# Tailored Care Management 109:

Intro to Quality Measurement/Improvement and Misconceptions on the Tailored Care Management Model

**December 10, 2021**

# Tailored Care Management Webinar Series

**Today's webinar is a part of a series to help develop a shared understanding of the Tailored Care Management model across the North Carolina provider community and any anyone else who is interested.**

| Date<br>*Fridays 12 -1 PM* | Topic |
|---|---|
| October 1, 2021 | Introduction to Tailored Care Management |
| October 8, 2021 | Becoming an AMH+/CMA |
| October 15, 2021 | Health IT Requirements and Data Sharing |
| October 22, 2021 | Partnering with a Clinically Integrated Network and Other Partners |
| October 29, 2021 | Delivery of Tailored Care Management |
| November 5, 2021 | Transitional Care Management<br>Community Inclusion Activities |
| November 19, 2021 | Conflict-Free Care Management and Additional Care Coordination Functions for Members Enrolled in the Innovations or TBI Waiver |
| December 3, 2021 | Deep Dive on Data Specifications |
| **December 10, 2021** | **Intro to Quality Measurement/Improvement and Misconceptions on the Tailored Care Management Model** |

# Tailored Care Management Webinar Series

- Time permitting, we will be holding a Q&A session at the conclusion of today's presentation.
  - You may ask a question at any time throughout the presentation, using the Q&A text box
  - Q&A Text Box is located at the lower right-hand side of the screen
  - Simply type in your question and click send

*For additional questions on Tailored Care Management, please email:*
Medicaid.TailoredCareMgmt@dhhs.nc.gov

- A recording of today's presentation and the slide deck will be available at https://medicaid.ncdhhs.gov/transformation/tailored-care-management/tailored-care-management-training.

*For more information on Tailored Care Management, please visit:*
https://medicaid.ncdhhs.gov/transformation/tailored-care-management

# Presenters

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NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

# Agenda

- **Overview of NC Medicaid Managed Care Quality**
  - Level-Setting
  - Quality Measures and Reporting
  - Promoting Health Equity
  - Provider Supports
- **Tailored Care Management Misconceptions**
- **Q&A**
- **Appendix**

# Overview of NC Medicaid Managed Care Quality

# Level-Setting

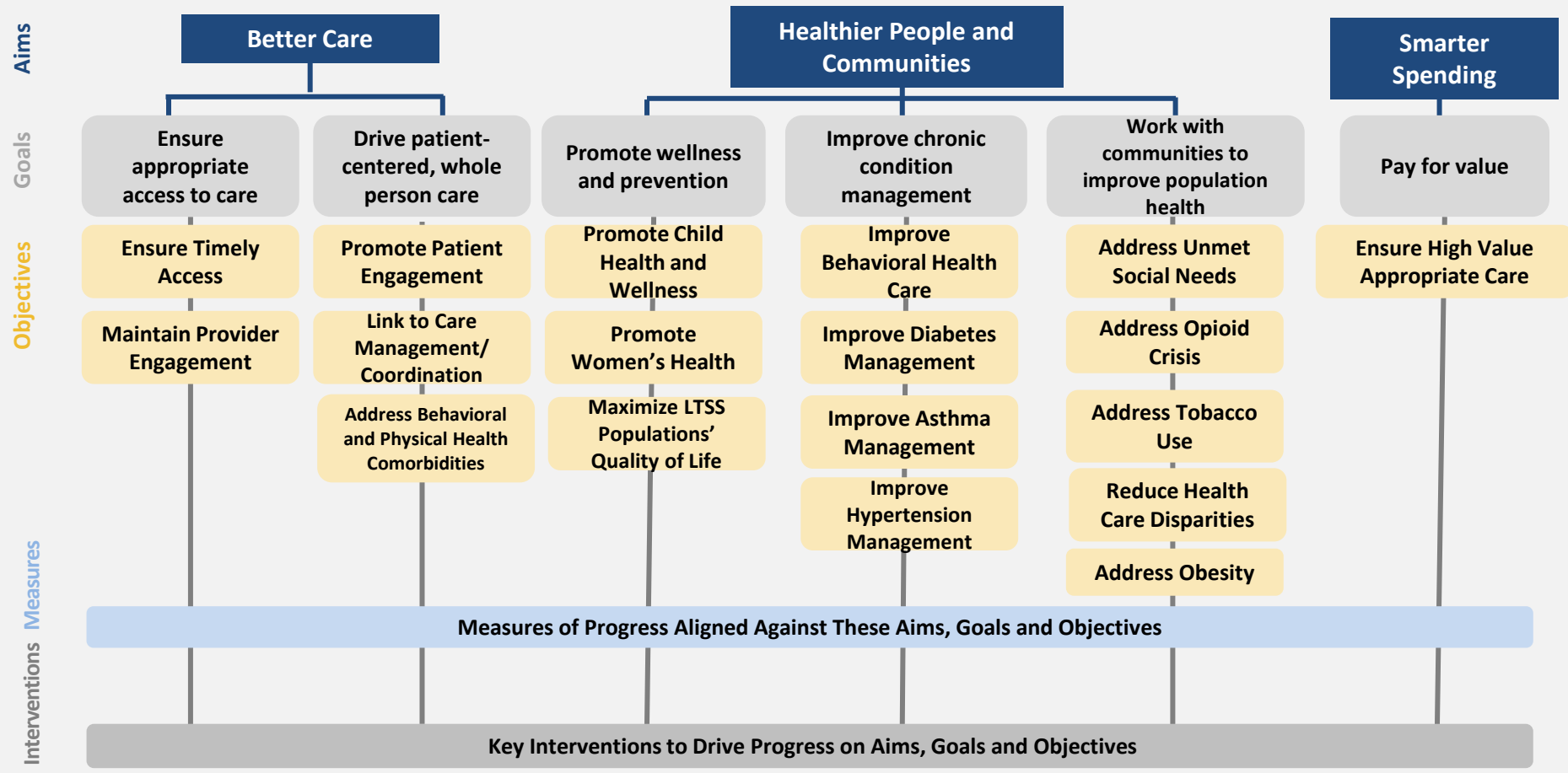
# Objectives for Today's Discussion

- Based on the Quality Strategy, the Department has developed a Medicaid quality management program that includes reporting, analysis and evaluation of quality measures and performance at various levels (e.g., Department, Medicaid Managed Care Plans, providers, external quality reviewer).

- Today's conversation is focused on reviewing the measures and reporting obligations at the Tailored Plan and provider levels, including Tailored Care Management specific requirements.

# Department's Quality Vision Applies to All Medicaid Members

**The NC Medicaid Quality Strategy* defines and drives the overall vision for advancing the quality of care provided to Medicaid beneficiaries in North Carolina. The strategy is comprised of three aims, with multiple underlying goals and objectives.**




*The Department's Quality Strategy can be found at: https://medicaid.ncdhhs.gov/transformation/quality-management-and-improvement

