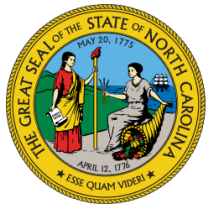
Virtual Quality Forum

October 12, 2021



NCDHHS
NC Medicaid
Division of Health Benefits

NORTH CAROLINA
AHEC

AmeriHealth Caritas
North Carolina

carolina
complete health

HealthyBlue

United
Healthcare
Community Plan

WellCare
Beyond Healthcare. A Better You.

Agenda

- Introduction
- DHHS NC Medicaid Managed Care Quality Strategy
- Quality Measure Data and Reporting to AMHs
- Performance Improvement Initiatives
  - Childhood Immunizations
  - Diabetes Control
  - Timeliness of Prenatal Care
- COVID-19 Vaccine Strategies
- Health Plan and AHEC Provider Supports

Introduction

Provider Quality Forum Objectives:

At the end of this session attendees will be able to:

- Explain why Health Plans conduct Performance Improvement Projects (PIPs);
- List DHB-specified PIPs for year one;
- Summarize quality indicator definitions;
- Recognize importance of individual practice performance; and
- Discuss the connection between published clinical practice guidelines and PIPs.
- Providers will know AHEC & PHP practice support resources and who to contact.

Quality Forum Workgroup

DHHS – Kelly Crosbie, Jaimica Wilkins, Taylor Zublena, Beth McDermott, and Shawn Latta

AHEC – Chris Weathington, Carol Stanley, and Monique Mackey

Carolina Complete Health – Melissa Fabrikant, Donetta Godwin, Diamond Stephens and Jesse Hardin

AmeriHealth Caritas of NC – Pamela Harris, Shaunesi Griffin, and George Cheely

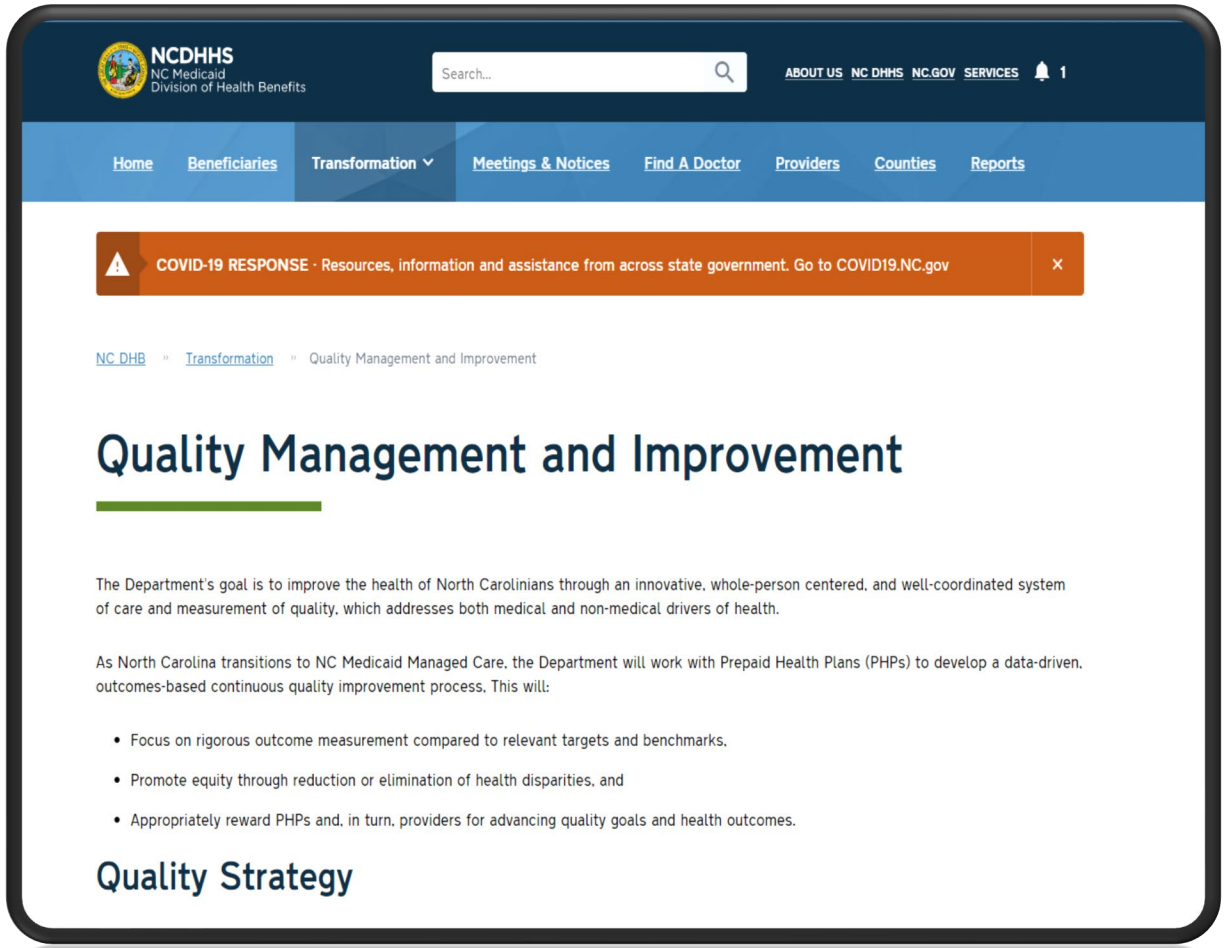
HealthyBlue of NC – Jeanne Leslie, Jaime Taylor, and Sabah Abernathy

