MCAC Quality Subcommittee

July 19, 2018

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Agenda

TIME	ITEM	PRESENTER
1:00-1:15 PM	Call to Order Roll Call	Linda Burhans, Quality Chair Kim Schwartz, Quality Chair
1:15-1:40 PM	Quality Committee Charter Membership, Terms, Vacancies	Jaimica Wilkins Senior Program Analyst-Quality & Population Health, DHB
1:40-1:45 PM	Quality and PHP Accountability Concept Papers- Public Comments	Taylor Zublena Senior Program Analyst-Quality & Population Health, DHB
1:45-2:30 PM	Quality Strategy Review, Measure Sets and Quality Accountability Levers	Kelly Crosbie Project Lead-Quality & Population Health, DHB
2:30-2:50 PM	Quality Committee Discussion	Kelly Crosbie Project Lead-Quality & Population Health, DHB
2:50-3:00 PM	Final Questions and Next Meeting Agenda	Quality Chairs

MCAC Quality Subcommittee Charter

Mission

Provide guidance on metrics and processes to promote evidence-based medicine, coordination of care and quality of care for health and medical care services that may be covered by the NC Medicaid Program.

Charter changes

Meetings

The QC meets at least quarterly or when necessary at the call of the committee chair(s). Meeting agendas will be decided by chairperson(s) in advance of the meeting. Meeting minutes will be drafted by staff designee, reviewed by chairpersons, approved by subcommittee at subsequent meeting and provided to members following each committee meeting.

Eight members present, or half of the current membership, whichever is less, shall constitute a quorum. At least one subcommittee chairperson or MCAC designee must be present at the meeting.

Quality Subcommittee Members

- **Explain Term Selection Methodology**
- **Discuss Terms**

Slot Represented	Proposed Individual	Company	Term
MCAC	Kim Schwartz	Roanoke Chowan Community Health Ctr	3
MCAC	Linda Burhans		2
MCAC	Chris DeRienzo	Mission Health	3
Board-certified physician internal medicine/family practice	Genie Komives	Duke Primary Care	1
Board-certified physician internal medicine/family practice	Robert L. Rich, Jr	Bladen Family Medicine	2
Board-certified physician pediatrics	Calvin Tomkins	Mission Health Partners	3
Board-certified physician pediatrics	Jason D. Higginson	Maynard Children's Hospital	3
Board-certified physician obstetrics & gynecology	Kate Menard	UNC Health Care	2
Behavioral health professional (or psychiatrist)	Charles “Ken” Dunham	Novant Health	3

Quality Subcommittee Members

Slot Represented	Proposed Individual	Company	Term
Beneficiary	Aaron Ari Anderson		1
Health Plan Association	Ken Lewis	NCHP	1
AHEC/Quality in the Field	Ann Lefebvre	NC AHEC	3
Hospital	Robert A. Eberle	Novant	1
Hospital	Samuel Cykert	UNC School of Medicine	3
Pharmacy	Andy Bowman	NC Board of Pharmacy	2
Provider Association	Michelle F. Jones	Board Member, NC Medical Society/ Wilmington Health Assoc.	1
Provider Association- Hospital	Karen Southard	NC Healthcare Association	3
Local Health Departments	Marianna TePaske Daly	Madison County Health Department	2
	Peter Charvat	Johnston Health	1
Academic/University	Darren A. DeWalt	UNC Population Health	2
Academic/University	Jason Foltz	ECU Physicians	2
Crisis/Emergency	David Kammer	Wake Emergency	1
Primary MD	J. Thomas (Tommy) Newton	Clinton Medical Center	1
LME-MCO	Katherine Hobbs Knutson	Alliance Behavioral Healthcare	2

Quality Concept Papers: Public Comments

The Provider Health Plan Quality Performance and Accountability and DRAFT Medicaid Managed Care Quality Strategy Papers posted March 20, 2018 for public comment and are now closed.

Comments received and synthesized to the following trended themes:

- Commended the Dept. on alignment with national measures/standards and agreed with the Aims, Goals, and Objectives of the Quality Strategy.
- Concerns of feasibility to report and extract measures and to whom (recommend a single source database such as NC HealthConnex);
- A few commenters asking for provider support to provide technical assistance for data infrastructure as will be needed for accurate and timely reporting.
- Many concerns for how this will add administrative burden if not supported appropriately.

Quality Concept Papers: Public Comments cont.

