

Medical Care Advisory Committee

Quality Subcommittee

April 15, 2021

Agenda

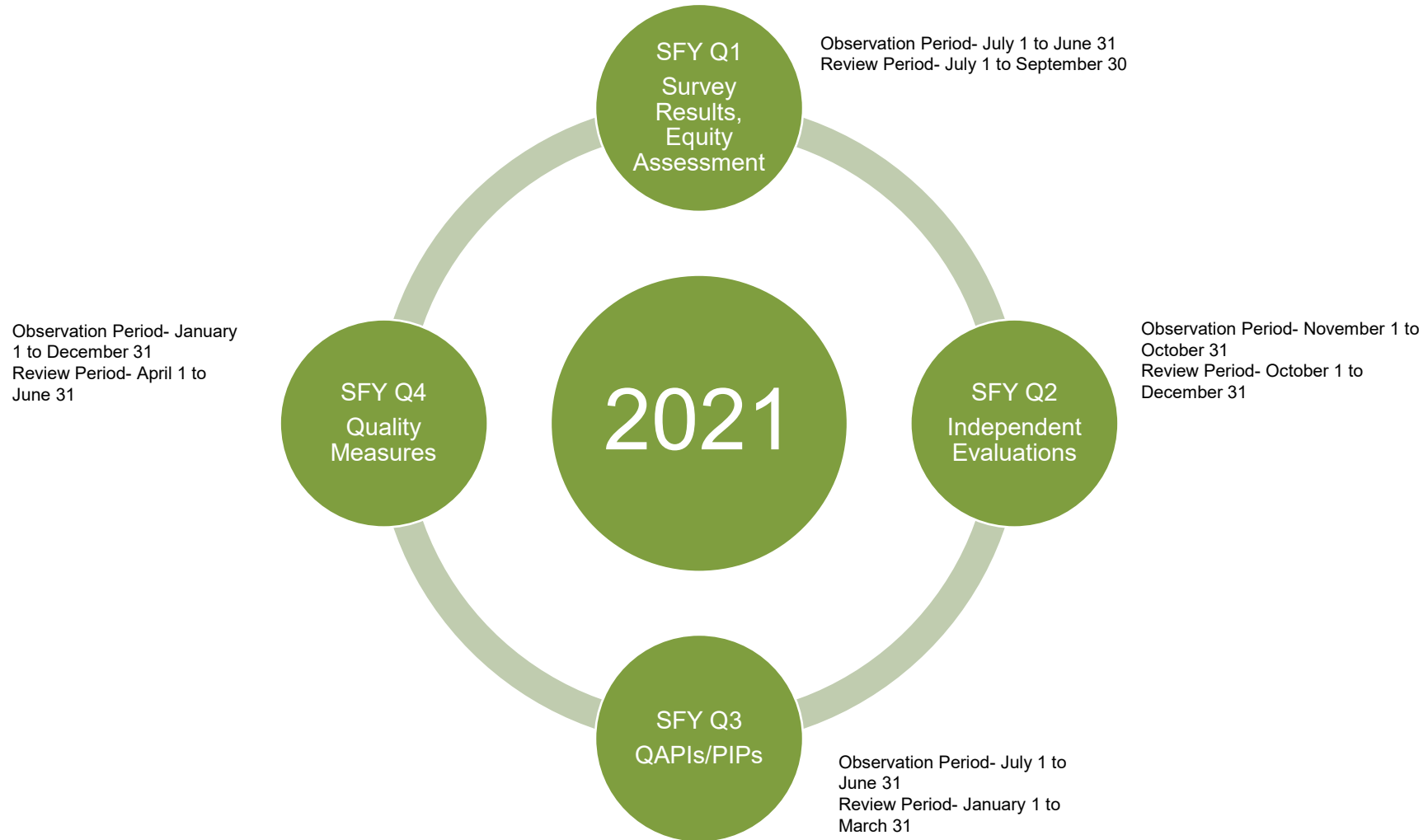
- **Call meeting to order/Welcome- Kim Schwartz and Joyce Winstead**
- **Announcement of Joyce Winstead (Co-Chair replacement) and voting in- Beth McDermott**
- **PHP Onboarding Plan and 2021 Governance- Beth McDermott**
- **Quality Management and Improvement- Jaimica Wilkins**
- **Telemedicine Monitoring and Evaluation- Sam Thompson**
- **Final Questions/Public Comment/Agenda for July meeting/Adjournment- Kim Schwartz, Joyce Winstead and Jaimica Wilkins**

PHP Onboarding Plans and 2021 Governance Calendar

2021 PHP Readiness

- **Standard Plan (SP) and Tribal Option Onsite Readiness Review**
 - Review systems and processes to ensure SPs and Tribe meets contract requirements.
 - Removal of portions of guides that are not applicable or do not need to be demonstrated by the Plans/Tribe.
- **PHP Deliverable review**
 - Quality Management and Improvement Program
 - Quality Assurance and Performance Improvement
 - Performance Improvement Plans
 - Provider Support Plans
- **External Quality Review Organization (EQRO)**
 - Templates
 - Reporting
 - Monitoring/Oversight
 - Measure Calculation

