Virtual Quality Forum

October 2, 2024

12:00pm – 1:00pm

NCDHHS
NC Medicaid
Division of Health Benefits

NC AHEC
RECRUIT
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AmeriHealth Caritas
North Carolina

carolina complete health

HealthyBlue

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Logistics for Today's Webinar

Question during the live webinar

Technical assistance

technicalassistanceCOVID19@gmail.com

Closed Captioning is available for this webinar

Participants can access real-time captioning by clicking "**Show Captions**" within Zoom.

Agenda

Topic	Presenter	Time
Welcome & Introductions	• Chris Weathington - NC AHEC	• 12:00-12:02
Priority Measure Quality Opportunities	• MY23 SP Aggregate Performance and Target Setting- Grace Ruffin- DHB • PPC – Allison Wood - United Health • CIS - Jennifer Frazer – AmeriHealth	• 12:02-12:12
Quality Opportunities and Value Based Programs	• Value Based Program Considerations- Leonard Croom- DHB • CIS Best Practice Provider- Tina Flynn-The Pediatric Center	• 12:12-12:22
HIE Update: DAV Certification Program	• Jenell Stewart- HIE	• 12:22-12:30
CAHPS Survey Results	• Stephanie Atkinson- WellCare	• 12:30-12:38
Provider Survey Results	• Hannah Fletcher - DHB	• 12:38-12:46
Administrative Simplification	• Melissa Fabrikant - Carolina Complete Health	• 12:46-12:51
Questions/Meeting Close	• Chris Weathington - NC AHEC	• 12:51-1:00

Priority Measure Quality Opportunities

Table 1: Aggregate Standard Plan Performance (2021-2023) and Targets (2024)*

CBE#	Measure Name	Stratification	2021 Rate[1]	2022 Rate	2023 Rate	2024 Target
0032	Cervical Cancer Screening (CCS)	Total	52.42%	49.03%	49.96%	55.04%
1516	Child and Adolescent Well-Care Visits (WCV)	Total	48.46%	50.77%	53.81%	53.31%
0038	Childhood Immunization Status (CIS)	Combination 10	34.15%	26.44%	24.65%	35.85%
0033	Chlamydia Screening in Women (CHL)[2]	Total (All Ages)	57.73%	58.24%	59.93%	61.15%
1407	Immunizations for Adolescents (IMA) – Combination 2	Combination 2	29.94%	29.34%	29.82%	31.44%
1768	Plan All-Cause Readmission (PCR)[3]	Total	N/A	0.81	Not Yet Available	0.77
1517	Prenatal and Postpartum Care (PPC)[4]	Timeliness of Prenatal Care	39.21%	51.82%	52.08%	54.41%
		Postpartum Care	53.84%	64.59%	65.35%	67.82%
1392	Well-Child Visits in the Frist 30 Months of Life (W30)	First 15 Months	62.23%	63.02%	66.33%	66.17%
		15-30 Months	66.10%	69.05%	70.64%	72.50%

*This table is an altered version of Table 2 in the Quality Measure Performance and Targets for the AMH Measure Set and does not include the Controlling High Blood Pressure (CBP), Hemoglobin A1c Control for Patients with Diabetes (HBD), Total Cost of Care (TCOC), and Screening for Depression and Follow-Up Plan (CDF) measures.

[1] 2021 data was department-calculated based on administrative claims and encounters, with supplemental data as acceptable from NC HealthConnex and the North Carolina Immunization Registry (NCIR). Standard Plans only existed for half of measurement year 2021 and, therefore, cannot be held totally accountable for performance. 2022 data was plan-reported via operational reporting to the Department. The Standard Plan aggregates in this table represent the sum of all Standard Plan reported data.

[2] The age stratification for this measure was excluded from this table.

[3] For this measure, a lower observed to expected ratio indicates better performance. As such, the target is a 5% relative decrease from the baseline.

[4] This measure was added to the AMH Measure Set in the 2023 Tech Specs. As such, the first measurement year in which this measure can be incentivized as an AMH measure is the claims-year running from January 2024 through December 2024.

MY 24 Standard Plan AMH Measure Target Setting

- DHB sets Standard Plan aggregate targets
- DHB sets individualized targets for PHPs
- PHPs negotiate targets with provider partners by considering DHB's targets as well as historical provider performance
- For future measure years beyond 2024, DHB is re-evaluating target setting methodology in hopes of creating more tailored and responsive targets. More information about this methodology will be communicated at a future date
- The full table and plan-specific tables are available here [medicaid.ncdhhs.gov].

Prenatal & Postpartum Care (PPC)

Prenatal and Postpartum Care (PPC)

Description:

The percentage of deliveries of live births on or between October 8 of the year prior to the measurement year (MY) and October 7 of the measurement year (MY). For these members, the measure assesses the following facets of prenatal and postpartum care:

Timeliness of Prenatal Care: The percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organizations

Postpartum Care: The percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery

Lookback Period:

October 8 of the year prior to the measurement year and October 7 of the measurement year
First Trimester is defined as 280-170 days prior to delivery OR expected date of confinement/expected due date (EDC/EDD)

Lines of Business:

Commercial, Medicaid (report each product line separately)

Required Exclusions:

Members who died anytime during the measurement year.
Members in hospice or using hospice services anytime during the measurement year.
Member was not pregnant, or pregnancy did not result in live birth.

Description	Codes*
Prenatal Bundled Service	**CPT/CPT II:** 59400, 59425, 59426, 59510, 59610, 59618 **HCPCS:** H1005
Stand-Alone Prenatal Visits	**CPT/CPT II:** 99500, 0500F, 0501F, 0502F **HCPCS:** H1000, H1001, H1002, H1003, H1004
Prenatal Office Visits with Diagnosis of Pregnancy	**CPT/CPT II:** 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99483 **HCPCS:** G0463, T1015
Pregnancy Diagnosis	**ICD -10 Diagnosis:** Z34.90, Encounter for supervision of normal pregnancy, unspecified, unspecified trimester
Telephone Visit, E-visit or Online Assessment with a Diagnosis of Pregnancy Telephone Visit	**CPT-CAT-II:** 98966, 98967, 98968, 99441, 99442, 99443
Postpartum Bundled Services	**CPT/CPT II:** 59400, 59410, 59510, 59515, 59610, 59614, 59618, 59622
Postpartum Visits	**CPT/CPT II:** 57170, 58300, 59430, 99501, 0503F **HCPCS:** G0101 **ICD -10 Diagnosis:** Z01.411, Z01.419, Z01.42, Z30.430, Z39.1, Z39.2

Prenatal

MCD Quality Compass 2023 (MY 2022) 50th percentile	MCD Quality Compass 2023 (MY 2022) 75th Percentile	NC DHHS 2023 Target	NC DHHS 2024 Target
84.23%	86.86%	37.31%	54.41%

Postpartum

MCD Quality Compass 2023 (MY 2022) 50th percentile	MCD Quality Compass 2023 (MY 2022) 75th Percentile	NC DHHS 2023 Target	NC DHHS 2024 Target
78.10%	80.78%	72.21%	67.82%

**Source: NCQA Quality Compass, 2023 and NC Medicaid Quality Measure Performance and Targets for the AMH Measure Set document, January 2024*

*Codes subject to change

PPC: Tips for Providers

Friendly Reminders for Our Providers

- We encourage you to submit a Care Management for High-Risk Pregnancies (CMHRP) screening form (English) (Spanish) to your local health department after the patient's first prenatal visit
- Offer comprehensive prenatal care to expectant mothers, including regular check-ups, appropriate screening tests, nutritional guidance, and emotional support throughout pregnancy.
- Identify high-risk pregnancies, such as those involving maternal age, pre-existing medical conditions, or previous complications because early identification allows for proactive management and appropriate referrals to specialists.
- Screen for perinatal mood disorders and offer appropriate counseling, therapy, or referral services.
- Establish breastfeeding-friendly environments, offer lactation support, and connect new mothers with lactation consultants if needed.
- Develop individualized postpartum care plans for each woman, considering her specific needs and circumstances, including information on physical recovery, contraception options, newborn care, and available community resources.
- Provide culturally competent care and ensure awareness of the diverse backgrounds and beliefs of patients. by respecting cultural preferences and providing tailored care that aligns with individual values, traditions, and practices.
- Establish mechanisms for continuous quality improvement, such as regular audits, feedback loops, and performance evaluations.
- Stay updated with evidence-based guidelines and participate in relevant professional development opportunities

When talking to members

- Providers should prioritize educating pregnant women about the importance of prenatal care, healthy lifestyle choices, and potential risks. Inform them about proper nutrition, exercise, and self-care practices during pregnancy.
- Promote the importance of continuity of care throughout the entire pregnancy and postpartum period and maintain consistent communication and collaboration, ensuring a seamless transition between prenatal, intrapartum, and postpartum care.
- Address the mental health needs of pregnant and postpartum women and encourage the establishment of support groups to foster a sense of community and reduce feelings of isolation.
- Emphasize the benefits of breastfeeding and provide support and education to promote successful breastfeeding.
- Promote family-centered care by involving partners and family members in prenatal and postpartum care decisions.
- Encourage open communication, shared decision-making, and the involvement of support persons during childbirth and postpartum recovery

New Information for Providers

Capturing F Codes

Table 2: F Codes for Capturing Prenatal and Postpartum Care Added to NC Medicaid's Clinical Policy			
CPT Code	**Type**	**Description**	**Physician/NPP/LHD Services Guidelines**
0500F	Individual	Initial Prenatal Care Visit*	Code reported to identify initiation of prenatal care. Report at first prenatal encounter with an obstetrical provider or other prenatal care practitioner. Report date of visit and in a separate field the date of the last menstrual period (LMP).
0503F	Individual	Postpartum Care Visit	Code reported to identify the comprehensive postpartum care visit. Postpartum visit can be to an obstetrical provider or other postpartum care practitioner, or primary care provider (PCP). Do not include postpartum care provided in an acute inpatient setting or other urgent/emergency room setting.