Other Concerns:

- Narrow time to set up valid data infrastructure in the allotted time
  - Recommend the Dept. allow providers and PHPs more time before applying withholds
  - Concerns for network adequacy and recommendations for edits to rural and urban for feasible and timely access
  - Payment and incentives were criticized as not being as actuarily sound as needed
    - need more incentives to make the tight timelines the Dept. proposes feasible

DHHS Quality Strategy

Aim

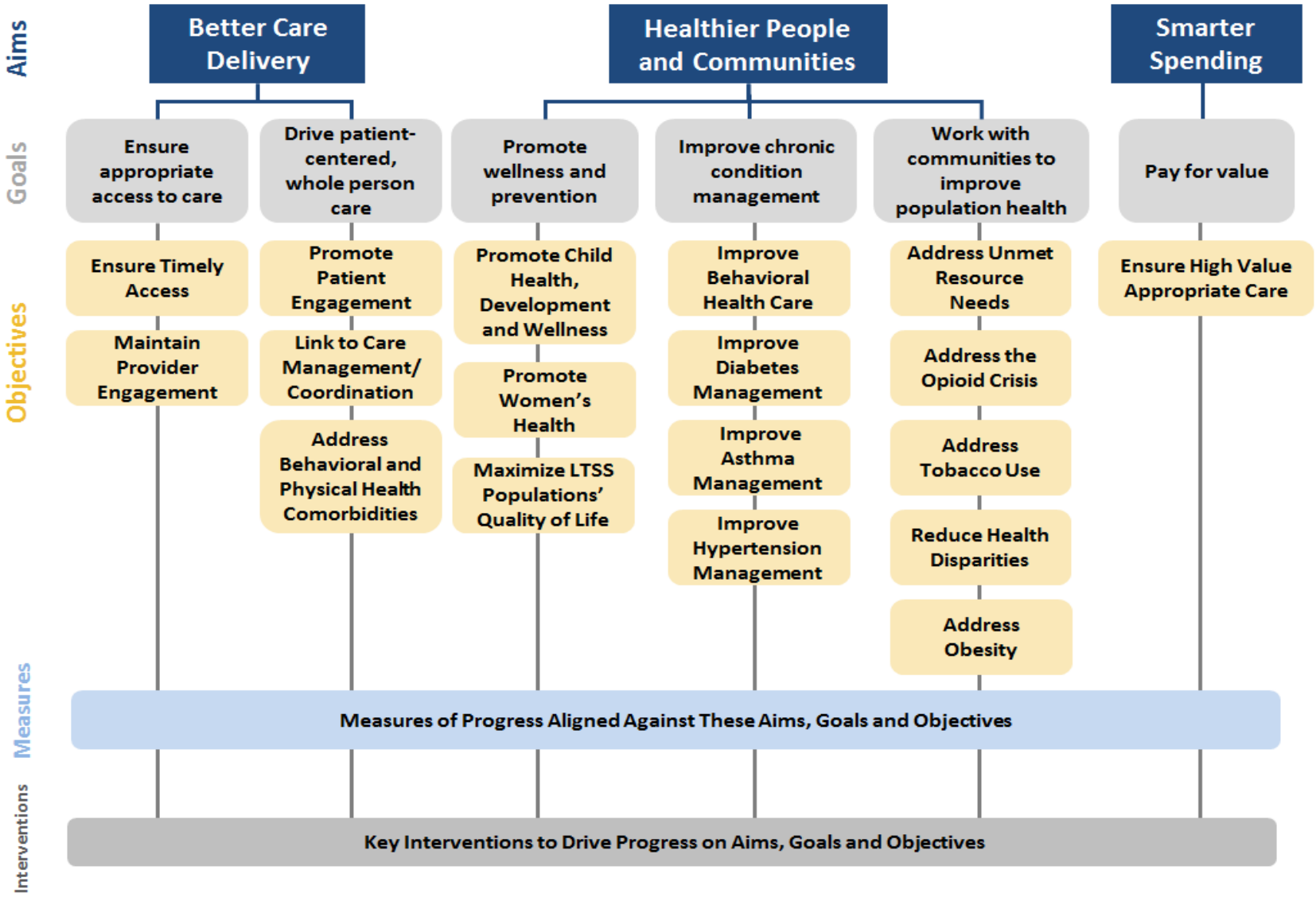
To advance high-value care, improve population health, engage and support providers, and establish a sustainable program with predictable costs.

