Medical Care Advisory Committee

Division of Health Benefits

October 21, 2021
AGENDA

• Call Meeting to Order/Welcome- Kim Schwartz- Chief Executive Officer, Roanoke Chowan Community Health Center and Joyce Winstead- Director, Practice, NC Board of Nursing

• Managed Care Updates- Kelly Crosbie- Chief Quality Officer, DHB

• AMH Attribution Method- Taylor Zublena- Associate Director, Quality Management, DHB

• 2020 Quality Measure Results- Taylor Zublena

• QAPIs/PIPs- Beth McDermott

• KKW Campaign recap- Beth McDermott

• Provider Experience Survey- Sam Thompson, Associate Director, Program Evaluation, DHB
Managed Care Updates
North Carolina’s Vision for Medicaid Transformation

To improve the health of North Carolinians through an innovative, whole-person centered, and well-coordinated system of care that addresses both the medical and non-medical drivers of health.
Managed Care Plan Types

There will be four (4) types of health plans under the North Carolina managed care system:

<table>
<thead>
<tr>
<th>Standard Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Standard Plans</strong> will provide integrated physical health, behavioral health, pharmacy, and long-term services and supports to the majority of Medicaid beneficiaries, as well as programs and services that address other unmet health related resource needs.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Behavioral Health I/DD Tailored Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Behavioral Health Intellectual/Developmental Disability (I/DD) Tailored Plans</strong> will provide the same services as Standard Plans, as well as additional specialized services for individuals with significant behavioral health conditions, I/DDs, and traumatic brain injury, as well as people utilizing state-funded and waiver services.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Specialized Plan for Children in Foster Care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A Specialized Plan for Children in Foster Care</strong> will be available to children in foster care and will cover a full range of physical health, behavioral health, and pharmacy services.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>EBCI Tribal Option</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The Eastern Band of Cherokee Indians (EBCI) Tribal Option</strong> will be available to tribal members and their families and will be managed by the Cherokee Indian Hospital Authority (CIHA).</td>
</tr>
</tbody>
</table>
Managed care implementation was “paused” in early 2020 due to the delayed State budget and COVID-19. The Department continued its planning efforts to prepare for launch.

Managed Care Launch Timeline

- **Standard Plans & EBCI Tribal Option**
  - (July 1, 2021)

- **Behavioral Health I/DD Tailored Plan**
  - (July 1, 2022)

- **Statewide Foster Care Plan**
  - Proposed implementation date
  - (July 1, 2023)

2020 2021 2022 2023

Medicaid Managed Care Health Plans

NC Medicaid Direct

Some people will not be eligible to enroll in a health plan; they will stay in NC Medicaid Direct and LME/MCOs.

1.6m Members are enrolled in Standard Plans
Advanced Medical Home (AMH) Attribution Model
AMH Quality Measure Attribution

Process for attributing beneficiaries to AMHs for quality measurement, VBP with PHPs to AMHs and performance incentives

The Department seeks to ensure that quality measurement for a given AMHs’ assigned member panel achieves the following goals:

1) Provides incentives for the AMH to proactively conduct outreach to their prospectively-assigned members to engage them in care and improve the quality of their care;

2) Ensures AMH performance incentive payments reflect all of the care they provide or are expected to provide; and

3) Aligns with the Department’s goal that AMHs are accountable for all assigned members.
Quality Initiatives within the AMH Program

The Department requires Standard Plans to monitor the performance of AMHs in all tiers to ensure delivery of high-quality care.

All practices will be eligible to earn negotiated Performance Incentive Payments based on the set of measures in the AMH measure set, which were selected for their relevance to primary care and care coordination.

Advanced Medical Home Measure Set

<table>
<thead>
<tr>
<th>NQF#</th>
<th>Measure Name</th>
<th>Steward</th>
<th>Frequency*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Pediatric Measures</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NA</td>
<td>Child and Adolescent Well-Care Visits (WCV)</td>
<td>NCQA</td>
<td>Annually</td>
</tr>
<tr>
<td>0038</td>
<td>Childhood Immunization Status (Combo 10) (CIS)</td>
<td>NCQA</td>
<td>Annually</td>
</tr>
<tr>
<td>1407</td>
<td>Immunizations for Adolescents (Combo 2) (IMA)</td>
<td>NCQA</td>
<td>Annually</td>
</tr>
<tr>
<td>NA</td>
<td>Well-Child Visits in the First 30 Months of Life (W30)</td>
<td>NCQA</td>
<td>Annually</td>
</tr>
<tr>
<td></td>
<td><strong>Adult Measures</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0032</td>
<td>Cervical Cancer Screening (CCS)</td>
<td>NCQA</td>
<td>Annually</td>
</tr>
<tr>
<td>0033</td>
<td>Chlamydia Screening in Women (CHL)</td>
<td>NCQA</td>
<td>Annually</td>
</tr>
<tr>
<td>0018</td>
<td>Controlling High Blood Pressure (CBP)</td>
<td>NCQA</td>
<td>Annually</td>
</tr>
<tr>
<td>0059</td>
<td>Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (&gt;9.0%)</td>
<td>NCQA</td>
<td>Annually</td>
</tr>
<tr>
<td>1768</td>
<td>Plan All-Cause Readmissions (PCR) [Observed versus expected ratio]</td>
<td>NCQA</td>
<td>Annually</td>
</tr>
<tr>
<td>0418/0418e</td>
<td>Screening for Depression and Follow-up Plan (CDF)</td>
<td>CMS</td>
<td>Annually</td>
</tr>
<tr>
<td>NA</td>
<td>Total Cost of Care</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Monthly gap measure reports are also required.