2021 Governance Calendar

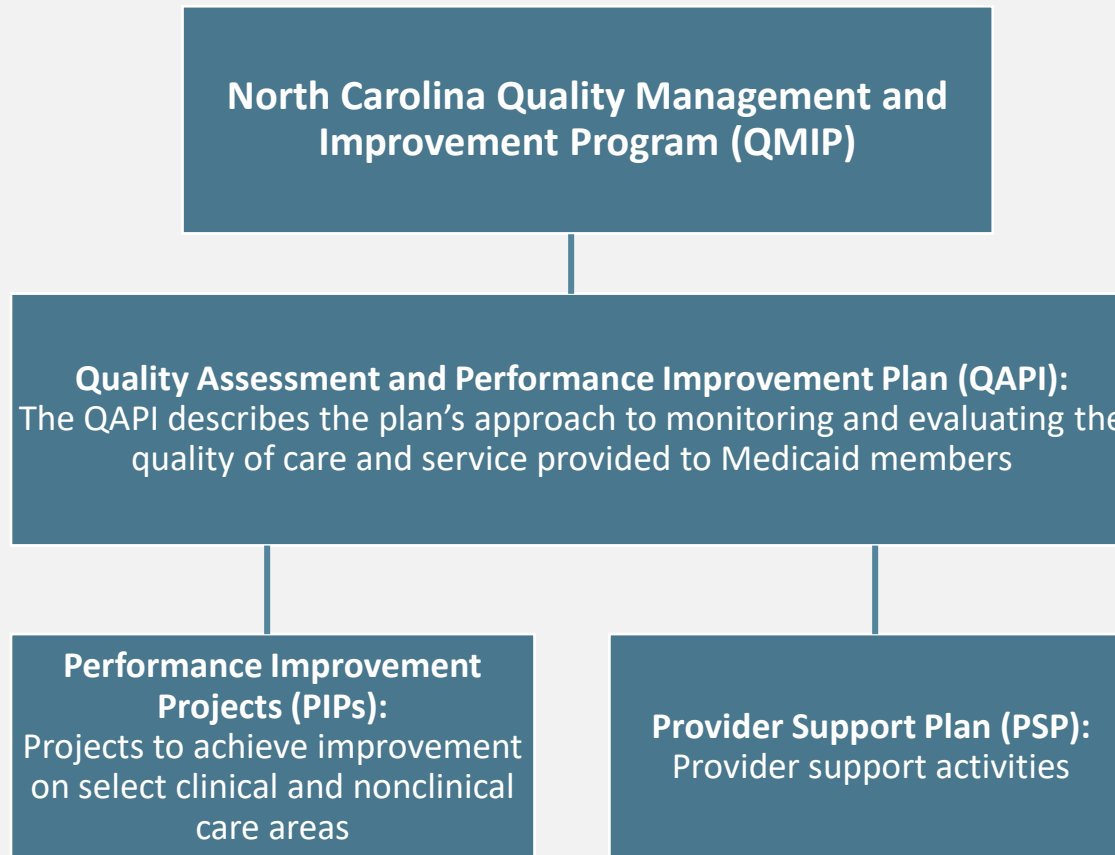


Source: Quality Governance document

Quality Management and Improvement

Quality Management and Improvement Program (QMIP)

Managed care plans shall have a robust Quality Management and Improvement Program (QMIP) that will focus on health outcomes, rather than only health care process measures.



! **The Department's Commitment to Health Equity:** Promoting health equity through reduction of health disparities will be a focus within North Carolina's QMIP. Managed care plans will identify disparities and implement interventions through their population health management programs to reduce disparities.

Performance Improvement Projects

Standard Plans and BH I/DD Tailored Plans are required to conduct PIPs that:

- Are designed to achieve significant improvement, sustained over time, in health outcomes and enrollee satisfaction;
- Include measurement of performance using objective quality indicators;
- Include implementation of interventions to achieve improvement in access to and quality of care;
- Include evaluation of the effectiveness of the interventions; and
- Include planning and initiation of activities for increasing or sustaining improvement.



Provider Implications: Plans will be working with you to develop and implement PIPs.



Patient Implications: Plans and providers are focused on continually improving the quality of care.

Performance Improvement Project Standardization

- Alignment of Performance Improvement Projects (PIPs) statewide for all Prepaid Health Plans (health plans)
- 3 PIPs standardized in Contract Year 1
 - **1 Clinical Adult PIP** -Comprehensive Diabetes Care: HbA1C Poor Control (>9.0%)
 - **1 Clinical Child PIP** - Childhood Immunization Status- CIS (Combo 10)
 - **1 Clinical Maternal Health PIP** – Prenatal and Postpartum care measure focused on Timeliness of Prenatal Care
- PIPs support Quality Strategy Aims, Goals and Objectives

Provider Support Plan

Each plan must develop a report detailing:



All planned technical support activities.



Detailed information regarding how its proposed provider supports activities will advance the aims, goals, and objectives outlined within the Department's Quality Strategy.



An overview of which metrics the Plan will use to evaluate its provider engagement progress over time.

Technical Assistance and Practice Support: Area Health Education Centers (AHEC)

AHEC will provide training and practice-level technical assistance for the transition to managed care, with a focus on safety net/essential and rural providers.

- Prior to Launch: AHEC will provide targeted training assistance to ensure providers are prepared to participate in Medicaid transformation initiatives.
- Prior to Launch: AHEC hosts Fireside Chats.
- Prior to Launch: AHEC leads the AMH Coaching Program.
- After Launch: AHEC will provider state-level webinars that highlight Statewide PIPs.
- After Launch: AHEC will host events and support health plan Regional Quality Forums.
- After Launch: AHEC will continue AMH Coaching Support.

We're here to help!!!



Provider Feedback Loop on Quality Improvement



Quality Forum Invitees

Primary Care Physicians and Advanced Medical Homes (all Tiers)

Obstetric/Gynecological Providers

Behavioral Health Providers

Local Health Departments

School-based Health Centers

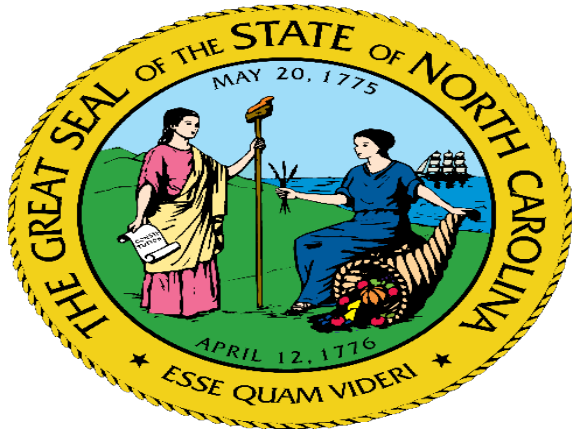
Hospitals

Long-term Services and Supports Agencies

Clinical Integrated Networks

Local Department of Social Service (DSS)