Goal

The Department's goal is to improve the health of North Carolinians through an innovative, whole-person centered and well-coordinated system of care, which addresses both medical and non-medical drivers of health.

DHHS Quality Goal: Develop a data-driven, outcomes-based continuous quality improvement process that focuses on rigorous outcome measurement against relevant targets and benchmarks, promotes equity, and appropriately rewards PHPs for advancing quality goals.

Overview of the Quality Framework



Reference the Priority Measure Set Draft Handout

Summary of Primary Levers for Quality Performance

1. **Quality Measure Reporting**

2. **Quality Baselining, Benchmarking, and Performance Target Development**

3. **Disparities Reporting and Tracking**

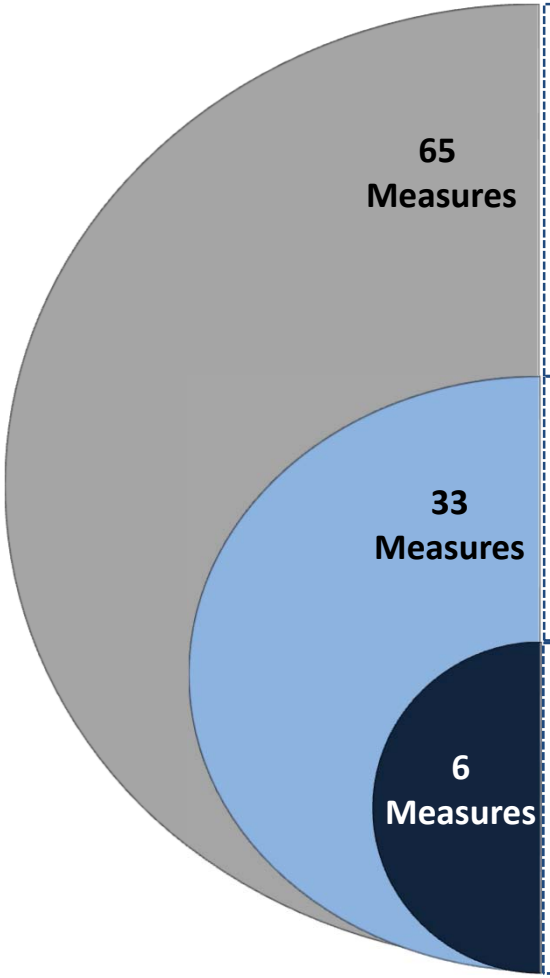
4. **Quality Assessment and Performance Improvement Programs (QAPIs)**
   - PHPs must develop a QAPI aligned to NC DHHS goals, and annually approved by NC DHHS
   - Key components include internal-to-PHP processes for monitoring and correcting performance, conducting performance improvement projects, and addressing disparities in care

5. **Value-Based Payment/Provider Incentives**
   - PHPs are required to develop a provider incentive program for AMH Tier 3 providers; incentives must be based on AMH quality measure list (a subset of the measures used for Quality reporting)
   - PHPs are given flexibility to develop provider incentives – a tool for: (1) meeting NC DHHS-set minimums for payments attributed to alternative payment models; and (2) meeting NC DHHS-set quality targets

6. **Cross-Cutting Quality Levers**
   - Accountability for quality performance is layered into accreditation requirements, member auto-assignment processes, and provider credentialing decisions

Quality Measure Reporting Framework

There are three measure sets designed to baseline PHP performance, set future priorities, and hold PHPs accountable to achieve quality outcomes for their enrollees.



Quality Measures Aligned with National, State and PHP Reporting

- *Quality measures are used by the DHHS to baseline PHP performance and set priorities in future years; DHHS may also elect to report on these measures publicly*
- *No measures require clinical data from EMRs/EHRs/HIE (will change, over time)**

Vision: Report on quality measures broadly in initial years, and streamline the measure set over time to priority areas

Priority Measures Aligned with DHHS Policies ("Appendix A" of the Quality Strategy)

- *Priority measures are aligned with the Quality Strategy and reflect NCIOM stakeholder input*
- *Priority measures will :*
  - *Be tied to the State Quality Strategy, AMH performance incentive programs, and withholds*
  - *Be the minimum set of measures that are publicly reported*

Vision: Leverage Priority Measures to Promote DHHS' Key Quality Areas

Quality Withhold Measures*

- *Quality withhold measures are used to financially reward and hold PHPs accountable against a sub-set of measures included in the **priority measure set***
- *Quality withholds account for 30% of the total withholds in Year 1 and 60% in subsequent years*
- *Quality measures are the only component of the measure universe where performance (as opposed to reporting) is tied to PHP financial outcomes.*

Vision: Make annual updates and changes to Quality Withholds Measures based on assessment of PHP readiness to move from process measures to outcome and population health measures

* 1 measure- Hypertension- required for Accreditation requires a clinical component; Withholds related to areas outside of quality measures comprise the rest of the withhold program.

