

**Plan for Implementation of Hospital Quality Outcomes Program  
and PHP Quality Outcomes Program**

**Session Law 2018-88, Section 7.(b)**



**Report to**

**The Joint Legislative Oversight Committee on**

**Medicaid and NC Health Choice**

**By**

**North Carolina**

**Department of Health and Human Services**

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## Introduction

Pursuant to Section 7 of Session Law (S.L.) 2018-88, the North Carolina Department of Health and Human Services (DHHS) is submitting this Plan for the development of Quality Outcomes Programs to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice, North Carolina General Assembly.

On June 15, 2018, the North Carolina General Assembly passed S.L. 2018-88, relating to the Medicaid transformation authorized under S.L. 2015-245 “An Act to Transform and Reorganize North Carolina’s Medicaid and NC Health Choice Programs.”<sup>1</sup> This new law authorizes a study to propose two coordinated quality outcomes programs that are consistent with subdivision (7) of Section 4 of S.L. 2015-245 requiring that the State's transformed Medicaid delivery system be built on defined measures and goals for risk adjusted health outcomes and quality of care subject to specific accountability measures.

Under Section 7.(b) of S.L. 2018-88, DHHS is required to submit this study to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice of the North Carolina General Assembly by October 1, 2018. (See Appendix for the relevant legislative text.) This report must contain five components:

- (1) Specific, measurable details of each component of the programs, including the time frame for implementation of each component and a description of the measurable improvement in health outcomes that the programs are designed to achieve.
- (2) An estimate of the cost to implement the programs and a description of all other resources that would be needed to implement the programs.
- (3) A projected estimate of the savings that would be generated as a result of the achievement of the proposed outcomes and quality measures included in the two programs. This estimate shall (i) identify the portion of savings that is projected to be achieved by the State and (ii) identify how the estimated savings will be achieved in addition to anticipated savings associated with the management functions to be performed by Prepaid Health Plans under the transformed Medicaid system.
- (4) Any anticipated barriers to implementation of the programs.

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<sup>1</sup> S.L. 2015-245 has been amended by S.L. 2016-121; Section 11H17.(a). of S.L. 2017-57; Part IV of S.L. 2017-186; Section 11H.10.(c) of S.L. 2018-5; S.L. 2018-48; and S.L. 2018-49.

- (5) A detailed description of any other initiatives or programs the Department is planning that will accomplish similar objectives.

This report addresses each item required by legislation. In the coming months, DHHS intends to further develop its outcome measures, quality reporting requirements and value-based purchasing strategy.

## **1. DHHS Will Measure and Reward Quality Outcomes Under Managed Care**

DHHS has reviewed S.L 2018-88 and determined that the requirements of Section 7 will be addressed within the structure of the managed care program. North Carolina is in the process of moving from a predominantly fee-for-service delivery system to managed care, pursuant to S.L. 2015-245. Managed care is the single, unified platform through which all utilization and quality gains will be achieved for enrolled populations. Through managed care contracting and quality reporting, DHHS can engage with both PHPs and (through PHPs) with hospitals, meaning that supplemental programs to engage with PHPs and hospitals are not necessary and may be duplicative. DHHS measures and rewards outcomes, including avoidance of potentially preventable or avoidable utilization<sup>2</sup> in three ways under managed care: capitation, quality measurement and value-based purchasing.

### *Capitation*

Pursuant to S.L. 2015-245, Prepaid Health Plans (PHPs) will receive capitated payments to provide statutorily mandated services. Capitated payments, by their nature, incentivize reduction of avoidable or preventable utilization: PHPs receive the same capitation payment regardless of their members' utilization of health care services, spending additional funds if members use more health care services than expected and retaining the balance of funds (subject to medical loss ratios) if members use less. This model gives them an incentive to reduce utilization generally, and avoidable utilization in particular (as efforts to reduce utilization that does not fall into the avoidable or preventable category may backfire if they lead

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<sup>2</sup> Avoidable utilization is utilization that could be eliminated or addressed in a lower-cost setting with an intervention at the time the patient seeks care. For example, a patient visiting an emergency department to refill a prescription even though his primary care practice has convenient appointments available would be considered avoidable utilization. Preventable utilization, in contrast, has become necessary by the time the patient seeks care, but could have been eliminated or addressed in a lower-cost setting through interventions earlier in the disease course. For example, a patient with congestive heart failure who misses several days of medication and is transported to the emergency department in acute pulmonary edema would be considered preventable utilization.

to complications and increased utilization later on).<sup>3</sup> The capitation rate-setting and payment process, in combination with requirements related to quality, aligns PHPs with DHHS efforts to ensure that services are delivered in the appropriate settings and to reduce inappropriate utilization of services.

