Frequently Asked Questions (FAQs): Care Management for High-Risk Pregnancies (CMHRP) and Care Management for At-Risk Children (CMARC) Benchmark Specifications

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In July 2023, NC Medicaid announced an extension to the period during which Standard Plans – also known as Prepaid Health Plans (PHPs) – are required to first offer contracts to Local Health Departments (LHDs) for providing care management services for the Care Management for High-Risk Pregnancies (CMHRP*) and* Care Management for At-Risk Children (CMARC) populations. LHDs that meet the criteria in the benchmark assessment process outlined in October 2023 will maintain contracts with PHP(s) for an additional year starting July 1, 2025. This extension is intended to continue to support the transition to voluntary contracting under the managed care environment while minimizing disruptions in care.

These FAQs provide additional information for LHDs and PHPs regarding NC Medicaid's benchmark specifications for this assessment. For additional information on the CMHRP and CMARC programs, please refer to the Program Guide.

Benchmark Process and Contracting

Q: Why is NC Medicaid implementing this benchmark assessment for CMHRP and CMARC programs?

A: To promote the provision of local, high-quality services to Medicaid-enrolled high-risk pregnant women and at-risk children, NC Medicaid designed a baseline assessment process that aims to strengthen accountability for program performance and maintain service provision among LHDs meeting performance and quality standards. The benchmark assessment process will enable LHDs that meet the criteria in the benchmark assessments to maintain contracts with PHPs for an additional year starting July 1, 2025.

Q: When will the benchmark assessment be shared and who will the results be shared with?

A: NC Medicaid will share baseline benchmark assessments individually with LHDs (specifically with LHD Directors and CMHRP/CMARC Supervisors) in January 2024 to provide initial information to LHDs on their performance. The baseline assessment is for informational purposes prior to the final assessment in October 2024.

The final benchmark assessment results will be shared with LHDs, PHPs and Tailored Plans (TPs). The final assessments will also include relevant baseline data to show LHD improvement. Results will not be posted online or available for public viewing.

Q: When will the benchmark assessments begin to affect LHD contracting?

A: Beginning July 1, 2025, PHPs will not be required to contract with LHDs that do not meet the benchmark for CMHRP and/or CMARC. From when the final benchmark assessment is released

(October 2024) through June 30, 2025, LHDs and PHPs will work collaboratively to prepare for new CMARC and/or CMHRP contracts, and transition service responsibility as necessary.

Q: If an LHD does not meet the benchmark assessment for a program, can a PHP still choose to contract with them?

A: PHPs can choose to continue contracting with an LHD even if the LHD does not meet the benchmark assessment(s). If a PHP chooses to contract with an LHD that does not meet the benchmark, this may result in LHDs being offered contracts with some PHPs, but not others.

Q: If an LHD does not meet the benchmark assessment for a program, will the contract be offered to another county in the area?

A: If an LHD does not meet the benchmark for a program and the PHP chooses not to contract with them, the PHP must adhere to the contracting hierarchy outlined in the Program Guide and restated in the July 2023 Program Update, which requires that they first attempt to contract with another willing LHD for CMARC or CMHRP services[1].

Q: If an LHD meets the benchmark for one program (e.g., CMHRP), but does not meet the benchmark for the other (e.g., CMARC), will the LHD maintain contracting exclusivity for the program for which they met the benchmark?

A: LHDs will maintain the one-year contracting exclusivity (through June 30, 2026) for the program for which they met the benchmark. For example, if an LHD met the benchmark for CMHRP, but not CMARC, the PHP(s) would be required to contract with that LHD for the CMHRP population through June 30, 2026, but the PHP would have the option to contract with the LHD for the CMARC program through June 30, 2026.

Q: What are the implications of the benchmarks for LHDs' responsibility for Standard Plan Behavioral Health Intellectual/ Developmental Disability Tailored Plan, and Medicaid Direct CMHRP/CMARC populations?

A: The final benchmark assessment results will be shared with Standard Plans (SPs) and Tailored Plans (TPs). For the first year of the TP contract, LHDs will retain contracting exclusivity for CMHRP and CMARC services. For Contract Year 2025-2026, both SPs and TPs will not be required to contract with LHDs that did not meet the benchmarks. The contracting exclusivity timelines for SP and TP populations will be aligned.