Other relevant stakeholders based on the agenda and goals of the Forum



Telemedicine Monitoring and Evaluation

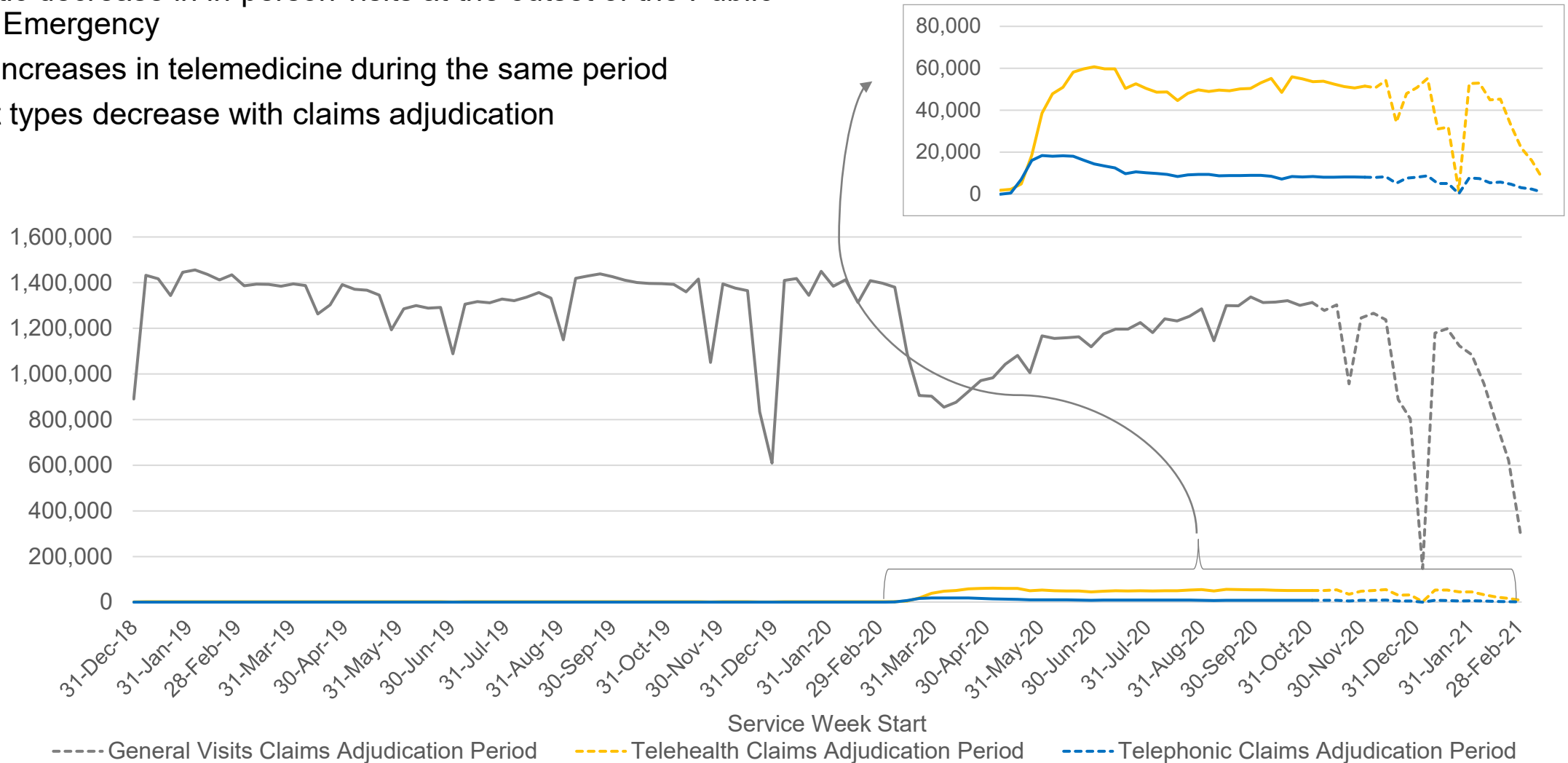
April,15 2021

Outline

1. There was an immense drop in the total volume of care delivered during the first few months of the Public Health Emergency.
2. A significant increase in telehealth and telephonic services (telemedicine) made up some of the gap created by the drop in in-person services.
3. Telemedicine uptake was particularly robust for behavioral health services.
4. The rate at which different demographic and geographic beneficiary subgroups participated in telemedicine varied.
5. The rate at which providers/practices participated in telemedicine varied.
6. Initial evidence suggests that telemedicine has replaced in-person services, to a significant extent, during the Public Health Emergency.

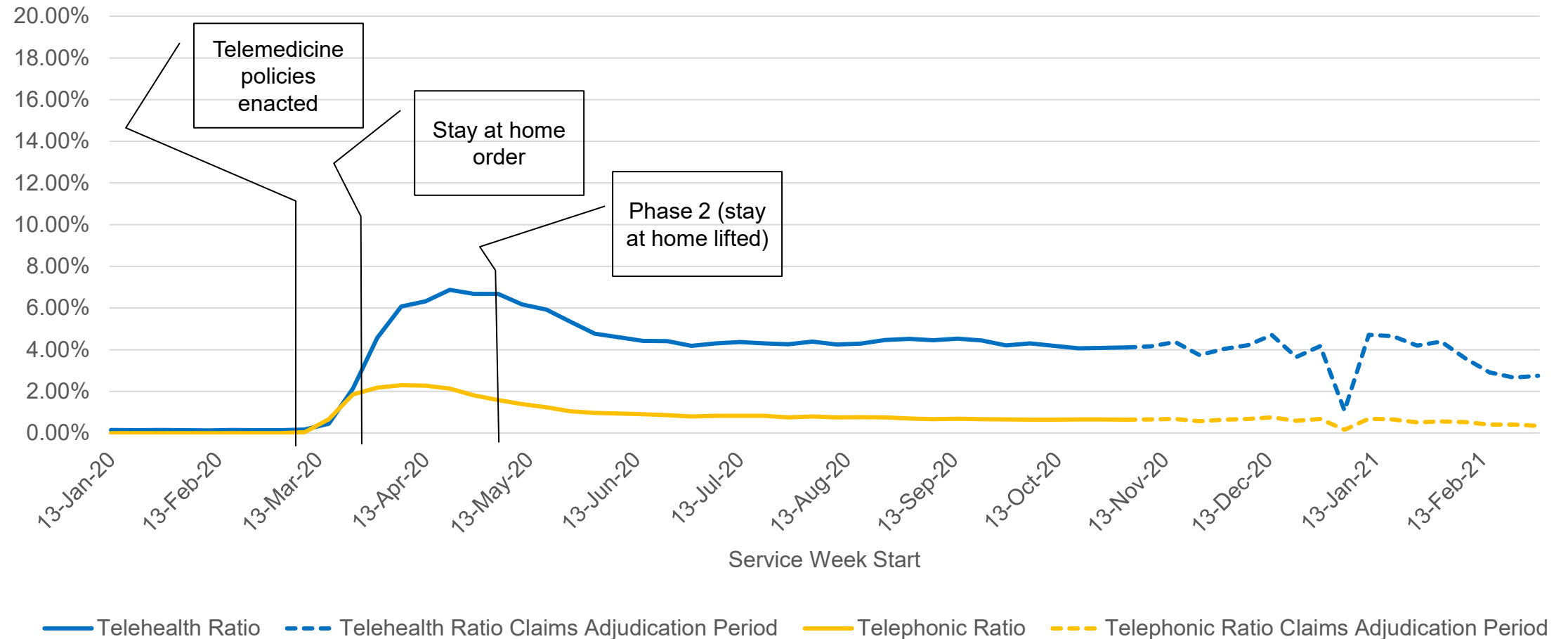
Telehealth, Telephonic, and In-person Claims Volume | 12/31/18 – 03/01/2021

- Dramatic decrease in in-person visits at the outset of the Public Health Emergency
- Steep increases in telemedicine during the same period
- All visit types decrease with claims adjudication