DHHS capitation rates have been developed to reflect DHHS' expectations regarding safe and sustainable rates of reduction in preventable or avoidable utilization, based on experience in other states, familiarity with North Carolina providers, and enrollees' historic utilization. These capitation rates were informed by estimates of preventable and avoidable utilization using methodology adapted from the [Agency for Healthcare Research and Quality \(AHRQ\)](#) and a variant of the [Billings/NYU algorithm](#)<sup>4</sup> modified by a clinical panel.<sup>5</sup> Potentially preventable or avoidable admissions, readmissions and emergency department (ED) visits were all considered.

Reducing preventable and avoidable utilization is a balance. Efforts to target inappropriate utilization must not discourage appropriate utilization. Capitation payments cover what DHHS has determined to be an optimal utilization level, and will be adjusted to take into account performance on selected quality measures as part of DHHS' planned withhold program. Thus, capitation and the rate setting process itself ensure that PHPs, and not the State, are at risk for achieving reductions in unnecessary utilization.<sup>6</sup> Capitation payments to PHPs for Year 1 assume that PHPs will achieve reductions in preventable and avoidable acute care hospital service utilization. Additional reductions will be assumed in later years (DHHS' capitation methodology assumes PHPs will require three years to ramp up to their highest savings level). PHPs that do not meet preventable and avoidable utilization reduction targets will be at increased risk of financial losses or reduced profits.

### *Quality Strategy*

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<sup>3</sup> This capitation payment from the State to PHPs is distinct from value-based payments, including capitation payments, that PHPs may arrange with contracting providers. These payments are discussed in further detail later in this section.

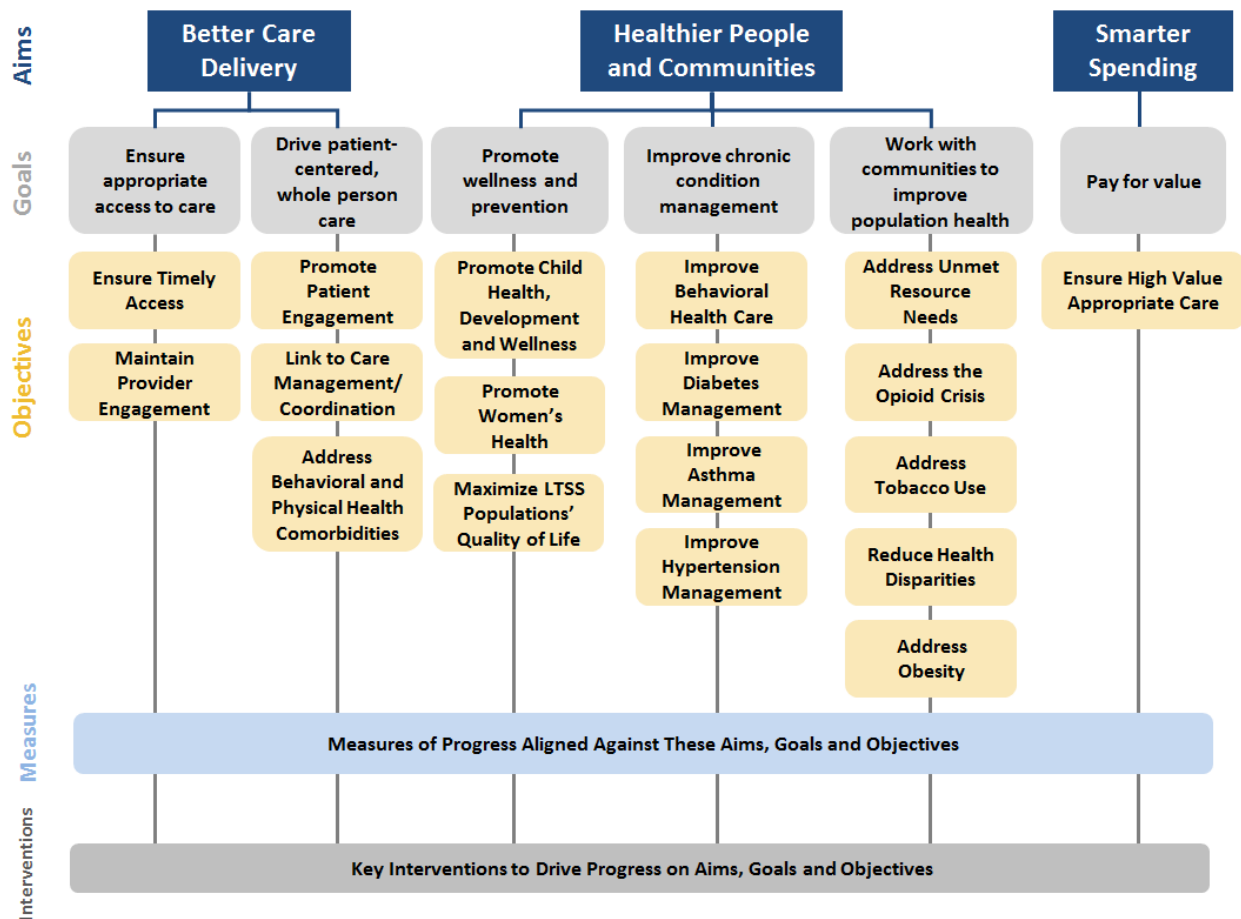
<sup>4</sup> This algorithm classifies emergency department utilization and can be found at <https://wagner.nyu.edu/faculty/billings/nyued-background#>.

