## What will determine the composite score?

- The composite performance score will factor in performance in the 4 weighted performance categories on a 0-100 point scale (Quality+Resource Use+Clinical Practice+Promoting Interoperability=)

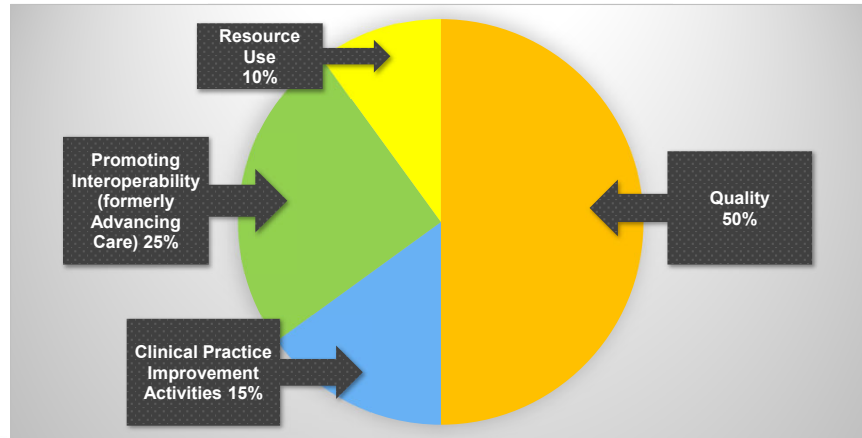


## Performance Score



3/25/2019 4

## Year 1: Performance categories and proposed weights



3/25/2019 5

## Performance Category Scoring

Performance Category	Maximum Points Possible	Percentage of Overall Score
<b>Quality:</b> category consists of 9 performance measures (5.55 points each)	50 points	50%
<b>Promoting Interoperability (Advancing Care):</b> category consists of 3 performance measures (8.33 points each)	25 points	25%
<b>Clinical Practice Improvement:</b> category consists of 5 performance measures (3.00 points each)	15 points	15%
<b>Resource Use:</b> category consists of 3 performance measure (3.33 points each)	10 points	10%



3/25/2019 6

## Performance Score Reporting

- Providers to receive their performance score with an opportunity for input
- Upon a 30 day review of the performance score, Partners will publish provider performance
- If corrective measures are taken after the APR has been completed, scores will be updated (monthly updates only)



3/25/2019 7

## Performance Measure Scoring

Measure Met = 1 Point

Measure Not Met = 0 Points

Measure N/A = 1 Point



3/25/2019 8

## Quality Performance Measures (50%)

### Quality # 1

- ▶ Sanctions/POC: Partners has issued 2 or more consecutive Plans of Correction against the Network Provider for the same or substantially similar findings within the 3 year credentialing cycle and/or re-credentialing cycle

### Quality # 2

- ▶ Sanctions/POC: The Network Provider has failed to implement a Plan of Correction Issued by Partners and the time for so has expired



3/25/2019 9

## Quality Performance Measures (50%)

### Quality # 3

- ▶ Sanctions: Partners has issued 2 or more sanctions or administrative actions against the network provider in a consecutive period of time

### Quality # 4

- ▶ Sanctions: The Network Provider has failed to remit an identified overpayment to or enter into an approved payment plan with Partners within the designated time frame



3/25/2019 10

## Quality Performance Measures (50%)

### Quality # 5

- ▶ Quality of Care: Partners BHM has logged quality of care concerns or other serious grievances about the network provider that have NOT been satisfied in requirement timelines.

### Quality # 6

- ▶ Monitoring: If Provider Overall Score 85% and above, then measure is met



3/25/2019 11

## Quality Performance Measures (50%)

### Quality # 7

- ▶ Provider provides a service that requires a fidelity review and is in compliance with fidelity score

### Quality # 8

- ▶ If the provider has a performance measure regarding ambulatory follow up in their contract and they are meeting the standard as indicated in their contract, then measure is met

### Quality # 9

- ▶ Provider maintains PBHM accreditation standard, if required



3/25/2019 12

## Promoting Interoperability Performance Measures (25%)

### Promoting Interoperability # 1

- ▶ If Provider has established connectivity to NC HealthConnex, then measure is met

### Promoting Interoperability # 2

- ▶ If Provider is submitting information to the NC-SNAP database, then measure is met

### Promoting Interoperability # 3

- ▶ If Provider is submitting information to the Rapid Resource for Families database, then measure is met



3/25/2019 13

## Clinical Practice Improvement (15%)

### Clinical Practice Improvement # 1

- ▶ If NCTOPPS initial interview submissions are in compliance with timely submission requirements (70% or higher), measure is met

### Clinical Practice Improvement # 2

- ▶ If NCTOPPS episode completion reason (completed treatment) score is in compliance (25% or higher), measure is met



3/25/2019 14

## Clinical Practice Improvement (15%)

### Clinical Practice Improvement # 3

- ▶ If NCTOPPS in-person & telephonic episode completion interview submissions are in compliance with timely submission requirements (65% or higher), then measure is met

### Clinical Practice Improvement # 4

- ▶ If Provider is participating in the ACORN tool, then measure is met



## Clinical Practice Improvement (15%)

### Clinical Practice Improvement # 5

- ▶ If Provider has implemented a patient-centered behavioral health model, then measure is met





## Resource Use (10%)

### Resource Use # 1

- ▶ If Provider has met the PBHM standard (80%) for overall claims approval rate (State funds), then measure is met

### Resource Use # 2

- ▶ If Provider has met the PBHM standard (80%) for overall claims approval rate (Medicaid B funds), then measure is met

### Resource Use # 3

- ▶ If Provider has met the PBHM standard (80%) for overall claims approval rate (Medicaid B funds), then measure is met



3/25/2019 17

## Provider Performance Reporting

- ▶ Questions?
- ▶ Comments?
- ▶ Suggestions?

[questions@partnersbhm.org](mailto:questions@partnersbhm.org)



3/25/2019 18