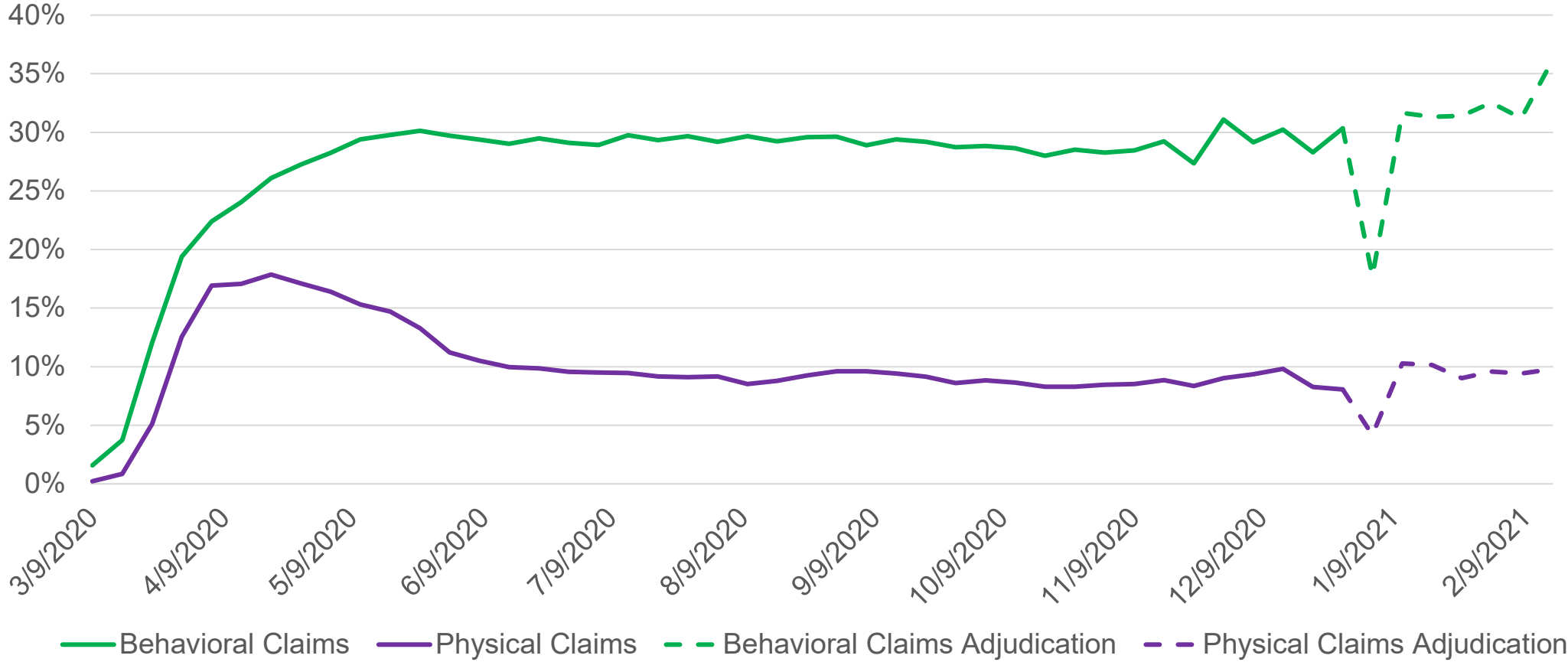
Ratio of Telehealth and Telephonic Claims to General Claims | 12/31/18 – 03/01/2021

Ratios jump after DHB's March 10th implementation telehealth/telephonic policy changes



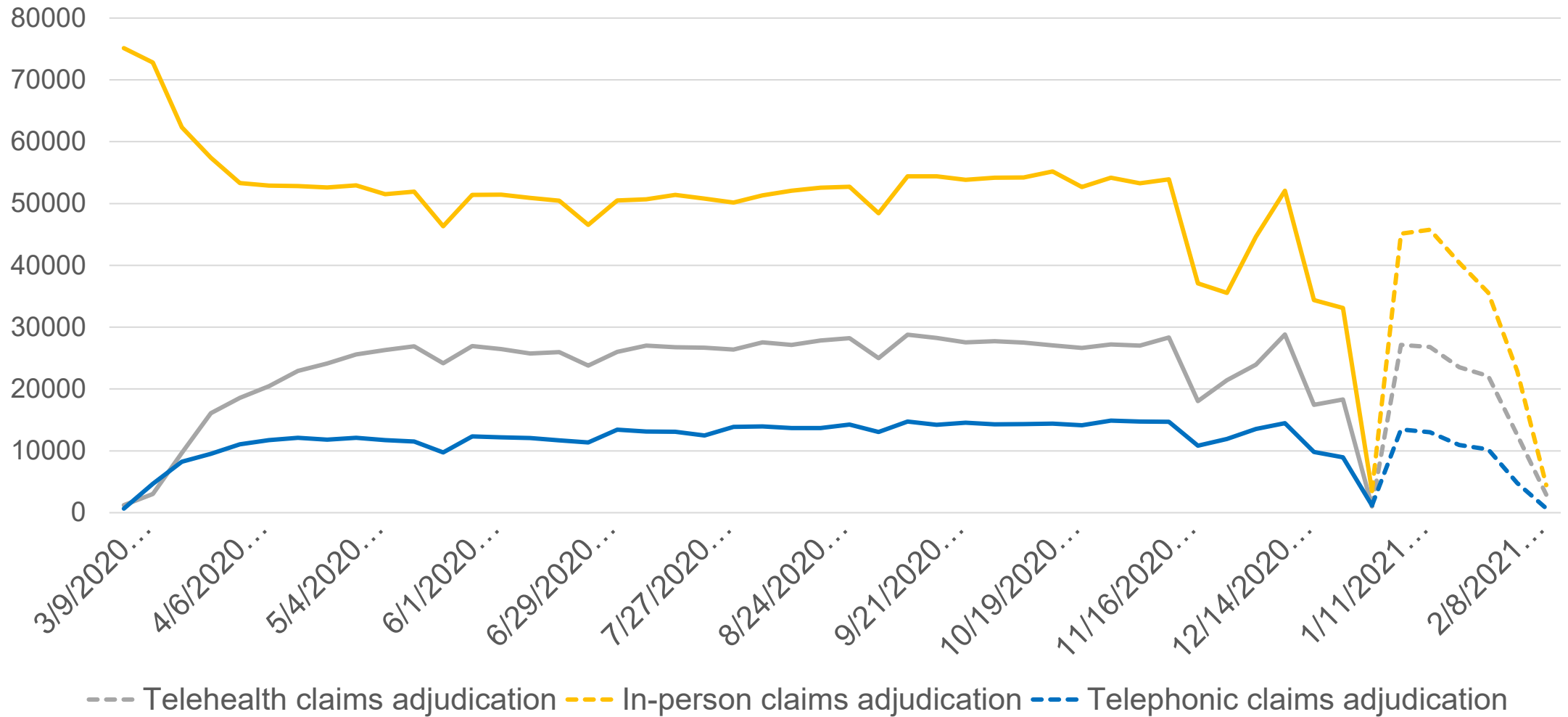
% Telehealth¹ for Physical vs. Behavioral Health | 3/09/2020 – 2/15/2021

Compared to other types of care telemedicine made up a much larger proportion of behavioral health visits



1. Remote encounters that include both audio and video

Telehealth, Telephonic, and In-person Behavioral Health Encounters Volume 03/09/2020 – 2/15/2021