<sup>5</sup> Most state Medicaid programs use some combination of metrics developed by AHRQ, metrics developed by 3M, and the NYU/Billings algorithm or similar modifications.

<sup>6</sup> Because the legislature has dictated PHP physician reimbursement, and hospital rate floors will apply in the short term to ensure maintenance of reimbursement levels similar to current, savings expectations are likely to be driven primarily by utilization changes, rather than by PHP provider contracting arrangements.

DHHS has developed a rigorous quality measurement and accountability strategy aimed at promoting the delivery of high-quality care. [North Carolina's Quality Strategy](#) is built around a set of aims, goals and objectives reflecting significant consumer and stakeholder feedback. These aims, goals and objectives, shown in Figure 1 below, informed plans for an innovative, whole-person, well-coordinated system of care, which promotes improved risk-adjusted health outcomes, increased patient satisfaction and reduced cost. DHHS will require PHPs to measure progress toward these aims, goals and objectives, including those that contribute to avoidable or preventable utilization (such as timely access to care and improved management of chronic conditions), and will require PHPs to develop interventions aimed at improving performance through value-based contracting (discussed in more detail below) and other approaches.

Figure 1: Overview of Quality Strategy Framework



PHPs are required to meet numerous performance and reporting requirements to remain in compliance with DHHS contract provisions; failure to achieve these minimum thresholds may

result in sanctions. These measures were developed with reference to the National Committee for Quality Assurance (NCQA) health plan accreditation measure set, the Healthcare Effectiveness Data and Information Set (HEDIS), and the Centers for Medicare & Medicaid Services (CMS) adults and child core measure sets, and include HEDIS measures of inpatient and ED utilization<sup>7</sup>. These measures will allow PHPs to track members' utilization against national and regional benchmarks.

DHHS anticipates adding further measures of potentially avoidable utilization for Year 1, including open-source measures of utilization developed by AHRQ. These measures<sup>8</sup> include Prevention Quality Indicators, measures of preventable or avoidable hospitalizations, Patient Safety Indicators, measures of preventable or avoidable hospital complications, and Pediatric Quality Indicators, which include measures of hospital complications and preventable or avoidable hospitalizations specifically tailored to the pediatric populations. Open-source measures are also available to assess readmissions for adults<sup>9</sup> and children<sup>10</sup>.

DHHS does not anticipate measuring performance at the provider level in the managed care framework. Rather, DHHS will measure performance at the PHP level and PHPs will, in turn, assess provider performance as part of their contractual relationships with providers. DHHS will review interim performance data with PHPs on a frequent basis, including data on preventable or avoidable utilization once those measures have been finalized. PHPs will be required to share performance data with their contracting practices to improve their performance even in the absence of financial incentives.

In a number of priority areas, DHHS is incentivizing PHPs to perform beyond compliance thresholds through a withhold program, in which a portion of each PHP's capitation rate is

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<sup>7</sup> PHPs will be required to report Ambulatory Care (AMB), a summary of utilization of outpatient visits and ED visits, and Inpatient Utilization – General Hospital/Acute Care (IPU) (NQF # 1598), a summary of utilization of total acute inpatient care services, and separate categories for utilization of acute inpatient care services related to maternity, surgery and internal medicine.