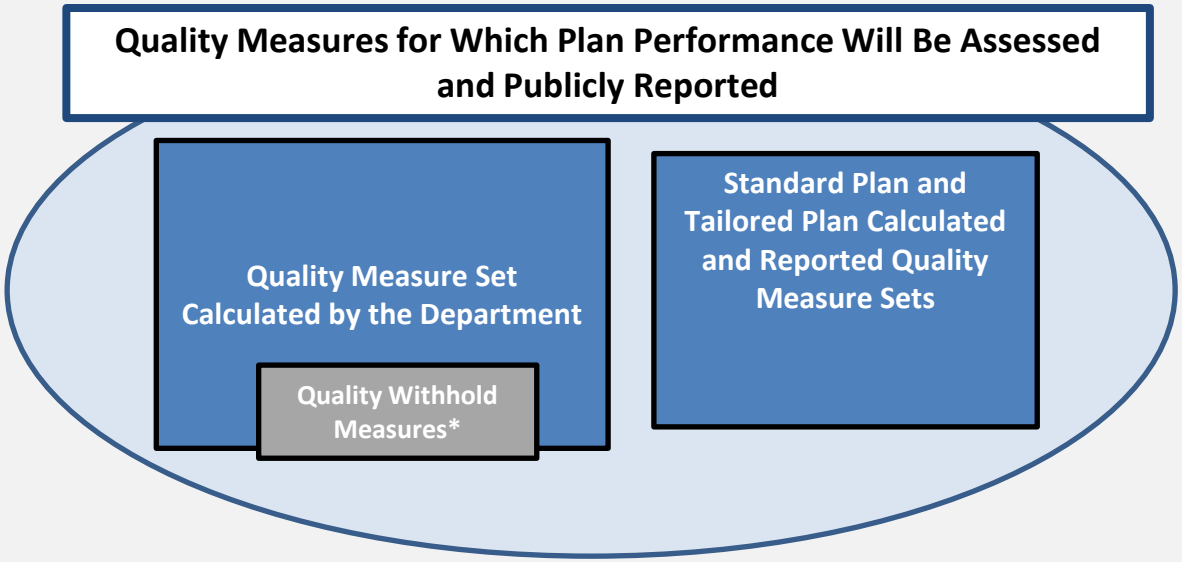
# Quality Measures and Reporting

# Tailored Plan Performance Measures are Standardized

- The Tailored Plan measures reflect the Department's commitment to reporting measures aligned with the HEDIS, Adult/Child Core sets.
  - The measures also reflect Tailored Care Management and Health Home requirements.
- Consistent with the Department's desire to benchmark its progress against other states' performance and assess key priorities to drive continuous quality improvement efforts, nearly all measures are nationally recognized.
- The Department will update quality measure sets and performance benchmarks annually to reflect the:
  - Evolution of measure sets and technical specifications; and
  - Discontinuity in performance reporting as providers transition to managed care.

# Quality and Administrative Reporting Responsibilities Differ By Measure

- All measures will be measured and calculated directly by the Department via claims submitted by Tailored Plans and clinical data from the HIEA.
- Tailored Plans will also collect, calculate and report quality measures to the Department
- At a future point, Tailored Plans will be held financially accountable for their performance on a set of quality withhold measures.




*The Quality Withhold Program will be at the plan-level. See Appendix for more information.

# NC will Release Standardized Measures for AMH+s/CMAs

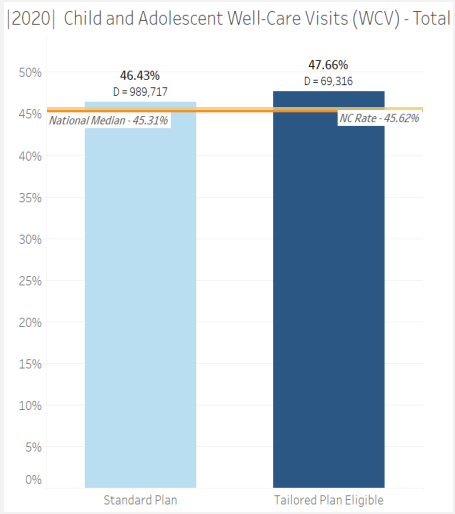
- For Standard Plans contracting with AMH practices, the Department has established a specific subset of measures Standard Plans can use in their contracts with Advanced Medical Homes. This set can be found in the Technical Specifications (link below).
- The Department has **not** yet established an analogous set of measures for Tailored Plans contracting with AMH+s/CMAs.
- The Department is exploring using a small set of measures to inform Tailored Care Management incentive payments to AMH+s and CMAs in future years (i.e., not in Year 1). More information will be forthcoming.
- ***These measures should be areas that can be affected by care management (see some examples on the next page).***
- The Tailored Plan is required to send 'care gap alerts' to providers to assist with quality and care delivery (i.e. '*alert that a child needs an immunization*')

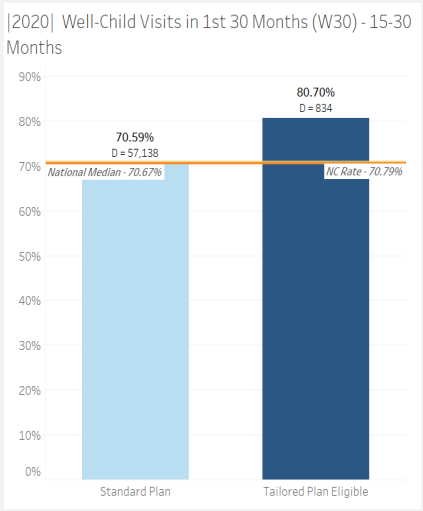
*The Technical Specifications can be found here: https://files.nc.gov/ncdma/Technical-Specifications-Manual-20210401.pdf

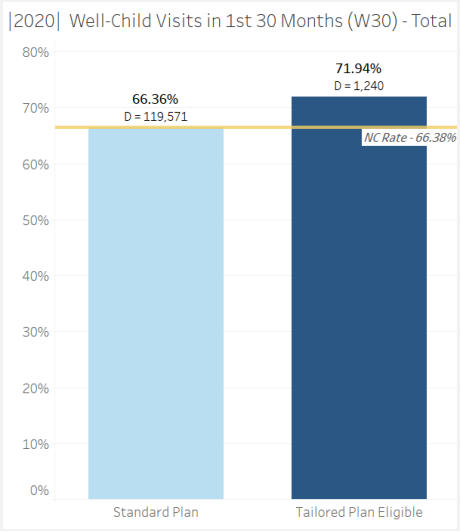
# Child/Adolescent Well-Visit Measures

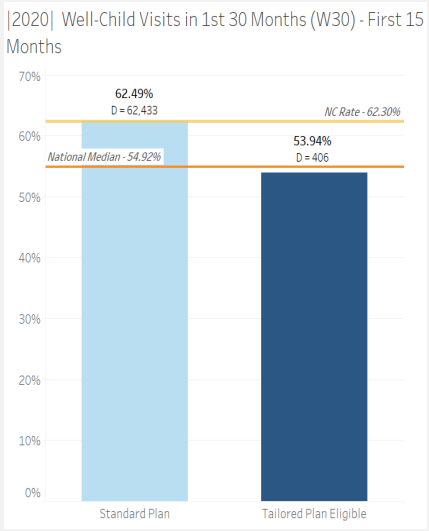
**Legend:**
=National Median
=NC Rate

| Measure Name | CY 2020 Performance | | |
|---|---|---|---|
| | Standard Plan Attributed | Tailored Plan Attributed | NC Overall |
| **Child and Adolescent Well-Care Visits (WCV)** | 46.43% | 47.66% | 45.62% |
| **Well-Child Visits in the First 30 Months of Life (W30)** | 66.36% | 71.94% | 66.38% |