*NOTE: Primary care providers who do not perform prenatal care should not submit claims for 0500F.

Submitting F Codes

Providers will have until July 1, 2025, to submit 0500F and 0503F codes per NC Medicaid Policy. These codes are for reporting purposes only and do not carry reimbursement rates or incentives. **After this date, claims for delivery will deny if 0500F is not in claims history**. Refer to Clinical Coverage Policy 1E-5, Obstetrical Services for detailed overview.

- ✓If a practice or health department assumes care during a pregnancy, the initial visit with the OB provider will also be recorded with 0500F.
- ✓If your electronic medical record system allows macros that auto-populate CPT Category II codes when submitting a claim for diagnostic tests (e.g., pregnancy urine test, ultrasound), please add prenatal code 0500F when individual E/M codes are used.
- ✓***Global package claims*** will require 0500F on line 1 and delivery code on line 2 if not already submitted.
- ✓0500F and 0503F are for reporting purposes only and do not carry reimbursement rates or incentives.

Please reference Clinical Coverage Policy 1E-5, Obstetrical Services and Clinical Coverage Policy Webinar for more information.

Childhood Immunization Status (CIS Combo 10)

Childhood Immunization Status Combo 10 (CIS)

Description:
The percentage of children 2 years of age who are up to date on recommended routine Combination 10 vaccines

Lookback Period:
Birth to 2 years of age for members who meet eligibility criteria for the CIS measure

Lines of Business:
Commercial, Medicaid (report each product line separately)

Required Exclusions:
- Members who died anytime during measurement year
- Members in hospice or using hospice services
- Members who had any of the following on or before 2nd birthday:
  - Severe combined immunodeficiency
  - Immunodeficiency
  - HIV
  - Lymphoreticular cancer, multiple myeloma, or leukemia
  - Intussusception

Description	Codes*
DTaP	**CPT:** 90697, 90698, 90700, 90723
HiB	**CPT:** 90644, 90647, 90648, 90697, 90698, 90748
HepA	**CPT:** 90633
HepB	**CPT:** 90723, 90740, 90744, 90747, 90748
IPV	**CPT:** 90697, 90698, 90713, 90723
Influenza	**CPT:** 90655, 90657, 90661, 90673, 90685, 90686, 90687, 90688, 90689, 90660, 90672
MMR	**CPT:** 90707, 90710
PCV	**CPT:** 90670
RV	**CPT:** 90680 (3 dose), 90681 (2 dose)
VZV	**CPT:** 90710, 90716
Hospice Care	**CPT:** 99377-99378 **HCPCS:** G0182, G9473-G9479, Q5003-Q5010, S9126, T2042-T2046

- Disparity noted for Black children in CY2022 NC Medicaid Childhood Immunization Status data
- Influenza, pneumococcal, and rotavirus adherence are drivers in Combo 10 performance

MCD Quality Compass 2023 (MY 2022) 50th percentile	MCD Quality Compass 2023 (MY 2022) 75th Percentile	NC DHHS 2023 Target	NC DHHS 2024 Target
30.9%	37.64%	35.85%	35.85%

Source: NCQA Quality Compass, 2023 and NC Medicaid Quality Measure Performance and Targets for the AMH Measure Set document, January 2024

*Codes subject to change

CIS: Tips for Providers

Friendly Reminders for Our Providers	When talking to members

• Target disparate populations by generating a list from Electronic Health Record (EHR) systems (Ex: families in rural areas and/or those with transportation issues)
• Utilize opportunities at visits outside of well visits to administer vaccines
• Document in the EHR and NC Immunization Registry if immunizations were received elsewhere
• Develop a workflow document to determine if immunizations were received elsewhere
• Use standing orders to empower nurses or other qualified health care professionals to administer vaccines (see www.immunize.org/catg.d/p3067.pdf)
• Partner with local Health Departments and PHPs to ensure communication/coordination flow
• Partner with school systems to advertise immunization clinics/dates being provided
• Run kid-friendly videos in well child clinics on importance of vaccinations
	• Remind members of open care gaps for preventive health during care management calls and other encounters
	• Use already developed handouts for parents related to importance of vaccines (www.immunize.org/catg.d/p4314.pdf)
	• Offer drive-through vaccination clinics, focus on flu vaccination
	• Mail post card reminders to families
	• Implement a well child/immunization promotion monthly with gift card drawing
	• Partner with PHPs and NC DHHS to
	  • Promote preventive care in conjunction with childcare centers and faith-based groups
	  • Public service announcements and state agency funded events
	  • PHP initiated care alerts via text messaging, emails, live outbound calls or Integrated Voice Response (IVR) messaging
	  • Offer member incentives for care gap closure

Additional CIS resources in Appendix

Quality Opportunities and Value Based Programs

Medicaid Expansion, Quality Measurement, and Incentive Programs

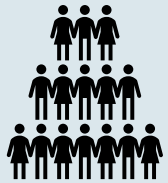
Expansion began on December 1, and the Department anticipates that 600,000 adults will be eligible. Expansion members who meet continuous enrollment criteria in their Standard Plan for 2024 will be included in quality measure calculations.

- Providers expressed concern about having the Expansion population included in their quality measure calculations for 2024, fearing quality measure performance will be adversely affected by an influx of enrollees who have not received regular care in the past and for whom limited data are available on previous care.

Medicaid Expansion Members and Quality Measurement

Research on states that have previously expanded Medicaid *do not* suggest systematic decreases in plan-level[1] or safety-net hospital level[2] quality performance.

However, the Department recognizes practices may have concerns about taking accountability for Expansion members:



Some Medicaid Expansion members may not have had a **regular source of care** in the past and providers will have less time in the first year to close care gaps for new members.

The Department will have **little or no data** on many Medicaid Expansion members' previous care.

The Department aims to:

1) Ensure **continued participation** in the Medicaid program by AMH providers
2) Encourage engagement of new Expansion members to **close care gaps.**
3) Minimize the impact of **VBP/APM arrangements entered into prior to the launch of Medicaid Expansion** from disincentivizing AMHs from serving Medicaid Expansion Members

1. Ndumele CD, Schpero WL, Trivedi AN. Medicaid Expansion and Health Plan Quality in Medicaid Managed Care. Health Serv Res. 2018 Aug;53 Suppl 1(Suppl Suppl 1):2821-2838. doi: 10.1111/1475-6773.12814. Epub 2017 Dec 12. PMID: 29230801; PMCID: PMC6056574.
2. Chatterjee P, Qi M, Werner RM. Association of Medicaid Expansion With Quality in Safety-Net Hospitals. JAMA Intern Med. 2021;181(5):590–597.

Expansion Members May Affect Performance on Certain Measures

8 of 13 AMH measures are expected to include a significant number of Expansion members in 2024 performance rates ("Expansion Sensitive"). The remaining measures assess care provided to previously eligible populations (i.e., children and pregnant enrollees).

Measure Name	Expansion Sensitive
Cervical Cancer Screening (CCS)	**Yes**
Child and Adolescent Well-Care Visits (WCV)	No
Childhood Immunization Status (Combination 10) (CIS)	No
Chlamydia Screening in Women (CHL)	**Yes**
Colorectal Cancer Screening (COL)	**Yes**
Controlling High Blood Pressure (CBP)	**Yes**
Glycemic Status Assessment (GSD)	**Yes**
Immunizations for Adolescents (Combination 2) (IMA)	No
Plan All-Cause Readmissions (PCR)	**Yes**
Prenatal and Postpartum Care (PPC)	No
Screening for Depression and Follow-Up Plan (CDF)	**Yes**
Total Cost of Care	**Yes**
Well-Child Visits in the First 30 Months of Life (W30)	No

Expansion Members in 2024 VBP Arrangements

NC Medicaid is implementing a temporary policy intended to minimize the impact of VBP arrangements entered into prior to the launch of Medicaid Expansion from disincentivizing providers from serving expansion members.

Standard Plans will be prohibited from refusing to make applicable incentive payments otherwise owed to Advanced Medical Homes or their networks for the 8 “expansion sensitive” measures, if the sole basis for the provider failing to meet the performance targets is caused by the inclusion of Medicaid Expansion members.

Standard Plans will submit information to NC Medicaid outlining:

1. How the plan will operationalize this requirement
2. Any changes being made to provider agreements to comply with these requirements

These requirements apply specifically to determining performance for value-based payment arrangements with AMHs or CINs for the quality measurement year 2024.

