NC DEPARTMENT OF
HEALTH AND HUMAN SERVICES

NORTH CAROLINA MEDICAID ACCESS MONITORING REVIEW PLAN

2016-2018

Contents

Overview

This Access Monitoring Review Plan (Plan) provides an overview of access to care for North Carolina Medicaid beneficiaries for 2016, 2017 and 2018. In 2015, the Centers for Medicare and Medicaid Services (CMS) began requiring[1] states to develop "medical assistance access monitoring review plans" to assess Medicaid beneficiaries' access to Medicaid services.

CMS requires that states "analyze data and supporting information to reach conclusions on sufficient access for covered services provided under fee-for-service. Every three years, states must conduct the analysis for: primary care services (including those provided by a physician, FQHC, clinic, or dental care); physician specialist services; behavioral health services, including mental health and substance use disorder; pre- and post-natal obstetric services, including labor and delivery; and home health services." In accordance with 42 CFR 447.203(b), North Carolina developed this Plan for the following service categories:

- Primary Care,
- Dental,
- Physician Specialist,
- Behavioral Health, and
- Obstetric services including labor and delivery

The Plan analyzes the extent to which the health care needs of Medicaid beneficiaries are being met through examining the number of providers, utilization of services, health care performance measures and measures of patient experience.

Data Sources

Except where otherwise noted, NC Tracks, North Carolina's multi-payer Medicaid Management Information System (MMIS), was the source of the data used for analysis in this Plan.

Measures in this Plan are from *The Health Care Effectiveness Data and Information Set* (HEDIS), a widely used set of performance measures developed and maintained by the National Committee for Quality Assurance (NCQA) and measures of patient experience with health care, collected through the HEDIS® *Consumer Assessment of Healthcare Providers and Systems* (CAHPS) survey established by the Agency for Healthcare Research and Quality (AHRQ). Several data sources were used to calculate the performance rates associated with each measure. The measures in this Plan are calculated from Medicaid fee-for-service claims and include populations that received services during Calendar Years (CY) 2016, 2017, and 2018.

[1] Federal Register Volume 80, Issue 211 (November 2, 2015).

Utilization data contained in this Plan are based on date of service for CY 2016-2018 and include beneficiaries for whom Medicaid is the only source of payment. Medicaid beneficiaries with Medicare (Duals) or other health care coverage have been excluded from the analyses; for dual eligibles, Medicaid is the secondary form of payment and the agency does not have complete claims data. The data were generated with a consistent claims run-out of at least three months beyond each reporting period. As required, three years of data are presented to help distinguish temporary fluctuations from trends over time.

About North Carolina Medicaid

This Access Monitoring Review Plan (Plan) provides an overview of access to care for North Carolina Medicaid beneficiaries for 2016, 2017 and 2018. Therefore, programmatic descriptions and data are reflective of the system for FY2016-2018.

North Carolina (NC) Medicaid provides health coverage to eligible low-income adults, children, pregnant women, seniors and individuals with disabilities. The North Carolina Department of Health and Human Services (NC DHHS) is the single state agency that administers the Medicaid program within the state. Within NC DHHS, NC Medicaid leads the day-to-day operation of the Medicaid program. In state fiscal year (SFY) 2018, NC Medicaid provided services to approximately 2.1 million enrolled beneficiaries, covering over 55 percent of deliveries and 40 percent of children in the state. Total Medicaid annual expenditures in 2018 were $14.8 billion.

North Carolina Medicaid's services are provided through a fee-for-service model, with the exception of behavioral health, substance use disorder (SUD), and intellectual and developmental disabilities (I/DD) services which are provided through behavioral health managed care entities, and services provided through the Program of All-Inclusive Care for the Elderly (PACE). North Carolina has a strong record of investment in innovative programs, managing cost growth; boasts high rates of beneficiary participation in primary care medical homes, and enjoys strong provider participation with over 65,000 enrolled providers.

Community Care of North Carolina (CCNC) provides a state-wide infrastructure for primary health care delivery to NC Medicaid beneficiaries across all 100 counties. CCNC has six networks that provide statewide coverage, with more than 1,650 primary care medical homes (including local health departments, FHQCs, and other safety net providers) who partner with hospitals, community-based organizations, community pharmacies, and specialty practices for coordinated care delivery. CCNC also uses multidisciplinary health care teams to provide community-based case management. CCNC provided primary care case management for Medicaid beneficiaries focuses on the management of chronic conditions such as diabetes and hypertension, coordination of care for individuals with complex health needs, and closing care gaps for preventative services, especially for children.

Today, North Carolina has separate payment and delivery systems for physical health services and behavioral health and intellectual/developmental disabilities (I/DD) services. Physical health services are delivered through fee-for-service and primary care delivery is managed through DHHS' Primary Care Case Management (PCCM) program. Behavioral health, SUD, and I/DD services are delivered by local management entity-managed care organizations (LME-MCOs), described below. Under NC Session Law 2015-245, the Department of Health and Human Services (DHHS) has been mandated to transition most beneficiaries into fully capitated managed care plans, called Prepaid Health Plans (PHPs). That transition is currently scheduled to launch on July 1, 2021.

NC Medicaid Beneficiary Population

More than 90 percent of North Carolina Medicaid beneficiaries are ages 0-64 and almost 60 percent are female. Figure 1 and Figure 2 provide a breakdown of NC Medicaid beneficiaries during the fourth quarter of 2018 by age, gender and eligibility.

Figure 1: Beneficiaries by Age

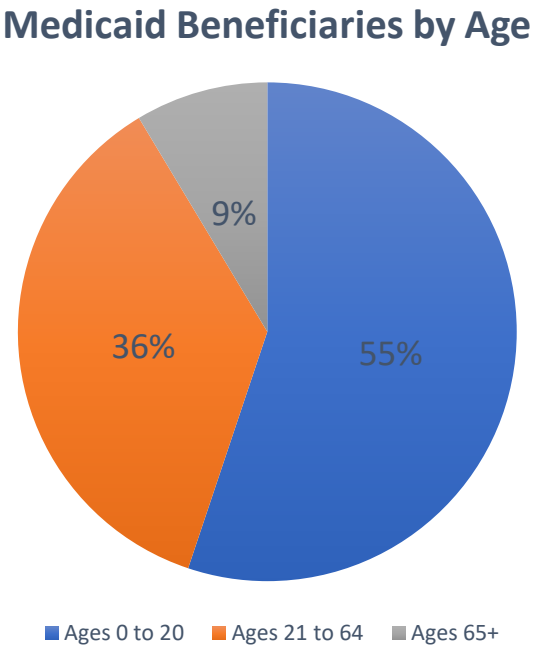
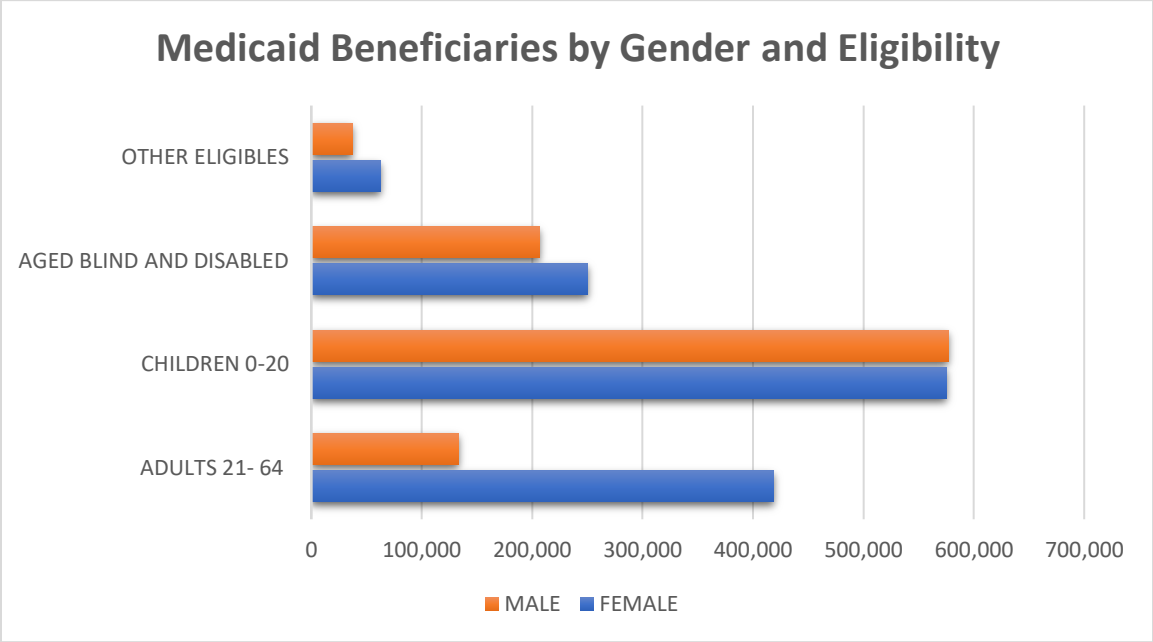