**CY2022** = First Measurement Period  
**CY2019** = Baseline Statewide Rates
AMH Quality Measure Attribution

- Performance Incentive Structure by AMH Tier
  - PHPs required to offer performance incentive payments to Tier 3 practices; not required, rather encouraged for Tiers 1 and 2.
    - Performance Incentive Payments for selected AMH measures

- Beneficiaries select PCP(AMH) or auto-assigned* upon enrollment
  - AMHs prospectively-assigned beneficiaries at beginning of measurement period (calendar year)

- PHPs reconcile AMH's prospective panel at end of measurement year
  - Has beneficiary been attributed to the provider for 6+ months?
  - Has beneficiary met technical requirements of the measure(s)?
    - Continuous enrollment and allowable gap in coverage criteria

* Auto-assignment process reflects existing or expected care relationships: Prior assignment, claims, family AMH assignment, geographic proximity, special medical needs, language/cultural preference
AMH Quality Measure Attribution

**Common Scenarios**

- **Scenario 1:** The assigned AMH has not yet seen the member.
  - **Resolution:** The AMH should conduct outreach to establish contact with the member. If outreach is unsuccessful, the AMH should contact the PHP to determine if the member has selected another AMH and needs to be re-assigned. If the member has not established a care relationship with another AMH, the initially-assigned AMH will continue to be accountable.

- **Scenario 2:** A Medicaid member is included in an AMH practice’s EHR records and identifies the practice as their medical home but does not appear on their assigned member panel.
  - **Resolution:** The AMH should work with the member and the Standard Plan to re-assign the member to the new AMH.

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DHHS/SP identifies a member who was enrolled in Medicaid and selects or is assigned to an AMH at some point in the calendar year

Was the member assigned to the AMH for more than six months* AND does not exceed allowable coverage gaps described in the measure specifications?

**No**

- **Not attributed to the assigned AMH at the end of the calendar year for the purpose of quality measurement and inclusion for performance incentives**

  Repeat process for any other AMH practices to which the member has been assigned at some point in the calendar year, until all the AMH practices to which the member has been assigned have been considered.

**Yes**

- **Attributed to their assigned AMH for the purpose of quality measurement and inclusion for performance incentives:**

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*Note: *The AMH is responsible for ensuring that all members assigned to them are seen at least once per year. However, if the member has not been assigned to an AMH for more than six months, the AMH may not be attributed for the purpose of quality measurement and inclusion for performance incentives. In such cases, the AMH should conduct outreach to establish contact with the member. If outreach is unsuccessful, the AMH should contact the PHP to determine if the member has selected another AMH and needs to be re-assigned. If the member has not established a care relationship with another AMH, the initially-assigned AMH will continue to be accountable. If the member has been assigned to an AMH for more than six months but the member does not appear on their assigned member panel, the AMH should work with the member and the Standard Plan to re-assign the member to the new AMH.
2020 Quality Measure Results
Results, especially in prevention, screening, and access to primary care measures indicate majority have little variability from prior year rates, despite COVID PHE. Slight improvement in some with slight decline in areas indicated below.

- **Childhood immunizations (Combo 10) (+1.14%)**
- **Timeliness of Prenatal Care (+4.45%)**
- **Antidepressant Medication Management (+2.56%)**
- **Asthma Medication Ratio (+7.46%)**
- **Avoidance of Antibiotics for Acute Bronchitis (Total,+3.73%)**
- **Postpartum Care (-4.26%)**
- **Follow up after Hospitalization for MH (30-day) (-3.2%)**
- **Breast Cancer Screening (-6%)**
- **Diabetes Screening: Schizophrenia/Bipolar and Antipsychotics (-5%)**
- **Annual Dental Visit (-10.51%)**
2019-2020 Comparison

Pediatric

- Measure changes 2020 for **Well Child Visits 0-21 years** - Submeasures indicate stability in comparison 2019-2020
  - Childhood immunizations (Combo 10) (+1.14%)
  - Immunizations for Adolescents (Combo 2) (-0.34%)

- Annual Dental Visit (-10.51%)
- Lead Screening (+1.94%)
- Weight Assessment and Counseling for Children- BMI (+1.43%), Nutrition (+3.73%), Physical (+2.63%)

- Appropriate Pharyngitis Testing (Ages 3-17yrs) (+.34%)
- Appropriate URI Treatment (3mo-17yrs) (+1.01%)
- Avoidance of Antibiotic Treatment for Acute Bronchitis (3mo-17yrs) (+3.07%)
2019-2020 Comparison

Pediatric

- Metabolic Monitoring for Children and Adolescents on Antipsychotics: Metabolic Testing (-3.86%)
- Use of First Line Psychosocial Care for Children and Adolescents (-1.27%)
- Follow up Care for Children on ADHD Medications: Initiation (+1.64%), Continuation (-0.67)
2019-2020 Comparison