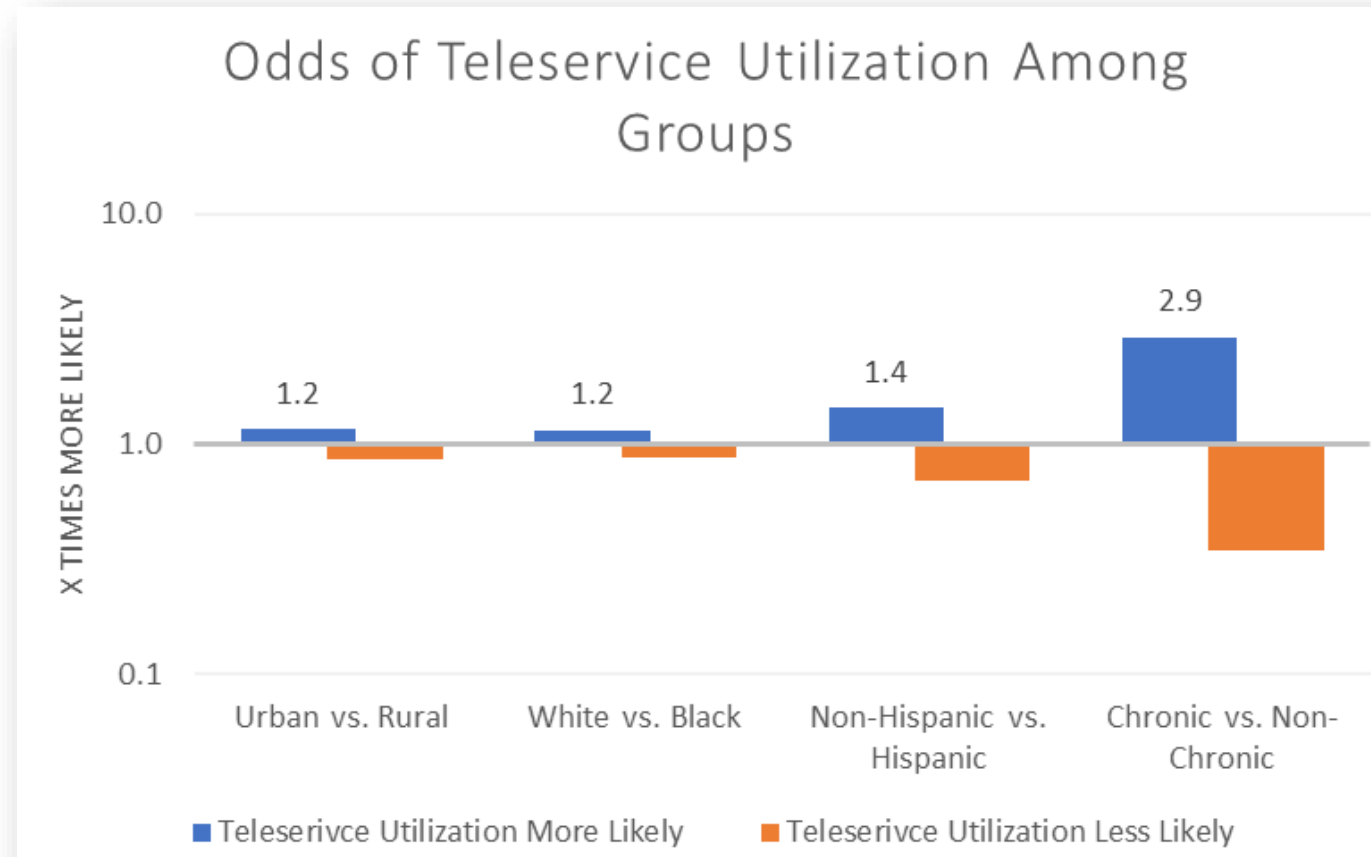


Teleservice Utilization Odds by Geography, Race and Disease Type

The COVID-19 diagnostic population may seek in-person care more readily.

The odds of teleservice utilization among:

- Beneficiaries living in urban geographies is 1.2x greater than utilization odds among beneficiaries living in rural geographies
- White beneficiaries is 1.2x greater than utilization odds among black beneficiaries
- Non-Hispanic beneficiaries is 1.4x greater than utilization odds among Hispanic beneficiaries
- Beneficiaries with a chronic disease is almost 3x greater than utilization odds among beneficiaries without a chronic disease



Beneficiary Survey Findings

- Of respondents whose most recent visit was virtual individual therapy (n=145) 59% said that they would like to continue virtual therapy if given the option to return in person.¹
 - Black or African American respondents were less likely to want to continue virtual individual therapy (44%, 24 of 54, $p < .00001$) compared to White respondents (73%, 48 of 66).¹
- 84% of respondents (n=186) reported no technical difficulties at their last virtual appointment.¹
- When comparing self reported outcomes from February 2020 (before transition to telehealth) to April 2020 (transition to primary telehealth model), self reported outcomes remain similar.²

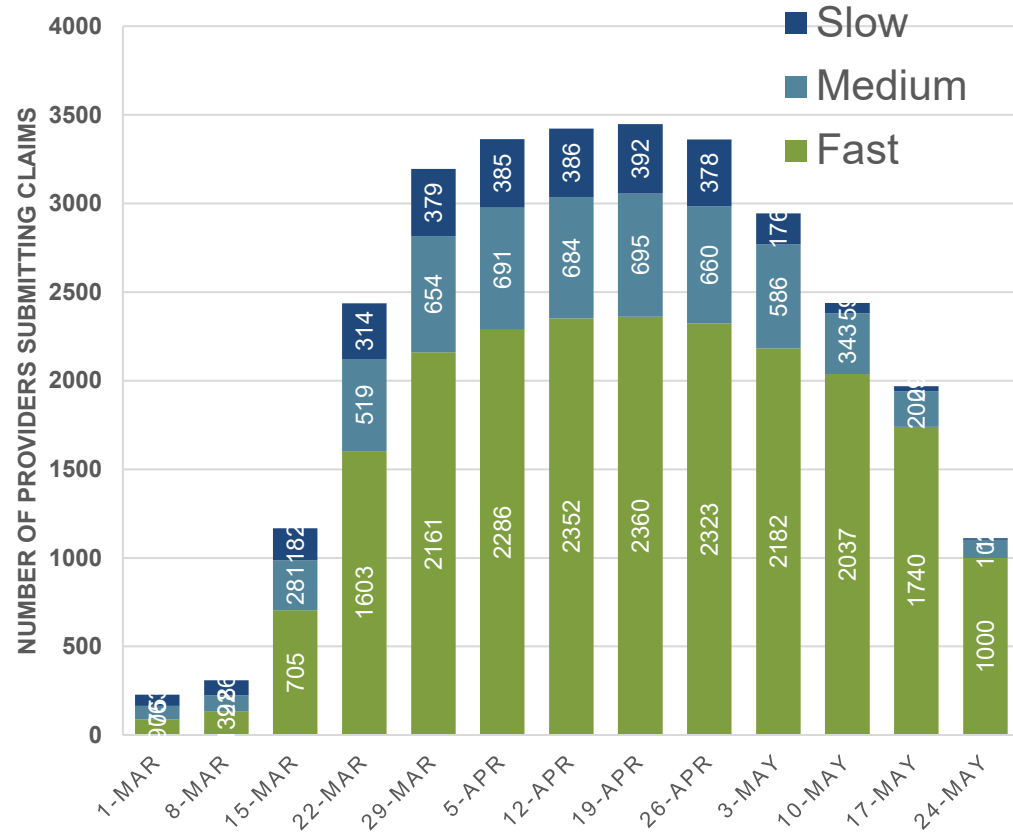
1. Intercept survey implemented by Carolina Outreach, a statewide behavioral health provider