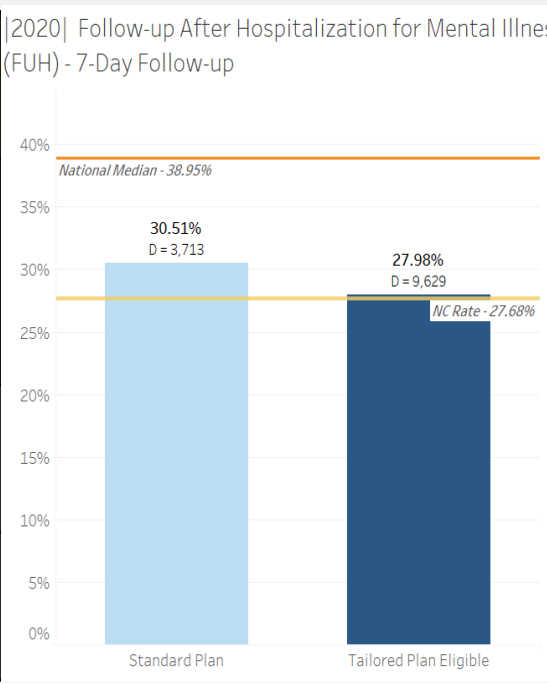

**Provider Implications:** Care managers can:

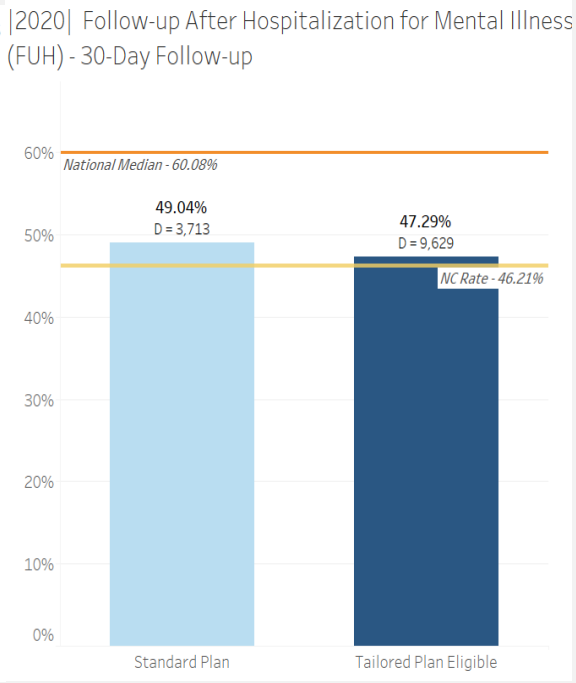
- Engage with members to share the importance and benefits of well-child visits, and help members develop lists of questions or concerns for providers to address;
- Work with members to schedule visits at the appropriate frequency;
- Proactively address barriers to attending visits such as need for transportation;
- Send timely reminders to ensure members are prepared to attend their visits; and
- Follow-up to confirm members attended their assigned visit, get feedback, and review follow-up plans (or schedule another visit if the member did not attend the initially-scheduled visit).

# Follow-up After Hospitalization for Mental Illness (FUH)

**Legend:**
=National Median
=NC Rate

| Measure Name | CY 2020 Performance: Standard Plan Attributed | CY 2020 Performance: Tailored Plan Attributed | CY 2020 Performance: NC Overall |
|---|---|---|---|
| **7-Day Follow Up** | 30.51% | 27.98% | 27.68% |
| **30-Day Follow Up** | 49.04% | 47.29% | 46.21% |




**Provider Implications:** Care managers can:

- Engage with the member's inpatient team to support discharge planning;
- Proactively address issues that may contribute to unplanned readmission, such as scheduling for immediate follow-up or modification of home supports prior to discharge;
- Schedule follow-up visits and engage with member to develop list of questions or concerns for provider;
- Attend follow-up visits with member or contact member after visit to confirm visit took place as scheduled and solicit feedback.

# Promoting Health Equity

# Benchmarking will Support Continuous Quality Improvement

**The Department is committed to developing performance targets that promote continuous quality improvement and health equity.**

**Contract Year 1 and 2:**

The Department's **benchmark for each 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., Tailored 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 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.**

**See Next Slides for Illustrative Examples**

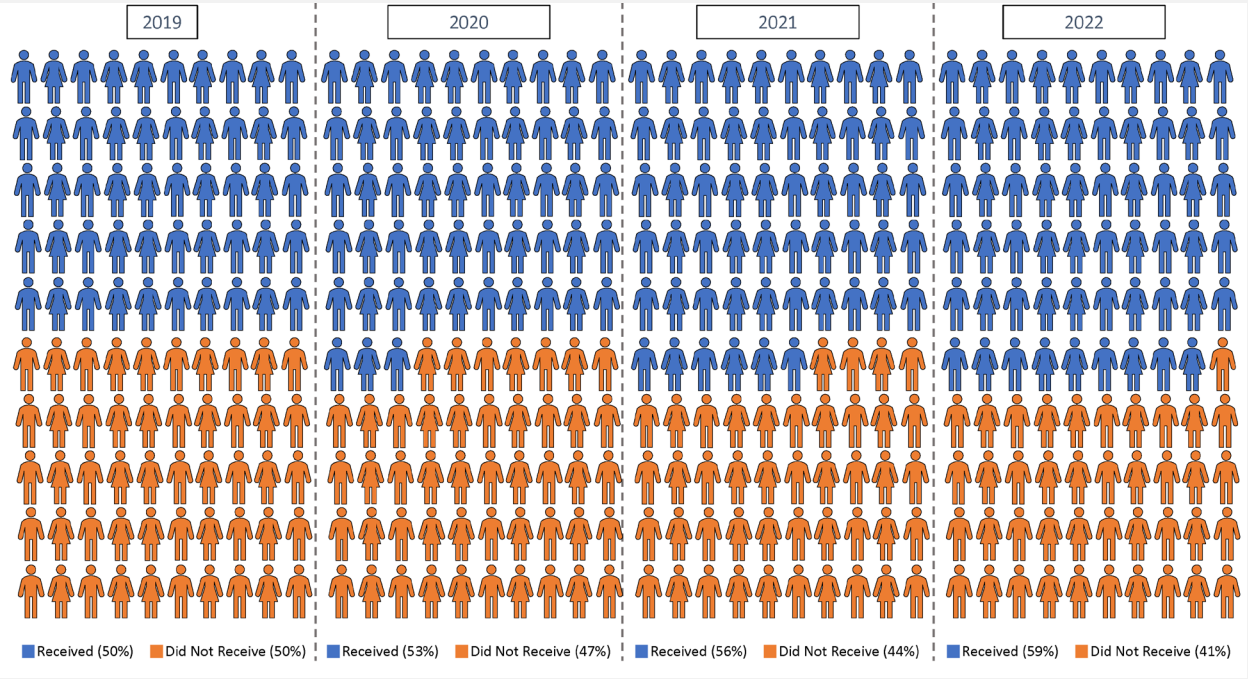
**Provider Implications:** Plans will be working with network providers to reach the performance targets.

*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 also monitor measure results to assess where contraceptive access may be insufficient.

# Contract Years 1-2: Incremental Quality Measure Targets

**Tailored 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.**

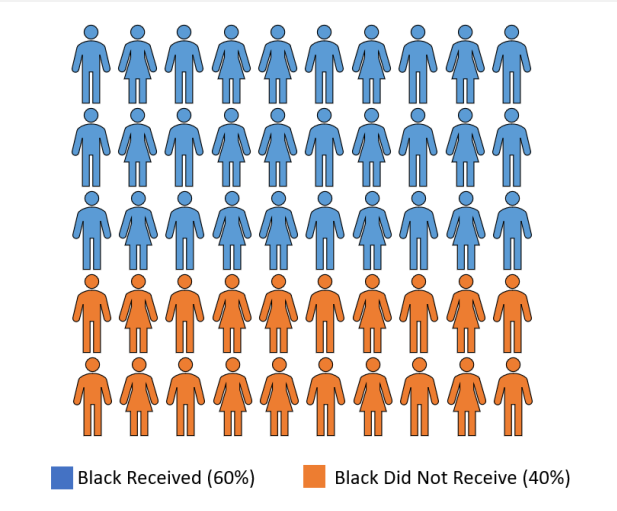
**Example:** Each year the proportion of eligible women in health plan A that receive a Chlamydia screening increases by 5%. Each blue icon represents 10 women who received their screening. Health plan A's performance goes from 50% (500/1000) in 2019 to 59% (590/1000) in 2022, meaning that health plan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

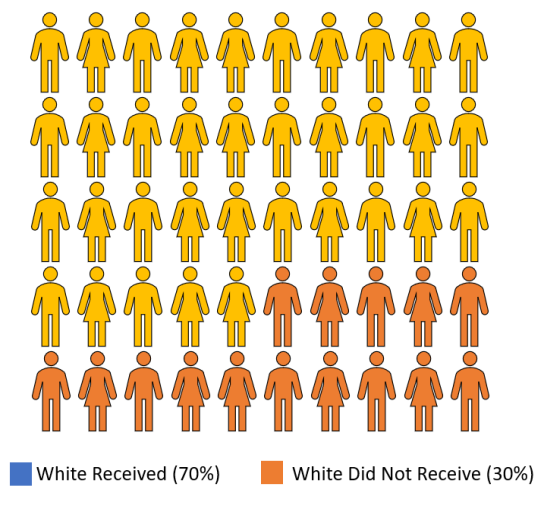


# Contract Years 3 and Beyond: Disparity Definition

**The Department will identify selected quality measures with significant disparities, defined as a greater than 10% relative gap in performance between a group of interest and a reference group.***

**Example:** 60% (300/500) of Black patients in health plan B receive the flu vaccine, while 70% (350/500) of white patients in health plan B receive the flu vaccine. (Each icon represents 10 patients.) This 50-patient difference equates to a disparity, so the measure of influenza vaccination demonstrates a significant disparity.