- Appropriate Pharyngitis Testing (+.49%)
- Appropriate URI Treatment (+1.95%)
- Asthma Medication Ratio—Total Rate (+7.46%)
- Avoidance of Antibiotic Treatment for Acute Bronchitis (+5.34%)
- Use of Spirometry Testing for COPD (-2.25%)
- Pharmacotherapy Management of COPD (Bronchodilator +.81%, Corticosteroid -.44%)

- Colorectal Cancer Screening (+.07%)
- Plan All Cause Readmission—Observed to Expected Ratio (-.06)
- Use of Imaging Studies for Low Back Pain (-.83%)
- Follow-up After Emergency Department Visit for People with High-Risk Multiple Chronic Conditions (NEW, 47.32%)
- Adult Access to Preventive Services (-2.83%)

Adult
2019-2020 Comparison

- Cardiac Rehabilitation-NEW
  - Initiation
  - Engagement > 12 sessions within 90 days
  - Engagement > 24 sessions within 180 days
  - Achievement > 36 sessions within 180 days

- Persistence of Beta Blocker Treatment (+1.56%)
- Statin Therapy for Patients With Cardiovascular Disease 80%--(+2.70%, Statin Therapy, -.72%)
- Statin Therapy for Patients With Diabetes 80%--(+2.31%, Statin Therapy -.47%)

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- Kidney Health Evaluation for Patients With Diabetes (NEW) 18.39%

- Comprehensive Diabetes Care
  - HbA1c Tested (-2.18%)
2019-2020 Comparison

Women’s and Maternal Health

- Breast Cancer Screening (-6.00%)

- Cervical Cancer Screening (-0.99%)
- Chlamydia Screening (Total Rate -.1.03%)
- Timeliness of Prenatal Care:
  - Prenatal Care (+4.45%)
  - Postpartum Care (-4.26%)
2019-2020 Comparison

Behavioral Health and Substance Use

- Adherence to Antipsychotics: Schizophrenia (+1.81%)
- Antidepressant Medication Management (Acute +1.95%, Continuance +2.56%)
- Cardiovascular Monitoring: Cardiovascular Disease and Schizophrenia (-5.85%)
- Diabetes Monitoring: Diabetes and Schizophrenia (-3.74%)
- Diabetes Screen: Schizophrenia or Bipolar and Antipsychotics (-5.00%)

- Follow-up after ED Visit for AOD (7-day -1.41%, 30-day -1.99%)
- Follow-up after ED Visit for Mental Illness (7-day -9.4%, 30-day -3.6%)
- Follow-up After Hosp for Mental Illness (7-day -1.80%, 30-day -3.20%)
- Follow-Up After Care for Substance Use Disorder (7-day -2.03%, 30-day -1.59%)
- Initiation and Engagement of AOD (Initiate -1.47%, Engagement -2.02%)

- Pharmacotherapy for Opioid Use Disorder (NEW) 45.83%
- Use of Opioids at High Dosage (NEW) 7.19%
- Use of Opioids From Multiple Providers (NEW)
  - Multiple Prescribers, Pharmacies, Multiple Prescribers and Pharmacies
<table>
<thead>
<tr>
<th>Measure</th>
<th>NQF #</th>
<th>Measure Group</th>
<th>CY2019 NC Rate</th>
<th>CY2019 US Median</th>
<th>CY2020 NC Rate</th>
<th>CY2022 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adolescent Well-Care Visit (AWC)* (Retired measure)</td>
<td></td>
<td>Pediatric</td>
<td>43.4</td>
<td>57.18</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Childhood Immunization Status (Combination 10) (CIS-CH)</td>
<td>0038</td>
<td>Pediatric</td>
<td>35.02</td>
<td>37.47</td>
<td>36.16</td>
<td>36.77</td>
</tr>
<tr>
<td>Immunization for Adolescents (Combination 2) (IMA)</td>
<td>1407</td>
<td>Pediatric</td>
<td>31.55</td>
<td>36.86</td>
<td>31.21</td>
<td>33.13</td>
</tr>
<tr>
<td>Percentage of Eligibles Who Received Preventive Dental Services (PDENT-CH)</td>
<td>N/A</td>
<td>Pediatric</td>
<td>52.1</td>
<td>49.1</td>
<td></td>
<td>54.71</td>
</tr>
<tr>
<td>Total Eligibles Receiving at least One Initial or Periodic Screen (Federal Fiscal Year)</td>
<td>N/A</td>
<td>Pediatric</td>
<td>52.98</td>
<td>-</td>
<td></td>
<td>55.63</td>
</tr>
<tr>
<td>Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)</td>
<td>2801</td>
<td>Pediatric</td>
<td>52.09</td>
<td>64.89</td>
<td>50.82</td>
<td>54.69</td>
</tr>
<tr>
<td>Well-Child Visits in the First 15 Months of Life - 6 or More Visits (W15)* (Retired Measure)</td>
<td>1392</td>
<td>Pediatric</td>
<td>65.71</td>
<td>67.88</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)* (Retired measure)</td>
<td>1516</td>
<td>Pediatric</td>
<td>70.48</td>
<td>74.7</td>
<td>N/A</td>
<td>N/A</td>
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<tr>
<td>Well-Child Visits in the First 30 Months of Life (New)</td>
<td></td>
<td>Pediatric</td>
<td>N/A</td>
<td>N/A</td>
<td>66.38</td>
<td>-</td>
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<tr>
<td>Child and Adolescent Well-Care Visits (New)</td>
<td></td>
<td>Pediatric</td>
<td>N/A</td>
<td>N/A</td>
<td>45.62</td>
<td>-</td>
</tr>
</tbody>
</table>