Figure 2: Medicaid Beneficiaries by Gender and Eligibility Q4 2018



Aged, Blind, and Disabled (ABD) consists of elderly individuals, those with visual-impairments and those with physical or mental disabilities.

Accessing Information About Care

Beneficiaries can access information about providers and covered services by calling the NC Medicaid Contact Center or by reviewing the NC Medicaid website which has pages dedicated to beneficiary information found here https://medicaid.ncdhhs.gov/beneficiaries. In addition, a list of primary care practitioners (PCPs) or medical homes and specialty providers is available at https://medicaid.ncdhhs.gov/find-a-doctor for beneficiaries who have access to the internet. Beneficiaries are informed of the online list of providers when they call the Contact Center for information about providers. Most Medicaid beneficiaries choose or are assigned a primary care provider (Medical Home) upon enrollment into Medicaid. Medicaid contact information, primary care provider information, and LME-MCO information is displayed on the beneficiary's Medicaid card.

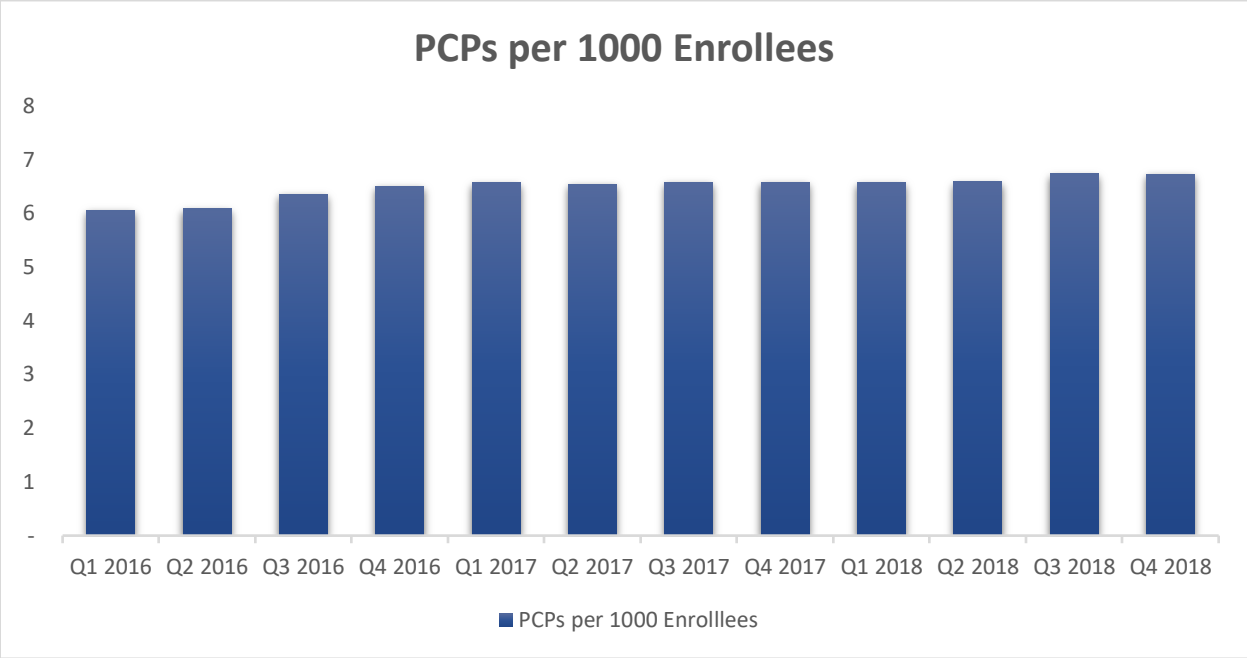
Change in Medicaid Rate Methodology

During 2016-2018, payment rates for physician and dental services have remained constant. While there were no rate changes for physician services during the period covered in this Plan, the agency continues to monitor access to care, but any observed changes are due to other factors, not rate changes.

Access to Primary Care Services

Between 2016 and 2018, the total number of individual Primary Care Practitioners (PCPs), including physicians and advanced practice providers, increased from 10,608 to 12,924 statewide. The number of PCPs statewide includes more than 5500 PCPs enrolled in CCNC's medical home program. Figure 3 depicts the number of PCPs in CY 2016, 2017, and 2018 per 1000 Medicaid enrollees which is an average of 6 PCPs per 1000 enrollees. In 2018, approximately 2,200 PCPs were in rural areas.

Figure 3: Number of PCPs Per 1000 Enrollees



Beneficiary PCP visits fluctuated between 2016 and 2018, ending 2018 in a slight decline; see Figure 4. The overall decline is primarily due to a more significant decline in visits for adults age 21-64, which is illustrated in Figure 5. Visits for age 0-20 remained consistent with the statewide fluctuation. PCP visits per 1000 beneficiaries include approximately 554,000 beneficiaries that visited their Carolina Access PCP. Among these, more than 452,000 were age 0-20 and approximately 101,000 were age 21-64.