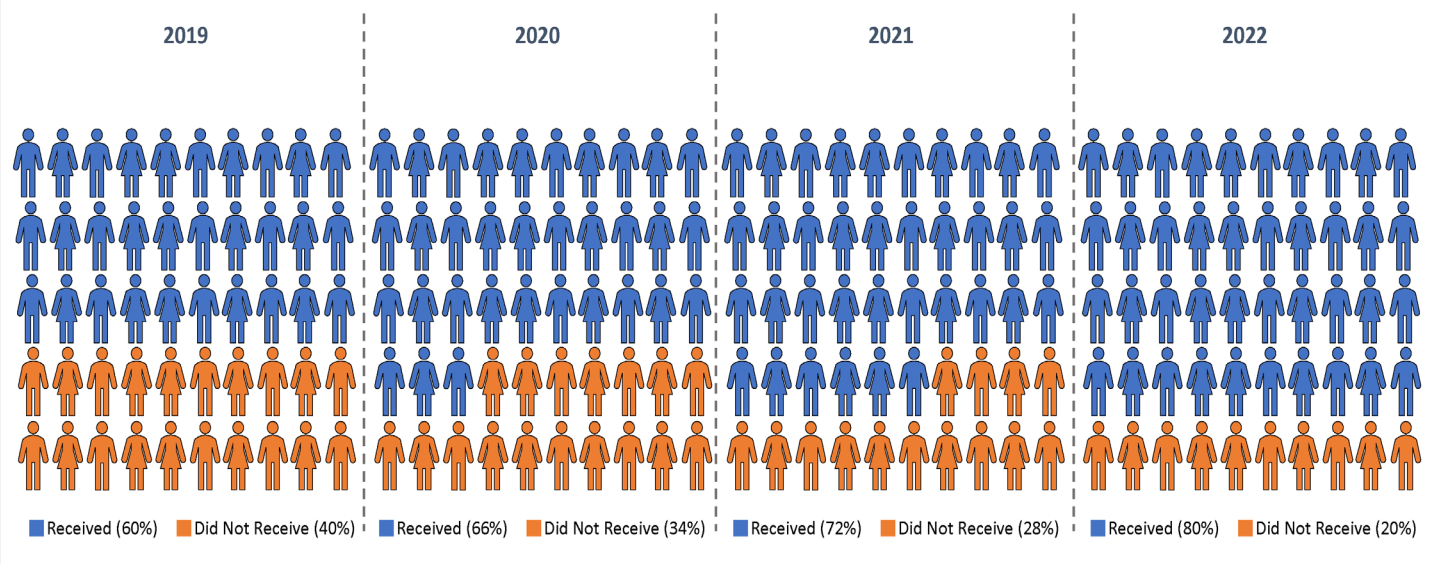




* This disparity definition was developed by AHRQ as outlined in the 2019 National Healthcare Quality and Disparities Report, available here: https://www.ahrq.gov/research/findings/nhqrdr/nhqdr19/index.html

# Contract Years 3 and Beyond: Incremental Disparity Targets

**The Department expects a 10% relative improvement in the performance for the group of interest for at least two years and until the gap between a group of interest and the overall population is less than a relative 10%.**

**Example:** Each year the proportion of Black patients in health plan B that receive the flu vaccine increases by 10%. Each blue icon represents 10 vaccinated patients. Performance within health plan B's Black population goes from 60% (300/500) in 2019 to 80% (400/500) in 2022, meaning that health plan B meets the disparity target.

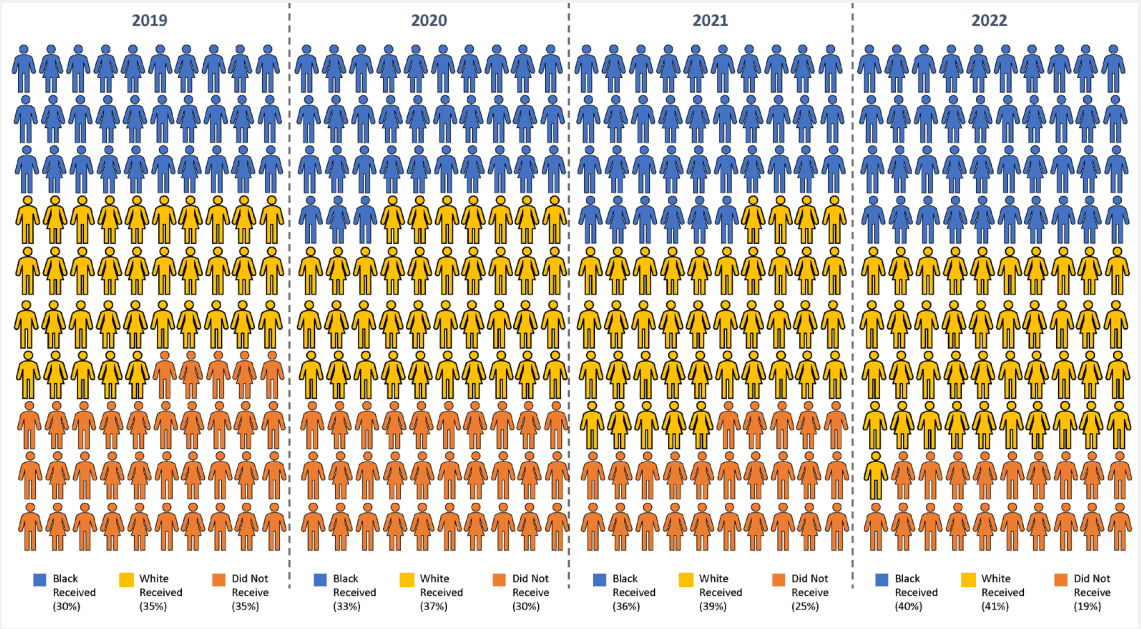



! Plans must achieve the disparity target for two years consecutively.

# Contract Years 3 and Beyond: Incremental Disparity Targets Combining Overall and Disparity Targets

**The Department plans to assess whether disparities have narrowed <u>in addition</u> to considering overall performance improvement for each plan's respective enrolled population compared against their Tailored Plan peers.**

**Example:** Each year the proportion of Black beneficiaries in health plan B that receive a flu vaccine (blue icons) increases by 10% while the proportion of white beneficiaries that receive a flu vaccine (yellow icons) increases by 5%. Health plan B's performance across their total population increases from 65% (650/1000) in 2019 to 81% (810/1000) in 2022 and the disparity has **also** been reduced, meaning that health plan B meets the combined target and is eligible for any withhold.