*Measure included here to report historical rates. PHPs will report the revised NCQA measures, W30 and WCV.
<table>
<thead>
<tr>
<th>Measure</th>
<th>NQF #</th>
<th>Measure Group</th>
<th>CY2019 NC Rate</th>
<th>CY2019 US Median</th>
<th>CY2020 NC Rate</th>
<th>CY2022 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cervical Cancer Screening (CCS)</td>
<td>0032</td>
<td>Adult</td>
<td>43.82</td>
<td>61.31</td>
<td>42.83</td>
<td>46.01</td>
</tr>
<tr>
<td>Chlamydia Screening in Women (Total Rate) (CHL)</td>
<td>0033</td>
<td>Adult</td>
<td>58.22</td>
<td>58.44</td>
<td>57.19</td>
<td>61.13</td>
</tr>
<tr>
<td>Concurrent Use of Prescription Opioids and Benzodiazepines (COB)</td>
<td>3389</td>
<td>Adult</td>
<td>14.86</td>
<td>-</td>
<td>13.42</td>
<td>14.11</td>
</tr>
<tr>
<td>Follow-Up After Hospitalization for Mental Illness</td>
<td>0576</td>
<td>adult</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7-Day Follow-up (Total)</td>
<td></td>
<td>Pediatric / Adult</td>
<td>29.48</td>
<td>27.68</td>
<td>30.95</td>
<td></td>
</tr>
<tr>
<td>30-Day Follow-up (Total)</td>
<td></td>
<td>Pediatric / Adult</td>
<td>49.41</td>
<td>46.21</td>
<td>51.88</td>
<td></td>
</tr>
<tr>
<td>Flu Vaccinations for Adults (FVA)</td>
<td>0039</td>
<td>Adult</td>
<td>42.9</td>
<td>43.44</td>
<td>49.49</td>
<td>45.05</td>
</tr>
<tr>
<td>Medical Assistance with Smoking and Tobacco Use Cessation (MSC)</td>
<td>0027</td>
<td>Adult</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advising Smokers and Tobacco Users to Quit</td>
<td></td>
<td>Adult</td>
<td>77.9</td>
<td>77.66</td>
<td>88.07*</td>
<td>81.8</td>
</tr>
<tr>
<td>Discussing Cessation Medications</td>
<td></td>
<td>Adult</td>
<td>48.1</td>
<td>54.15</td>
<td>61.71*</td>
<td>50.51</td>
</tr>
<tr>
<td>Discussing Cessation Strategies</td>
<td></td>
<td>Adult</td>
<td>49.0</td>
<td>47.92</td>
<td>55.17*</td>
<td>51.45</td>
</tr>
<tr>
<td>Plan All-Cause Readmissions - Observed to expected ratio (PCR)</td>
<td>1768</td>
<td>Adult</td>
<td>0.93</td>
<td>-</td>
<td>0.99</td>
<td>0.88</td>
</tr>
<tr>
<td>Use of Opioids at High Dosage in Persons Without Cancer (OHD)</td>
<td>2940</td>
<td>Adult</td>
<td>8.09</td>
<td>-</td>
<td>8.19</td>
<td>7.69</td>
</tr>
</tbody>
</table>

*Telehealth and In-Person combined
### Standard Plan Measures: Maternity

<table>
<thead>
<tr>
<th>Measure</th>
<th>NQF #</th>
<th>Measure Group</th>
<th>CY2019 NC Rate</th>
<th>CY2019 US Median</th>
<th>CY2020 NC Rate</th>
<th>CY2022 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of Low Birthweight Births (modified measure)</td>
<td>N/A</td>
<td>Maternity</td>
<td>11.5</td>
<td>9.5</td>
<td>Not yet available</td>
<td>10.93</td>
</tr>
<tr>
<td>Prenatal and Postpartum Care (Both Rates) (PPC)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Timeliness of Prenatal Care</td>
<td></td>
<td>Maternity</td>
<td>35.53</td>
<td>89.05</td>
<td>39.98</td>
<td>37.31</td>
</tr>
<tr>
<td>Postpartum Care</td>
<td></td>
<td>Maternity</td>
<td>68.77</td>
<td>76.40</td>
<td>64.51</td>
<td>72.21</td>
</tr>
<tr>
<td>Timeliness of Prenatal Care (NC HEDIS-like)</td>
<td></td>
<td>Maternity</td>
<td>83.34</td>
<td>N/A</td>
<td>Not yet available</td>
<td>N/A</td>
</tr>
<tr>
<td>Postpartum Care (NC HEDIS-like)</td>
<td></td>
<td>Maternity</td>
<td>73.48</td>
<td>N/A</td>
<td>Not yet available</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Measure rates suggest that NC Medicaid performed **significantly below the national median**, indicating a possible area for improvement. However, the pregnant Medicaid population can also be identified using one or more claims with a pregnancy diagnosis code and then capturing other claims for pregnancy related labs and radiology procedures, indicating a likely visit. Thus, the HEDIS-like measure rate reflect a more accurate picture of the timeliness of prenatal care.
Standard Plan Quality Measurement Timeline