Figure 4: Number of PCP visits per 1000 beneficiaries statewide

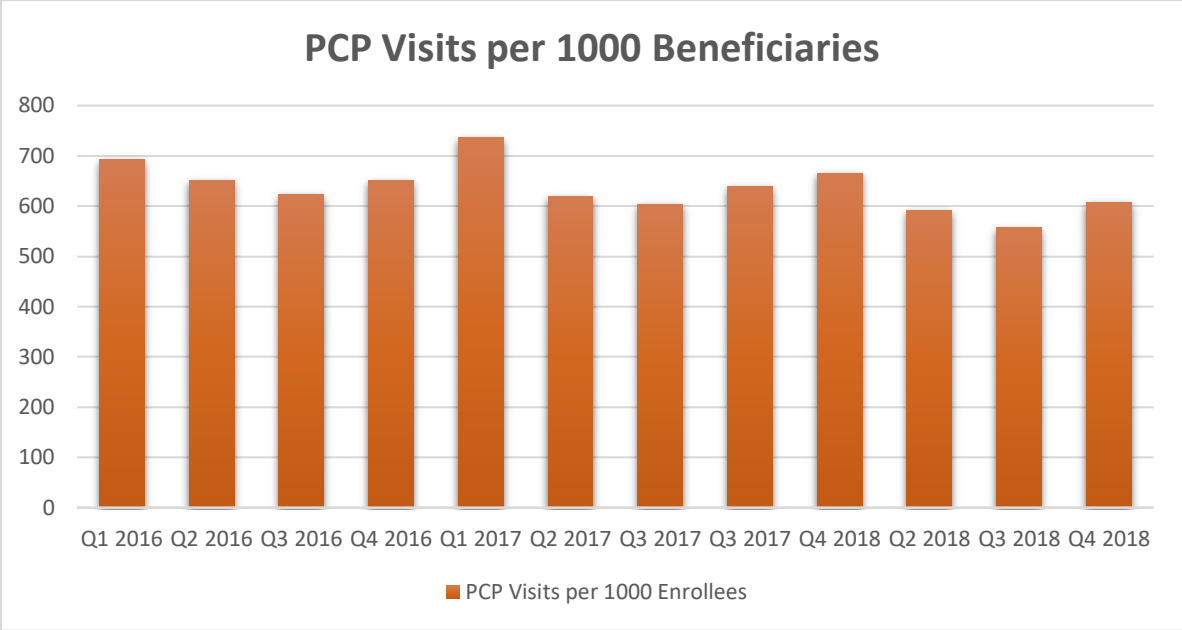
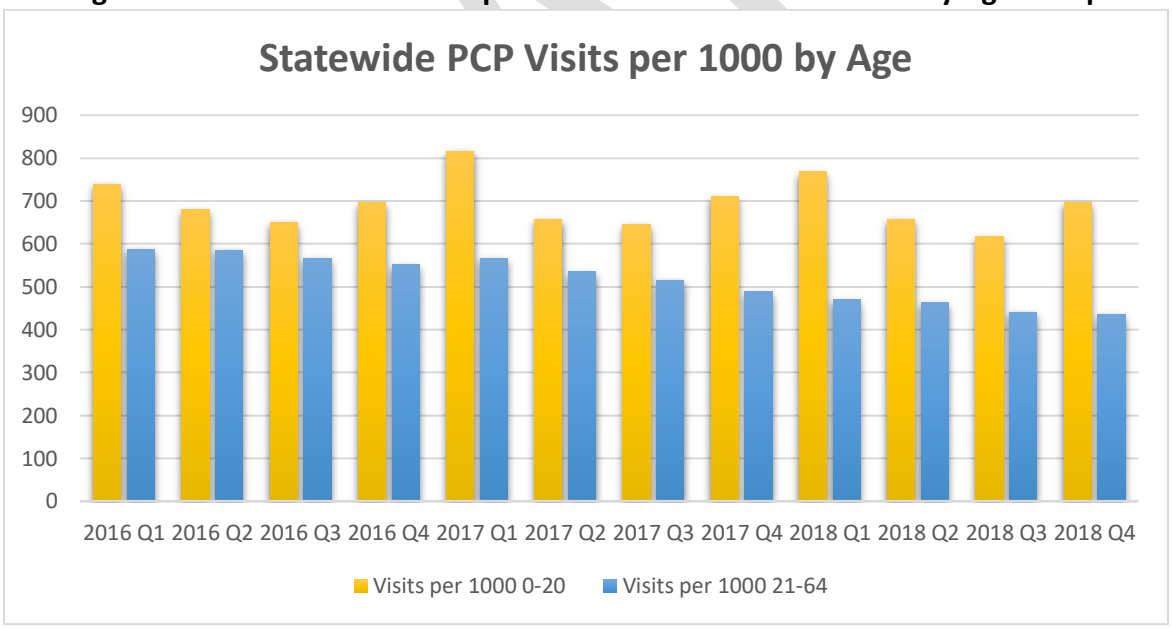


Figure 5: Number of PCP visits per 1000 beneficiaries statewide by Age Group



Adult Access to Primary Care

While the numbers above show generic primary care utilization, it is important to look at national standard-of-care access and utilization measures to understand appropriate access. North Carolina's performance rates on ***Adults Access to Preventive/Ambulatory Health Services***, which is a part of the HEDIS Access/Availability of Care measure set are provided in Table 1. This measure captures the percentage of members 20-64 years who had an ambulatory

or preventive care visit. The proportion of beneficiaries who had an ambulatory or preventive care visit declined over the three-year period, with decreases across age cohorts, racial and ethnic groups, and in both urban and rural counties (Tables 1, 2, and 3). North Carolina's rates fall below the 2018 national median of 81.57 percent. Some discussion of countermeasures can be found in the conclusion, starting on page 20 below.

Table 1: Adult Access to Preventive Care by Age

Measure Name	CY 2016 %	CY 2017 %	CY 2018 %	2018 National Median %
Adult Access to Preventative/Ambulatory Health Services	68.46	63.95	59.21	81.57
20-44 Years	65	60	56	77.97
45-64 Years	80	77	70	86.49

Table 2: Adult Access to Preventive Care by Race/Ethnicity

Measure Name	CY 2016 %	CY 2017 %	CY2018 %
Adult Access to Preventative/Ambulatory Health Services	68.46	63.95	59.21
Hispanic	72	68	50
Multiracial	75	72	65
Non-Hispanic Am-Indian/Alaska Native	55	48	68
Non-Hispanic Asian/Pacific Islander	66	62	44
Non-Hispanic Black/African	72	67	58
Non-Hispanic White	59	58	62
Other Non-Hispanic	62	59	54
Unreported Race/Ethnicity	62	59	57

Table 3: Adult Access to Preventive Care by Geography

Measure Name	CY 2016 %	CY 2017 %	CY 2018 %
Adult Access to Preventative/Ambulatory Health Services	68.46	63.95	*59.21*
Rural	73	69	64
Urban	67	62	57

Despite the decrease in adults who had an ambulatory or preventive care visit between 2016 and 2018, responses to the CAHPS survey of adult Medicaid beneficiaries (2018) assessing their experience and satisfaction with their health care were positive. See Table 4. Over 89.84 percent of respondents were satisfied with customer service, and 84.22 percent reported that they always or usually could get care quickly.[2]

[2] Survey included a sample of 1350 NC Medicaid adult members.

Table 4: CAHPS Survey of Adult Medicaid Beneficiaries in 2018

Measure Name	CY 2018 %
Customer Services (Health Plan gave necessary information/help)	89.84
Customer Services (Health Plan gave necessary information/help)	89.84
Getting Care Quickly (Illness/Injury, Non-Urgent)	84.22
Getting Needed Care (Access to Care, Tests, Treatment & Specialists)	82.99

Child/Adolescent Access to Primary Care

For children and adolescents, access to primary care is particularly important, as consistent well visits allow providers to monitor growth and development at regular intervals. Table 4 provides North Carolina's performance on HEDIS measures of children's access to primary care and well visits. On measures of child and adolescent access to primary care, North Carolina performs on par or slightly better than the national median.

Table 4: Children's Access to Primary Care

Measure Name	CY 2016 %	CY 2017 %	CY 2018 %	2018 National Median %
Children and Adolescents' Access to Primary Care Practitioners: Percentage who had a visit with a primary care provider				
12 - 24 months of age	96.01	96.46	96.42	95.66
25 months - 6 years old	88.4	88.75	88.55	87.47
7- 11 years old	91.44	91.51	91.42	90.69
12- 19 years old	88.18	88.31	88.45	89.56
Well-Child Visits in the First 15 Months of Life – 6 or More Visits	59.38	62.52	64.99	66.23
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	69.25	69.88	70.14	73.89

Nearly all of the youngest children in NC Medicaid had at least one primary care visit per year. While children ages 25 months – 6 years old and 12-19 years old have had much lower visits, the rates at which children in NC Medicaid had an age-appropriate number of well child visits has remained constant. North Carolina performed slightly above the national median for children ages 12 months – 11 years but performed slightly below the national median for children ages 12 to 19 years.