# Transparency in Performance Data

**The Department is committed to sharing performance data with the public and providers.**

- **<u>Department to share with public:</u> Plan-level performance for all measures across all plans, to facilitate comparison among plans.***
    - The Department, in partnership with a third party, will field the CAHPS Survey to assess patient experience in receiving care. The Department will publish overall ratings of plans, overall ratings of all care received and other findings from this survey.
- **<u>Department to share with plans:</u>** Results for the measures that the Department calculates as well as Year 1 benchmarks.
- **<u>Tailored Plans to share with providers:</u> Reports to identify specific members who are not getting recommended care (i.e. gap reports).**

**Provider Implications:** Providers should expect to see gap and summary reports to help close care gaps and meet quality targets!

*The Department may not share performance on measures with low population sizes or measures with evolving specifications.

# Promoting Health Equity

# Health Equity is a Key Priority for the Quality Program

**The Department is committed to promoting health equity in all aspects of the Medicaid managed care program, including, but not limited to, the Quality Program.**

- The Department expects Tailored Plans to ensure improvements in quality performance are equitably distributed, including across race and ethnicity.
- As described in and in alignment with the Department's Quality Strategy, Tailored Plans are expected to collect and report quality measures to support activities aimed at promoting health equity.
- As mentioned in the previous slides, beginning in the third contract year, the Department will hold Tailored Plans financially accountable for ensuring equity in improvements for selected quality measures.

# Reporting will Support Identification of Disparities

**Tailored Plans are required to capture and report metrics on disparities to inform targeted health equity interventions.**

- Tailored Plans are directed to report most quality measures using specified strata (see Table 1).
- This data will inform the development of an **annual health equity report** that identifies trends in variation in health services and outcomes based on the stratification variables.

| Table 1. Required Stratifications |
| --- |
| Age |
| Race |
| Ethnicity |
| Gender |
| Primary Language |
| LTSS Needs Status (e.g., Aged, Blind and Disabled (ABD), Non-ABD) |
| Disability Status |
| Service Region (e.g., 1-7) |
| Geography |
| *For 2022:* Transitions to Community Living |

# Tailored Plans Must Develop and Implement Health Equity Interventions

- The Department will monitor stratified measure reporting to identify disparities, and – based on their results over time – will develop (or require plans to develop) targeted interventions and/or other strategies to address identified disparities.
- These interventions may include, among others, development of disparity-specific quality measure improvement targets, on a program-wide and/or plan-specific basis; and development of modified, or additional, plan performance improvement plan requirements.
- On an annual basis, the Department will review the plans' strategies to actively address and respond to opportunities to improve health disparities in collaboration with Department-developed, cross-plan interventions.

**Provider Implications:** Providers should expect outreach from plans to support activities that promote more equitable service delivery and outcomes.

# Provider Supports

# Support for Providers in Quality Improvement Efforts

**To build upon North Carolina's existing infrastructure to drive clinical improvement, the Department (through Tailored Plans) will provide additional resources to support providers in their efforts to achieve quality improvement goals.**

- The Department will offer state-led training and feedback sessions (e.g., webinars, virtual office hours, fireside chats and, where feasible, in person trainings).
- Additionally, Tailored Plans will be responsible for training providers on plan-specific policies and programs and must develop a Provider Support Plan that will be reviewed by the Department and updated on an annual basis.
- The Provider Support Plan must include:
  - All planned technical support activities;
  - Detailed information regarding how its proposed provider supports activities will advance the aims, goals, and objectives outlined within the Department's Quality Strategy; and
  - An overview of which metrics the Tailored Plan will use to evaluate its provider engagement progress over time.

# Opportunities for Provider Dialogue and Information Sharing

**Providers will have opportunities (in-person, online, routine/ad-hoc) to raise local challenges and exchange best practices related to quality and population health outcomes with Tailored Plans.**

- Clinical leadership at the regional level will meet with plan leadership **at least quarterly** to discuss implementation of quality improvement activities aligned with the Quality Strategy and implementation of Department-led transformation initiatives.
  - Clinical leadership should include active network providers as well as the plan's CMO and Quality Director.
  - The Department's quality staff and medical leadership will also be invited participants.
- Providers are welcome to participate in the annual Quality Forum hosted by the Tailored Plans.

| Quality Forum Invitees |
| --- |
| Primary Care Physicians and Advanced Medical Homes (all Tiers) |
| Obstetric/Gynecological Providers |
| Behavioral Health Providers |
| Local Health Departments |
| School-based Health Centers |
| Hospitals |
| Long-term Services and Supports Agencies |
| Clinical Integrated Networks |
| Local Department of Social Service (DSS) |
| Other relevant stakeholders based on the agenda and goals of the Forum |

# Tailored Care Management Misconceptions

# Misconceptions from the Field

**The Department understands there may be areas of confusion about the Tailored Care Management model and would like to address and provide clarification on areas of confusion it has directly heard from stakeholders**

# Misconception #1: EHR Certification

***Incorrect:***
AMH+ practices and CMAs need to have electronic health records (EHR) that meet the Office of the National Coordinator for Health Information Technology's criteria for certified EHR technology.[1]

***Correction:***

- **The Department does not presently require EHRs to be certified for the purposes of Tailored Care Management.**

- Providers' EHRs or clinical systems of record are required to have the capability to electronically record, store, and transmit member clinical information.

*1. https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Certification*

# Misconception #2: Relationship Between AMH+/CMA Certification and Billing for Other Medicaid Services

***Incorrect:***
Organizations providing behavioral health or I/DD services must be certified as an AMH+ or CMA in order to continue billing Medicaid for these services.

***Correction:***

- Providers do **not** need to be certified as an AMH+ practice or CMA to bill for Medicaid-covered behavioral health, I/DD, or TBI services.
- **Only providers interested in delivering the new Tailored Care Management service line must undergo the AMH+/CMA certification process.**
- When Tailored Plans launch, to continue providing Medicaid services beyond Tailored Care Management or State-funded behavioral health, I/DD, or TBI services, providers must be in-network with a Tailored Plan.
    - *Example: A provider does not need to obtain AMH+/CMA certification to provide substance abuse comprehensive outpatient treatment (SACOT) services.*

# Misconception #3: Care Manager Caseloads

***Incorrect:***
Organizations providing Tailored Care Management—AMH+ practices, CMAs, and Tailored Plans—must maintain specific care manager-to-member caseloads.

***Correction:***

- The Department has not established care manager-to-member caseloads that AMH+ practices, CMAs, and Tailored Plans must maintain.
- **Providers have flexibility to build care teams as they see fit** (e.g., using extenders, adjusting caseloads, etc.), assuming they meet a certain set of programmatic requirements, including:
  - Establish a multidisciplinary care team with a care manager, supervising care manager, primary care provider, behavioral health provider, I/DD and/or TBI providers, as applicable, and other specialists and individuals identified in the Provider Manual and RFA
  - Ensure regular communication and information sharing across care team members
  - Meet the care manager-to-supervisor ratio of no more than 8:1
- At the request of providers, the Department released information about the caseload assumptions that were used to inform the rates, but these caseload assumptions are **not** programmatic requirements.
- More details on caseload assumptions informing the rate development process are available here: https://files.nc.gov/ncdma/Updated-Guidance-on-Tailored-Care-Management-vF.pdf

# Misconception #4: Care Management Comprehensive Assessments

***Incorrect:***
The Tailored Care Management comprehensive assessment is the same as the comprehensive clinical assessment.

***Correction:***

- The **Tailored Care Management comprehensive assessment is a person-centered assessment** of a member's healthcare needs, functional and accessibility needs, strengths and supports, goals, and other characteristics that will inform the care plan or Individual Support Plan (ISP) and treatment.
  - The member's **care manager** performs this assessment.

- The **comprehensive clinical assessment is a clinical evaluation** that provides the necessary and relevant clinical data and recommendations that are used when developing the person-centered plan or service plan with the individual.
  - A **licensed professional or associate level licensed professional** performs this assessment.
  - Information from the comprehensive clinical assessment may be used as an input or otherwise inform the Tailored Care Management comprehensive assessment.