- **Standard Plan Launch**: July 1, 2021
- **Start of Plan Year 1**: Jan 1, 2022
- **Start of Plan Year 2**: July 1, 2022
- **Start of Plan Year 3**: Jan 1, 2023
- **Start of Plan Year 4**: July 1, 2023
- **Start of Plan Year 5**: Jan 1, 2024
- **Earliest date withhold can apply**: July 1, 2022
- **Withhold applies, reflecting 2022 data**: Jan 1, 2024
- **Calendar Year 2022**: Contract Year 1
- **Calendar Year 2023**: Contract Year 2
- **Calendar Year 2024**: Contract Year 3

Timeline:

- July 1, 2021
- Jan 1, 2022
- July 1, 2022
- Jan 1, 2023
- July 1, 2023
- Jan 1, 2024
- July 1, 2024
- Jan 1, 2025
- July 1, 2025
Behavioral Health and I/DD Tailored Plan Measures
Standard Plan Quality Measurement Cycle


- 2022 measurement year (used for 2023 targets)
- 2022 measurement year claims runnout
- PHPs report 2022 measure results
- DHB produces 2022 results and derives 2023 targets
- 2024 measure set determined
- 2023 measurement year
- 2023 measurement year claims runnout
- PHPs report 2023 measure results
- DHB produces 2023 results and derives 2024 targets
- DHB produces rolling year, HEDIS-like measures monthly
### 2022 Tailored Plan Quality Measures

#### Pediatric Measures

<table>
<thead>
<tr>
<th>NQF #</th>
<th>Measure Name</th>
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<td>Child and Adolescent Well-Care Visit (WCV)</td>
<td>NCQA</td>
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<td>NA</td>
<td>Percentage of Eligibles Who Received Preventive Dental Services (PDENT-CH)</td>
<td>CMS</td>
<td>Annually</td>
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<tr>
<td>0038</td>
<td>Childhood Immunization Status (CIS) (Combo 10)</td>
<td>NCQA</td>
<td>Annually</td>
</tr>
<tr>
<td>0108</td>
<td>Follow-up for Children Prescribed ADHD Medication (ADD)</td>
<td>NCQA</td>
<td>Annually</td>
</tr>
<tr>
<td>1407</td>
<td>Immunizations for Adolescents (IMA)</td>
<td>NCQA</td>
<td>Annually</td>
</tr>
<tr>
<td>2800</td>
<td>Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)</td>
<td>NCQA</td>
<td>Annually</td>
</tr>
<tr>
<td>NA</td>
<td>Well-Child Visits in the First 30 Months of Life (W30)</td>
<td>NCQA</td>
<td>Annually</td>
</tr>
<tr>
<td>2801</td>
<td>Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)</td>
<td>NCQA</td>
<td>Annually</td>
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</table>

#### Maternal Health Measures

<table>
<thead>
<tr>
<th>NQF #</th>
<th>Measure Name</th>
<th>Steward</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>NA</td>
<td>Percentage of Low Birthweight Births (Live Births Weighing Less than 2,500 Grams)</td>
<td>NC DHHS</td>
<td>Annually</td>
</tr>
<tr>
<td>NA</td>
<td>Prenatal and Postpartum Care</td>
<td>NCQA</td>
<td>Annually</td>
</tr>
<tr>
<td>N/A</td>
<td>Rate of Screening for Pregnancy Risk</td>
<td>DHHS</td>
<td>Annually</td>
</tr>
</tbody>
</table>

#### Survey Measures and General Measures: Patient and Provider Satisfaction

<table>
<thead>
<tr>
<th>NQF #</th>
<th>Measure Name</th>
<th>Steward</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>0006</td>
<td>CAHPS Survey</td>
<td>AHRQ</td>
<td>Annually</td>
</tr>
<tr>
<td></td>
<td>Provider Experience Survey</td>
<td>NC DHHS</td>
<td>Annually</td>
</tr>
</tbody>
</table>

---

Fill indicates also a Standard Plan Measure
## 2022 Tailored Plan Quality Measures