Q: Are the benchmark specifications final, and are there opportunities to provide comments or ask questions?

A: The benchmark specifications are final, though NC Medicaid reserves the right to update the specifications if deemed necessary. NC Medicaid is committed to ongoing engagement with community partners, including LHDs, PHPs, providers, and members on the benchmark assessments. Questions about the CMHRP and CMARC benchmarks can be submitted at Medicaid.CMHRP.CMARC@dhhs.nc.gov.

[1] Continuation of the existing hierarchy is only effective through June 30, 2026.

Q: How can LHDs monitor their progress against the benchmark assessment measures on an ongoing basis?

A: LHDs can track their performance on process measures in the Care Impact system and are encouraged to use internal data to model their expected performance against benchmark specifications. LHDs should reach out to PHPs if they are interested in receiving updates on their performance on quality measures.

Measures and Methodology

Q: How did NC Medicaid determine which measures to use for each benchmark?

A: NC Medicaid worked in partnership with the Division for Public Health (DPH) and Division for Child and Family Well-Being (DCFW) to select measures for the CMHRP and CMARC benchmarks based on current policy and programmatic targets. NC Medicaid engaged community partners, including LHDs and PHPs, in finalizing the benchmark measures, taking into account their feedback on measure feasibility, appropriateness, and data limitations.

Q: How does NC Medicaid account for factors that may be outside of an LHD's influence when setting thresholds for these measures? For example, an LHD outreaches to a member to inform them of the benefits of certain medical appointments, but the member is not attending their medical appointments, such as well-child visits, or unable to secure a postpartum appointment with an OB?

A: NC Medicaid included both process and quality measures in the benchmark assessment to better understand the work care managers are doing (e.g., attempting patient-centered interactions), as well as member outcomes (e.g., well-child visits). NC Medicaid incorporated community partner feedback when determining which measures to include in the benchmark specifications, prioritizing those over which LHDs have most influence.

Additionally, NC Medicaid has lowered thresholds for some process measures that LHDs identified as being more challenging to influence and has weighted process measures higher than quality measures (80 points total vs. 20 points total), placing greater emphasis on work performed directly by care managers. For example, an LHD can still meet the benchmark without meeting the threshold for any quality measure(s).

Q: Were the measures pulled by Care Manager County or Member County?

A: Members were attributed to the care manager county if available. If the care manager county was not available for the member, the member would be attributed to the LHD corresponding to their residential county.

Q: If an LHD has a small population, situations beyond the influence of the care manager with just a few members or even one member may significantly bring down performance.

A: To avoid unfairly penalizing smaller LHDs that could be affected by unpredictable events with a few members and be potentially higher performing than their score suggests, NC Medicaid will implement a statistical adjustment to assess counties utilizing a confidence interval approach.

For each practice, NC Medicaid will calculate a performance range (confidence interval) for each LHD and will use this upper bound of the confidence interval for scoring purposes. An LHD will meet the threshold for a measure as long as the upper bound of its performance range is at or above the threshold. For example, if an LHD scores 65% but their confidence interval is [55, 88] then they would pass a measure that had an 85% threshold. Please see Appendix B of the Benchmark Specifications for a more detailed explanation.

Q: What is the Upper Bound Confidence interval?

A: Confidence interval is a statistical adjustment that provides "a range around a measurement that conveys how precise the measurement is". The upper bound helps us understand what is the most reasonable amount that we could see the LHD possibly scoring. If the LHD's upper bound is over the threshold, then the LHD meets that measure.

Q: Will the confidence interval adjustment be applied to the baseline and final assessment?

A: The Confidence Interval will be applied for the baseline and final assessments. For the quality measures, it will be based on the confidence interval around change between the two measurements (i.e. baseline and final). If the upper bound of the confidence interval is above the benchmark, then the LHD would meet the benchmark for that quality measure.

Q: Is the confidence interval adjustment applied to all measures?

A: Yes, the confidence interval adjustment will be applied to all measures for all LHDs.