# Misconception #5: Conflict-Free Care Management

***Incorrect:***
To meet conflict-free requirements, CMAs can set up "firewalls" that separate home and community-based service (HCBS) delivery and Tailored Care Management (e.g., having separate reporting structures for Tailored Care Management and service delivery, separating the care plan development function from the direct service provider function).

***Correction:***

- The Department explored allowing HCBS providers/CMAs to develop firewalls between Tailored Care Management and service delivery; however, CMS informed the State that such an approach is not compliant with federal conflict-free rules.
- **To comply with conflict-free rules, a behavioral health, I/DD, or TBI provider cannot deliver both Tailored Care Management (in their capacity as a CMA) and 1915(c) Innovation/TBI or 1915(i) HCBS to the same individual.**
- Since AMH+ practices and Tailored Plans do not deliver HCBS, conflict-free case management rules are not applicable.
- The Department is planning to connect with CMS to determine its approach for conflict-free care management for individuals in the Tribal Option, including the extent to firewalls can be used.

# Misconception #6: Capacity Building Estimates

***Incorrect:***

AMH+ practices and CMAs will be held to the estimates of members that will be served and staffing submitted in their initial capacity building needs assessments.

***Correction:***

- The Department recognizes that AMH+ practices and CMAs have limited data on the number of members they will be serving and their staffing needs. The Department also understands that providers are still exploring making HIT investments.
- **AMH+ practices and CMAs will have the opportunity to submit updated estimates as they obtain additional data.**
- As estimates are refined, Tailored Plans can update their distribution plans and submit them to the Department for approval.

# Misconception #7: Capacity Building Reimbursement

***Incorrect:***
AMH+ practices and CMAs must spend funds in order to be reimbursed with capacity building dollars.

***Correction:***

- The Department designed the capacity building program to **allow providers to receive some funding from future Tailored Plans in advance of spending**, to ensure "start-up" funding for important capacity building activities.
- Following the approval of their distribution plans, future Tailored Plans will receive their first capacity building payment from the Department; future Tailored Plans can use these funds to provide start-up funding to AMH+ practices and CMAs.
- To access funds, providers must participate in a capacity building needs assessment administered by future Tailored Plans and, on an ongoing basis, meet a series of targets demonstrating progress towards achieving specific capacity building milestones.
- Providers will receive their first distribution of capacity building funds only once they are certified as an AMH+ practice or CMA.
- More details on the capacity building program are available here: https://medicaid.ncdhhs.gov/transformation/tailored-care-management/tailored-care-management-capacity-building-program

# Questions?

**Thank you to all who participated in the webinar series.**

***Please check the below website regularly for additional webinars, guidance, and resources***

https://medicaid.ncdhhs.gov/transformation/tailored-care-management

# Appendix

# NC Medicaid Quality Measure Sets

# Tailored Plan Quality Measure Set (1 of 2)

Plans will be responsible for reporting the following measures:

| NQF # | Measure Name | Steward |
|---|---|---|
| **Pediatric Measures** | | |
| NA | Child and Adolescent Well-care Visits (WCV) | NCQA |
| 0038 | Childhood Immunization Status (Combo 10) (CIS) | NCQA |
| 0108 | Follow-up for Children Prescribed ADHD Medication (ADD) | NCQA |
| 1407 | Immunization for Adolescents (Combo 2) (IMA) | NCQA |
| 2800 | Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM) | NCQA |
| NA | Total Eligibles Receiving at least One Initial or Periodic Screen (Federal Fiscal Year) | NC DHHS |
| 2801 | Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP) | NCQA |
| NA | Well-Child Visits in the First 30 Months of Life (W30) | NCQA |
| **Adult Measures** | | |
| 0105 | Antidepressant Medication Management (AMM) | NCQA |
| 0032 | Cervical Cancer Screening (CCS) | NCQA |
| 0033 | Chlamydia Screening in Women (CHL) | NCQA |
| 0059 | Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) | NCQA |
| 3389 | Concurrent use of Prescription Opioids and Benzodiazepines (COB) | PQA |
| 3175 | Continuation of Pharmacotherapy for Opioid Use Disorder | USC |
| 0018 | Controlling High Blood Pressure (CBP) | NCQA |
| 1932 | Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are Using Antipsychotic Medications (SSD, SMD, SMC) | NCQA |

**Notes**: Innovations and TBI measures are also included in the Tailored Plan measure set.
Standard Plans and Behavioral Health I/DD Tailored Plans are required to provide gap reports for selected measures to AMHs and AMH+/CMAs, respectively.

# Tailored Plan Quality Measure Set (2 of 2)

Plans will be responsible for reporting the following measures:

| NQF # | Measure Name | Steward |
|---|---|---|
| **Adult Measures** | | |
| 0039 | Flu Vaccinations for Adults (FVA, FVO) | NCQA |
| 0576 | Follow-up After Hospitalization for Mental Illness (FUH) | NCQA |
| 0027 | Medical Assistance with Smoking and Tobacco Use Cessation (MSC) | NCQA |
| 1768 | Plan All-cause Readmissions (PCR) | NCQA |
| NA | Rate of Screening for Unmet Resource Needs | NC DHHS |
| 0418/ 0418e | Screening for Depression and Follow-up Plan (CDF) | NCQA |
| NA | Total Cost of Care | TBD |
| 2940 | Use of Opioids at High Dosage in-Persons Without Cancer (OHD) | PQA |
| 2950 | Use of Opioids from Multiple Providers in-Persons Without Cancer (OMP) | PQA |
| **Maternal Health Measures** | | |
| NA | Low Birth Weight | NC DHHS |
| NA | Prenatal and Postpartum Care (PPC) | NCQA |
| NA | Rate of Screening for Pregnancy Risk | NC DHHS |

**Notes**: Innovations and TBI measures are also included in the Tailored Plan measure set.
Standard Plans and Behavioral Health I/DD Tailored Plans are required to provide gap reports for selected measures to AMHs and AMH+/CMAs, respectively.
The Department will work jointly with plans to calculate and report the low birth weight measure.

# Department-Calculated Measure Set (1 of 3)

The Department will calculate and monitor the following quality measures in the Medicaid program but may report these measures at the plan-level.

| NQF # | Measure Name | Steward |
|---|---|---|
| **Pediatric Measures** | | |
| N/A | Avoidable Pediatric Utilization PDI 14: Asthma Admission Rate PDI 15: Diabetes Short-term Complications Admission Rate PDI 16: Gastroenteritis Admission Rate PDI 18: Urinary Tract Infection Admission Rate | Agency for Healthcare Research and Quality (AHRQ) |
| 0004 | Initiation/Engagement of Alcohol and Other Drug Dependence Treatment (IET) | NCQA |
| NA | Percentage of Eligibles Who Received Preventive Dental Services (PDENT) | CMS |
| 2803 | Tobacco Use and Help with Quitting Among Adolescents | NCQA |
| 0024 | Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) | NCQA |
| **Adult Measures** | | |
| N/A | *Planned for 2022:* Ambulatory Care: Emergency Department (ED) Visits (AMB) | NCQA |
| 1879 | Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA) | NCQA |
| 0543 | Adherence to Statin Therapy for Individuals with Coronary Artery Disease | CMS |
| N/A | *Planned for 2022:* Admission to an Institution from the Community (AIF) | CMS |
| 0023 | Adult BMI Assessment (ABA) | NYC Dept. of Health and Mental Hygiene |
| 1800 | Asthma Medication Ratio (AMR) | NCQA |
| NA | Avoidable Adult Utilization PQI 01: Diabetes Short-term Complication Admission Rate; PQI 05: COPD or Asthma in Older Adults Admission Rate; PQI 08: Heart Failure Admission Rate; PQI 15: Asthma in Younger Adults Admission Rate | AHRQ |
| 2372 | Breast Cancer Screening (BSC) | NCQA |
| 0061 | Comprehensive Diabetes Care (CDC): Blood Pressure Control (<140/90 mm Hg) | NCQA |
| 0575 | Comprehensive Diabetes Care (CDC): Hemoglobin A1c (HbA1c) Poor Control (<8.0%) | NCQA |
| 0057 | Comprehensive Diabetes Care (CDC): HbA1c Testing | NCQA |
| 0064 | Comprehensive Diabetes Care (CDC): LDL-C Control (<100 mg/dL) | NCQA |
| 0063 | Comprehensive Diabetes Care (CDC): LDL-C Screening | NCQA |