Baselines, Benchmarks & Performance Targets

DHHS will establish PHP performance targets for quality through the use of baselines, targets, and benchmarks that are adapted over time to promote continuous quality improvement.

Recommendations

- **NC DHHS will set PHP performance targets for quality**
  - ✓ For all quality measures, DHHS will calculate **baselines** to understand historic performance and areas of strength and weakness
  - ✓ For all priority measures, over time DHHS will set **benchmarks** to guide PHP performance incentive efforts, as priority measures are used for AMH and other performance incentive programs
  - ✓ For all quality withhold measures, DHHS will calculate **benchmarks** and **targets** annually **(withholds begin after 18 months)**

Terminology:
Baseline: Historic performance
Target: Performance level required to receive partial or total withhold
Benchmark: Optimal performance

Future Years

- ✓ **Incorporate newly-collected data into withhold strategy to advance performance measurement**
- ✓ **Reassess withhold measure list based on priority measure performance**
- ✓ **Work with PHPs to support new approaches to gathering data, including clinical and patient-reported data**
- ✓ **Determine approach to developing disparity-specific targets and scoring (see disparities slide)**

Context/Other State Practices

- *In general, other states collect a total of 40-50+ measures and utilize a set of 8-10 measures that are tied to withholds. States use a range of approaches to target development, benchmarking and scoring systems.*

Disparities Reporting and Tracking

DHHS will address disparities in health outcomes through quality measure stratification and reporting approaches that become more advanced over time.

Recommendations	Future Years
✓ DHHS will select measures for disparities tracking from the **Quality Measures** list, and will: ✓ Select all HEDIS/CAHPS Measures which will require less system programming than other measures (e.g. PQA/OPA, etc.); ✓ Require stratified reporting for withhold measures ✓ DHHS will define how they want to stratify selected measures including by race, ethnicity, geography, primary spoken language and, as possible, by age and gender ✓ PHPs will be required to report on selected measures to DHHS annually ✓ EQRO will validate the selected measures and incorporate <u>results into technical report and produce a separate disparity report</u> ✓ State reviews PHP performance on disparities measures and determines how each PHP needs to address inequities in QAPIs (PHPs also consider) ✓ PHPs are required to build improvement strategies into QAPIs around low performance measures (State will review and approve QAPI)	✓ DHHS will consider disparity measure changes annually. ✓ DHHS will collect baseline data on chosen measures ✓ DHHS will consider and set targets based on disparities. ✓ DHHS will consider incorporating disparities measures into the AMH measures and into the withholds measure set, if possible based on measure limitations.

Context/Other State Practices

- *Other states typically require stratified reporting of some or all of their quality measures. We did not find any state that currently incorporates measures of equity into its withhold, although Minnesota may do so in future years (after further data collection).*

Withholds Measure Reporting Framework

The draft withhold measure set includes process measures and one intermediate outcome measure

Withholds Measure Set

The **draft** withhold set of measures includes 5 HEDIS and 1 CAHPS measure:

- **(Intermediate Outcome Measure)** Comprehensive Diabetes Care (HbA1c poor control >9.0%)
- Asthma Medication Ratio (total rate)
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (both rates)
- Medical Assistance with Smoking and Tobacco Cessation
- Prenatal and Postpartum care (both rates)
- Well-Child Visits in the Third, Fourth, Fifth, and Sixth years of Life

