Advanced Medical Home (AMH) Technical Advisory Group (TAG)

Meeting #8: AHEC Introduction;

AMH Data Strategy Update; PHP Contract Amendments; PHP Auto-Enrollment and PCP Auto-Assignment

November 20, 2019 10:00 am – 1:00 pm

Williams Building, 1800 Umstead Drive, Room 123B

AMH TAG Membership Introductions and Rollcall

Name	Organization	Stakeholder
C. Marston Crawford, MD, MBA	Pediatrician Coastal Children's Clinic – New Bern, Coastal Children's	Provider (Independent)
David Rinehart, MD	President-Elect of NC Family Physicians North Carolina Academy of Family Physicians	Provider (Independent)
Gregory Adams, MD	Member of CCPN Board of Managers Community Care Physician Network (CCPN)	Provider (CIN)
Zeev Neuwirth, MD	Senior Medical Director of Population Health Carolinas Physician Alliance (Atrium)	Provider (CIN)
Amy Russell, MD	Medical Director Mission Health Partners	Provider (CIN)
Kristen Dubay, MPP	Senior Policy Advisory Carolina Medical Home Network	Provider (CIN)
Jan Hutchins, RN	Executive Director of Population Health Services UNC Population Health Services	Provider (CIN)
Joy Key, MBA	Director of Provider Services Emtiro Health	Provider (CIN)
Tara Kinard, RN, MSN, MBA, CCM, CENP	Associate Chief Nursing Officer Duke Population Health Management Office	Provider (CIN)
George Cheely, MD, MBA	Chief Medical Officer AmeriHealth Caritas North Carolina, Inc.	PHP
Michael Ogden, MD	Chief Medical Officer Blue Cross and Blue Shield of North Carolina	PHP
Michelle Bucknor, MD	Chief Medical Officer UnitedHealthcare of North Carolina, Inc.	PHP
Thomas Newton, MD	Medical Director WellCare of North Carolina, Inc.	PHP
William Lawrence, MD	Chief Medical Officer Carolina Complete Health, Inc.	PHP
Jason Foltz, DO	Medical Director, ECU Physicians MCAC Quality Committee Member	MCAC Quality Committee Member

Agenda

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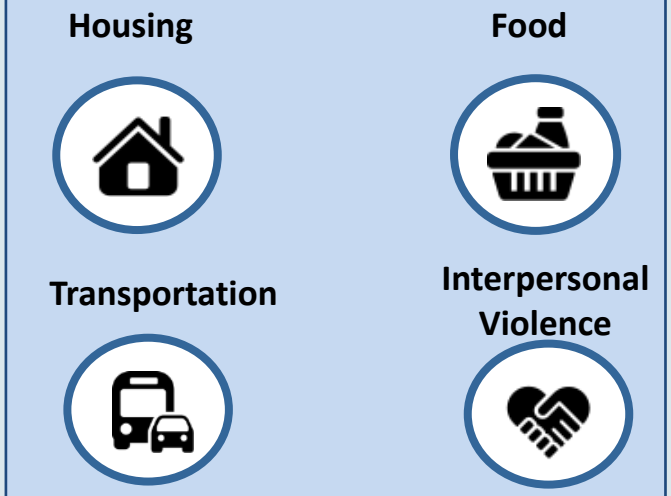
Recap: AMH TAG Meeting #7

1

North Carolina's Healthy Opportunities Priority Domains



2

1. ***Healthy Opportunities in Medicaid Managed Care -- Update --*** *On Nov. 5, 2019, the North Carolina Department of Health and Human Services (DHHS) released a Request for Proposals (RFP) for Lead Pilot Entities (LPEs) in the Healthy Opportunities Pilots.*

2. ***Tier 2 Reversion Guidance:*** *on DHHS website, here.*

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NORTH CAROLINA
AHEC

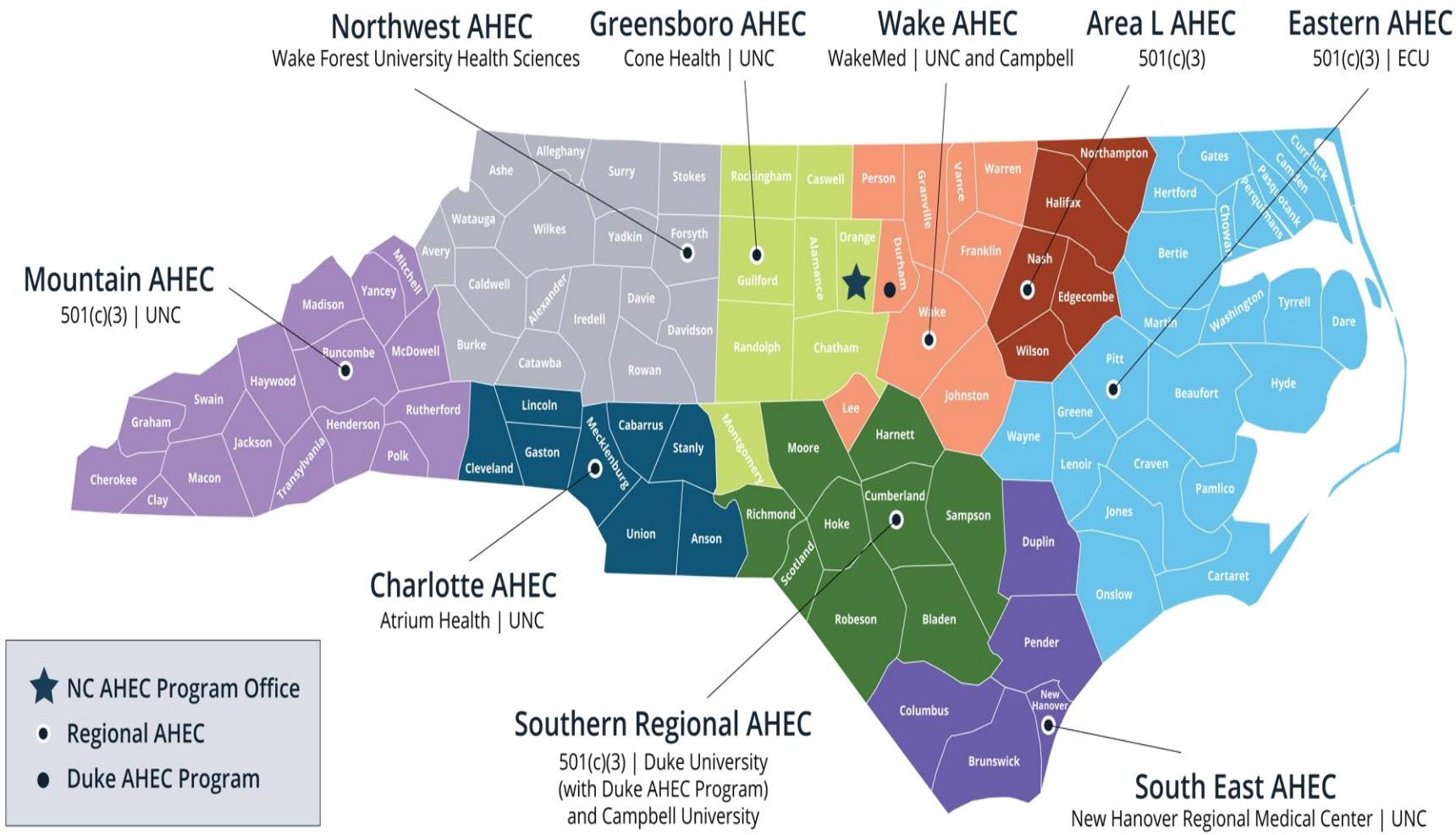
NC AHEC Practice Support and Medicaid Transformation