<table>
<thead>
<tr>
<th>NQF #</th>
<th>Measure Name</th>
<th>Steward</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>0105</td>
<td>Antidepressant Medication Management (AMM)</td>
<td>NCQA</td>
<td>Annually</td>
</tr>
<tr>
<td>0032</td>
<td>Cervical Cancer Screening (CCS)</td>
<td>NCQA</td>
<td>Annually</td>
</tr>
<tr>
<td>0033</td>
<td>Chlamydia Screening in Women (CHL)</td>
<td>NCQA</td>
<td>Annually</td>
</tr>
<tr>
<td>0059</td>
<td>HbA1c Poor Control (&gt;9.0%)</td>
<td>NCQA</td>
<td>Annually</td>
</tr>
<tr>
<td>3389</td>
<td>Concurrent use of Prescription Opioids and Benzodiazepines (COB)</td>
<td>PQA</td>
<td>Annually</td>
</tr>
<tr>
<td>3175</td>
<td>Continuation of Pharmacotherapy for Opioid Use Disorder</td>
<td>USC</td>
<td>Annually</td>
</tr>
<tr>
<td>0018</td>
<td>Controlling High Blood Pressure (CBP)</td>
<td>NCQA</td>
<td>Annually</td>
</tr>
<tr>
<td>1932</td>
<td>Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are Using Antipsychotic Medications (SSD)</td>
<td>NCQA</td>
<td>Annually</td>
</tr>
<tr>
<td>0039</td>
<td>Flu Vaccinations for Adults (FVA, FVO)</td>
<td>NCQA</td>
<td>Annually</td>
</tr>
<tr>
<td>0576</td>
<td>Follow-up After Hospitalization for Mental Illness (FUH)</td>
<td>NCQA</td>
<td>Annually</td>
</tr>
<tr>
<td>0027</td>
<td>Medical Assistance with Smoking and Tobacco Use Cessation</td>
<td>NCQA</td>
<td>Annually</td>
</tr>
<tr>
<td>0418/</td>
<td>Screening for Depression and Follow-up Plan (CDF)</td>
<td>NCQA</td>
<td>Annually</td>
</tr>
<tr>
<td>0418e</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2940</td>
<td>Use of Opioids at High Dosage in-Persons Without Cancer (OHD)</td>
<td>PQA</td>
<td>Annually</td>
</tr>
<tr>
<td>2950</td>
<td>Use of Opioids from Multiple Providers in-Persons Without Cancer (OMP)</td>
<td>PQA</td>
<td>Annually</td>
</tr>
<tr>
<td>1768</td>
<td>Plan All Cause Readmissions (PCR) [Observed versus expected ratio]</td>
<td>NCQA</td>
<td>Annually</td>
</tr>
<tr>
<td>TBD</td>
<td>Total Cost of Care</td>
<td>TBD</td>
<td></td>
</tr>
<tr>
<td>N/A</td>
<td>Rate of Screening for Unmet Resource Needs</td>
<td>DHHS</td>
<td>Annually</td>
</tr>
</tbody>
</table>

**Fill indicates also a Standard Plan Measure**
Quality Assessment and Performance Improvement/Performance Improvement Projects
# Quality Assessment and Performance Improvement (QAPI) Plan: Components

The Quality Assessment and Performance Improvement (QAPI) plan must include the following elements:

## Performance Measures

<table>
<thead>
<tr>
<th>Performance Measures</th>
<th>Mechanisms to assess:</th>
<th>Additional Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Table including:</strong></td>
<td><strong>Under/Overutilization</strong>: Managed care plans must provide feedback on quality scoring results to each AMH practice</td>
<td><strong>PIP</strong>: Performance improvement projects (see next slide)</td>
</tr>
<tr>
<td>Measures performance against state benchmarks</td>
<td><strong>Special Health Care Needs</strong>: Assess the quality and appropriateness of care for members with special health care needs</td>
<td><strong>Provider Support</strong>: provider supports that relate to each PIP or quality improvement effort</td>
</tr>
<tr>
<td>Measures stratified as directed by DHB</td>
<td><strong>LTSS</strong>: Assess the quality and appropriateness of care including assessment of care between settings, services/supports received vs in the member’s treatment/service plan, detect and remediate critical incidents including LTSS services and programs</td>
<td></td>
</tr>
<tr>
<td>Measures of focus for performance/quality improvement (all measures less than DHB-target must be addressed in the QAPI).</td>
<td><strong>Disparities</strong>: Assess and process identifying interventions to improve quality disparities based on age, race, ethnicity, sex, primary language, geography and by key population group</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Population Health</strong>: mechanisms to incorporate population health programs targeted to improve outcome measures</td>
<td></td>
</tr>
</tbody>
</table>
Standard Plans are required to conduct Performance Improvement Projects (PIPs) that:

- 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.

Address disparities and promote health equity.
Standard Plans must conduct PIPs according to the following requirements and must align with approved focus areas:

- Are required to conduct two clinical and one non-clinical mandatory PIPs annually

- Focus areas for year one include:
  - Diabetes prevention and control
  - Childhood Immunizations
  - Maternal Health- Timeliness of Prenatal Care
While historical rates for this measure are not available for HbA1c Control, secondary indicator rates of hemoglobin A1c (HbA1c) testing provide historical performance on diabetes care in NC Medicaid.
Health Equity: Interventions

Health equity data will be used to develop a plan of action for measuring and evaluating efforts to remediate disparities in the Medicaid program.

- The health equity data captured will inform an annual health equity report that identifies trends in variation in health services and outcomes based on the factors.

- The Department will take into consideration this analysis and develop focused interventions, where practical. As appropriate, these interventions will include:
  - Development of disparity-specific quality measure improvement targets, on a program-wide and/or plan-specific basis;
  - Adjustment to, or the introduction of new, program-wide interventions and/or policies catered to the needs of those identified populations;
  - Development of modified, or additional, plan PIP requirements; and/or
  - Additional requirements for plan QAPIs.

- The Department will use the health equity analysis and other reports in its annual review of each plan’s proposed QAPI to ensure that each plan is actively assessing – and responding to – opportunities to improve health disparities in collaboration with Department-developed, cross-plan interventions.
Keeping Kids Well Campaign
To help increase well-child visits and immunization rates, Community Care of North Carolina (CCNC) and NC AHEC, under the direction of the Department launched the Keeping Kids Well program.