Access to Dental Services

Specific dental services are provided to Medicaid beneficiaries of all ages in most eligibility categories per defined Medicaid Clinical Coverage Policy. The number of dentists who actively participate in Medicaid has increased slightly between 2016 and 2018, rising from 2,395

dentists to 2,458 dentists. Dental services are available at one or more locations in every county of the state, except for Camden, Gates, Hyde, and Tyrrell counties. Each of these four counties border one or more counties where dental services are available within one hour of driving time. In addition, other counties are finding ways of providing dental care in innovative ways. The Dare County Health Department, for example, provides services to Hyde County Public Schools via a mobile dental clinic. Border counties in northeast North Carolina also have access to dental providers in Chesapeake and the Tidewater area of Virginia. Dental services are available in Myrtle Beach and Spartanburg for beneficiaries along the South Carolina border. Dentists and dental specialists located in eastern Tennessee also provide access to dental care for some North Carolina beneficiaries.

Table 4 depicts rates of specific dental services that Medicaid enrolled children received in 2016, 2017, and 2018. ***Annual Dental Visit*** (ADV) is a HEDIS standard of care on which North Carolina consistently performs better than the national median ***Percentage of Eligible Beneficiaries who Received Preventive Dental Services*** and ***Dental Sealants for 6-9-Year-Old Children at Elevated Caries Risk*** are a part of the Early and Periodic Screening Treatment and Diagnosis (EPSTD). These services are reported at the state and county level annually and are posted on the NC Medicaid website.[3] For FFY 2018, CMS reported that NC Medicaid was in the median quartile for ADV and in the top quartile of the 32 states that reported the ***Sealants for 6-9 Year Old Children at Elevated Caries Risk*** (SEAL-CH) measure at 28.8 percent.

Table 4: Dental Services

Measure Name	CY 2016 %	CY 2017 %	CY 2018 %	2018 National Median %
Annual Dental Visit (ADV): Percentage of members 2-20 years of age who had at least one dental visit	60.23	60.77	60.76	56.6
Percentage of Eligible Beneficiaries Who Received Preventive Dental Services	50.63	51.02	51.42	48[4]

Access to Physician Specialist Services

For this Plan, NC Medicaid selected to report on the availability of general surgeons because of concerns previously raised by the NC DHHS Office of Rural Health regarding the lack of

[3] https://medicaid.ncdhhs.gov/providers/programs-and-services/medical/wellness-visits-and-diagnostic-and-treatment-services

[4] National median calculated by CMS for 51 States that reported this measure. Quality of Care for Children in Medicaid and CHIP: Finding from the 2018 Child Core Set, September 2019 https://www.medicaid.gov/medicaid/quality-of-care/downloads/performance-measurement/2019-child-chart-pack.pdf

availability of general surgeons in rural areas of the state. Between 2016 and 2018, there were an average of 8 surgeons per 1000 beneficiaries in urban areas, but only 4 general surgeons per 1000 beneficiaries in rural areas. Figure 7 illustrates the disparities between urban and rural areas. While the analysis does not allow for a determination of the reason for the decreasing supply of general surgeons in rural areas, this trend is likely due to the increasing specialization of surgeons, and a move away from general surgeons in the workforce. Because of this trend, smaller hospitals such as Critical Access Hospitals which are in rural areas, may be losing their capacity to offer general surgery.

Figure 6: Number of General Surgeons by statewide

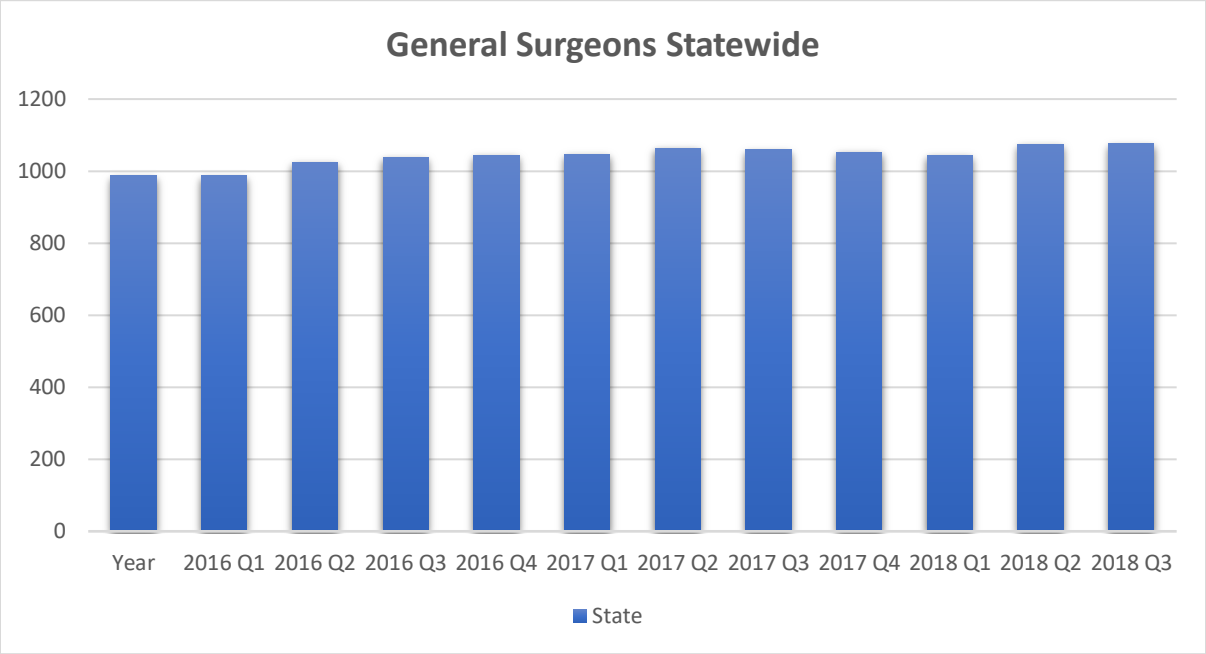
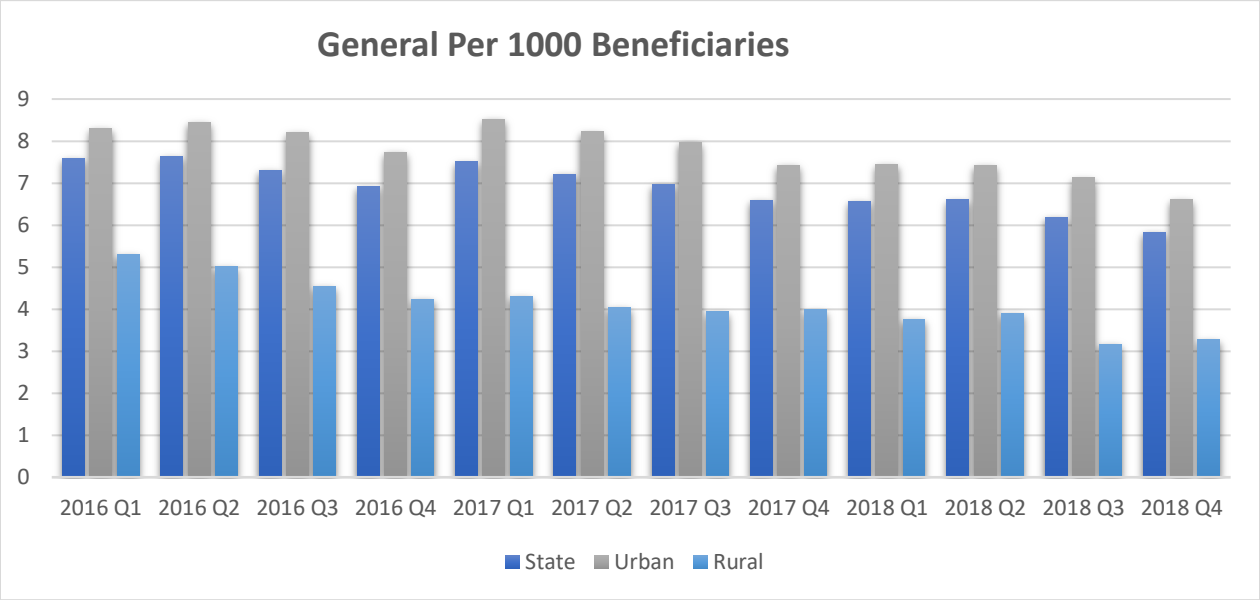