The Pediatric Center: CIS Best Practices

- Vaccination is a team sport!
- Regular use of reporting to identify patients who are due for vaccines
- Patient outreach to schedule appointments (calls, postcards)
  - Focus on phone calls to children under 2 who are due or 2nd flu shot
- Weekly flu clinics from 8:30am-6:00pm beginning in September
  - Mass email and social media campaigns once vaccines are available in clinic
  - Saturday clinics to be offered if needed
- Providers are seen as vaccine advocates and spend time during visits educating parents on the importance of vaccines
- Posters in exam rooms with required vaccines by grade level prompts parent inquiry and discussion about vaccines

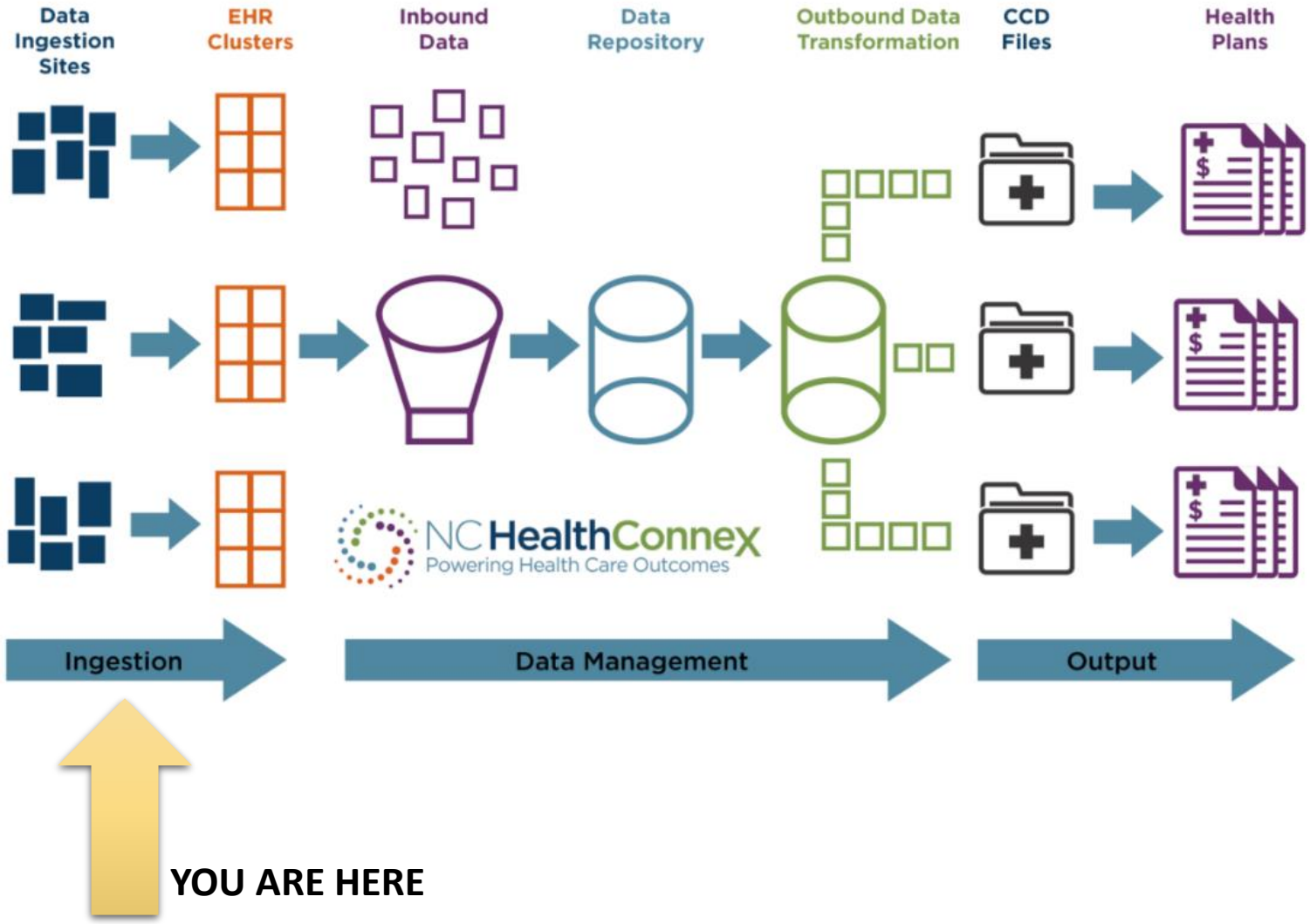
HIE Update: DAV Certification Program

What is the Data Aggregator Validation (DAV) program?

- NCQA's Data Aggregator Validation (DAV) program evaluates the ingestion, transformation, and output of aggregated clinical data to ensure data integrity.[1]
- This helps ensure that health plans, providers, government organizations, and others can trust the accuracy of data for use in Healthcare Effectiveness Data and Information Set (HEDIS®) reporting and other quality programs.

[1]For more information about the DAV program, visit NCQA's Data Aggregator Validation page here.

What does the DAV process look like?



- Three primary validation activities:
  1. Process standards review
  2. Primary Source Verification (PSV)
  3. Conformance to NCQA guidelines
- Validating a data stream takes between **12-18 weeks**, with cohorts beginning in January and July of each year.
- Organizations must be revalidated/recertificated annually to maintain their status.

Long-term Goals Leveraging DAV

- Since validated data can be used for HEDIS® reporting, one of the major benefits of the DAV program is easing the burden of audits and validation work for health plans and providers.
  - Specifically, the DAV program reduces the time and effort spent on manual data validation and reduces the need for chart reviews and additional data validation requirements (such as primary source verification).
- This is considered a crucial component in the shift towards digital quality measures (dQMs), as outlined in CMS' Digital Quality Measurement Strategic Roadmap.

Current State and Next Steps

2023

Achieved DAV compliance for four data streams:

1. Duke Inpatient
2. Duke Ambulatory
3. UNC Inpatient
4. UNC Ambulatory

2024

Remediation of 2023 findings and intensive end-to-end revalidation of Duke and UNC inpatient and outpatient.

2025 and Beyond

Remediation of last year's findings, revalidation of previous organizations, and onboarding additional participants for initial validation.

Interested in participating in a future DAV cohort?

Please contact us:

Email: hiea@nc.gov

Additional information can be found:

www.nchealthconnex.gov

CAHPS

CAHPS

PURPOSE

Every year, a random sample of patients are surveyed about their experiences with their healthcare providers and Medicaid plans.

CAHPS surveys allow patients to rate the aspects of care delivery that matter the most to them.

Results represent two populations:

Adult Medicaid Respondents (self-report data)
Child Medicaid Respondents (data reported by a parent, guardian, or similar figure)

As a provider, <u>you</u> are the most critical component of that experience.

PROGRAM

CAHPS is an annual survey administered to an anonymous, random sample of members (February - May). The survey is used to evaluate consumer experiences, and how members perceive key aspects of the care they received in the last seven months.

Member experience and satisfaction are not the same thing. A member can find their experience to be positive but not necessarily be satisfied with the results.

As a result of the CAHPS survey, the following are several measures that are produced based on the member experience.

MEASURES

Getting needed care.

Getting care quickly.

How well doctors communicate.

Health plan customer service.

How people rated their health plan.

	MEDICAID
SURVEY TIME PERIOD*	February - May
NCQA NATIONAL CAHPS DATABASE SUBMISSION DEADLINE*	End of May
SURVEY TYPE/ REQUIREMENT	Adult Child Child CCC
SURVEY LENGTH	Adult- 40 questions Child- 41 questions Child CCC- 76 questions
MINIMUM SAMPLE SIZE	Adult- 1,350 Child- 1,650 Child CCC- 3,490
SURVEY MODALITY	Paper survey via mail Web-based survey
SUPPLEMENTAL QUESTIONS	Max of 10
LANGUAGE	English and Spanish
BLACK OUT PERIOD	No Blackout Period

All NC Standard Plan Aggregate CAHPS Survey Data*

ADULT		
	2022	2023
Rating of Personal Doctor	84.51%	83.97% ***
Rating of Specialist Seen Most Often	83.82%	84.26% ***
How Well Doctors Communicate	93.46%	93.60% ***
Coordination of Care	85.45%	86.02% ***
Getting Needed Care	81.15%	82.96% ***
CHILD		
	2022	2023
Rating of Personal Doctor	89.20%	90.63% ***
Rating of Specialist Seen Most Often	88.90%	87.15% ***
How Well Doctors Communicate	91.68%	95.91%↑ ****
Coordination of Care	82.16%	84.64% ***
Getting Needed Care	82.76%	85.74% ***

↑ Indicates the 2023 score is statistically significantly higher than the 2022 score.

Please note: NCQA National Percentile Distributions Used to Assign Star Ratings. * (Using 2023 Quality Compass National HMO Benchmarks)

Most recent survey results report can be found here:
https://medicaid.ncdhhs.gov/2023-cahps-survey-full-report/download?attachment

*Data is non-inclusive of Medicaid Direct, EBCI Tribal Option, TP, etc.

BEST PRACTICES

Patient Experience

Engage patients in the decision-making process and ask about their past care and treatment.

Make sure patients are called about test results and delays and consider implementing a patient portal.

Appointment Availability

Offer appointment times outside of regular hours and allow time for walk-ins.

Set aside time for urgent visits and use a triage system to ensure at-risk patients are seen quickly.