<sup>8</sup> Further information about these measures can be found at <http://www.qualityindicators.ahrq.gov/Modules/default.aspx>

<sup>9</sup> An overview of readmission measures is available at [https://www.hcup-us.ahrq.gov/reports/methods/2012\\_04.pdf](https://www.hcup-us.ahrq.gov/reports/methods/2012_04.pdf)

<sup>10</sup> Pediatric All-Condition Readmission Measure specifications are available at [https://www.ahrq.gov/sites/default/files/wysiwyg/policymakers/chipra/factsheets/chipra\\_14-p008-1-ef.pdf](https://www.ahrq.gov/sites/default/files/wysiwyg/policymakers/chipra/factsheets/chipra_14-p008-1-ef.pdf)

withheld and paid when the PHP meets reasonably achievable performance targets. The withhold program, per legislation, will be implemented after 18 months of managed care rollout. PHP-level accountability will also encourage PHPs to promote referrals to higher-quality providers, and employ other methods to promote quality improvement within existing contracts.

#### *Value-Based Purchasing (VBP)*

DHHS also is deploying a VBP strategy that requires PHPs to reward providers who can deliver consistently high quality outcomes. To ensure that payments to providers are increasingly focused on population health outcomes, appropriateness of care, and other measures of value, rather than on a fee-for-service basis, DHHS requires accelerated adoption of VBP arrangements between PHPs and providers. Pursuant to contractual requirements, the portion of each PHP's medical expenditures governed under VBP arrangements shall either increase by 20 percentage points by the end of Year 2 of the PHP contract, or represent at least 50% of total medical expenditures. In addition, one tier of the Advanced Medical Home program will be restricted to participating practices that are in VBP arrangements with PHPs; DHHS is setting targets for PHP contracting with practices at that AMH tier.

PHPs are required and incentivized to develop and lead innovative strategies to increase the use of VBP arrangements over time – including arrangements that appropriately incentivize providers to reduce potentially preventable or avoidable utilization, such as incentive payments for improved performance. PHPs engaging in VBP contracts will be required to lead several activities related to provider-level quality measurement as part of their VBP-related efforts, including:

- Receiving administrative, clinical and claims/encounter data and sharing such data with providers and DHHS;
- Sharing quality measurement across different practices and for specific providers within practices for attributable populations under these contracts; and
- Sharing cost measurement across different practices and for specific providers within practices for attributable populations under these contracts.

DHHS expects these activities will facilitate PHP measurement of hospital-level preventable or avoidable complications and readmissions, contributing to future reductions in these outcomes.

In the early years of Medicaid managed care, DHHS plans to convene stakeholders, including hospitals, to develop a longer-term VBP Roadmap. DHHS anticipates requiring the use of open-source measures developed by AHRQ to measure preventable utilization in VBP programs at that time.



## **2. Estimate of Cost to Implement and Needed Resources**

Capitation, quality measurement and VBP have already been incorporated into planning around the implementation of managed care. Because PHP capitation payments, which serve as the PHP-level financial incentive to minimize potentially-preventable or avoidable utilization, will be incorporated into the DHHS budget, no additional costs are anticipated. DHHS has designed its quality measures program around widely-used measures, such as HEDIS, for which costs (for example, engaging NCQA-certified HEDIS vendors) have already been factored into rate setting. Furthermore, DHHS' plan for measurement for preventable events includes using AHRQ's open source measures, which are free not only to DHHS, but also to other stakeholders (meaning acquisition costs do not need to be incorporated into future capitation rates). Mandating use of specific proprietary methodologies to calculate preventable or avoidable utilization would increase costs for PHPs and the state, potentially requiring additional allocations.

Relying on this approach as planned maximizes efficiency by avoiding the overhead associated with creation of a separate, duplicative program.

## **3. Estimate of Savings**

Because PHPs will be paid on a capitation basis, and because capitation rates already anticipate reductions in utilization, we do not anticipate additional savings beyond what is already envisioned under managed care. Capitation rates already assume PHPs will reduce medical service costs by approximately 10% in the first full year of implementation for aged, blind and disabled (ABD) populations, and between 5% and 13% for newborn, child and adult populations covered under Temporary Assistance to Needy Families (TANF) and other non-ABD eligibility categories. These estimates of medical service costs were informed by analyses of potentially preventable or avoidable utilization under fee-for-service Medicaid. These analyses suggested that:

- Costs associated with low acuity non-emergency (LANE) diagnosis codes make up approximately 50% of total ED spend, and less-intensive (potentially avoidable) LANE visits comprise approximately 8% of total ED spend.
- Potentially preventable admissions comprise approximately 5 to 7% of inpatient costs, while the readmission rate in inpatient settings is approximately 10%. (This rate varies substantially by population, from a high of 25% for ABD enrollees to a low of 5% for TANF or other related enrollees.)