About NC AHEC

The North Carolina Area Health Education Centers Program was established in 1972 to meet the state's health and health workforce needs. NC AHEC's Program Office, nine regional centers, and the Duke AHEC Program provide educational programs and services that bridge academic institutions and communities to improve the health of the people of North Carolina with a focus on underserved populations.

- Health Careers & Workforce Diversity
- Student & Preceptor Services
- Graduate Medical Education Services
- Continuing Professional Development
- Practice Support
- Library Services

NC AHEC Serves Nine Regions Across the State

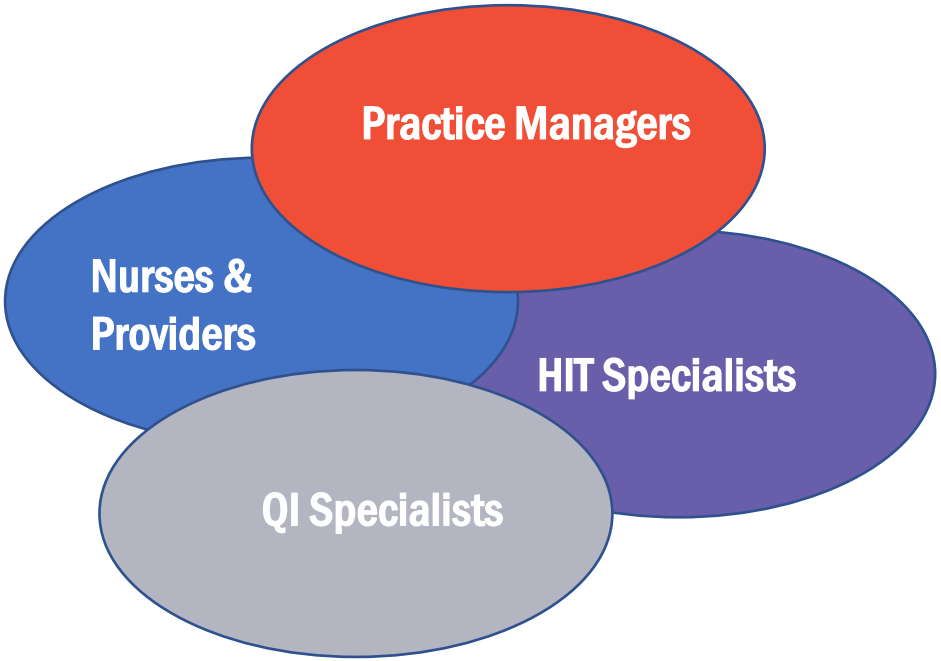


Practice Support

NC AHEC works with medical practices to transform the delivery of care.

Our practice support teams ensure that rural and under-resourced medical practices have the help they need to evolve with the ever-changing health care system – from quality improvement to electronic health records to Medicaid transformation – ultimately reducing costs and improving quality of care. NC AHEC Practice Support is all payor inclusive and will work with any interested CIN or ACO to serve these practices.

Practice Support Coaches Have Versatile Skill Sets



- 36 practice support coaches
- 1 embedded health science librarian and digital library resource
- 9 regional teams – each has a robust skill set
- Majority of coaches in their 2nd career; we pull heavily from their 1st career experience

NC AHEC Practice Support Services

Quality Improvement (PCMH,QPP/MIPS, Medicaid MU)	**EHR Selection & Optimization**	**Needs Assessments & Workflow Redesign**
Medicaid Transformation (contracted partner with NC Medicaid)	**NC HealthConnex** (contracted partner with NCHIEA)	**Special Grant Initiatives**

Heart Health NOW: An Example of Practice Support & Quality Improvement Success

- Project was funded by AHRQ involving NC AHEC, UNC Sheps Center, CCNC and NCQHA.
- Objective was to evaluate the effectiveness of risk stratification, practice facilitation, and quality improvement techniques on cardiovascular disease for high risk adults served by small North Carolina primary care practices.
- Worked with 219 practice sites covering 437,000 patients. Over 150,000 patients were identified to have a high risk of heart attack, stroke or death.
- Average risk score in the group was 23.5%. After practice facilitation and intervention, risk dropped to 17% with 10,000 prevented incidents of heart attack, stroke or death.
- Practices were able to use population health management techniques and act more aggressively and consistently with blood pressure control, statin and aspirin use for qualified patients.