# Department-Calculated Measure Set (2 of 3)

The Department will calculate and monitor the following quality measures in the Medicaid program but may report these measures at the plan-level.

| NQF # | Measure Name | Steward |
|---|---|---|
| **Adult Measures** | | |
| 0547 | Diabetes and Medication Possession Ratio for Statin Therapy | NCQA |
| 2607 | Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI) | NCQA |
| 3488 | Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA) | NCQA |
| 3489 | *Planned for 2022:* Ambulatory Care: Follow-Up After Emergency Department Visit for Mental Illness (FUM) | NCQA |
| 3210/32 10e | HIV Viral Load Suppression (HVL) | HRSA |
| N/A | *Planned for 2022:* Inpatient Utilization (IU) | CMS |
| 2856 | Pharmacotherapy Management of COPD Exacerbation (PCE) | NCQA |
| 0028 | Preventive Care and Screening; Tobacco Use: Screening and Cessation Intervention | PCPI Foundation |
| N/A | *Planned for 2022:* Prevention Quality Indicator (PQI) 92: Chronic Conditions Composite (PQI 92) | AHRQ |
| 2597 | Substance Use Screening and Intervention Composite | American Society of Addiction Medicine |
| 2600 | Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence | NCQA |
| 3400 | *Planned for 2022:* Use of Pharmacotherapy for Opioid Use Disorder (OUD) | CMS |

# Department-Calculated Measure Set (3 of 3)

The Department will calculate and monitor the following quality measures in the Medicaid program but may report these measures at the plan-level.

| NQF # | Measure Name | Steward |
|---|---|---|
| **Maternal Health Measures** | | |
| **2904** | Contraceptive Care: Access to Long-acting Reversible Contraception (LARC) (CCW) | US Office of Population Affairs |
| **2903** | Contraceptive Care: Most and Moderately Effective Methods (CCW) | US Office of Population Affairs |
| **2902** | Contraceptive Care: Postpartum (CCP) | US Office of Population Affairs |
| **1382** | Live Births Weighing Less Than 2500 Grams | CDC |
| **NA** | Prenatal Depression Screening and Follow-up (PND) | NCQA |
| **Select Public Health Measures** | | |
| **NA** | Diet/Exercise<br>o Increase fruit and vegetable consumption among adults<br>o Increase percentage of adults who get recommended amount of physical activity<br>Opioid Use<br>o Reduce the unintentional poisoning mortality rate<br>Tobacco Use<br>o Decrease the percentage of adults who are current smokers<br>o Decrease the percentage of high school students using tobacco<br>o Decrease the percentage of women who smoke during pregnancy<br>o Decrease exposure to secondhand smoke in the workplace | NA |
| **Patient Satisfaction** | | |
| **0006** | CAHPS Survey | AHRQ |
| **Provider Satisfaction** | | |
| **NA** | Provider Survey | DHHS |

# Patient Reported Outcomes Measure Surveys

**The Department uses the following survey and tools to assess beneficiary and provider perceptions:**

| Tool | Description |
|---|---|
| **The CAHPS Plan Survey** | • Phone/mail survey<br>• Assesses consumer satisfaction, access to care and members' experience with their personal doctor, specialists and health plan |
| **NC Treatment Outcomes Performance Program System (NC-TOPPS)** | • Face-to-face or phone interviews by qualified professionals<br>• Assesses consumer experience with services received, treatment outcomes and quality of life following a consumer across an "episode of care", with multiple data collection points across the episode |
| **Mental Health Statistics Improvement Program Survey** | • Face-to-face or phone interviews by qualified professionals<br>• Assesses consumer satisfaction, access to care and perceptions of quality and outcomes of mental health and substance use services |
| **National Core Indicators Survey** | • Face-to-face or phone interviews by qualified professionals<br>• Assesses consumer satisfaction and perceptions of quality and outcomes with I/DD case management |
| **Provider Survey** | • The Department, in partnership with the EQRO fields the survey<br>• Assess providers' experience with Tailored Plans<br>• The Department will publish overall satisfaction rates and other findings from this survey.<br>• Provider satisfaction results will be incorporated into a larger report around Network Access/Access to Care |

**In future years,** the Department may develop other surveys to capture additional outcomes of interest or may adapt existing surveys to support more in-depth tracking of patient-reported outcomes.

# Additional Quality Measures

**The following are additional measures that will be collected as part of managed care:**

| Measure Area | Reporting Responsibility | Description | Relevant Measures |
|---|---|---|---|
| Modified Measures | Tailored Plans; with coordination support from the Department's division of Vital Records (Vital Records) | The Department seeks to understand how transition to managed care has impacted birth outcomes and to reward plans that decrease rates of low birth weight in their assigned population. | • Low birth weight outcomes measures |
| Measures of Utilization | Tailored Plans; with calculation support from the Department | The Department added measures of utilization to the quality measure set to assess the degree to which plans' care management and utilization management efforts are able to reduce avoidable utilization. | • Hospital Readmissions<br>• Total Costs of Care |
| Administrative Measures | Tailored Plans | The Department will be monitoring Standard Plans and Tailored Plans administration of select screening measures. | • Screening for Unmet Health-related Social Needs<br>• Screening for Pregnancy Risk |

**Provider Implications:** Providers are expected to work with managed care plans to collect data elements to support plans' calculation of measures.

# *Under Development:* Quality Withhold Program

- The withhold measures will be drawn from the set of measures Tailored Plans reported the previous year.
- Initial withhold measures for Tailored Plans will be shared prior to Tailored Plan launch.
- The withhold measure set will shift toward outcome measures over time, with an increasing focus on improving performance under a gap-to-goal assessment approach as well as eliminating disparities.

**In future years,** the Department will implement new uses for Tailored Plans quality scores that go beyond calculation of withhold targets. For example, the Department will expect Tailored Plans to further incorporate quality scores into internal ongoing quality improvement and value-based purchasing efforts.

**Provider Implications:** Providers are expected to work with Tailored Plans to collect quality measures the plans are responsible for as part of the withhold.

# Federal Health Home Core Set

# Federal Health Home Core Set

| Measure Name | Steward/NQF # | Description | Numerator | Denominator | Data Source | Entity Responsible for Reporting |
|---|---|---|---|---|---|---|
| **Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)** | NCQA/NQF #004 | Assesses adults and adolescents 13 years of age and older with a new episode of alcohol or other drug (AOD) dependence who received the following:<br><br>• Initiation of AOD Treatment<br>• Engagement of AOD Treatment | • Initiation of AOD Dependence Treatment: Initiation of AOD treatment through an inpatient admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of diagnosis.<br>• Engagement of AOD Treatment: Initiation of AOD treatment and two or more inpatient admissions, outpatient visits, intensive outpatient encounters or partial hospitalizations with any AOD diagnosis within 30 days after the date of the Initiation encounter (inclusive). | Members age 13 years of age and older with a medical and chemical dependency benefit who were diagnosed with a new episode of alcohol and drug dependency (AOD) during the intake period of January 1-November 15 of the measurement year. | Administrative or EHR | Tailored Plan in collaboration with providers sharing clinical data, as needed. |

Source: https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/downloads/2021-health-home-core-set.pdf