Pressure to reduce utilization further in order to realize additional savings could lead to PHP stinting of needed care, placing enrollees at risk. Even if PHPs were able to safely and appropriately reduce utilization beyond what is already anticipated, short-term savings would

accrue to PHPs while savings to the state would lag. Any additional cost reductions associated with care improvements developed through VBP will be realized by the state through the rate-setting process in future years.

Future VBP discussions will further align payment with outcomes.

#### **4. Anticipated Barriers to Program Implementation**

Payment and quality measurement and reporting efforts are already underway, so DHHS does not anticipate additional barriers for these programs. Implementing alternative arrangements would create significant legal and regulatory challenges for DHHS. First, DHHS is not permitted to make direct payments to hospitals reflecting care provided under managed care. Second, DHHS is barred from making withhold adjustments for PHPs, for any reason for the first 18 months of managed care.

#### **5. Other Initiatives or Programs With Similar Objectives**

DHHS's approach to capitation and quality, described above, have been described in depth in [a series of white papers](#), [a quality strategy](#), [the Request for Proposals](#), and [a draft rate book](#). Specific payment models and mechanisms to be used in DHHS' VBP approach will be further specified after the early years of managed care.

## **Appendix: Legislative Text of Session Law 2018-88, Section 7**

SECTION 7.(a) The Department of Health and Human Services (Department) shall conduct a study to propose two coordinated quality outcomes programs that are consistent with subdivision (7) of Section 4 of S.L. 2015 245 requiring that the State's transformed Medicaid delivery system be built on defined measures and goals for risk adjusted health outcomes and quality of care subject to specific accountability measures. One program shall be designed to apply to all acute care hospitals participating in the State Medicaid program. Another program shall be designed to apply to all Medicaid Prepaid Health Plans in the State. Components to be included in the proposed programs are as follows:

(1) The programs shall be designed to reduce unnecessary and inappropriate service utilization by providing hospitals and Prepaid Health Plans with information and incentives to reduce potentially avoidable hospital admissions, hospital readmissions, and emergency department visits.

(2) The programs shall be designed to generate sustainable savings within the Medicaid program that are quantifiable within a three year period following implementation.

(3) The programs shall be initiated with comprehensive analysis of State Medicaid databases to identify potentially avoidable events causing waste in the Medicaid system. The Department shall establish the methodology for identifying potentially avoidable events, that is, to the extent possible, consistent with methodologies utilized by other state Medicaid programs or commercial payers. For hospitals and Prepaid Health Plans, potentially avoidable events shall include potentially avoidable hospital readmissions and complications. For Prepaid Health Plans, potentially avoidable events shall also include potentially avoidable hospital admissions and emergency department visits.

(4) The programs shall include the establishment of benchmarks for measurement of outcomes and cost savings related to potentially avoidable events for each program, based on the incidence and cost of potentially avoidable events identified through the comprehensive analysis.

(5) The programs shall include the establishment of a potentially avoidable events reporting system for hospitals and Prepaid Health Plans and monitoring of this system.

"(6) The programs shall include financial incentives related to the reduction of potentially avoidable events by hospitals and Prepaid Health Plan utilizing value based payments consistent with sub subdivision a. of subdivision (5) of Section 5 of S.L. 2015 245.

SECTION 7.(b) No later than October 1, 2018, the Department shall submit a report to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice containing the proposed programs required by this section. This report shall also contain the following information:

- (1) Specific, measurable details of each component of the programs, including the time frame for implementation of each component and a description of the measurable improvement in health outcomes that the programs are designed to achieve.
- (2) An estimate of the cost to implement the programs and a description of all other resources that would be needed to implement the programs.
- (3) A projected estimate of the savings that would be generated as a result of the achievement of the proposed outcomes and quality measures included in the two programs. This estimate shall (i) identify the portion of savings that is projected to be achieved by the State and (ii) identify how the estimated savings will be achieved in addition to anticipated savings associated with the management functions to be performed by Prepaid Health Plans under the transformed Medicaid system.
- (4) Any anticipated barriers to implementation of the programs.
- (5) A detailed description of any other initiatives or programs the Department is planning that will accomplish similar objectives.