Figure 7: Number of General Surgeons per 1000 beneficiaries by state, urban and rural



Access to Behavioral Health Services

In 2005, the North Carolina Department of Health and Human Services (DHHS) implemented a concurrent 1915(b)/(c)[5] Medicaid waiver to establish managed behavioral health and I/DD care through LME-MCOs. The LME-MCO concept was initially designed as a pilot project to serve Medicaid beneficiaries with mental health, developmental disability, and substance abuse needs in a limited catchment area. The pilot LME-MCO also delivered home- and community-based services and supports through the Innovations waiver, a 1915(c) home and community-based services waiver for individuals with intellectual/developmental disabilities. In 2009, DHHS elected to expand the 1915 (b)/(c) Medicaid waiver statewide and initiated a collaborative effort with the North Carolina Division of Medical Assistance (DMA) and the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS). The goal was to restructure the delivery system for Medicaid and state-funded mental health, substance abuse, and intellectual/developmental disabilities services.[6] Currently, DHHS contracts with LME-MCOs to operate Medicaid-funded services through a capitated prepaid inpatient health plan (PIHP) in different regions of the State.

[5] The waiver that allowed DHHS to restructure the management responsibilities for the delivery of services to individuals with mental illness, intellectual and other developmental disabilities, and substance use disorders through managed care arrangements with local management entity managed care organizations (LME-MCOs).

[6] The statewide expansion was authorized by the General Assembly in 2011 in Session Law 2011-264, available at http://www.ncleg.net/EnactedLegislation/SessionLaws/HTML/2011-2012/SL2011-264.html

Adequacy of Behavioral Health Networks

LME-MCO, the behavioral health managed care organizations in North Carolina, can have closed networks. However, they are required to conduct annual Network Adequacy and Accessibility analyses of their networks that consider NC Medicaid adequacy requirements, community gap analysis, and input from consumers, providers, and other stakeholders. LME-MCOs are then required to develop a Network Development Plan to meet identified community needs, following the Department's published Network Adequacy and Accessibility requirements. The External Quality Review Organization (EQRO) reviews and approves these Network Development Plans.

Measures of Behavioral Healthcare Access

In addition, to adequacy standards, NC Medicaid tracks measures of standard-of-care utilization specific to behavioral health and substance use disorder services. The HEDIS measure ***Initiation and Engagement of Alcohol and other Drug Abuse or Dependence (AOD) Treatments***, is an important indicator of access/availability of care. The measure captures the percentage of adolescent and adult members with a new episode of alcohol or other drug abuse or dependence who received initiation of AOD treatment within 14 days of diagnosis, and among those, the percentage that had remained engaged with treatment (had two or more additional services or medication treatment within 34 days).

The rates at which North Carolina Medicaid beneficiaries initiated and engaged in AOD treatment increased between 2016 and 2018. By 2018, North Carolina was above the national median for both measures. See Table 5 for year-over-year rates.

Table 5: Behavioral Health Services

Measure Name	CY 2016 %	CY 2017 %	CY 2018 %	2018 National Median %
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Both Rates)				
Age 13-17 years: Initiation of AOD Treatment	32.53	32.06	37.76	41.56
Age 18+ years: Initiation of AOD Treatment	38.66	40.88	44.23	42.11
Total Rate: Initiation of AOD Treatment	38.23	40.31	43.51	42.22
Age 13-17 years: Engagement of AOD Treatment	14.21	11.55	14.29	14.34
Age 18+ years: Engagement of AOD Treatment	15.4	16.23	18	13.24
Total Rate: Engagement of AOD Treatment	15.32	15.93	17.7	13.58

HEDIS measure ***Follow-up care for children prescribed ADHD Medication*** assesses the percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD)

medication who had a follow-up visit with a practitioner with prescribing authority within 30 days (Initiation Phase), and who remained on the medication for at least 210 days and had an additional two visits within the nine months after the initiation phase (Continuation and Maintenance phase). Rates of follow-up visits have improved over the three-year period for both the initiation and continuation phase. See Table 6.

Table 6: Behavioral Health Services

Measure Name	CY 2016 %	CY 2017 %	CY 2018 %	2018 National Median %
Follow-Up for Children Prescribed ADHD Medication (Both Rates)				
Initiation Phase	42.95	43.09	49.71	45
Continuation and Maintenance (C&M) Phase	53.9	55.25	60.28	57.09

Individuals with behavioral health needs or substance use disorders require care management services that coordinate care between both physical and behavioral health providers. Care management ensures that each type of provider is aware of and responsive to individuals' full range of needs. For individuals who are hospitalized for mental illness, follow-up services are critical for monitoring mental wellbeing, detecting potential medication problems, and preventing readmissions. ***Follow-up After Hospitalization for Mental Illness*** captures the percentage of beneficiaries six years and older who were hospitalized for treatment of mental illness and received a follow-up visit with a mental health practitioner within seven and thirty days of discharge. Although the percentage of beneficiaries with a follow-up visit increased slightly between 2016 and 2018, the North Carolina rates are below the national median. Table 7 illustrates the North Carolina's performance on these measures.

Table 7: Behavioral Health Services

Measure Name	CY 2016 %	CY 2017 %	CY 2018 %	2018 National Median %
Follow-Up After Hospitalization for Mental Illness				
7- Day Follow-up	26.29	27.5	28.3	36.46
30-Day Follow-up	45.9	47.06	46.67	59.66

The Department is monitoring follow-up care for enrollees with behavioral health needs requiring hospitalization. NC Medicaid has designated this measure as a quality improvement priority and holds LME-MCOs financially accountable for performance targets for the 7-day follow-up measure.

In 2018, 15 percent of adults in North Carolina Medicaid had been diagnosed with diabetes compared to nine percent of North Carolina adults with other health insurance.[7] The prevalence of diabetes is even higher among individuals with schizophrenia, and antipsychotic treatments for schizophrenia can impair glucose regulation, increasing diabetes risk or, for current diabetics, worsening glycemic control.[8] Given this increased risk, regular diabetes screening for individuals with schizophrenia is particularly important. ***Diabetes Screening for People with Schizophrenia or Bipolar Disorder*** measures the proportion of 18 to 64-year-olds with schizophrenia or bipolar disorder who were dispensed an antipsychotic medication and received a diabetes screening during the measurement year. The rate in North Carolina remained stable over the three-year period, with 78.39 percent receiving screening in 2016 and 78.73 percent receiving screening in 2018. North Carolina rates are just below the national median.