- NC Medicaid data are showing a marked decrease in well-child visits and recommended vaccinations for almost every practice in the state, especially for African-American and Latinx populations.

- CCNC and NC AHEC work with practices experiencing a greater number of care gaps to improve these measures and work to raise awareness of the problem among North Carolina’s parents.

- **Patient and provider resources are available at:** communitycarenc.org/keeping-kids-well

Improving Well-Child Care and Immunization Rates Across North Carolina
Keeping Kids Well Program Highlights

• Launched August 3, 2020
• 3-pronged approach
  • Patient Outreach – English/Spanish and Latinx/African American
  • Practice Support – 1:1 Coaching to 300 practices with > 500 care alerts
  • Advisory Group- NCAFP, NC Peds, Reach Out and Read, Office of Rural Health, Division of Public Health, Local Health Departments
• Partnerships – Reach Out and Read, Health Systems, Pharmaceutical Companies, Pfizer VAKS Program
• 9 Interventions – EHR, Internet/Social Media, Staff Engagement, School Systems, News Outlets, Promotion Months, Acute Care Visits, Clinical/Operational Workflow, Group Visits

KKW stabilized the downward trend of immunizations
Lessons Learned for Keeping Kids Well

Challenges
- Practices overwhelmed
- Ensuring practices received timely, concise and non-duplicative information
- Time Intensive – collaboration of all parties involved
- Not a short-term, “one size fits all” effort

Wins
- Flattened the curve of outstanding immunizations
- Established effective outreach and performance metrics that are achievable and meaningful
- 57,000+ Postcards delivered to 198 offices
- Practices, coaches, and practice relations representatives learned from each other
- Practices, coaches, and PRRs learned from each other
- Helped lead into AMH tier support work
Provider Experience Survey Results
Background

• The Sheps Center for Health Services Research at UNC-CH worked with DHB to develop a provider experience survey for practice managers, medical directors, or other leaders of systems and practices that deliver primary care to Medicaid beneficiaries.

• The survey was built to understand the experience of health care providers delivering primary care and OB-GYN care during North Carolina’s transition to Medicaid managed care.
Purpose

Objectives
1. Ascertain satisfaction with support for healthcare quality
2. Understand experience with administrative process
3. As a baseline for comparison against PHP performance in future years
4. To assess PHP performance on provider experience

Future use
- We will use survey findings as a leading indicator for PHP quality improvement. We will do more specific/detailed investigation of issues and opportunities for improvement via other data collection (e.g., focus groups, interviews, claims analyses)
Instrument

Domains:
- Background items (e.g., respondent’s role at the organization, contact information, organizational information, organization’s Medicaid involvement)
- Practice characteristics (type of organization, Independent Practice Association/Clinically Integrated Network participation and support, Medicaid patient population, medical home, and accountable care organization participation)
- History and overall experiences working with the Medicaid program
- Overall expectations from Medicaid transformation (quality, cost, and patient experience)
- Contracting/negotiating with PHPs (current contracting approach and priorities, overall experience thus far with PHPs)
Sample

- Initial SP implementation focuses on Primary Care and OB/GYN. These providers will assess TPs’ performance in future years.
- Responses are collected at the organizational level
  - For large group practices and health systems, the decision to contract with the PHPs, data sharing and other interactions occur at the system level.
  - For independent practices, responses are collected at the practice level (where they are making decisions about contracting and interacting with PHPs).
- Our approach to surveying behavioral health providers is still in development.
Response Rate

Survey responses were collected between May 10 and September 3, 2021.

<table>
<thead>
<tr>
<th>Final designations</th>
<th>Response Count (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completed &amp; eligible respondents</td>
<td>305 (45.7%)</td>
</tr>
<tr>
<td>Refusals</td>
<td>196 (29.3%)</td>
</tr>
<tr>
<td>Ineligible</td>
<td>136 (20.4%)</td>
</tr>
<tr>
<td>Duplicates</td>
<td>8 (1.2%)</td>
</tr>
<tr>
<td>Unknown eligibility</td>
<td>23 (3.4%)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>668 (100%)</strong></td>
</tr>
</tbody>
</table>
Overall Experience with NC Medicaid

![Bar chart showing the distribution of overall experience with NC Medicaid for Independent Practices, Health Systems, and OB-GYN. The chart indicates the percentage of respondents who rated their experience as Excellent, Good, Fair, Poor, and I don’t know, with a focus on the 'Good' category which shows a predominant response.]
Satisfaction with CCNC/Carolina ACCESS and Current Medicaid program

**Highest rated items**

<table>
<thead>
<tr>
<th>Item</th>
<th>% rated Excellent or Good</th>
</tr>
</thead>
<tbody>
<tr>
<td>Timeliness of claims processing</td>
<td>79%</td>
</tr>
<tr>
<td>Accuracy of claims processing</td>
<td>77%</td>
</tr>
<tr>
<td>Experience with provider relations overall</td>
<td>74%</td>
</tr>
</tbody>
</table>