NC DHHS Has Contracted with NC AHEC to Provide Practice Support for Medicaid Transformation

- On-site Practice Support coach to answer important provider questions in areas such as credentialing, contracting, billing, patient auto-assignment/enrollment, and quality measures.
- Effort primarily targets independent primary care practices, FQHCs/RHCS and health departments in rural and underserved areas. The resource is also provided to a variety of health care provider specialties covering physical and behavioral health.
- On-site Practice Support coach distributes important FAQs as new information is released and facilitates the completion of a provider satisfaction survey.
- On-site Practice Support coach provides rapid feedback regarding provider concerns to the NC Medicaid and PHPs to ensure services are customer focused and patient driven.

NC DHHS Has Contracted with NC AHEC to Provide Practice Support for Medicaid Transformation

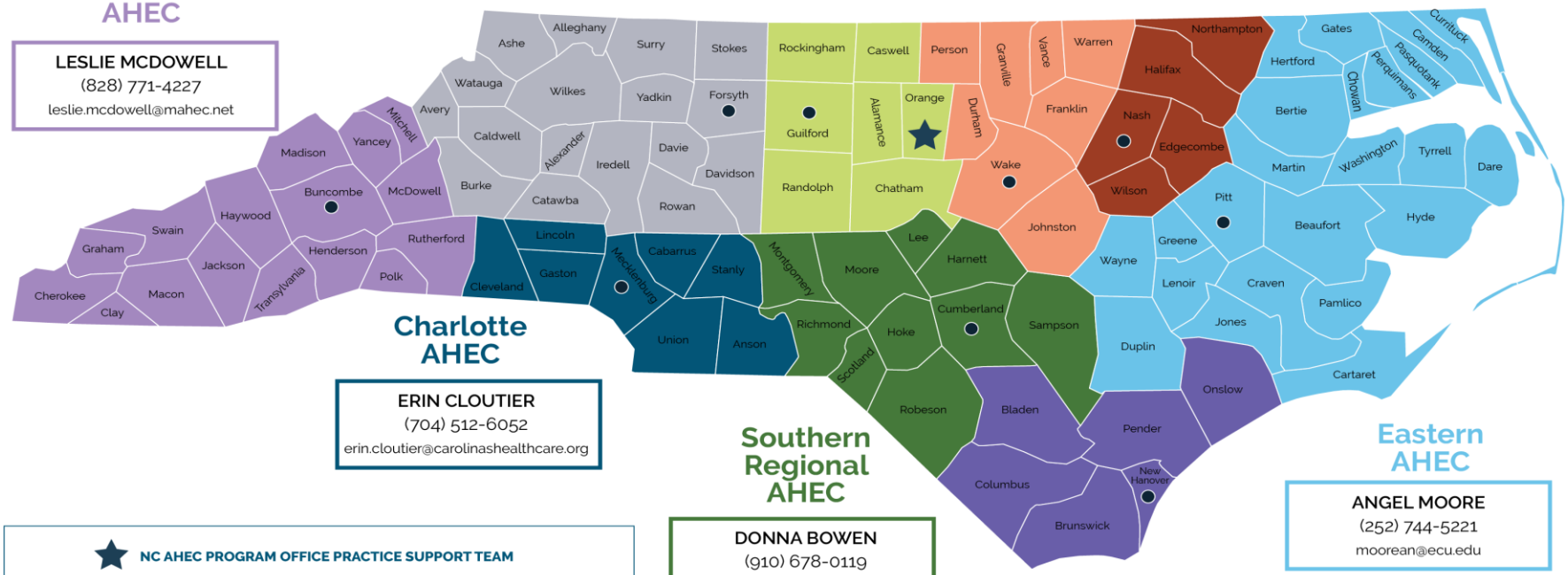
- On-site Practice Support coach assists with other managed care transition issues such as quality improvement, AMH attestation and gap analysis, workflow redesign, EHR optimization and interoperability, operational needs assessments, and population health initiatives.

- A call center is being developed comprising up to 6 Provider Engagement and Education Specialists. This group will co-locate at NC Medicaid, answer incoming questions, host virtual office hours and webinars on various topics, and develop FAQs based on common questions from practices.

How to Contact Us?

- **Telephone: 919-445-3508**
- **Email: practicesupport&ncahec.net**

NORTH CAROLINA AHEC REGIONAL PRACTICE SUPPORT CONTACTS



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AHEC Introduction: *For Discussion*

DHHS is working with AHEC to identify the highest priorities for practice support, especially for independent practices.

- What should the highest priorities be?
- Where do AMHs need the most help?

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AMH Data Strategy
Prioritizing Data Topics & Identifying Key Challenges

- DHHS is working with PHPs, AMHs and CINs to support the flow of information for the AMH Program.
- To inform which data flows to focus on, what challenges to address, and how and when to address them, DHHS conducted a survey and follow up research on key AMH data topics.

Polling of Priorities

Request

On October 3, DHHS released a survey to **five PHPs and seven CINs** asking them to consider each data topic/flow with respect to its importance to the provision of care management.

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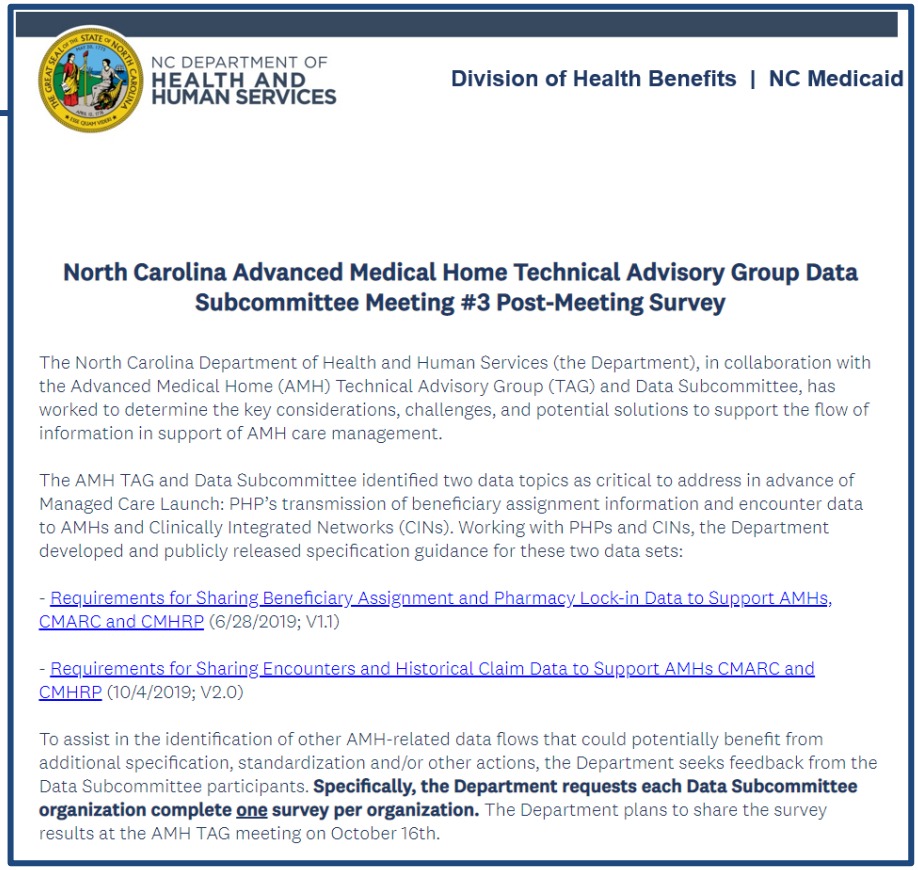