2. Patient-reported outcomes survey implemented by Access Family Services, statewide behavioral health agency

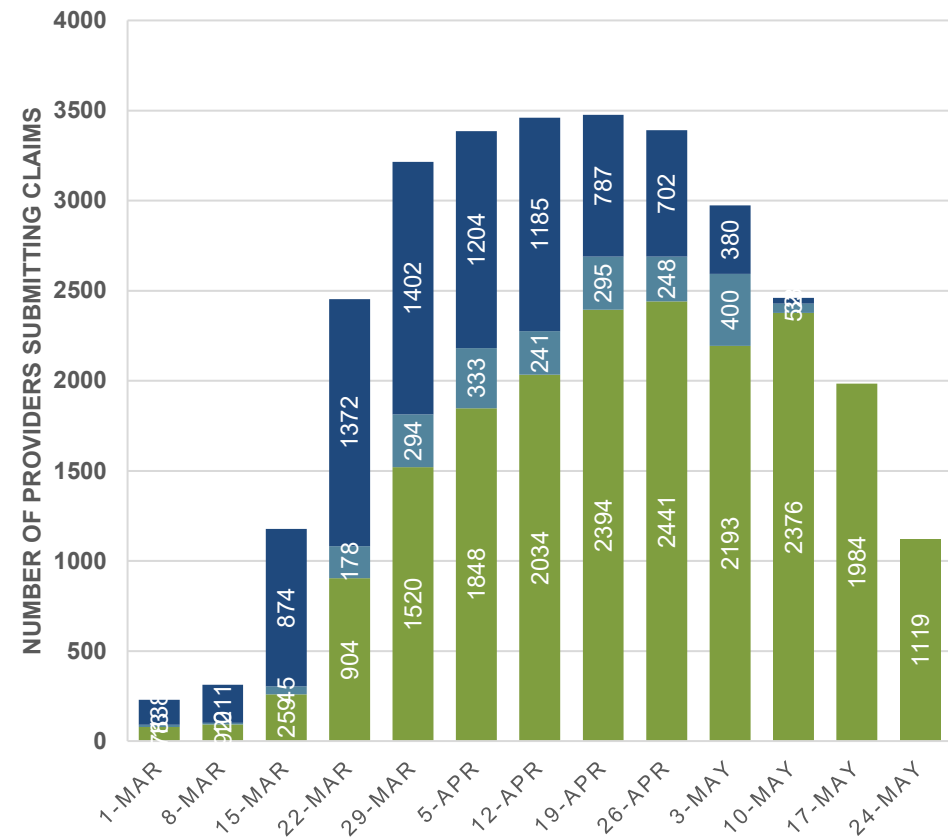
Providers engaged in teleservices were slower to bill

Claims submission speed for providers submitting teleservice claims during the first three months of the COVID-19 period was slower than the speed at which those same providers submitted claims 180 days prior.

Lookback Period (Sept.-Dec. 2019)



COVID-19 Period (March-May 2020)



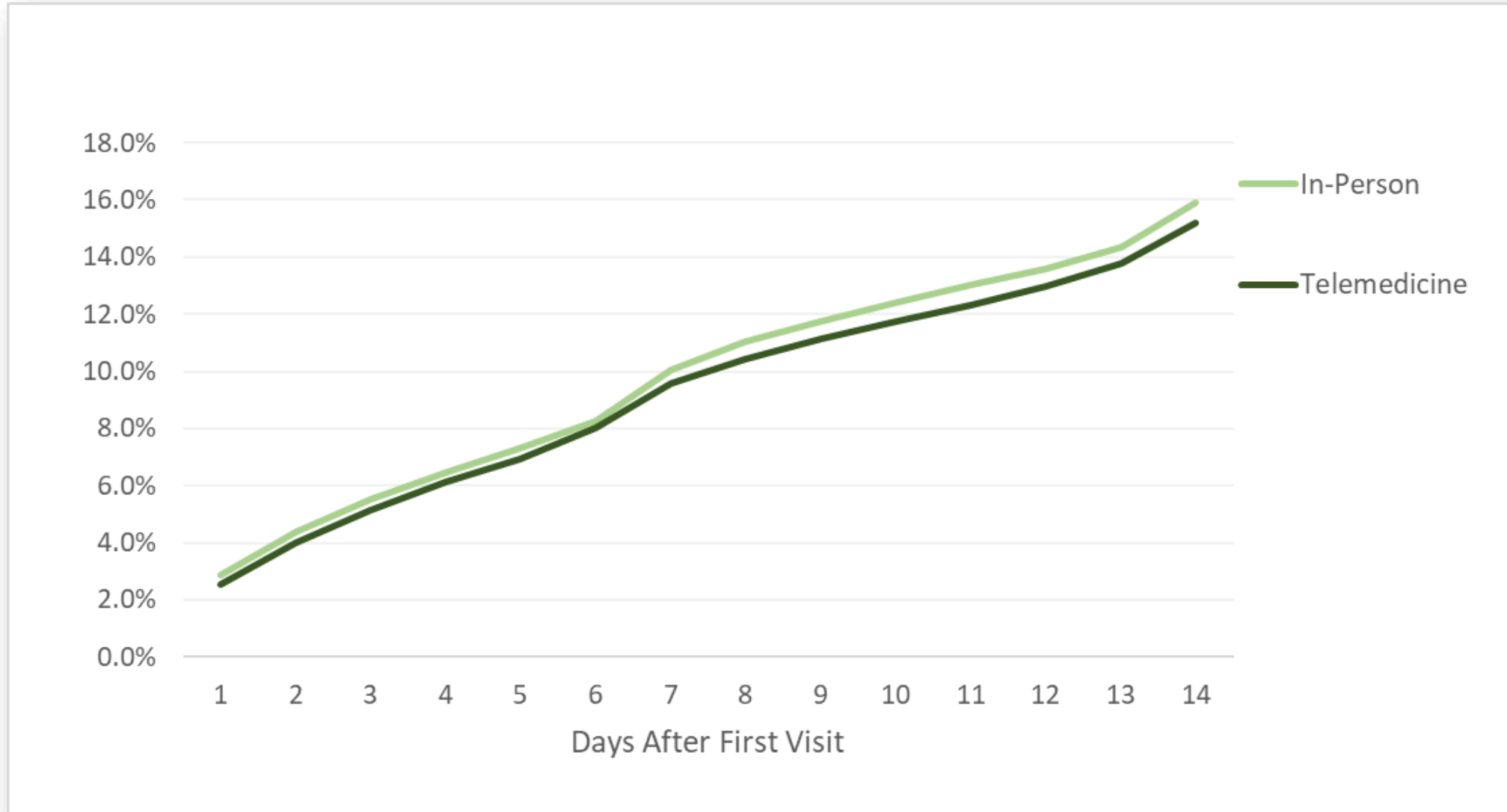
Using Teleservices to Close Care Gap

Primary care practices that adopted telemedicine at higher rates saw a much larger proportion of their patients during the first five months of the Public Health Emergency.