Table 8: Behavioral Health Services

Measure Name	CY 2016 %	CY 2017 %	CY 2018 %	2018 National Median %
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	78.39	79.13	78.73	81.55

Access to Pre- and Post-natal Obstetric Services

NC Medicaid beneficiaries account for more than 55 percent of all deliveries in North Carolina.[9] Of these births, approximately six percent were covered by emergency Medicaid and the mother did not have access to prenatal care through Medicaid prior to delivery. This is a significant increase over the past decade. In 2006, only 38 percent of births in North Carolina were to women with Medicaid coverage in pregnancy. In 2019, 60 percent of the pregnant Medicaid women qualified for full Medicaid coverage and 40 percent of those are eligible for Medicaid coverage only during pregnancy and the postpartum period.

Obstetric services for NC Medicaid beneficiaries with full Medicaid coverage or those with Medicaid for Pregnant Women (MPW) are provided through the CCNC Pregnancy Medical Home (PMH) program. Operating since 2011, the program includes more than 469 practices and 2500 individual providers. The PMH model is a partnership between Obstetric providers, who agree to work on evidenced-base care delivery and quality improvement projects in maternal care and

[7] North Carolina Center for Health Statistics, https://schs.dph.ncdhhs.gov/data/brfss/medicaid/docs/Medicaid_2018_tables.pdf, 2018.
[8] Newcomer JW et al. Abnormalities in Glucose Regulation During Antipsychotic Treatment of Schizophrenia. Arch Gen Psychiatry. 2002;59(4):337–345. doi:10.1001/archpsyc.59.4.33
[9] https://schs.dph.ncdhhs.gov/schs/births/matched/2018/all.html

Local Health Departments who provide pregnancy care management for women with high-risk pregnancies.

In addition, the PMH program develops clinical pathways to promote evidence-based, best practice care. PMH Care Pathways are developed by the OB physician leadership of all CCNC networks through a collaborative process. These clinical pathways include:

- Perinatal Tobacco Use
- Management of Substance Use in Pregnancy
- Induction of Labor in Nulliparous Patients
- Progesterone Treatment and Cervical Length Screening
- Management of Obesity in Pregnancy
- Management of Hypertensive Disorders of Pregnancy
- Multifetal Pregnancy
- Postpartum Care and the Transition to Well Woman Care

Clinical pathways will be revised periodically based on emerging evidence.

PMH providers are paid an incentive rate for performing a Pregnancy Risk Screen and for completing a postpartum visit with women after delivery. In 2018, as reported by CCNC, Medicaid had 53,300 Non-Emergency Medicaid deliveries. Of those 43,898 (82 percent) received care in a Pregnancy Medical Home (PMH) and 16,353 (31 percent) received care management during the pregnancy.

HEDIS measures ***Prenatal and Postpartum Care*** assess the percentage of pregnant women in NC Medicaid who had a timely prenatal or postpartum care. Table 9 illustrates North Carolina's performance using HEDIS technical specifications.

Table 9: Pre- and Post-Natal Obstetrics Services (HEDIS)

Measure Name	CY 2016 %	CY 2017 %	CY 2018 %	2018 National Median %
Prenatal and Postpartum Care (Both Rates)				
Timeliness of Prenatal Care[10]	37.66	36.92	36.37	83.21
Postpartum Care	59.03	59.36	58.89	65.21
Screening for Pregnancy Risk[11]	78.2	78	77.9	N/A

Charts 1 and 2 and Map 1 further illustrate North Carolina's performance. The yellow lines in the charts represent the national median.

[10] One of the reasons for North Carolina's low rate on this measure is that providers do not consistently document in their claims, the appropriate diagnosis code for pregnancy that would indicate that the visit is for prenatal care.
[11] North Carolina Community Care Networks, Inc. *FY 2019 Annual Quality Report,* 2019.

Chart 1. Timeliness of Prenatal Care *– This chart illustrates the proportion of deliveries for which the mother received a prenatal care visit in the first trimester or within 42 days of enrollment in NC Medicaid.*