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

Division of Health Benefits | NC Medicaid

North Carolina Advanced Medical Home Technical Advisory Group Data Subcommittee Meeting #3 Post-Meeting Survey

The North Carolina Department of Health and Human Services (the Department), in collaboration with the Advanced Medical Home (AMH) Technical Advisory Group (TAG) and Data Subcommittee, has worked to determine the key considerations, challenges, and potential solutions to support the flow of information in support of AMH care management.

The AMH TAG and Data Subcommittee identified two data topics as critical to address in advance of Managed Care Launch: PHP's transmission of beneficiary assignment information and encounter data to AMHs and Clinically Integrated Networks (CINs). Working with PHPs and CINs, the Department developed and publicly released specification guidance for these two data sets:

- Requirements for Sharing Beneficiary Assignment and Pharmacy Lock-in Data to Support AMHs, CMARC and CMHRP (6/28/2019; V1.1)

- Requirements for Sharing Encounters and Historical Claim Data to Support AMHs CMARC and CMHRP (10/4/2019; V2.0)

To assist in the identification of other AMH-related data flows that could potentially benefit from additional specification, standardization and/or other actions, the Department seeks feedback from the Data Subcommittee participants. **Specifically, the Department requests each Data Subcommittee organization complete one survey per organization.** The Department plans to share the survey results at the AMH TAG meeting on October 16th.

AMH Data Flow Priorities*

Ranked from highest to lowest priority

PHPs and seven CINs :

- Ranked 14 data topics based on its importance to care management at managed care launch ("1" being the highest rank and "14" being the lowest) .
- Provided feedback on (a) the rationale for the ranking, (b) any obstacles or challenges to the data flow, and (c) any timing implications.

"Overall" Rank	Initial List of Data Topics [*Data Sources-> Targets*]	"Ave" Rank
1	Risk Stratification Scores [PHPs -> AMHs, LHDs, CINs]	1.64
2	Care Needs Screening Results [PHPs -> AMHs, LHDs, CINs]	2.73
3	Admission, Discharge, Transfer (ADT) Information [HIEs -> AMHs, CINs]	5.09
4	Comprehensive Assessment Results [PHPs -> AMHs, LHDs, CINs]	5.27
5	Care Plans [PHPs -> AMHs, LHDs, CINs]	6.82
6	Prior Authorizations [PHPs <-> AMHs]	7.64
7	Quality Measures Performance Information [AMHs, LHDs, CINs -> PHPs]	7.91
8	Quality Measure Performance Information [PHPs -> AMHs, LHDs, CINs]	8.64
9	Clinical Information [HIEs -> PHPs & AMHs, CINs]	8.64
10	Unmet Health-related Resource Needs [PHPs, AMHs, CINs Human Service Organizations]	8.91
11	Immunization Data [NC Immunization Registry -> PHPs, AMHs, CINs]	10.64
12	Controlled Substance Data [NC CSRS -> PHPs & AMHs, CINs]	11.18
13	Sharing Data with Patients and Caregivers [AMHs -> Patients]	11.55
14	Sharing Data with Patients and Caregivers [PHPs -> Patients]	12.64

**** Full listing in the Appendix***

AMH Data Flow Challenges
Lack of Standardization

Lack of Standardization

Findings

Respondents indicated that the lack of standards for key data elements limits their ability to automate the receipt of data into their systems and workflows.

Example(s)

- Regarding risk stratification, one CIN stated that their biggest challenge will be to normalize "*across all PHPs such that the data can be interpreted for action*"

Next Steps

1. Determine roles for DHHS, PHPs, CINs, AMHs and statewide entities like the NC HIE Authority to address standardization efforts.

2. With respect to "high priority" data (risk stratification scores, care needs screen results), identify the formats and exchange methods that PHPs will use to transmit data at managed care launch.

AMH Data Flow Challenges
Accessing Various Types of Data

Accessing Data

Findings

For a few data topics, respondents cited issues regarding completeness of the data, the costs of HIE services to access the data, and/or the reliability of HIE services to provide the data.

Example(s)

- Regarding access to ADT alerts, one CIN indicated that it will need "*connection with NC HIE or pay for data through other sources*"

Next Steps

1. Compile PHP and CIN feedback on approaches and concerns regarding access to ADT alerts.
2. Share findings with Data Subcommittee and determine next steps

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Overview: Upcoming PHP contract amendments

On November 11, DHHS issued guidance providing advance notice of upcoming amendments to the PHP contract

Effective Immediately

The amendments will:

- Add new guardrails around “downgrade” actions by PHPs to provide AMH Tier 3s with a time-limited glide path;
- Prohibit PHPs from conditioning AMH Tier 3 contracts on audits or other monitoring activities that go beyond what is necessary for practices to meet the AMH Tier 3 standards; and
- Clarify the Department’s expectations for PHPs’ oversight of Clinically Integrated Networks (CINs)/Other partners

For the full document, please visit the DHHS website : https://files.nc.gov/ncdma/AMH-Contract-Amendment-Guidance-20191108.pdf

1: Guardrails around "downgrade" actions for a limited glide path

Effective Immediately

To provide modest standardized protections for practices against immediate downgrades, and to provide assurance that PHPs are giving practices reasonable time to remedy issues, we are adding two additional guardrails to the PHP contract:

- PHPs may not downgrade practices certified as AMH Tier 3 for any reason until **90 days after Medicaid Managed Care go-live.**
- PHPs must allow AMHs and CINs/other partners **at least 30 days** for remediation of non-compliance with AMH Tier 3 standards before pursuing a downgrade.