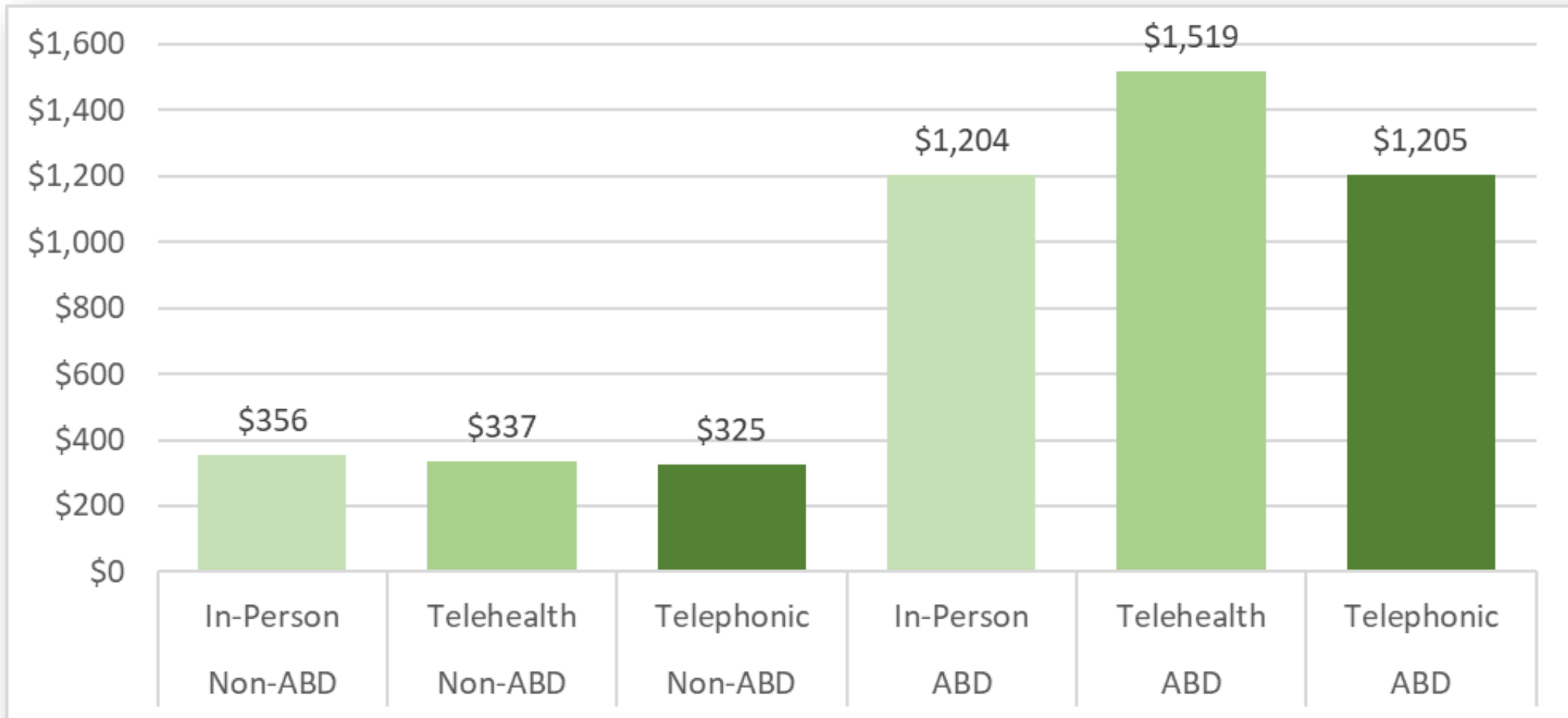
Level of Uptake (number of teleservice claims during the pandemic so far)	No. of Practices	No. of Patients Receiving Primary Care During Pandemic	Est. % of Panel Accessing Practice During Pandemic
HIGH (300+)	221	628,360	106%
MED (50-299)	515	375,928	80%
LOW (1-49)	723	242,819	62%
NONE	380	71,449	45%
Grand Total	1,839	1,318,556	82%

Practices see more Medicaid patients than they have in their enrollment. The numerator is the number of unique patients that visit that practice. The denominator is the CA-II enrollment. Beneficiaries in the numerator and may not be the same as those denominator.

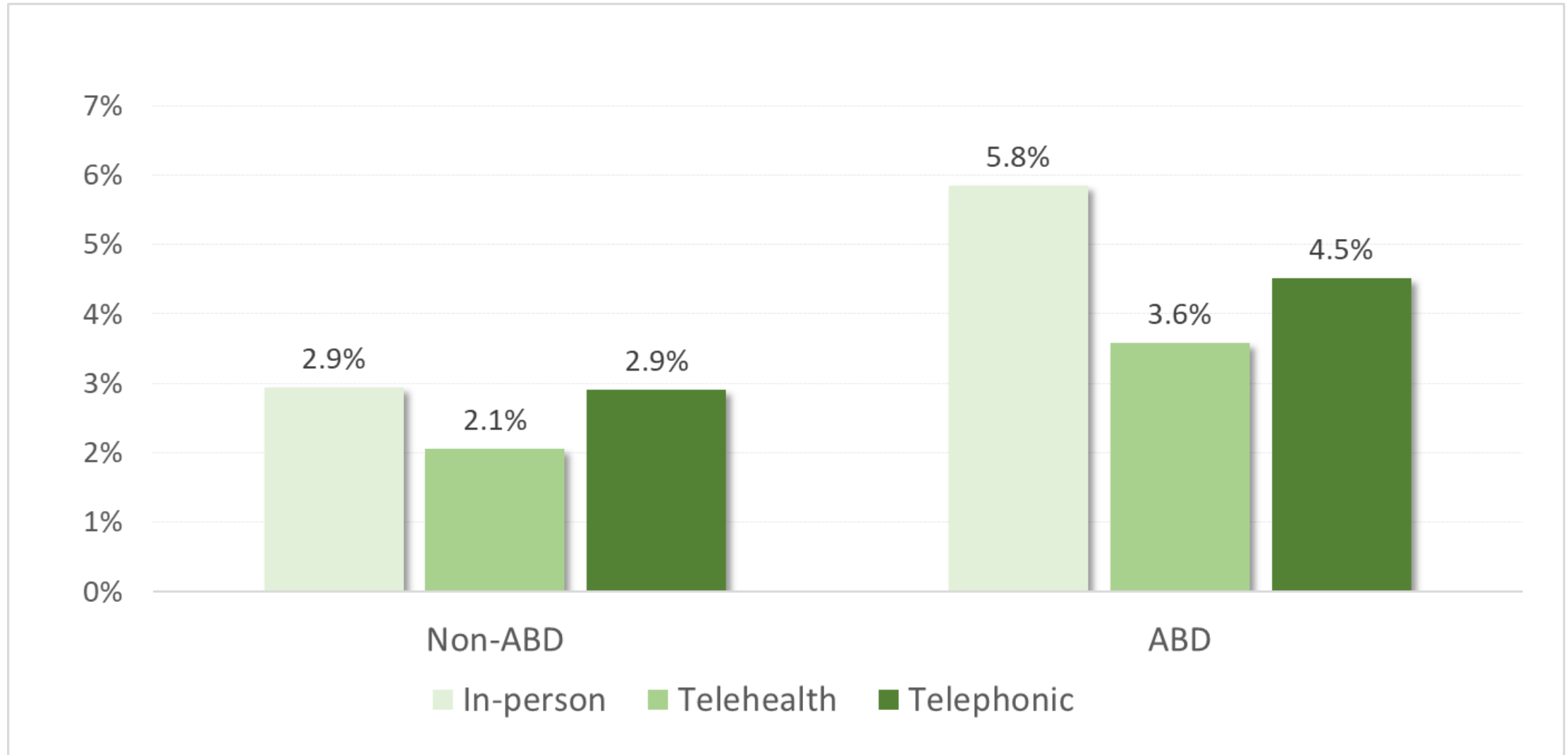
A Second Visit Was Less Likely After Teleservices