**Lowest rated items**

<table>
<thead>
<tr>
<th>Item</th>
<th>% rated Excellent or Good</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to behavioral health therapists for Medicaid patients</td>
<td>36%</td>
</tr>
<tr>
<td>Access to behavioral health prescribers for Medicaid patients</td>
<td>38%</td>
</tr>
<tr>
<td>Process for managing grievances and appeals</td>
<td>53%</td>
</tr>
</tbody>
</table>
NC Medicaid – Claims processing

**Timeliness of claims processing**

- **Excellent**
- **Good**
- **Fair**
- **Poor**
- **I don’t know**

**Accuracy of claims processing**

- **Excellent**
- **Good**
- **Fair**
- **Poor**
- **I don’t know**

- Independent Practices (n=282)
- Health Systems (n=23)
- OB-GYN (n=42)
NC Medicaid - Access to behavioral health

Access to behavioral health prescribers for Medicaid patients

Access to behavioral health therapists for Medicaid patients

Independent Practices (n=282)  Health Systems (n=23)  OB-GYN (n=42)
Importance of factors when deciding to contract with PHPs

Note: All items had very high importance ratings (lowest: 85% very important or important)

*Most important items*

<table>
<thead>
<tr>
<th>Item</th>
<th>% rated Very Important or Important</th>
</tr>
</thead>
<tbody>
<tr>
<td>Timeliness of claims processing</td>
<td>97%</td>
</tr>
<tr>
<td>Accuracy of claims processing</td>
<td>97%</td>
</tr>
<tr>
<td>Adequacy of reimbursement to provide the care needed for Medicaid patients</td>
<td>97%</td>
</tr>
<tr>
<td>Access to medical specialists for Medicaid patients</td>
<td>97%</td>
</tr>
<tr>
<td>Access to behavioral health prescribers for Medicaid patients</td>
<td>97%</td>
</tr>
<tr>
<td>Access to needed drugs for Medicaid patients (formulary)</td>
<td>97%</td>
</tr>
</tbody>
</table>
Anticipations for the PHP transition

For Medicaid patients in North Carolina, how do you feel prepaid health plans will affect the following?

- **Per capita costs**
  - Strongly Worsen: 5%
  - Worsen: 35%
  - No Change: 43%
  - Improve: 16%
  - Strongly Improve: 2%

- **Overall quality of health care delivery**
  - Strongly Worsen: 7%
  - Worsen: 36%
  - No Change: 47%
  - Improve: 8%
  - Strongly Improve: 2%

- **Overall provider experience**
  - Strongly Worsen: 7%
  - Worsen: 29%
  - No Change: 40%
  - Improve: 21%
  - Strongly Improve: 3%

- **Overall patient experience**
  - Strongly Worsen: 6%
  - Worsen: 33%
  - No Change: 46%
  - Improve: 13%
  - Strongly Improve: 2%

- **Overall health and wellbeing**
  - Strongly Worsen: 6%
  - Worsen: 42%
  - No Change: 44%
  - Improve: 6%
  - Strongly Improve: 2%

- **Ability to access care**
  - Strongly Worsen: 9%
  - Worsen: 34%
  - No Change: 38%
  - Improve: 17%
  - Strongly Improve: 3%
Summary take-aways

1. Systems and practices were generally been satisfied with North Carolina’s pre-existing Medicaid program.

2. When considering contracting with PHPs, respondents prioritized claims and reimbursement as well as access to specialists and behavioral health for patients.

3. Services like case management, QI support, and trainings were of less importance. Organizations were resoundingly aligned in wanting timely, accurate claims, and streamlined logistics. (Get out of our way)

4. Most survey respondents feel ambivalent to hopeful about the impact of the PHP transition for North Carolina.
Appendix
Continuous Quality Improvement: Benchmarking and Attention to Addressing Health Equity

The Department is committed to developing targets for all health plan-reported quality measures that promote overall continuous quality improvement and health equity.

**Contract Year 1 and 2:**
The Department’s benchmark for each plan-reported quality measure* will be a 5% relative improvement over the prior year’s North Carolina Medicaid statewide performance for that measure.

Plans will each be compared against their respective program’s historical performance (i.e., Medicaid Managed Care plan-level targets will be a 5% relative increase from the previous year’s product-line-wide rate).

Measures will be risk-adjusted where appropriate based on the specifications of each measure.

**Contract Year 3 and Beyond:**
The Department will hold Standard Plans and BH I/DD Tailored Plans financially accountable for ensuring that improvements in quality narrow or eliminate health disparities.

The Department may adjust the benchmarking methodology based on information gathered in the first two years.

The Department will continue to promote accurate data collection.

*For measures of contraceptive care, the Department will not apply an external performance benchmark, reflecting the preference-sensitive nature of contraceptive care. The Department will monitor measure results to assess where contraceptive access may be insufficient.

See the Next Slide for Further Detail
Health plans will be compared against their program’s historical performance and are expected to show at least a 5% relative improvement over the prior year’s North Carolina Medicaid statewide performance for that measure.

**Example:** Each year the proportion of eligible women in health plan A that receive a Chlamydia screening increases by 5%. Each blue icon represents 10 women who received their screening. Health plan A’s performance goes from 50% (500/1000) in 2019 to 59% (590/1000) in 2022, meaning that health plan A meets the target.