Note: *The combination of these guardrails means that a PHP would be permitted to downgrade an AMH Tier 3 practice as early as 90 days following Medicaid Managed Care go-live but* ***must provide at least 30 days for remediation of non-compliance prior to completing that downgrade****.*

2: PHPs must limit requirements on AMH Tier 3 practices to the AMH Tier 3 model

Effective Immediately

- **PHPs must monitor AMHs and CINs/other partners against AMH Tier 3 requirements.**[1]

- **PHPs must not hold AMH Tier 3 practices to requirements that go over and above the AMH Tier 3 program requirements until 2021**, including requirements imposed as part of National Committee for Quality Assurance (NCQA) pre-delegation auditing.
  - During this time, PHPs and AMH practices may still work together by mutual agreement to prepare for NCQA delegation, but PHPs may not condition contracts on any such activities.

- The Department's requirement that PHPs achieve plan-level NCQA accreditation by Year 3 of Medicaid Managed Care will remain unchanged.

[1] For full AMH Tier 3 measure set, please see Appendix Slide 2

3: Clarify Department's expectations for PHP oversight of CINs/other partners

Effective Immediately

Within 90 days of contracting, each PHP must share with each AMH Tier 3 practice a description of the oversight process it will use to monitor practices' performance against specific AMH requirements, including the processes it will use to monitor the CIN/other partner with which the practice is affiliated.

In the event of a compliance action against a CIN/other partner, the PHP must provide notice to each AMH Tier 3 practice affiliated with that CIN/other partner **within 60 days.**

- The PHP must not automatically change the tier status of an AMH Tier 3 practice as a result of any corrective action plan or other compliance action imposed at the CIN/other partner level.
- In the event that a PHP terminates its contract with a CIN/other partner, the PHP must provide individual AMH Tier 3 practices affiliated with the CIN/other partner notice of their options, including contracting directly with the PHP, contracting with another CIN/other partner, or reverting to AMH Tier 2.

Note: The AMH TAG previously reviewed these provisions during TAG Meeting #6

Additional planned PHP contract amendments

In the near term future, the Department will release notice of additional amendments. These amendments will:

- Add liquidated damages associated with the AMH Tier 3 contracting requirement
  - **Up to $100,000** per region per month

- Revise the requirements for AMH Tier 3 Care Management Fees and Performance Incentive Payments:
  - **Care Management Fees:** Must be per member per month payments that provide a **minimum guaranteed revenue** to the practice and are **not placed at risk** based on measures of utilization, cost, or quality.
  - **Performance Incentive Payments:** Must be **additional to Care Management Fees.** Performance Incentive Payments may be based on metrics outside of the AMH quality measure set, but such metrics must be approved by the Department.

- Require Departmental approval of changes to AMH payment terms
  - Plans must resubmit templates for approval **at least 90 calendar days** before use in the market

Upcoming PHP Contract Amendments: *For Discussion*

- What has been the market reaction to the immediate amendments listed on slide 27?
- What is the TAG's feedback on the future planned amendments?

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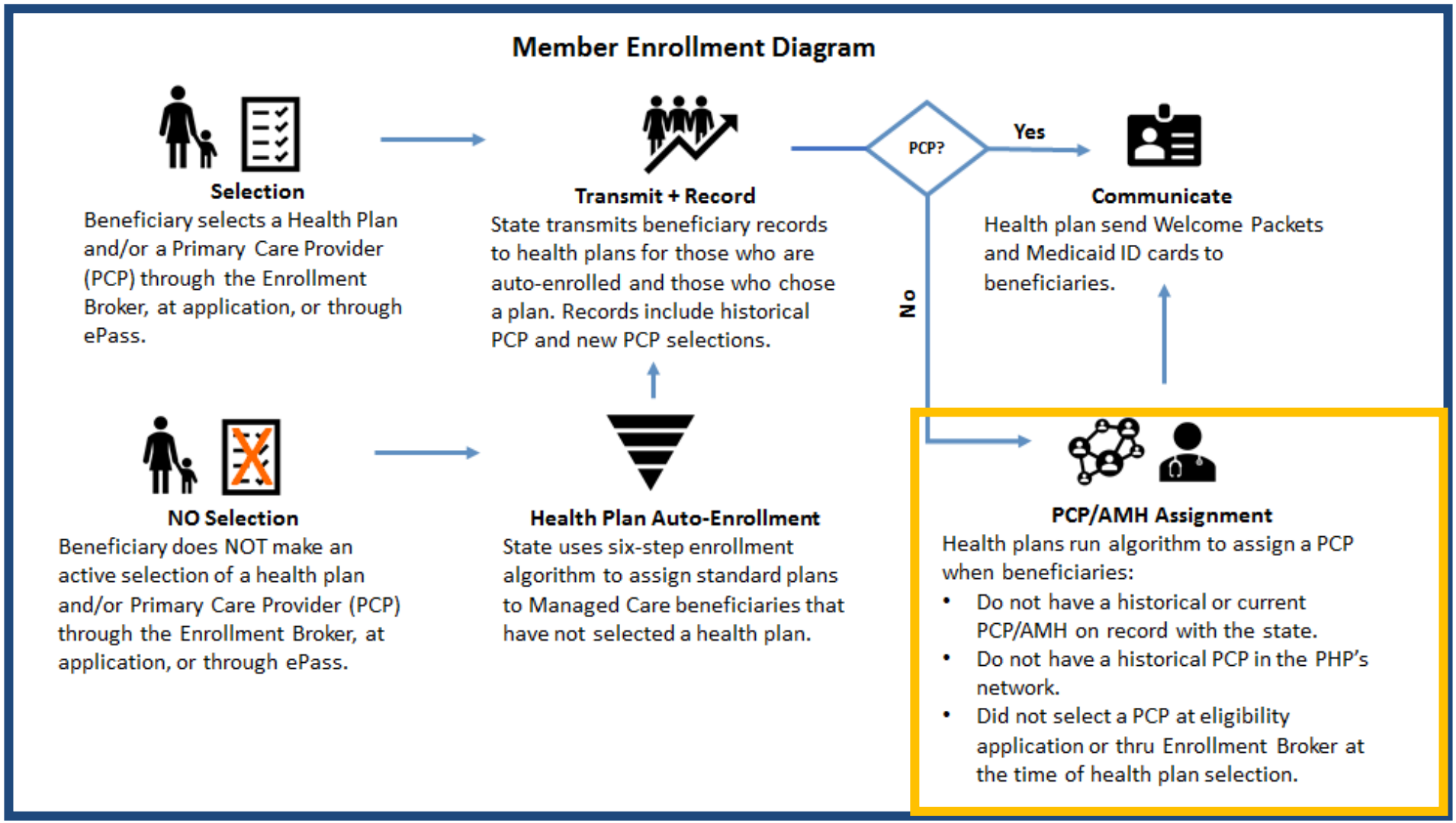
PHP Auto-Enrollment and PCP Auto-Assignment are approaching