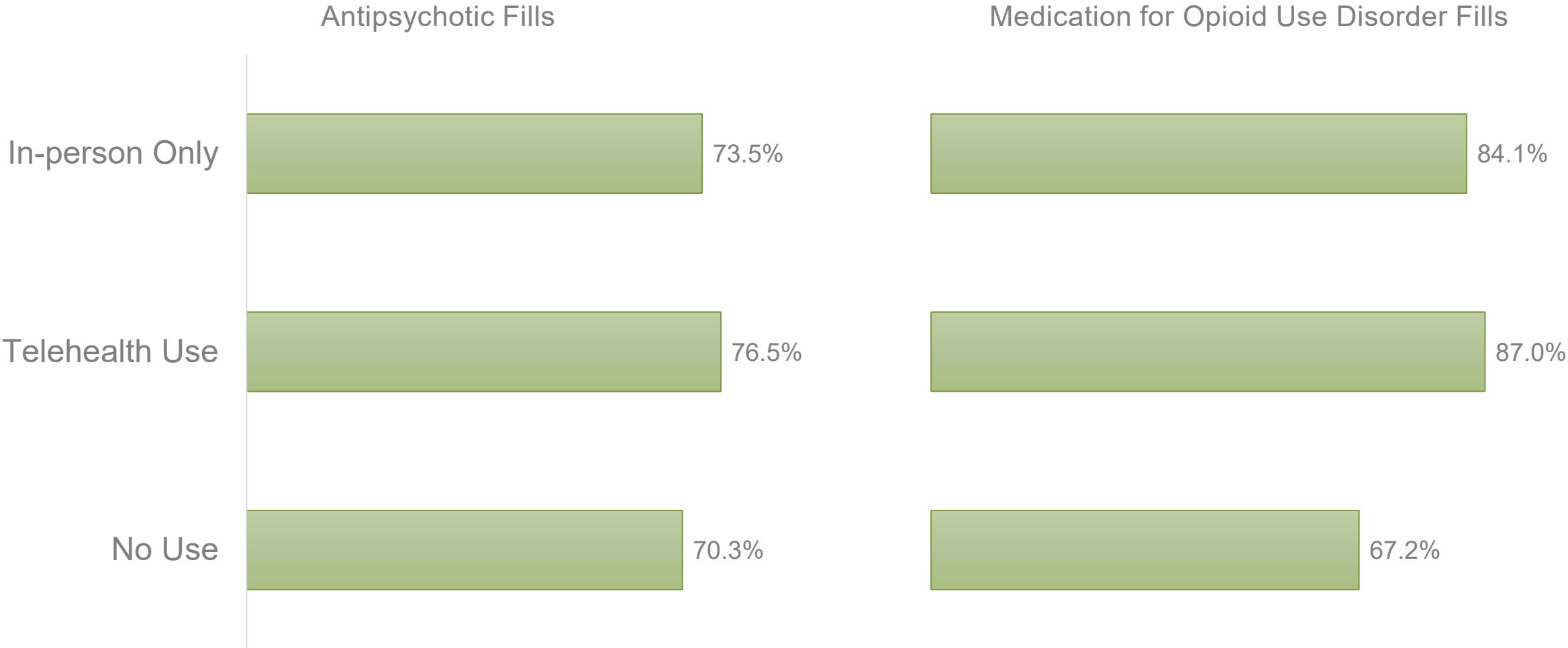
Total Cost of Care in Two Weeks Following Primary Care Visit



% Using Hospital Within Two Weeks of Primary Care Visit



Probability of medication use between June 2020-January 2021 was higher for beneficiaries that received some services during March 2020 – May 2020



Results were sustained in propensity-weighted models

- In doubly-robust IPTW models (first stage=3 categories of use during Mar-May), we find:
 - Higher rates of antipsychotic adherence for those who were on antipsychotics prior to the PHE:
 - Telehealth only beneficiaries had 6.8% point higher probability of an antipsychotic fill, compared to beneficiaries that did not receive services
 - In-person only beneficiaries had a 3.9% point higher probability of an antipsychotic fill, compared to beneficiaries that did not receive services
 - Higher rates of MOUD for those who were on MOUD prior to March:
 - Telehealth only beneficiaries had 17.3% point higher probability of an MOUD fill, compared to beneficiaries that did not receive services
 - In-person BH users had a 15.3% point higher probability of an MOUD fill, compared to beneficiaries that did not receive services

Further Analyses

1. Working with North Carolina's Health Information Exchange and State Lab data to observe teleservice health outcomes
2. Fielding a Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey with a sampling approach that will allow responses to be stratified by teleservice utilization by the following demographic categories:
 - a) Child | Adult
 - b) Race (Black | White | General)
 - c) Ethnicity (Latinx | Not Latinx | General)
3. Examining the impact of primary care providers' telehealth uptake on COVID-19 rates within their patient panel coupled with an examination of the degree to which receiving care via telehealth is a factor in beneficiaries contracting COVID-19
4. Partnering with the Sheps Center for Health Services Research on a metanalysis of teleservice findings in provider surveys implemented during the first several months of the COVID-19 period, as well as a follow-up survey of providers' experience with teleservices