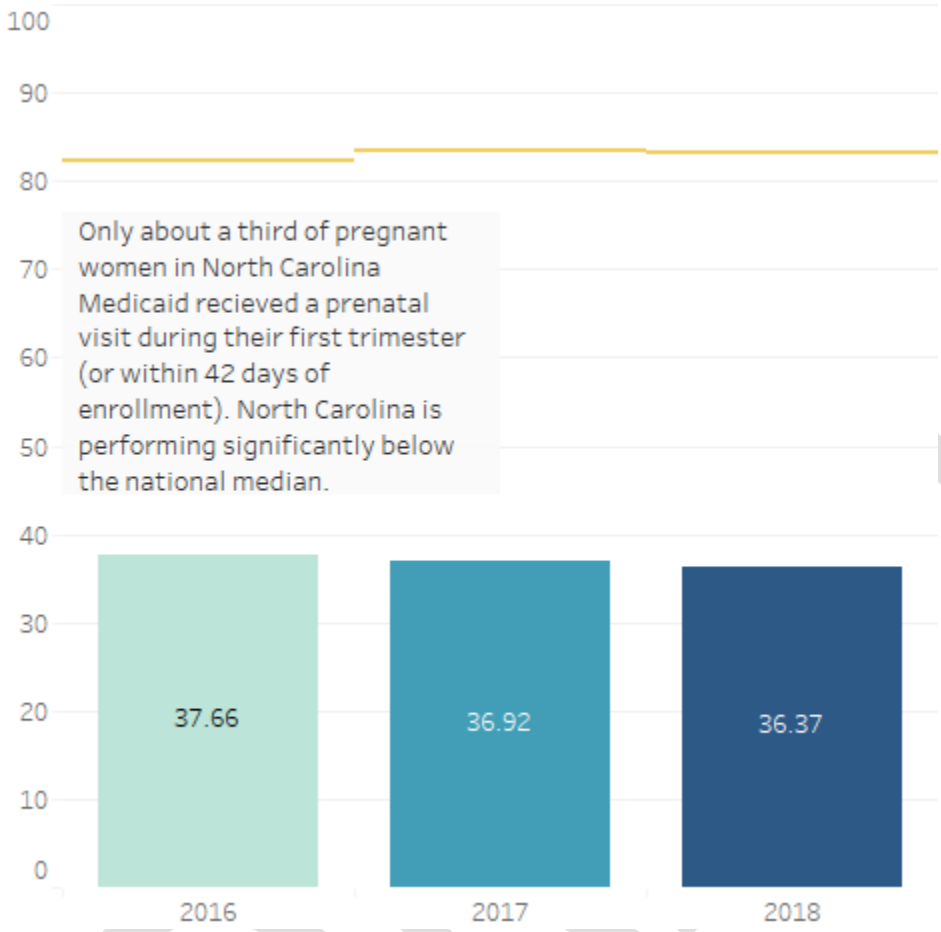
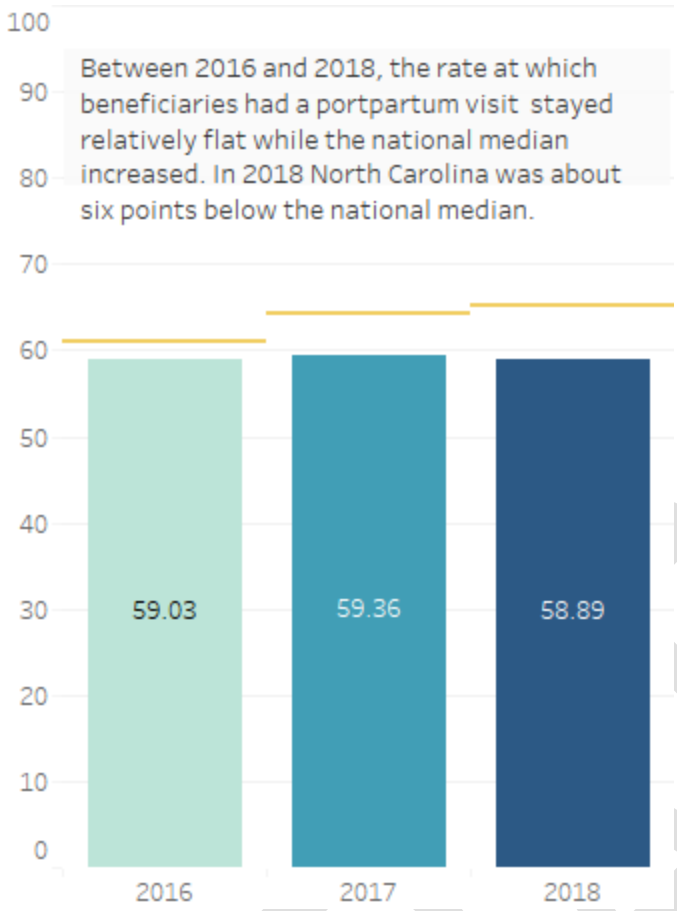
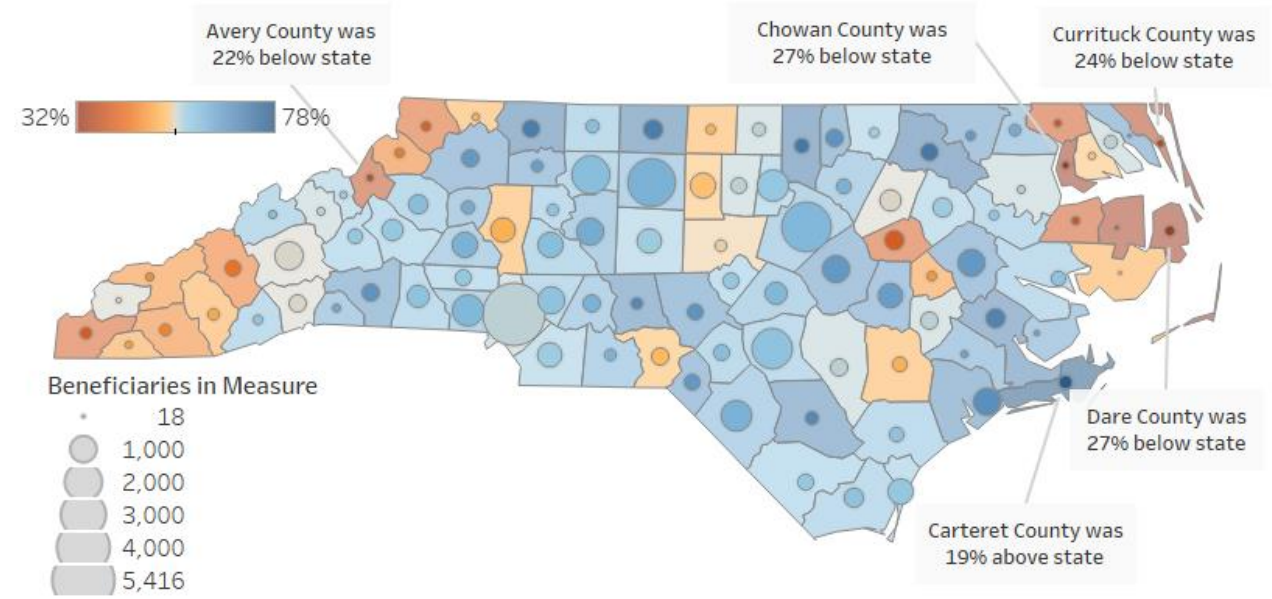


Chart 2. Postpartum Care *– This chart illustrates the proportion of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.*



Map 1. Postpartum Care *– This map illustrates, for each county in North Carolina, the 2017 proportion of Medicaid deliveries that had a postpartum visit on or between 21 and 56 days after delivery.*



As illustrated, North Carolina's performance on prenatal and postpartum care is below the national median. This low performance can be attributed to the lack of consistent documentation by Obstetrics providers. Many Obstetrician claims for prenatal care do not include a pregnancy diagnosis code. In compliance with HEDIS technical specification, Obstetrics claims without a pregnancy diagnosis code are not included when calculating HEDIS pregnancy measure rates which results in very low rates.

As an alternative, the pregnant Medicaid population can be identified using one or more claims with a pregnancy diagnosis code and then capturing other claims for pregnancy related labs and radiology procedures that happened near the time of a visit, which indicate that a pregnancy visit most likely took place. Performance rates calculated using this method are a lot higher. See Table 7.

Table 10: Prenatal and Postpartum Care HEDIS-like measure

Measure Name	CY 2017 %	CY 2018 %	2018 National Median%[12]
Timeliness of Prenatal Care	72.35	68.19	83.21
Postpartum Care	66.48	68.81	65.21

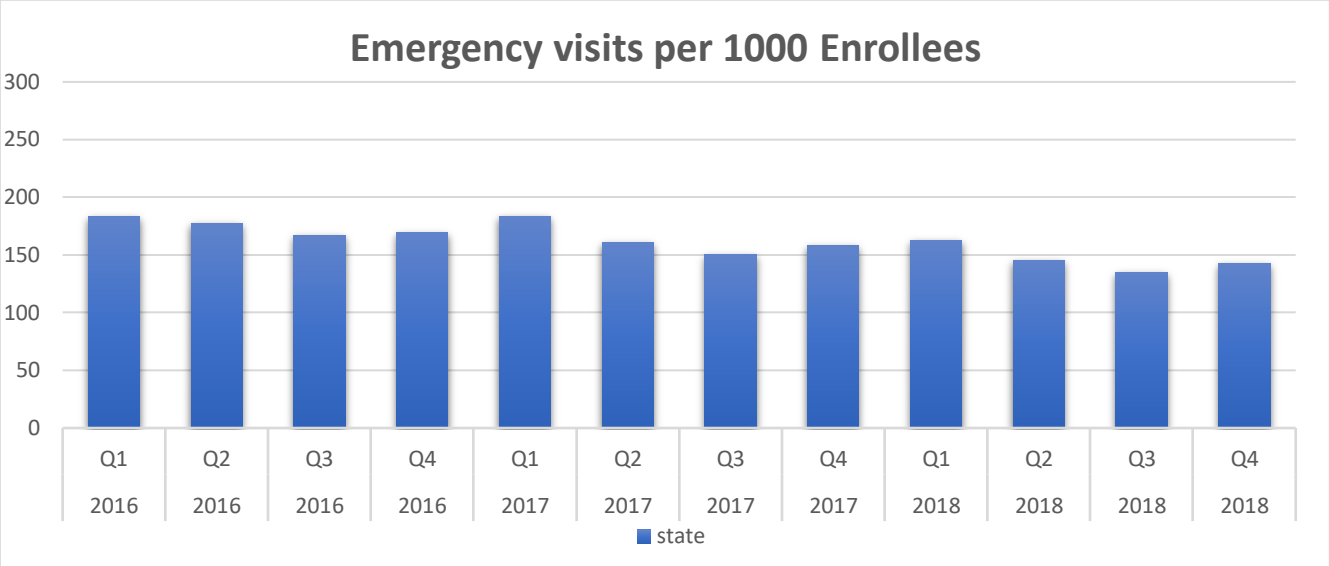
To ensure progress towards improved birth outcomes, the Department will continue to monitor timeliness of pre- and post-natal care. NC Medicaid is exploring ways to improve outcomes in this area in partnership with our Obstetrics providers enrolled in our Pregnancy Medical Home Program (PMH).