Communication

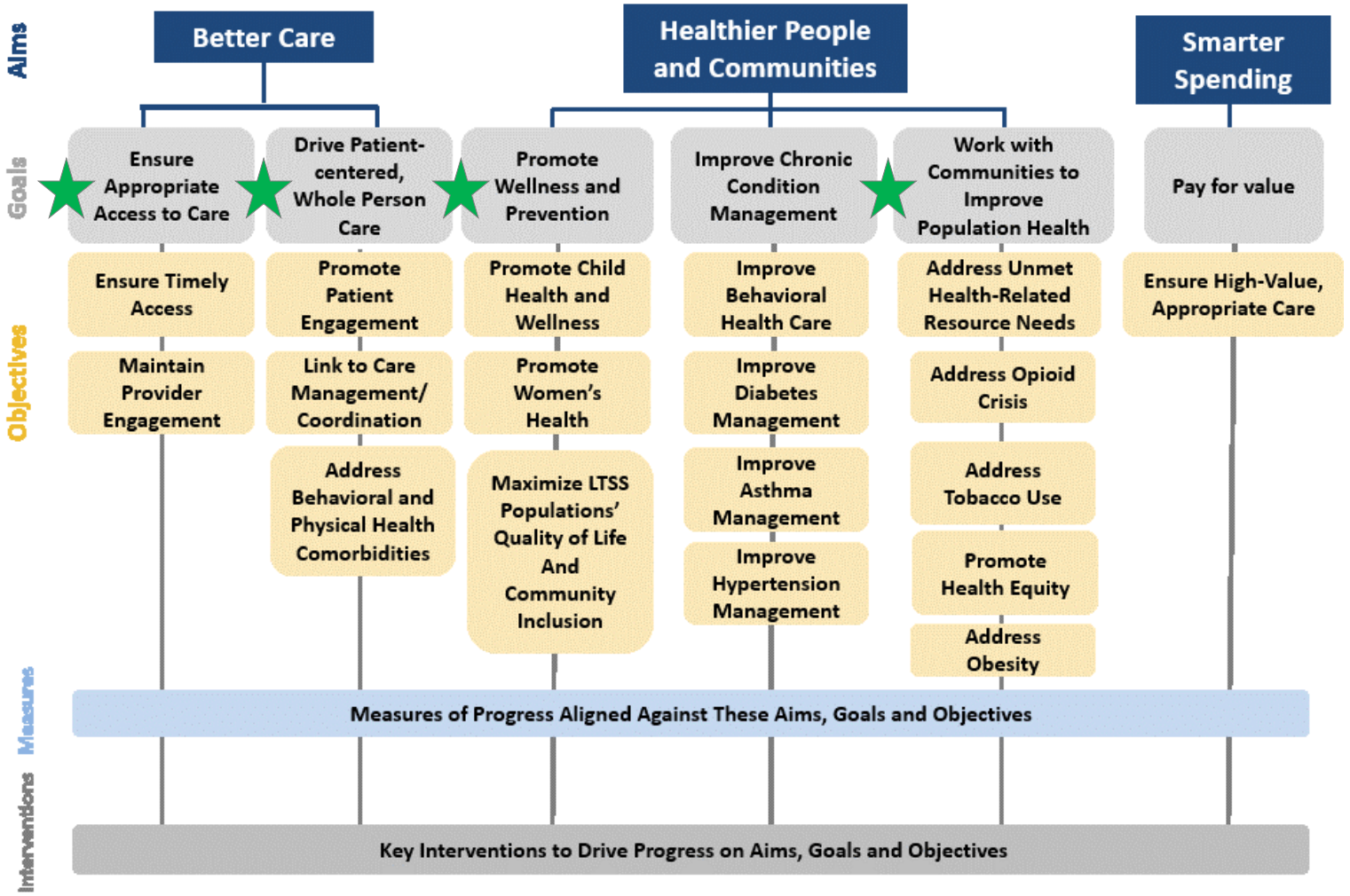
Ensure patient data is accurate, including addresses, phone numbers, and communication preferences.

Utilize the teach back method to ensure patients understand the information shared with them.

Encourage patients to complete the survey

Provider Survey Results

NC Medicaid Quality Strategy



Provider Experience Survey Overview

NC Medicaid contracts with the Sheps Center for Health Services Research at the University of North Carolina at Chapel Hill for the survey administration and reporting of results annually

- Developed to evaluate the influence of NC Medicaid Transformation on primary care and obstetrics/gynecology (Ob/Gyn) practices that contract with Medicaid.
- Administered across all North Carolina independent primary care practices, medical groups, and health care systems that provide primary care or Ob/Gyn care.
- The 2023 results present provider experience at the end of the 2nd year of Managed Care in NC.

2023 Provider Experience Survey Administration

- The survey was fielded from March 27 to July 12, 2023, representing experience with the SPs from the second year of Medicaid managed care
- The final response rate for 2023 was **60.8%** (total n=346 respondents)

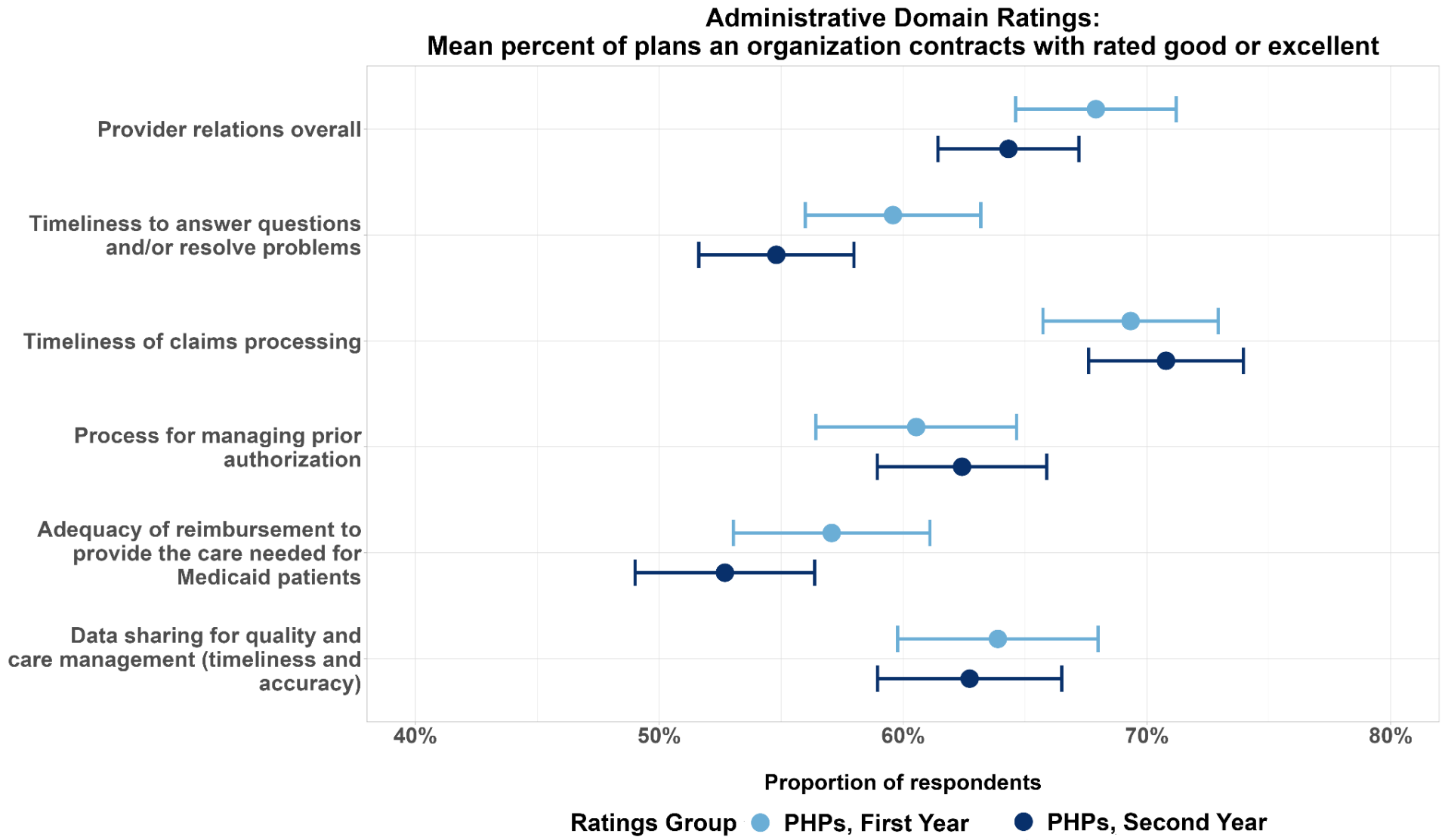
2023 Health System and Practice Characteristics	Self-Identified Health Systems (N = 16)	Self-Identified Medical Groups and Independent Practices (N = 330)
Services Provided for Patients with Medicaid		
Primary Care	15 (93.8%)	323 (97.9%)
Prenatal/Postnatal Care	14 (87.5%)	37 (11.2%)
Inpatient Obstetrics Care	15 (93.8%)	15 (4.5%)
Number of Providers (IQVIA-sourced)		
1-2 providers	0 (0.0%)	136 (41.2%)
3-9 providers	0 (0.0%)	148 (44.8%)
10 or more providers	16 (100.0%)	46 (13.9%)
Geography		
No Rural Practice Sites	2 (12.5%)	152 (46.1%)
Any Rural Practice Sites	14 (87.5%)	178 (53.9%)