United Healthcare – Atha Gurganus, Lorrie Jones-Smith, and Marian Hawkins

WellCare – Katherine Cornish, Michelle Minton, Frances Johnson, Lena Klumper, and Emori Campbell

State Medicaid Managed Care Quality Strategy

NC Medicaid Quality Management and Improvement

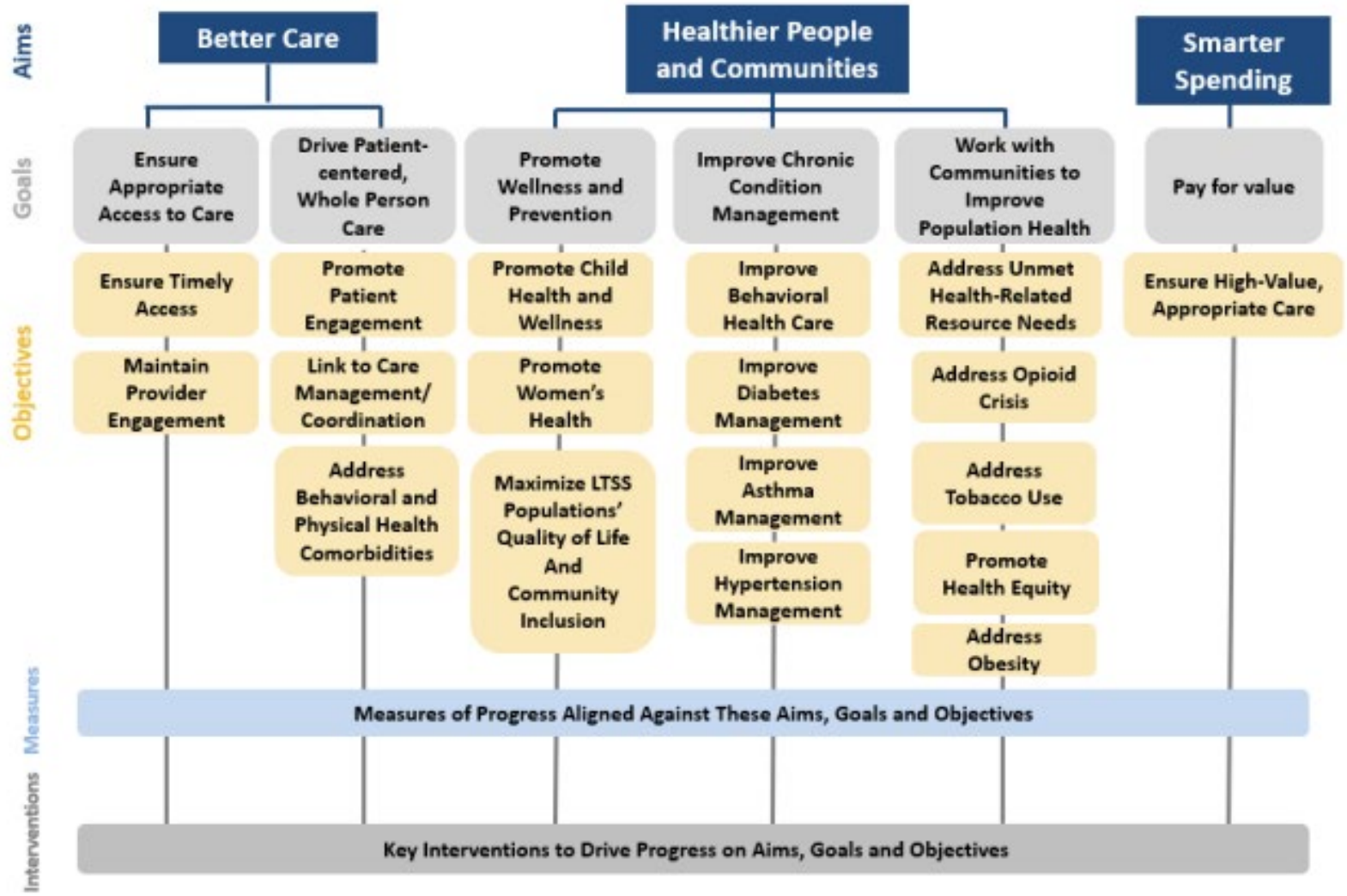


- ✓ ***Medicaid Quality Strategy***—outlines aims, goals, objectives and interventions to assure, monitor, and improve quality
- ✓ ***Annual Quality Report (AQR)***—4 years of data on Medicaid quality
- ✓ ***Quality Measure Technical Specifications:*** Standard Plan and Tailored Plan measure sets with technical specifications and targets