	Health Plan Auto-Enrollment	PCP/AMH Assignment
Owner	NC Department of Health & Human Service	Health Plans – WellCare, United, HealthyBlue, Carolina Complete Health, AmeriHealth
Purpose	To enroll beneficiaries who did not choose a health plan to a plan.	To assign beneficiaries with a Primary Care Provider (PCP/AMH). An PCP/AMH is assigned when a beneficiary: • Did not select a PCP at eligibility application or through Enrollment Broker at the time of health plan selection. • Does not have a historical or current PCP on record with the state. • Does not have a historical PCP in the health plan's network.
When	➢ Begins December 16 for current Managed Care population. ➢ New beneficiaries will be auto-enrolled at the time they are determined eligible for Medicaid Managed Care.	➢ Begins December 17 for current Managed Care population. ➢ New health plan members will be assigned PCPs within 7 days of enrollment, thereafter.
Factors	Region, special designations, historical provider relationship, family's health plan enrollment, previous health plan enrollment	Prior PCP/AMH assignment, member claims history, family PCP/AMH assignment, family claims history, geographic proximity, special medical needs, and language/cultural preference

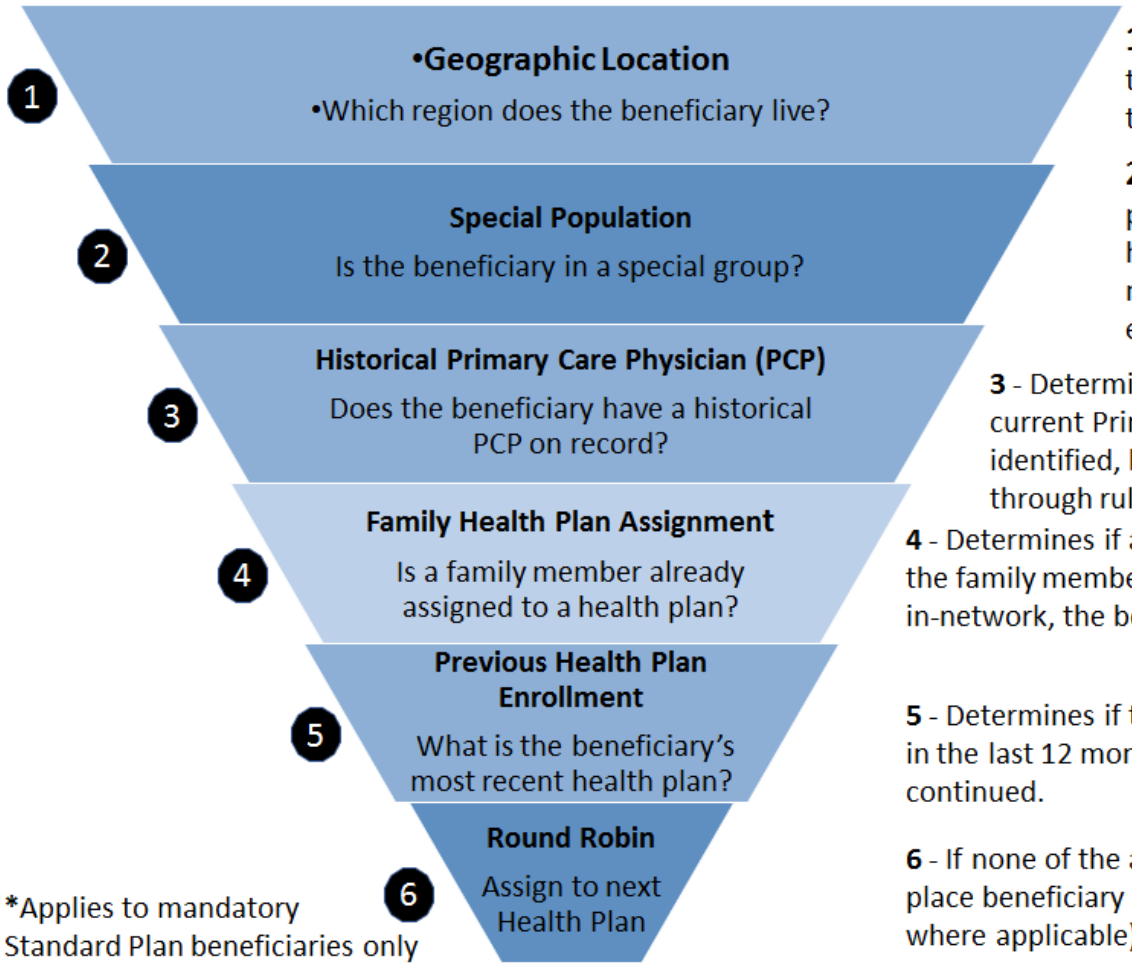
Source: North Carolina DHHS

PHP Enrollment and PCP Assignment Process Flow



Source: North Carolina DHHS

Prepaid Health Plan Auto Enrollment Algorithm*



1 - Determines where the beneficiary lives, determines the region, and removes health plans not contracted in that region.