Provider Experience Survey Administrative & Clinical Domains

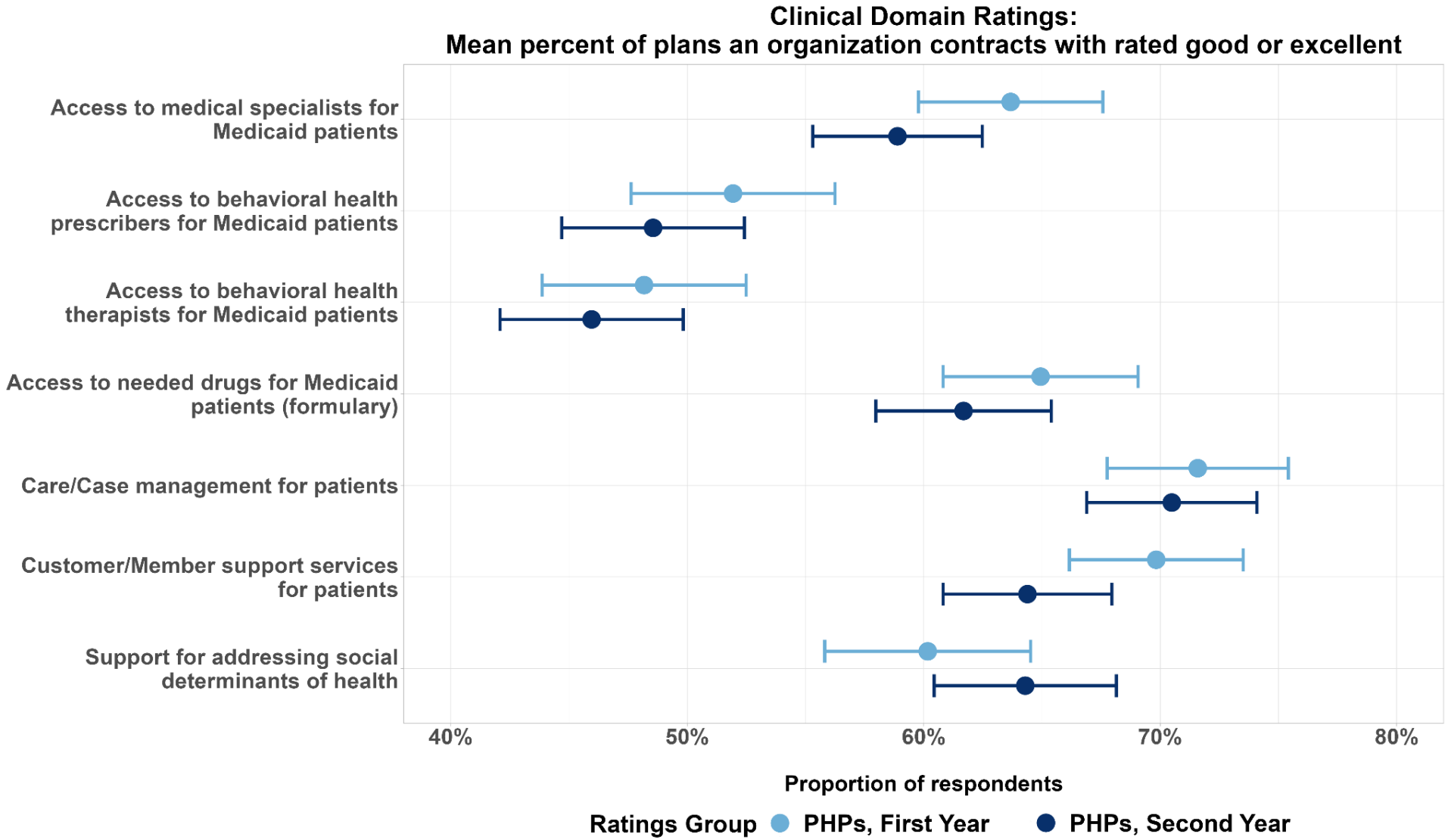
Domain Description	Category
Provider relations overall	Administrative
Timeliness to answer questions and/or resolve problems	Administrative
Timeliness of claims processing	Administrative
Process for managing prior authorizations	Administrative
Adequacy of reimbursement to provide the care needed for Medicaid patients	Administrative
Data sharing for quality and care management (timeliness and accuracy)	Administrative
Access to medical specialists for Medicaid patients	Clinical
Access to behavioral health prescribers for Medicaid patients	Clinical
Access to behavioral health therapists for Medicaid patients	Clinical
Access to needed drugs for Medicaid patients (formulary)	Clinical
Care/Case management for patients	Clinical
Customer/Member support services for patients	Clinical
Support for addressing social determinants of health	Clinical

Respondents answered questions in these domains using a scale from “poor” (equivalent to 1 numerically) to “excellent” (equivalent to 4)

Provider Experience With Administrative Domains



Provider Experience With Clinical Domains



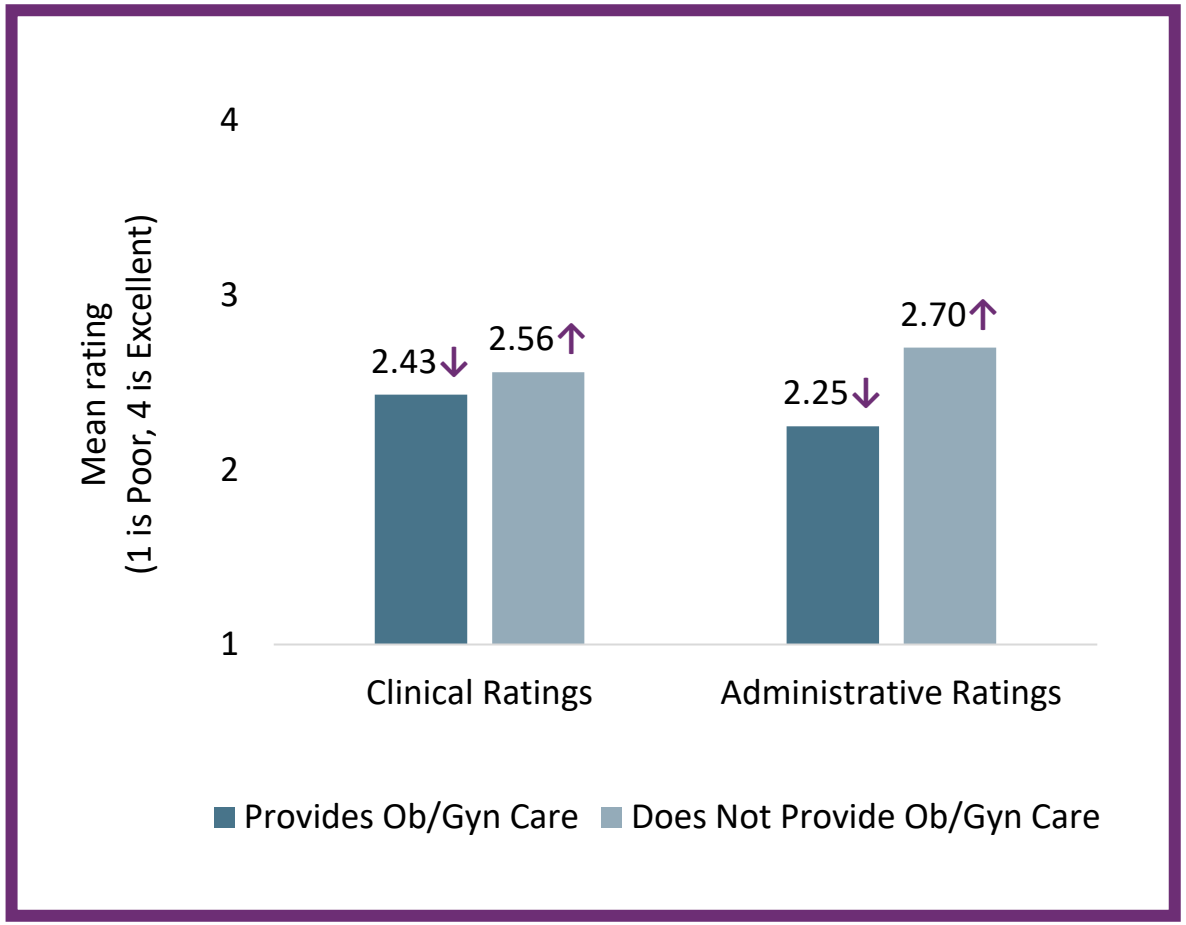
2023 Provider Perceptions of Transition to Managed Care

Providers' perceptions on how SPs have affected various aspects of health care delivery in North Carolina.

Item	Strongly Improve N (%)	Improve N (%)	No Change N (%)	Worsen N (%)	Strongly Worsen N (%)
Overall health and well-being	13 (3.8%)	84 (24.5%)	189 (55.3%)	43 (12.6%)	13 (3.8%)
Overall quality of health care delivery	11 (3.1%)	80 (23.3%)	189 (55.0%)	43 (12.6%)	20 (6.0%)
Overall patient experience	13 (3.7%)	81 (23.6%)	159 (46.5%)	69 (20.0%)	21 (6.2%)
Overall financial health of your medical group or practice	9 (2.6%)	69 (20.1%)	144 (42.2%)	79 (23.3%)	40 (11.9%)
Overall provider experience	11 (3.2%)	62 (18.0%)	141 (41.2%)	86 (25.2%)	43 (12.5%)
Ability to access care	12 (3.4%)	74 (21.5%)	168 (49.0%)	60 (17.6%)	29 (8.6%)