Conclusion

In general, access and utilization remained relatively consistent over the three-year period with the notable exception of Adult Access to Preventative/Ambulatory Care. The latter measure shows no distinct pattern of disparity and most groups (rural/urban and race/ethnicity groupings) show decreased access to preventative/ambulatory care over the past 3 years. In general, we know that individuals are seeking care in different ways—urgent care, walk-ins, and retail-based clinics—and this might be impacting our results. It is encouraging that a commensurate increase in emergency room or inpatient rates has not been observed. Between 2016 and 2018, emergency department visits decreased from 183 per 1000 beneficiaries in the first quarter of 2016 to 142 per 1000 beneficiaries in the fourth quarter 2018 (see Figure 8 below). During the same period, inpatient hospital stays remained constant beginning at 31.9 per 1000 beneficiaries in the first quarter of 2016 and ending at 29.1 per 1000 beneficiaries in the fourth quarter of 2018.

[12] UU medians for HEDIS versions of measures

Figure 8: Number of Emergency Department Visits per 1000 beneficiaries



NC DHHS will continue to observe access to primary care, emergency department use, and relationships between access to services and corresponding outcomes. For all services reviewed in this Plan, NC Medicaid's Quality and Health Outcomes Committee (internal) and Medical Care Advisory Committee Quality Subcommittee (external) will review provider, utilization, and other data on a quarterly basis to ensure access to services on statewide, rural and urban levels. NC Medicaid is currently involved in quality improvement action planning within the agency, with our Medical Home, CCNC, and our LME-MCO partners to improve critical measures of access year-over-year. NC Medicaid will also continue its partnership with the Office of Rural Health, which is continuously engaged in recruiting primary care physicians, nurse practitioners, physician assistants, dentists, dental hygienists, and psychiatrist to the practices that service rural and underserved populations across the state.

Appendix A - Comparative analysis of Medicaid Payment rates to Medicare and other payers

NC Medicaid does not have access to payment rates for private insurers as the information is considered proprietary. This Plan offers a comparison of Medicaid to Medicare payment rates except for dental services. The 2018 National Dental Advisory Service (NDAS) Comprehensive Fee Report is used for dental rate comparisons as Medicare does not cover dental services and no rates were available.

Comparison Rates: Medicaid and Medicaid Rates for primary care

Table 9 shows data for the top six codes for paid claims (in dollars) in which Medicare also covered and paid for the same CPT codes. Some CPT codes for Medicaid that were originally in the top 10 codes for paid claims were not covered by Medicare; therefore, those codes were omitted from the analysis. The rates are for care provided in a facility, such as a hospital, or a non-facility, such as a physician's office or clinic. NC Medicaid typically pays approximately 80 percent of the Medicare rate.

Table 9: Medicaid – Medicare Rate for Primary Care

CPT Code and Description	Medicaid non-facility rate	Medicare non-facility rate	% Medicare non-facility rate	Medicaid facility rate	Medicare facility rate	% Medicare facility rate
99203 -Office outpatient new 30 minutes	80.86	104.48	77.39%	60.58	74.98	80.79%
99204 -Office outpatient new 45 minutes	125.39	160.01	78.36%	101.72	126.83	80.20%
99205 -Office outpatient new 60 minutes	158.51	201.48	78.67%	132.38	165.62	79.93%
99213 -Office outpatient visit 15 minutes	54.26	70.86	76.57%	40.13	50.41	79.61%
99214 -Office outpatient visit 25 minutes	81.76	104.76	78.05%	62.08	77.28	80.33%
99215 -Office outpatient visit 40 minutes	110.58	141.38	78.21%	88.14	109.21	80.71%

Comparison Rates: Medicaid and NDAS Rates for Dental Care

Table 10 provides data for top codes for paid dental claims (in dollars) for both children and adults. Since Medicare does not cover dental services, there were no Medicare rates for comparison. The percentage of Medicaid rate to NDAS rate is shown. Per the NDAS Report, fee information is collected through direct mail surveys to dentists in private practice. Fees in the report are provided for the 40th percentile by increments of 10 percentage points through the 90th percentile and for the 95th percentile. The 50th percentile urban fee was used in the table below. For the codes below, on average Medicaid pays 43.8 percent of the NDAS 50th percentile rate in urban areas.

Table 9: Medicaid – NDAS Rates for Dental Care

CDT Code and Description	2018 Medicaid rate in dollars (only one rate regardless of facility or non-facility)	2018 NDAS comprehensive fee report in dollars - 50th percentile	% of NDAS rate
D0120 Periodic oral evaluation - established patient	24.51	55	44.56%
D0140 Limited oral evaluation - problem focused	34.94	80	43.68%
D0150 Comprehensive oral evaluation - new or established patient	42.41	94	46.60%
D0220 Intraoral - periapical first radiographic image	14.18	32	44.31%
D0230 Intraoral - periapical each additional radiographic image	11.44	27	42.37%
D0145 Oral evaluation for a patient under three years of age and counseling with primary caregiver	34.55	72	47.99%
D0160 Detailed and extensive oral evaluation - problem-focused, by repo	64.89	161	40.30%
D0170 Re-evaluated-limited, problem focused	27.32	75	36.43%
D0210 Intraoral - complete series of radiographic images	68.25	145	47.07%
D0220 Intraoral - periapical first radiographic image	14.18	32	44.31%

Comparison Rates: Medicaid and Medicaid Rates for primary care

The data in Table 10 compares Medicaid and Medicare rates for the top 10 codes for paid surgical claims. The rates are for care provided in a facility, such as a hospital, or non-facility such as an office or clinical setting.

Table 10: Medicaid – Medicare Rate for General Surgery

CPT Code and Description	Medicaid non-facility rate	Medicare non-facility rate	% Medicare non-facility rate	Medicaid facility rate	Medicare facility rate	% Medicare facility rate
15003 - Prep site trunk/arm/leg addl 100 SQ CM/1PCT	51.48	73.02	70.50%	34.13	45.2	75.51%
15101 -Split agrft T/A/L ea 100 CM/EA 1% BDY INFT/CHLD	134.12	178.26	75.24%	83.21	108.21	76.90%
15274 -App skn sub grft T/A/L AREA>/=100SCM ADL 100SQ CM	39.36	68.58	57.39%	25.05	45.12	55.52%
33405 - Rplcmt post aortic valve open XCP Homogrf/Stent	1816.56	2223.6	81.69%	1816.56	2223.6	81.69%
33533 -CABG w/ arterial graft single arterial graft	1503.79	1831.71	82.10%	1503.79	1831.71	82.10%
33863 -AS-AORT GRF w/card byp & aortic root rplcmt	2476.9	3090.35	80.15%	2476.9	3090.35	80.15%
33945 -Heart Transplant w/wo recipient cardiectomy	3652.63	4751.64	76.87%	3652.63	4751.64	76.87%
36247 - SLCTV CATHJ 3RD+ ORD SLCTV ABDL PEL/LXTR BRNCH	1473.56	1431	102.97%	266.39	301.53	88.34%
36475 -Endoven abltj incmptntI vein XTR RF 1ST vein	1329.66	1446.5	91.92%	271.88	276.81	98.22%
36478 -Endoven abltj incmptnt vein XTR laser 1ST vein	1098.29	1155.6	95.04%	274.4	275.48	99.61%