# Federal Health Home Core Set

| Measure Name | Steward/NQF # | Description | Numerator | Denominator | Data Source | Entity Responsible for Reporting |
|---|---|---|---|---|---|---|
| **Controlling High Blood Pressure (CBP)** | NCQA/NQF #0018 | Assesses adults 18–85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90 mm Hg). | The number of beneficiaries in the denominator whose most recent blood pressure (both systolic and diastolic) is adequately controlled during the measurement year. | Patients 18 to 85 years of age by the end of the measurement year who had at least one outpatient encounter with a diagnosis of hypertension during the first six months of the measurement year. | Administrative, hybrid, or EHR | Tailored Plan in collaboration with providers sharing clinical data, as needed. |
| **Screening for Depression and Follow-Up Plan (CDF)** | NCQA/NQF #0418/0418e | The percentage of members 12 years of age and older who were screened for clinical depression using a standardized instrument and, if screened positive, received follow-up care. | Patients screened for clinical depression on the date of the encounter using an age-appropriate standardized tool AND, if positive, a follow-up plan is documented on the date of the positive screen. | All patients aged 12 years and older. | Administrative or EHR | |

Source: https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/downloads/2021-health-home-core-set.pdf

# Federal Health Home Core Set

| Measure Name | Steward/NQF # | Description | Numerator | Denominator | Data Source | Entity Responsible for Reporting |
|---|---|---|---|---|---|---|
| **Follow-Up After Hospitalization for Mental Illness (FUH)** | NCQA/NQF #0567 | The percentage of discharges for enrollees 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had a follow-up visit with a mental health practitioner. | • 30-Day Follow-Up: A follow-up visit with a mental health practitioner within 30 days after discharge.<br>• 7-Day Follow-Up: A follow-up visit with a mental health practitioner within 7 days after discharge. | Discharges from an acute inpatient setting (including acute care psychiatric facilities) with a principal diagnosis of mental illness during the first 11 months of the measurement year (i.e., January 1 to December 1) for patients 6 years and older. | Administrative | Tailored Plan |
| **Plan All-Cause Readmissions (PCR)** | NCQA/NQF #1768 | For members 18-64 years of age, the number of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. | At least one acute readmission for any diagnosis within 30 days of the Index Discharge Date. | Members ages 18-64 as of the Index Discharge Date with an acute inpatient or observation stay discharge on or between January 1 and December 1 of the measurement year. | Administrative | Tailored Plan |

Source: https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/downloads/2021-health-home-core-set.pdf

# Federal Health Home Core Set

| Measure Name | Steward/ NQF # | Description | Numerator | Denominator | Data Source | Entity Responsible for Reporting |
|---|---|---|---|---|---|---|
| **Use of Pharmacotherapy for Opioid Use Disorder (OUD)** | CMS/NQF #3400 | Percentage of adults aged 18 years and older with pharmacotherapy for opioid use disorder (OUD) who have at least 180 days of continuous treatment. | Adults in the denominator who have at least 180 days of continuous pharmacotherapy with a medication prescribed for OUD without a gap of more than seven days. | Adults aged 18 years and older who had a qualifying encounter during the performance year, and a diagnosis of OUD and pharmacotherapy for OUD during the denominator identification period. | Administrative | The Department |
| **Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)** | NCQA/NQF #3488 | Assesses emergency department visits for members 13 years of age and older with a principal diagnosis AOD or dependence, who had a follow up visit for AOD. | • 30-Day Follow-Up: A follow-up visit with any practitioner, with a principal diagnosis of AOD within 30 days after the ED visit (31 total days).<br>• 7-Day Follow-Up: A follow-up visit with any practitioner, with a principal diagnosis of AOD within 7 days after the ED visit (8 total days). | Adults aged 18 and older as of the ED visit. | Administrative | |
| **Prevention Quality Indicator (PQI) 92: Chronic Conditions Composite (PQI92)** | AHRQ/NQF Not Available | Number of inpatient hospital admissions for ambulatory care sensitive chronic conditions. | Discharges for patients age 18 and older who meet the criteria for any of the following Prevention Quality Indicators: PQI 01, PQI 03, PQI 05, PQI 07-08, PQI 14-16 | Total number of months of enrollment for beneficiaries age 18 and older during the measurement period. | Administrative | |

Source: https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/downloads/2021-health-home-core-set.pdf

# Federal Health Home Core Set

| Measure Name | Steward/NQF # | Description | Numerator | Denominator | Data Source | Entity Responsible for Reporting |
|---|---|---|---|---|---|---|
| **Admission to an Institution from the Community (AIF)** | CMS/NQF Not Available | The number of MLTSS enrollee admissions to an institution (nursing facility or intermediate care facility for individuals with intellectual disabilities [ICF/IID]) from the community that result in a short-term (1 to 20 days), medium-term (21 to 100 days), or long-term stay (greater than or equal to 101 days) during the measurement year per 1,000 enrollee months. | Number of admissions to an institution (nursing facility or ICF/IID) during the measurement year per 1,000 enrollee months for MLTSS beneficiaries 18 and older. | Number of enrollee months for MLTSS beneficiaries age 18 and older. | Administrative | The Department |
| **Ambulatory Care: Emergency Department (ED) Visits (AMB)** | NCQA/NQF Not Available | Rate of emergency department (ED) visits per 1,000 beneficiary months among children up to age 19. | Number of ED visits (non-duplicative). | Number of beneficiary months. | Administrative | |
| **Inpatient Utilization (IU)** | CMS/NQF Not Available | Rate of acute inpatient care services (total, mental and behavioral disorders, surgery, and medicine) per 1,000 enrollee months. | Inpatient stays and length of stay. | Eligible population. | Administrative | |

Source: https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/downloads/2021-health-home-core-set.pdf

# Advisory Subcommittees

# Advisory Subcommittees

**The Department will leverage its internal Quality and Health Outcomes Committee and external advisory Quality Subcommittees (e.g. Medical Care Advisory Committee, Consumer and Family Advisory Committee) to effectively monitor and review plan performance.**

- The external subcommittees are charged with providing input to the Department on the following:
  - Tailored Plans' proposed QAPI plans;
  - Proposed updates or revisions to the Department's Quality Strategy, including accounting for the recommendations put forth by the EQRO;
  - Development of and changes to key Department programs designed to assess plan performance, reward quality improvement, and ensure plan accountability, including the withhold program; and
  - Quality measure sets Tailored Plans are required to report to the Department, based on statewide priorities and clinical advancements.

**Provider Implications:** Providers are invited to participate in advisory subcommittees.

# National Committee for Quality Assurance (NCQA) Accreditation

# NCQA Accreditation Requirements

**Tailored Plans are required to attain accreditation from the NCQA within the first three years of operations, to include achieving LTSS distinction.**

- However, plans must meet key accreditation milestones starting in Contract Year 1, to include:
  - Meeting the clinical practice guidelines required for Health Plan Accreditation; and
  - Submitting all reports, findings, and other results from private accreditation review(s) to the Department and, as determined by the Department, to the EQRO.
- Certain accreditation requirements include activities that will also be reviewed by the state's designated EQRO.

**Provider Implications:** Plans will be working with you to achieve accreditation.

# External Quality Review Organization (EQRO)

# Role of the EQRO

**The State's EQRO will play a critical role in ensuring the validity of plans' reported encounter data, as well as in the validation and calculation of quality measures.**

- The EQRO is an independent contractor that has been selected by the State.*
- The EQRO will perform an annual external quality review (EQR) of each Tailored Plan.
- The EQR will include (but is not limited to):
  - Determining plan compliance with network adequacy and access requirements;
  - Confirming the adequacy of each plan's network; and
  - Validating Tailored Plans' data.
- The EQRO must include the findings of the annual EQR in a technical report, which will be posted on the State's website.

**Provider Implications:** Plans may request information and support related to the annual EQR.

* Further information on federal requirements for the EQRO can be found: 42 C.F.R. § 438.354(c); 42 C.F.R. § 438.364(b) and 42 C.F.R. § 438.354(b)