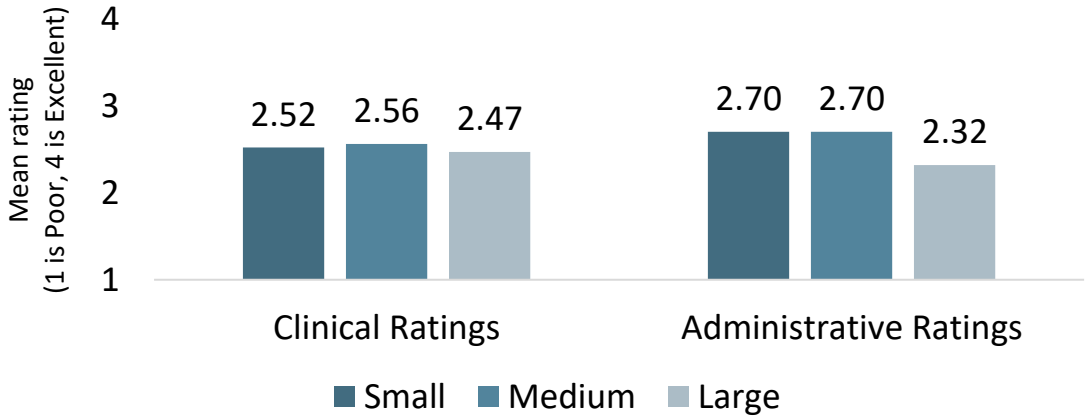
Stratified Clinical and Administrative Ratings

2023 Provider Experience with Clinical and Administrative Domains, by Provision of Ob/Gyn Care

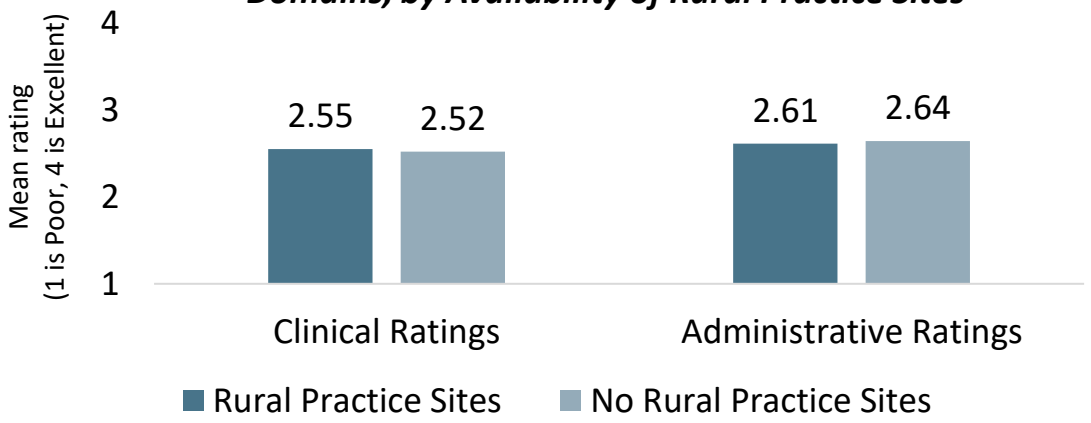


↑↓ Indicates findings are significantly different than its comparator.

2023 Provider Experience with Clinical and Administrative Domains, by Size of Provider Organization



2023 Provider Experience with Clinical and Administrative Domains, by Availability of Rural Practice Sites



Qualitative Findings: Major Themes Working with SPs

Patient attribution

- Many provider organizations report incorrect patient attribution and the process to correct attribution lists is difficult and an administrative burden. Reportedly, issues with attribution are impacting providers' ability to process claims and to report on required quality measures.

Claims denials and processes for resolution

- Many provider organizations report overall dissatisfaction with the claims process. A commonly reported issue is resolving denied claims.

Administrative burden of working with many SPs

- Provider organizations cited issues with different billing processes, incentive programs, and quality measures across PHPs.

Key Takeaways: 2023 Provider Experience Survey

- Rates of contracting with each of the five available Health Plans ranged from **73.3% to 97.2%**, and the organizations contracted with an **average of 4.3 plans**.
- Overall, providers rated their experience with plans on clinical domains (e.g., access to specialists) **slightly worse** than on administrative domains (e.g., claims processing).
- **Small but meaningful differences** were found in provider experience with Plans overall compared with the first year of managed care.
  - Plans in the second year had higher experience ratings than the first year on the timeliness of claims processing domain, an important factor considered when contracting with PHPs.
  - Plans in the second year performed worse than in the first year on timeliness to answer questions and/or resolve problems, and customer/member support services for patients.
- Open-ended comments revealed notable **administrative burden** in sustaining multiple Plan relationships
  - Financial strain on provider organizations, harmed patient access to care, and has imposed stress on the healthcare system more broadly.

Provider Experience Survey Activity Status

Complete:

- 2023 Published Findings: Full Report and Two-Page Summary
- The 2024 Survey was administered between April to June 2024
  - Updates to 2024 Survey Instrument:
    - Respondents asked to describe their overall experience with administrative and clinical domains for their largest commercial payor contract
    - New questions added:
      - Experience with the process and accuracy of patient assignment to practice
      - Experience thus far with Medicaid Expansion
      - Contracting with organizations to pursue an alternative payment model or ACO-like contract

In Progress:

- 2024 Survey findings expected to be published in Spring 2025
- NC Medicaid continues to work with SP Leadership on solutions to improve provider experience

PHP Administrative Simplification Workgroup 2024

Administrative Simplification – Projects Completed

Completed Initiatives	Description
Orientation	PHPs streamlined and updated orientation for Medicaid providers, resulting in saving an estimated 1.75 hours per provider.
Training/ Resources	• PHPs collaborated to identify one unified training for providers for Culturally and Linguistically Appropriate Services • Tip sheet developed for Behavioral Health Crisis Services
Quality Forums	Convened joint quality forums since 2022 to reduce the complexity of meeting separately with multiple PHPs in each region
COVID-19 Vaccination Incentive Guide	Created a simple quick reference guide for providers to easily access member incentives available from each PHP

Administrative Simplification – Projects Completed

Completed Initiatives	Description
Quick Reference Guide	Developed one shared template for all PHPs to use for critical information regularly referenced by provider offices
Primary Care Provider Change Form	Developed a single form for providers to easily facilitate changes to the assigned PCP when desired by beneficiaries
Prior Authorization	Identified and implemented changes to the Prior Authorization form, eliminating several time-consuming fields with limited operational value
Survey	Conducted a survey through key professional organizations to seek administrative simplification priorities, with insights shared across PHPs

Administrative Simplification – Projects In Flight

- Member Reassignment Form
- Cultural Competency Provider Training Attestation
- Process Provider Redetermination Guide (review pending)

Questions & Answers

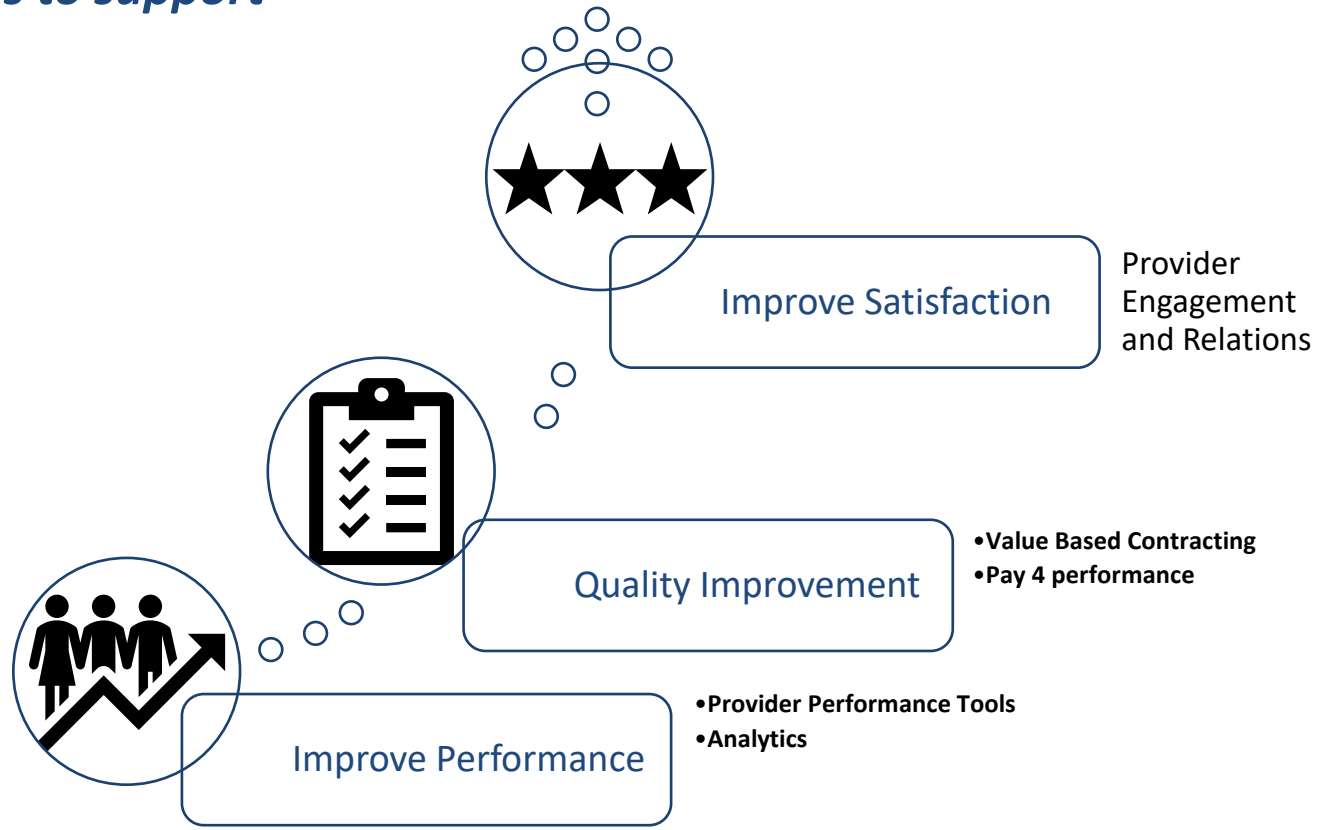
Appendix

AMH Support-
NC AHEC & Standard Plans

Health Plan and AHEC Practice Support

A common goal to provide quality care and services to support your success in Medicaid Transformation!