2 - Determines if the beneficiary is part of a special population and should be assigned to a specific type of health plan. Currently, there is one special population--newborns. If not already selected, newborns are enrolled with their mother's health plan.

3 - Determines which health plan networks include the beneficiary's current Primary Care Provider (PCP). If only one health plan identified, beneficiary is enrolled. If more than one, proceed through rules.

4 - Determines if a family member is already enrolled in a health plan. If the family member is enrolled, and the beneficiary's historical PCP is also in-network, the beneficiary is enrolled to the family member's plan.

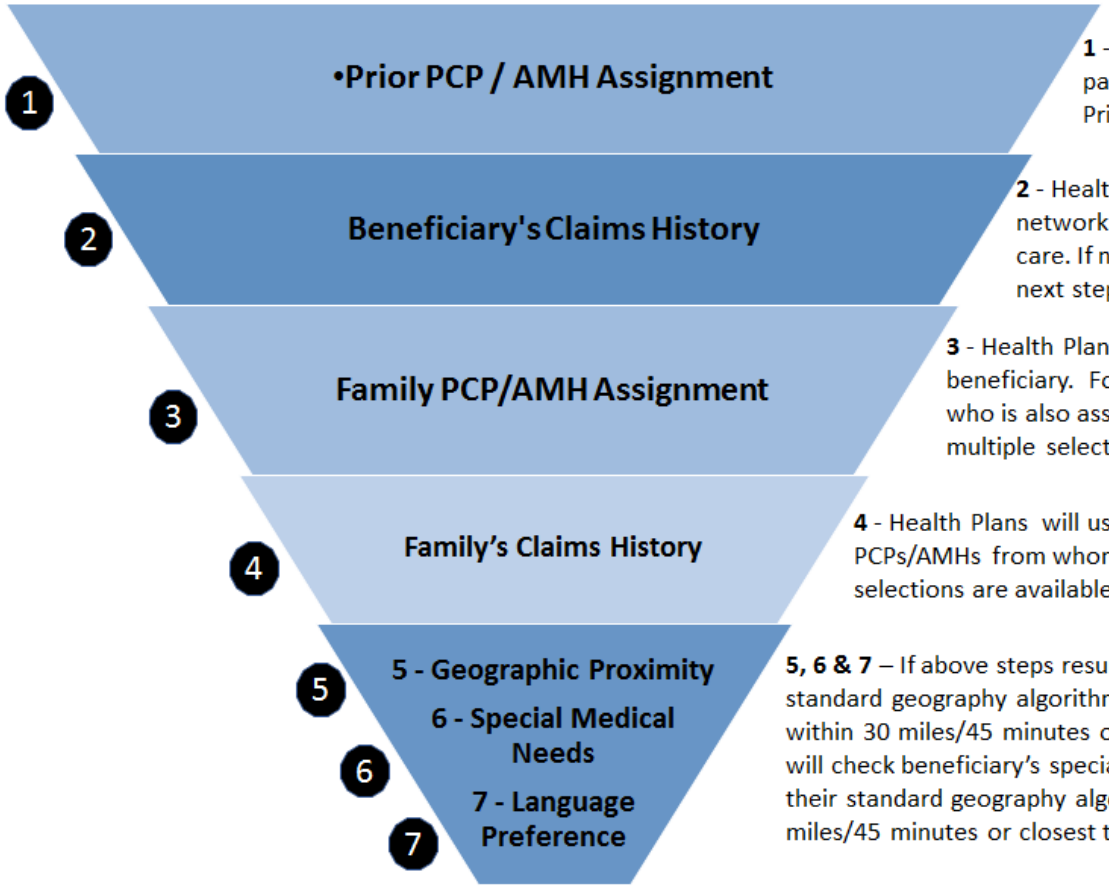
5 - Determines if the beneficiary has been enrolled with a health plan in the last 12 months. If so, the enrollment with the last health plan is continued.

6 - If none of the above result in enrollment, a rotating selection will place beneficiary in a health plan (maintaining the in-network PCP, where applicable).

Source: North Carolina DHHS

PCP Auto Assignment Algorithm*

PCP / AMH Auto Assignment Algorithm *



1 - If the beneficiary has a Prior PCP/AMH and that PCP/AMH is part of the Health Plan network – Health Plans will assign their Prior PCP/AMH to the beneficiary.

2 - Health Plans will use beneficiary's claims history to match to an in-network PCP/AMH from whom the beneficiary has previously received care. If no results or multiple selections are available then proceed to next step.

3 - Health Plans will assign to an PCP/AMH assigned to another family beneficiary. For children, preference is to assign an in-network pediatrician who is also assigned to any other child within the family. If no results or multiple selections are available then proceed to next step.

4 - Health Plans will use family claims history to match to in-network PCPs/AMHs from whom the family has received care. If no results or multiple selections are available then proceed to next step.

5, 6 & 7 – If above steps result in multiple PCPs/AMHs then Health Plans will use their standard geography algorithm to narrow the results to an in-network PCP/AMH that is within 30 miles/45 minutes or closest to beneficiary's home. Otherwise Health Plans will check beneficiary's special medical needs and/or language preference and apply their standard geography algorithm to find an in-network PCP/AMH that is within 30 miles/45 minutes or closest to beneficiary's home.

*Applies to Standard Plan beneficiary's only

Source: North Carolina DHHS

PCP Auto Assignment Example

Example Use Case: Individual Beneficiary without Prior PCP / AMH

Jackie Smith is a current Medicaid recipient that is part of the mandatory Standard Plan population. She lives in Region 4 and currently does not have an assigned PCP. Jackie did not select a Health Plan prior to the end of Open Enrollment. The Department enrolls Jackie to Health Plan B using the auto-enrollment process. Health Plan B assigns Jackie to a PCP using the AMH/PCP auto assignment process.