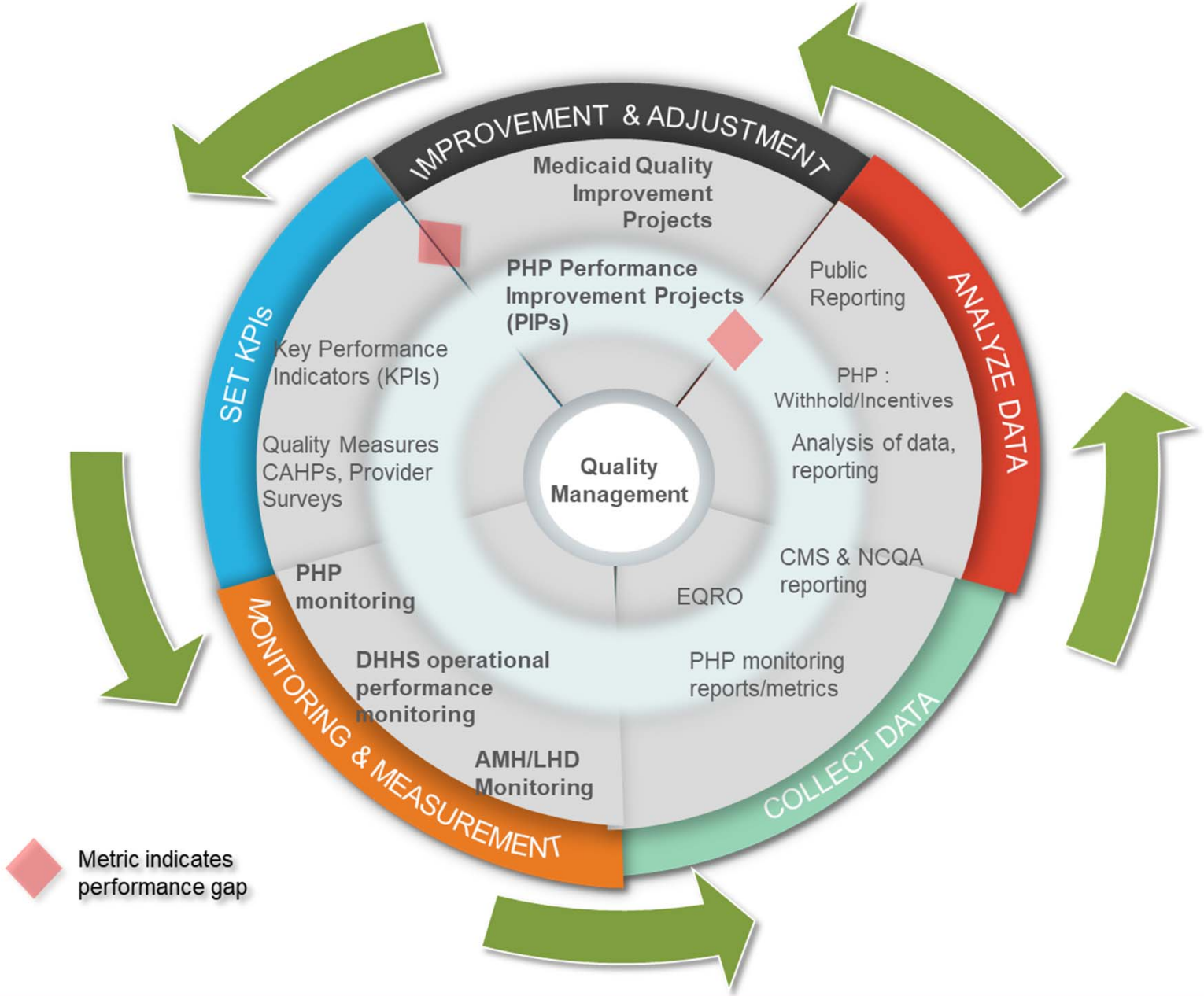
Evolution of Withholds Strategy

The initial withhold strategy will focus on rewarding PHPs for attainment of process measures while in later years, PHPs will be rewarded for improved outcomes against historic and regional targets.

Component*	Approach
Measure Set Size	<10 measures in all years (6 currently selected)
Targets	Attainment of specified performance measure (same for all PHPs) in Y1, transitioning to gap-to-goal target (unique for each PHP, depending on prior performance) as baseline data becomes available
Measure Type	Process measures in phase 1, transitioning to outcome measures in subsequent years (phases) as risk-adjustment data becomes available
Comparison Group	In phase 1, translate historic state data (where available) to equivalent national performance percentile, and target against that national level. Over time transition to state, regional or historic comparators as data becomes available
Assessing Risk for Non-Clinical (Such As Sociodemographic) Factors	Stratified data reporting in all years, with incorporation of disparities into target development and scoring in future years. No risk adjustment for sociodemographic factors
Weighting	Not recommended in Y1, or in subsequent years unless withhold measure set increases in size

*See Appendix for detailed recommendations

DHHS Quality Management/Improvement Cycle



QUESTIONS

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