- PHP Known Issues Tracker
- Timely education and training
- Customized engagement strategies based upon the needs and preferences of the practice
- Local boots-on-the-ground support with onsite or virtual visit
- Cross-collaboration with providers, PHPs, Health Systems, CINs/ACOs, and AHEC.
- Support with Medicaid quality measures and Performance Improvement Projects (PIPs)
  - NC AHEC developed helpful PIP Tip Sheets in collaboration with AHEC coaches and NC DHHS. Access them via NC AHEC's website devoted to Medicaid Quality Improvement
- Genuine interest in your input and feedback!



AHEC Practice Support Resources

- Quality & Health Equity Improvement (Medicaid, Medicare, All Payors)
- Medicaid managed care education & issue resolution
- Clinical workflow redesign & process improvement
- Behavioral health integration (including Collaborative Care Model)
- COVID19 vaccine & clinical workflow assistance
- Practice operational assessments
- EHR optimization, telehealth integration
- HIE training and optimization
- Revenue cycle management
- Billing & coding guidance
- Advanced Medical Home (AMH) tier education and support
- Tailored Care Management (AMH+/CMA) support
- Community Health Worker integration and training
- Social Determinants of Health Workflow Optimization
- Virtual Collaborative Educational Programming

NC AHEC | RECRUIT TRAIN RETAIN

Health Plan Practice Support: Quality

Each health plan focuses on driving performance through actionable data

- Secure PHP Provider Portal with various analytic & performance tools
- Customized reports and dashboards that are timely, actionable and available via provider portal
- P4P and Quality Incentive Data
- Assistance with reviewing and interpreting performance data
- Education & support around panel management and care-gap closure

Health Plan Practice Support Contacts

NC Medicaid Division of Health Benefits

Phone: **1-833-870-5500**

(TTY: 1-833-870-5588)

Monday – Saturday 7am-8pm

AmeriHealth Caritas:
amerihealthcaritasnc.com

Phone: **1-888-738-0004**

(TTY: 1-866-209-6421)

24 hours a day, 7 days a week

Carolina Complete Health:
carolinacompletehealth.com

NetworkRelations@CCH-Network.com

Phone: **1-833-552-3876, # 7**

(TTY: 711)

Monday – Saturday 7am-6pm

HealthyBlue of NC:

HealthyBlueNC.com

AMH@healthybluenc.com

United Healthcare Community Plan:
uhccommunityplan.com/NC

Phone: **1-800-349-1855**

(TTY: 711)

Monday – Saturday 7am-6pm

WellCare:

wellcare.com/NC

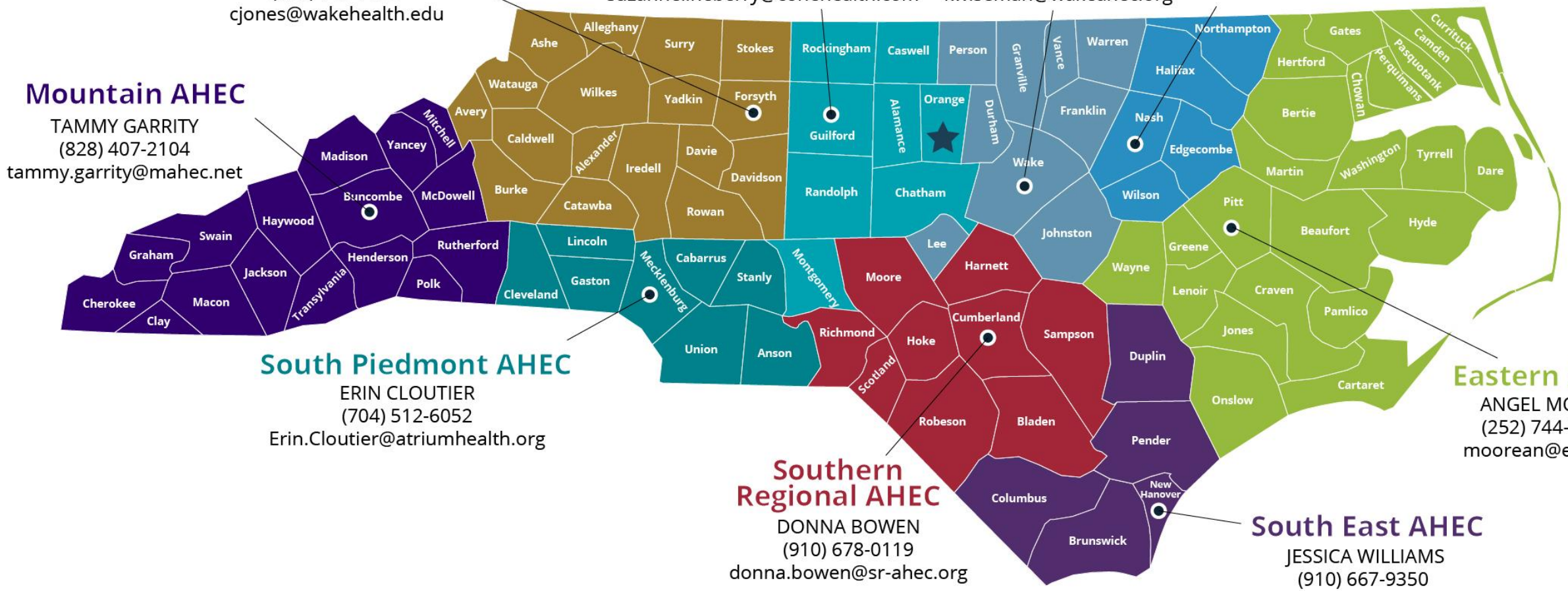
WellcareNC_Provider_Quality@wellcare.com

NCProviderRelations@Wellcare.com

Phone: **1-984-867-8637**

(TTY: 711)

NORTH CAROLINA AHEC REGIONAL PRACTICE SUPPORT CONTACTS



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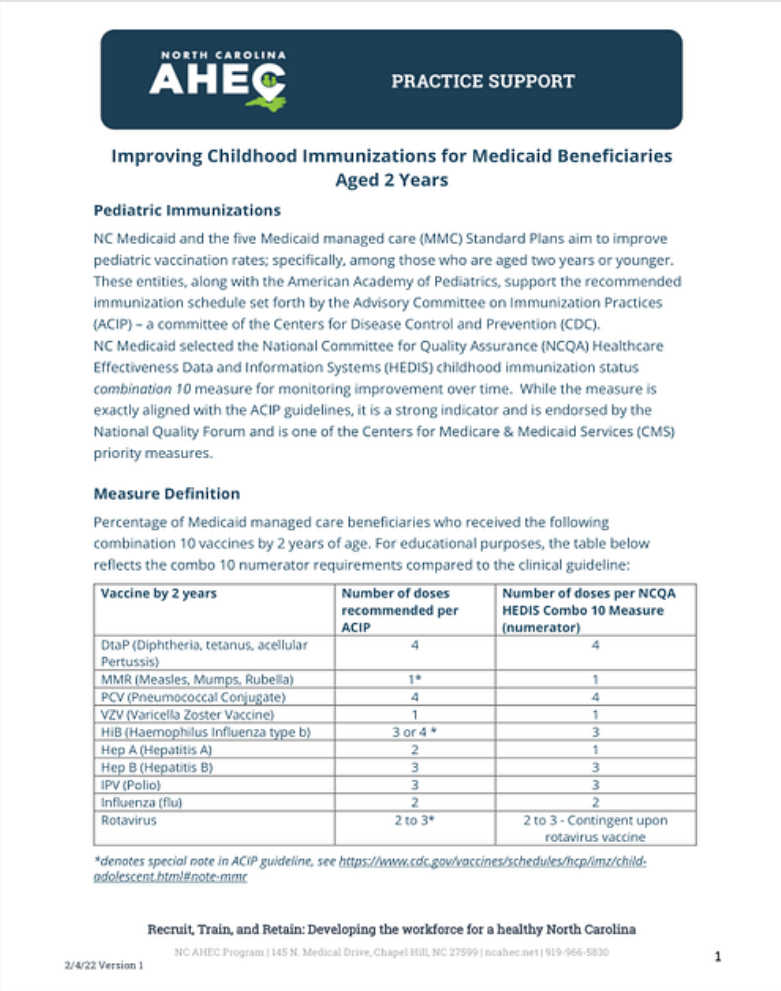
AHEC Practice Support Contacts

- You may also contact us at practicesupport@ncahec.net.
- More information is listed at Practice Support | NC AHEC.

NC AHEC RECRUIT TRAIN RETAIN

Measure Resources

AHEC Practice Support Tip Sheets



NORTH CAROLINA AHEC PRACTICE SUPPORT

Improving Childhood Immunizations for Medicaid Beneficiaries Aged 2 Years

Pediatric Immunizations

NC Medicaid and the five Medicaid managed care (MMC) Standard Plans aim to improve pediatric vaccination rates; specifically, among those who are aged two years or younger. These entities, along with the American Academy of Pediatrics, support the recommended immunization schedule set forth by the Advisory Committee on Immunization Practices (ACIP) – a committee of the Centers for Disease Control and Prevention (CDC).
NC Medicaid selected the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Systems (HEDIS) childhood immunization status *combination 10* measure for monitoring improvement over time. While the measure is exactly aligned with the ACIP guidelines, it is a strong indicator and is endorsed by the National Quality Forum and is one of the Centers for Medicare & Medicaid Services (CMS) priority measures.