1 Prior PCP/AMH Assignment

Jackie does not have a prior PCP/AMH. Go to next step.

2 Beneficiary's Claims History

Jackie's claims history will be analyzed for PCP visits. Jackie visited three PCPs in the past, they will be picked up for assignment

PCP A ✓
PCP B ✓
PCP C ✓

3 Family PCP Assignment

Jackie is an individual and does not have associated family. All PCPs selected in last step remain available to her.

PCP A ✓
PCP B ✓
PCP C ✓

4 Family's Claims History

Jackie is an individual and does not have associated family. All PCPs selected in last step remain available to her.

PCP A ✓
PCP B ✓
PCP C ✓

5 Geographic Proximity

PCP A & PCP B are within 35 miles or 45 minutes from Jackie's home. PCP B is closet to her home and is assigned to Jackie. Criterion 6 & 7 do not apply to Jackie.

~~PCP A~~
PCP B ✓
~~PCP C~~

6 Special Medical Needs

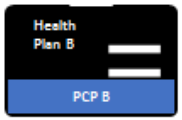
Jackie does not have any special needs so this criterion does not apply to her.

~~PCP A~~
PCP B ✓
~~PCP C~~

7 Language Preference

Jackie does not have any language preference so this criterion does not apply to her.

PCP B is assigned to Jackie based on her claims history and geographic proximity.



Auto-Assignment: *For Discussion*

- What issues or items are you hearing about [PCP] auto-assignment in the market? Are those issues addressed by this information?
- What else could the Department do to clarify the process?

Agenda

1	Recap: Advanced Medical Home (AMH) TAG Meeting #7	10:00 am – 10:10 am
2	AHEC Introduction	10:10 am – 10:45 am
3	AMH Data Strategy Update	10:45 am – 11:15 am
4	Break	11:15 am – 11:30 am
5	PHP Contract Amendments	11:30 am – 12:20 pm
6	Auto-Enrollment and Auto-Assignment	12:20 pm – 12:50 pm
7	Next Steps	12:50 pm – 1:00 pm

Next Steps

1. **TAG Members to provide any additional feedback based on today's discussion to Alexa at apicciotto@manatt.com**

2. **Next AMH TAG: January 29, 2020, 10:00 am – 1:00 pm**

Appendix

AMH Data Flow Priorities*

Ranked from highest to lowest priority & noting those w/ 1st or 2nd ranks

Initial List of Data Topics [*Data Sources-> Targets*]	"Ave"	Ranked 1 or 2
Risk Stratification Scores [PHPs -> AMHs, LHDs, CINs]	1.64	9
Care Needs Screening Results [PHPs -> AMHs, LHDs, CINs]	2.73	7
Admission, Discharge, Transfer (ADT) Information [HIEs -> AMHs, CINs]	5.09	4
Comprehensive Assessment Results [PHPs -> AMHs, LHDs, CINs]	5.27	1
Care Plans [PHPs -> AMHs, LHDs, CINs]	6.82	0
Prior Authorizations [PHPs <-> AMHs]	7.64	0
Quality Measures Performance Information [AMHs, LHDs, CINs -> PHPs]	7.91	0
Quality Measure Performance Information [PHPs -> AMHs, LHDs, CINs]	8.64	0
Clinical Information [HIEs -> PHPs & AMHs, CINs]	8.64	1
Unmet Health-related Resource Needs [PHPs, AMHs, CINs Human Service Organizations]	8.91	0
Immunization Data [NC Immunization Registry -> PHPs, AMHs, CINs]	10.64	0
Controlled Substance Data [NC CSRS -> PHPs & AMHs, CINs]	11.18	0
Sharing Data with Patients and Caregivers [AMHs -> Patients]	11.55	0
Sharing Data with Patients and Caregivers [PHPs -> Patients]	12.64	0

Other Topics Identified by a PHP or a CIN [*Data Sources-> Targets*]	Rank
Care Management Beneficiary Extract Report [AMHs->PHPs->DHHS]	4
Comprehensive Assessments [AMHs-> PHP]	3
Care Plans [AMHs/CINs -> PHP]	4
Lab Data from Non-HIE Sources [Labs, Hospitals->AMHs]	5
Value-Added Benefits [PHPs-> AMHs]	15
Covered Benefit Information [PHPs-> AMHs]	16
Network Provider/Specialty Information [PHPs<-> AMHs]	17

**** Ranking based on polling survey of five PHPs and seven CINs conducted Oct 4-Oct 11, 2019***

AMH Tier 3 Measure Set

Table 3: Measures Selected for Use in PHP Assessments of AMH Practice Quality

NQF#	Measure Title	Relevant Population	
		Adult	Pediatric
0038	Cervical Cancer Screening	X	
0032	Childhood Immunization Status (Combination 10)		X
0059	Comprehensive Diabetes Care: HbA1c poor control (>9.0%)	X	*
1800	Asthma Medication Ratio	X	*
0576	Follow-up After Hospitalization for Mental Illness	X	X
0027	Medical Assistance With Smoking and Tobacco Use Cessation	X	*
1516	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life		X
1407	Immunization for Adolescents		X
0024	Weight Assessment and Counselling for Children and Adolescents		X
0018	Controlling High Blood Pressure	X	*
1604	Total Cost of Care		
N/A (NYU/ Billings)	Avoidable/Preventable ED Utilization	X	X
N/A (AHRQ)	Avoidable/Preventable Inpatient Utilization	X	*
N/A	PQI-01: Diabetes Short-Term Complication Admission Rate	X	
N/A	PQI-05: COPD or Asthma in Older Adults Admission Rate	X	
N/A	PQI-08: Heart Failure Admission Rate	X	
N/A	PQI-15: Asthma in Younger Adults Admission Rate	X	
N/A	PDI-14: Asthma Admission Rate		X
N/A	PDI-15: Diabetes Short-Term Complications Admission Rate		X
N/A	PDI-16: Gastroenteritis Admission Rate		X
N/A	PDI-18: Urinary Tract Infection Admission Rate		X
1768	Readmission Rates	X	*

* = Likely low rate for pediatric-only practices

Source: North Carolina's Medicaid Managed Care Quality Measurement Technical Specifications Manual