Q: Over what time interval will performance be measured (e.g., monthly, quarterly, annually) for the final benchmark assessment?

A: For process measures, LHDs will be assessed on performance for the state fiscal year from July 2023 to June 2024. For quality measures, LHDs will be assessed on performance for the calendar year from January 2023 to December 2023. NC Medicaid will calculate average monthly performance rates across the timeframe for process measures.

Q: If an LHD works with multiple PHPs, how will this affect their benchmark assessments? Will an LHD be assessed in aggregate, or will it be assessed for each PHP population individually?

A: LHD performance will be assessed in the aggregate, across PHPs. NC Medicaid is only doing one assessment per health department; therefore, all PHPs will be using the same assessment. If an LHD does not meet the benchmark assessment for CMHRP or CMARC, none of the PHPs with which the LHD contracts will be required to maintain their contracts for that program with that LHD beginning in July 2025. Each PHP has the option to continue to contract with LHDs to provide these services.

Q: If an LHD performed well during its first assessment, how will that affect its improvement scoring for the quality measures?

A: The thresholds for quality measures are calculated based on LHD improvement between the baseline and final assessments. LHDs will be required to meet pre-determined improvement thresholds based on their initial baseline performance on a quality measure – the percentage

point improvement required is higher if an LHD's baseline performance is lower (and vice versa). LHDs that have met the specified improvement threshold between the baseline and final assessments will receive full points for the measure.

LHDs that demonstrate a baseline performance of 75% or above on a quality measure will not be required to have met an improvement threshold for the purposes of the benchmark assessments and will automatically receive full points for the measure, as long as final performance remained at 75% or above. For example, if LHD A's postpartum visit rate at the baseline was 80%, they will not need to have demonstrated improvement as long as the final performance rate was 75% or more. More details on the improvement thresholds can be found in the Benchmark Specifications.

Q: The quality measures include historical data and LHDs will not have time to improve after the baseline assessment. Why is that?

A: Quality measures are assessed on a calendar year basis, and due to the timeline of the assessment period, it will not be possible to wait an additional year after the baseline assessment. However, the quality measures included in measurement have been listed in the CMHRP and CMARC guidance as DHHS priorities for some time; for this reason, DHHS expects that LHDs participating in CMARC and CMHRP will have been working towards improvement already. However, LHDs that have not been able to achieve high performance or improvement on quality measures also have the opportunity to achieve the benchmark on CMARC and CMHRP without meeting these measures.

Q: If an LHD provides CMHRP and/or CMARC services for multiple counties, will their performance be measured and combined across all counties, or will performance for each county be measured individually?

A: LHD performance will be measured in aggregate, for all counties in which they provide CMHRP and/or CMARC services. If an LHD meets the benchmarks, they will maintain contracting exclusivity for their entire service area. If an LHD does not meet the benchmarks, PHPs will have the option to contract with another CMARC or CMHRP provider for the entire service area.

Q: Will the data reflect only members placed in "Managed", "Monitored", or "Engaged" status in CMHRP and CMARC?

A: The process measure data will only include members in a "managed" status. Please see Appendix A of the Benchmark Specifications for further details on the numerator and denominator of each measure.

Q: LHDs will be assessed on the timeliness of a postpartum visit between 7 and 84 days after delivery; however, the CMHRP program concludes at 60 days postpartum. Why are LHDs being assessed on a measure for a time frame in which the program does not cover?

A: The education and outreach LHDs conduct for a member in the first months postpartum contribute to the timeliness of postpartum visits after this time period as well. For example, an LHD may work with a member to schedule an appointment that the member does not attend until a later date. Including postpartum visits that happen after the direct involvement of the

CMHRP program will allow LHDs' performance to include all cases where the LHD's involvement contributes to a member receiving needed follow-up, even if that follow-up happens after the program technically ends.

Q: How will NC Medicaid assess and report for LHDs that have assumed CMHRP and/or CMARC services for another LHD?