Measure Definition

Percentage of Medicaid managed care beneficiaries who received the following combination 10 vaccines by 2 years of age. For educational purposes, the table below reflects the combo 10 numerator requirements compared to the clinical guideline:

Vaccine by 2 years	Number of doses recommended per ACIP	Number of doses per NCQA HEDIS Combo 10 Measure (numerator)
DtaP (Diphtheria, tetanus, acellular Pertussis)	4	4
MMR (Measles, Mumps, Rubella)	1*	1
PCV (Pneumococcal Conjugate)	4	4
VZV (Varicella Zoster Vaccine)	1	1
HiB (Haemophilus Influenza type b)	3 or 4 *	3
Hep A (Hepatitis A)	2	1
Hep B (Hepatitis B)	3	3
IPV (Polio)	3	3
Influenza (flu)	2	2
Rotavirus	2 to 3*	2 to 3 - Contingent upon rotavirus vaccine

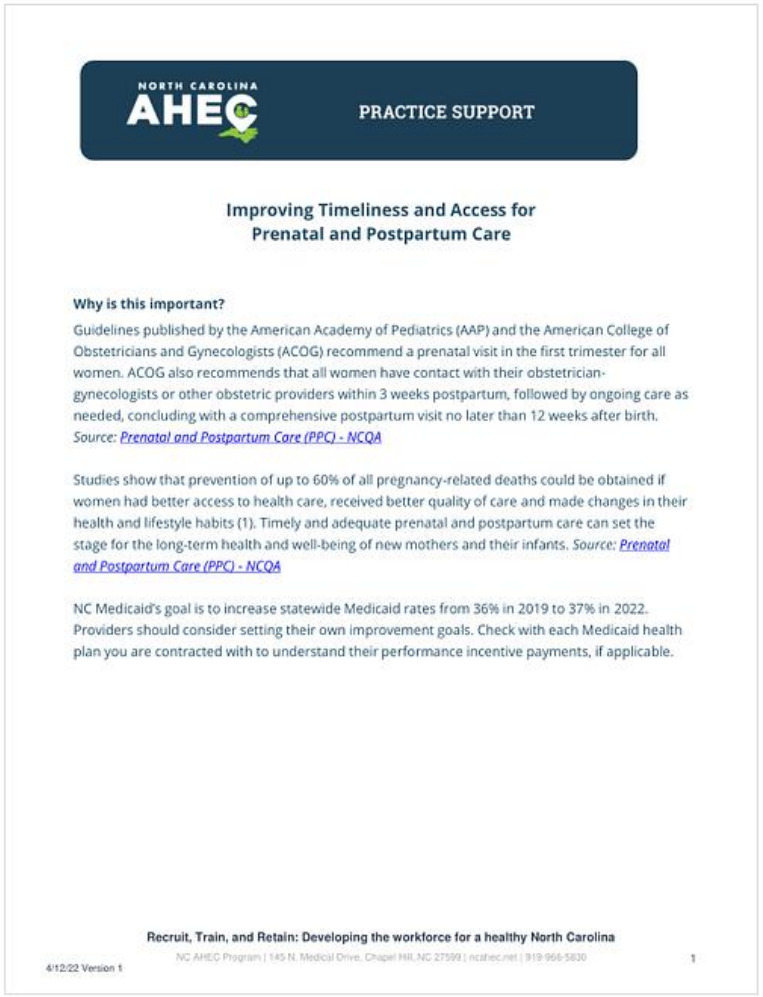
**denotes special note in ACIP guideline, see https://www.cdc.gov/vaccines/schedules/hcp/imz/child-adolescent.html#note-mmr*

Recruit, Train, and Retain: Developing the workforce for a healthy North Carolina

NC AHEC Program | 145 N. Medical Drive, Chapel Hill, NC 27599 | ncahec.net | 919-966-5830

2/4/22 Version 1

1



NORTH CAROLINA AHEC PRACTICE SUPPORT

Improving Timeliness and Access for Prenatal and Postpartum Care

Why is this important?

Guidelines published by the American Academy of Pediatrics (AAP) and the American College of Obstetricians and Gynecologists (ACOG) recommend a prenatal visit in the first trimester for all women. ACOG also recommends that all women have contact with their obstetrician-gynecologists or other obstetric providers within 3 weeks postpartum, followed by ongoing care as needed, concluding with a comprehensive postpartum visit no later than 12 weeks after birth.
Source: Prenatal and Postpartum Care (PPC) - NCQA

Studies show that prevention of up to 60% of all pregnancy-related deaths could be obtained if women had better access to health care, received better quality of care and made changes in their health and lifestyle habits (1). Timely and adequate prenatal and postpartum care can set the stage for the long-term health and well-being of new mothers and their infants. *Source: Prenatal and Postpartum Care (PPC) - NCQA*

NC Medicaid's goal is to increase statewide Medicaid rates from 36% in 2019 to 37% in 2022. Providers should consider setting their own improvement goals. Check with each Medicaid health plan you are contracted with to understand their performance incentive payments, if applicable.

Recruit, Train, and Retain: Developing the workforce for a healthy North Carolina

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4/12/22 Version 1

1

Click on each sheet above to access the full tip sheet or click here to access all AHEC Practice Support Tip Sheets.

Childhood Immunization Status: Documentation Best Practices

Acceptable Documentation	Common Documentation Gaps
The following notations are examples of **acceptable** documentation for CIS: • A note indicating the name of the specific antigen and the date of the immunization. • A certificate of immunization prepared by an authorized health care provider or agency including the specific dates and types of immunizations administered. • Initial HepB given “at birth” or “nursery/hospital” should be documented in the medical record or indicated on the immunization record as appropriate. • Immunizations documented using a generic header (e.g., polio vaccine) or “IPV/OPV” can be counted as evidence of IPV. ****Use of correct billing codes or documentation in NCIR are critical to data capture. Remember to include correct codes when billing for administration of vaccines from federal Vaccines for Children (VFC) immunization stock.**	The following notations are examples of common documentation gaps for CIS: • Immunizations administered after the 2nd birthday. • PCP charts do not contain immunization records if vaccine(s) received elsewhere such as those given in health departments or those given in the hospital at birth. • No documentation of Contraindications/Allergies. • FluMist® only meets criteria when administered on the 2nd birthday. • A note that “member is up to date” with all immunizations does not constitute compliance due to insufficient data. • Parental refusal does not meet compliance. • Rotavirus documentation does not specify if 2 dose or 3 dose.

Prenatal and Postpartum Care (PPC) Documentation Best Practices

Acceptable Documentation (Compliant Record)	Unacceptable Documentation (Non-Compliant Record)
Prenatal care visit to an OB/GYN or other prenatal care practitioner, or PCP. For visits to a PCP, a diagnosis of pregnancy must be present. Documentation in the medical record must include a note indicating the date when the prenatal care visit occurred and evidence of ***one*** of the following: • Documentation indicating pregnancy (LMP, EDD, gestational age, or OB history) • A basic physical obstetrical examination that includes FHR or fundal Postpartum visit to an OB/GYN or other prenatal care practitioner, or PCP on or between 7 and 84 days after delivery. Do not include postpartum care provided in an acute inpatient setting. Documentation in the medical record must include a note indicating the date when a postpartum visit occurred and ***one*** of the following: • Notation of postpartum care • Screening for depression • Evaluation of breastfeeding • Documentation of infant care • Documentation of intercourse • Documentation of resumption of physical activity.	The following notations are examples of documentation that is **not acceptable** for HBD: • Progress notes that are unclear if the breast/breastfeeding was assessed • Progress notes that are unclear if the abdomen or incision was assessed • Documentation of "All 10 systems reviewed" is not specific and would not meet criteria • A negative finding of breastfeeding • Progress notes that are documented outside the parameters for a prenatal visit (First Trimester is defined as 280-170 days prior to delivery ***OR*** expected date of confinement/expected due date (EDC/EDD) • Progress notes that are documented outside the parameters for a postpartum visit (postpartum visits should occur on or between 7 and 84 days after delivery) • Progress notes that are documented outside the lookback period (October 8 of the year prior to the measurement year and October 7 of the measurement year)

CAHPS Analysis

National Percentile Comparisons			
NC Medicaid Program, NC PHP Aggregate, PHP, and population-specific positive ratings were			
compared to NCQA's 2023 Quality Compass Benchmark and Compare Quality Data to determine			
which NCQA national percentile range the scores fell within. Using the percentile distributions shown in			
Table 3-2, a star rating was assigned from one (*) to five (*****) stars, where one star is below the			
national 25th percentile and five stars is greater than or equal to the national 90th percentile. For more			
detailed information regarding these comparisons, please refer to the Reader's Guide beginning on page			
35.			
Table 3-2—NCQA National Percentile Distributions Used to Assign Star Ratings			
Stars	Percentiles		
***** Excellent	At or above the 90th percentile		
**** Very Good	At or between the 75th and 89th percentiles		
*** Good	At or between the 50th and 74th percentiles		
** Fair	At or between the 25th and 49th percentiles		
* Poor	Below the 25th percentile		

NC HealthConnex

NC HealthConnex-Connection Information

Click here for general information.

FAQs?
Click here.

Click here for information on how to connect.

For more information:
N.C. Health Information Exchange Authority
Mail Service Center 4101, Raleigh, NC 27699-4101
(919) 754-6912 hiea@nc.gov