A: An LHD that has transferred and terminated either or both CMHRP/CMARC services will not receive a scorecard for the services that have been terminated. The receiving LHD (the LHD that assumes the CMHRP and/or CMARC services) will be assessed from when they assumed services and services they provided. This means that for the receiving LHD, members will be counted for months where were assigned to the receiving LHD.

Data Concerns

Q: How is NC Medicaid addressing issues related to data completeness? For example, LHDs are concerned about not being assessed for members that are reflected in Care Impact as "No Payer" and newborn members without a Medicaid ID.

A: DHB recognizes that the data LHDs see in Care Impact is not always current due to lags from payer data that do not update until the middle of each month. Incomplete data may also reflect services provided to members with pending Medicaid IDs, which do not appear in Care Impact until the member's Medicaid ID becomes active.

DHB extracted the data for analysis several months after the time periods during which services were provided, by which time services initially not captured due to data lags are expected to have been documented; the measurement period for the baseline is July 2022 to June 2023, but the data was not pulled from Care Impact until December 2023.

If LHDs notice other issues with missing data (e.g., a measure or column is missing), LHDs should bring up these issues to CCNC directly through their help center process for resolution.

Q: How will the assessment account for interventions that occur outside the specified measurement period? For example, if a child attends their well-care visit on the day after the last day of the measurement period specified for the Child Well-Care Visit measure, will it count toward the LHD's performance?

A: Quality measures such as WCC have specifications developed by external measure stewards such as the National Committee on Quality Assurance and the Centers for Medicare & Medicaid Services (CMS), and the NC Medicaid cannot unilaterally change these specifications. Because the measure captures services delivered during a calendar year, it will miss some cases where a child has no visits during that time even if the child received visits before or after the calendar year. However, the LHD does not need all of its assigned members to receive well-care visits to meet the measure; LHDs will be scored on these measures according to improvement and are not required to hit a benchmark. Furthermore, LHDs can meet the benchmark for each program without meeting any of the quality measures as long as they meet all of the process measures.

Q: How will NC Medicaid account for the data issues that have been occurring since the transition to managed care? Where should LHDs report issues with the data?

A: NC Medicaid is working on an auditing process to examine the various data sources flowing between PHPs, CCNC and DHB to try and diagnose an issue. The goal is to make system improvements before the final assessment in October 2024. For issues relating to Virtual Health, Care Impact, and LHD Beneficiary Assignment (BA) File, LHDs should reach out to CCNC directly through the established channels.

Future of CMHRP and CMARC After the Benchmark Assessment

Q: Will LHDs continue to provide CMARC and CMHRP services after July 2026?

A: Starting July 2026, NC Medicaid will remove all contracting specifications for exclusive LHD contracting for CMARC and CMHRP. At that time, PHPs can choose to contract with LHDs for CMARC and CMHRP but will not be required to do so. PHPs will be expected to follow the existing broader local care management requirements that are inclusive of both the CMHRP and CMARC programs.

Q: Are there opportunities for counties that do not meet the Benchmark Specifications in 2025 to be considered for contracts in 2026?

A: Effective July 2026, PHPs will not be required to exclusively contract LHDs for the provision of CMHRP and CMARC services but may contract with LHDs to provide these services.

Q: Will LHDs that maintain contracts for CMARC or CMHRP services after July 2026 continue to use the Virtual Health Platform?

A: The Technology Support for CMARC and CMHRP Contract (Virtual Health contract) between North Carolina Community Care Networks (NC3N) and NC Medicaid is currently anticipated through June 30, 2026.

Q: Will LHDs be measured against these benchmarks in future years to inform CMARC and CMHRP contracting?

A: The benchmark assessments are a one-time measurement meant to serve as a bridge to allow high-performing LHDs to extend their exclusive CMARC and CMHRP contracts for an additional year. Beginning July 1, 2026, it will be up to the LHD and PHPs to negotiate contracting agreements for CMARC and CMHRP services.

Q: Will PHPs be able to access Virtual Health or Care Impact data after the required contracting period has ended in 2026?

A: PHPs do not currently have access to Virtual Health or Care Impact. However, PHPs will be able to continue accessing the reports they currently receive from CCNC and LHDs, including the Interaction Level Report and the Daily Member Report for LHDs they are contracted with.