Link: ***https://medicaid.ncdhhs.gov/transformation/quality-management-and-improvement***

Quality Strategy Framework

North Carolina's Quality Strategy is built around the desire to build an innovative, whole-person, well-coordinated system of care that addresses both medical and non-medical drivers of health and promotes health equity.



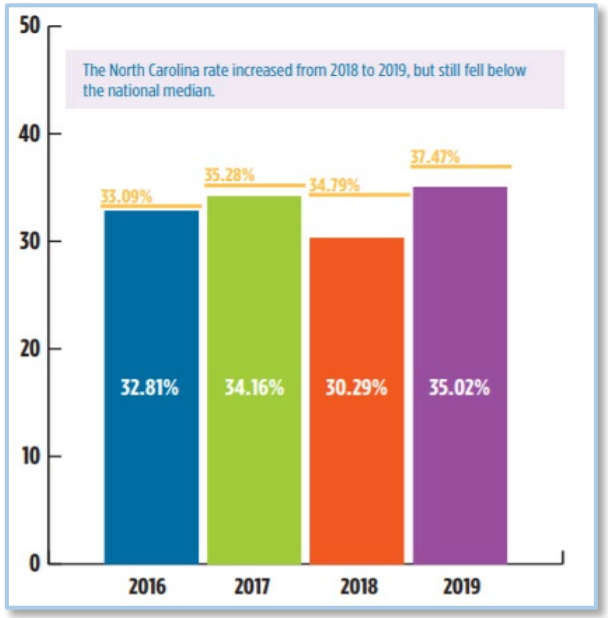
Defines and drives the overall vision for advancing the quality of care provided to Medicaid beneficiaries in North Carolina.

Pediatric Prevention: Well Care and Immunizations

Measure Name	2016 Rates %	2017 Rates %	2018 Rates %	2019 Rates %	Comparison to 2019 National Median
Ambulatory Care: ED Visits Ages 0-19 (Per 1000)	—	45.70	45.53	46.83	◇ 43.6[27]
Childhood Immunization Status (Combination 10)[28]	32.81	34.16	30.29	35.02	★★
DTaP	75.23	77.37	74.12	77.62	★★
IPV	90.18	92.42	87.82	92.00	★★
MMR	91.46	91.09	89.45	90.93	★★
HiB	87.40	89.26	86.09	88.92	★★
Hepatitis B	91.91	94.1	84.56	93.6	★★
VZV	91.20	91.03	88.96	90.69	★★
Pneumococcal Conjugate	76.37	79.11	76.22	79.16	★★
Hepatitis A	82.31	82.89	82.56	84.22	★★
Rotavirus	71.77	73.81	72.22	74.55	★★
Influenza	45.42	45.9	44.70	45.34	★★
Follow-Up After Hospitalization for Mental Illness (Ages 6-17 years)					
7-Day Follow-up	—	—	15.8	15.49	★
30-Day Follow-up	—	—	23	22.84	★
Immunizations for Adolescents (Combination 2)[29]					
Combination 2 Rate	15.62	21.67	28.89	31.55	★★
Combination 1 Rate	57.94	72.26	83.91	86.26	★★
Meningococcal	62.17	75.98	85.71	87.89	★★
Tdap (Tetanus, Diphtheria, Acellular Pertussis)	76.83	82.33	87.52	89.25	★★
HPV (Human Papillomavirus)	23.95	26.19	30.91	33.27	★★

Percentage of Eligibles Receiving at least One Initial or Periodic Screen	**52.9**	**51.42**	**51.61**	**52.98**	◇ **51.61[31]**
Percentage of Eligible Beneficiaries Who Received Preventive Dental Services (PDENT-CH)[32]	50.6	51	51.4	52.1	◇ 45.86[33]
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (the total of all ages for each of the 3 rates)[34]					
Total BMI Percentile documentation	28.9	34.19	38.44	42.56	★
Total Counseling for Nutrition	10.42	15.27	17.93	21.06	★
Total Counseling for Physical Activity	0.85	1.2	2.23	5.2	★
Well-Child Visits in the First 15 Months of Life – 6 or More Visits	59.38	62.52	64.99	67.71	★★
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	69.25	69.88	70.14	70.48	★★

Childhood Immunization Status (Combo 10)



The proportion of children in NC Medicaid who received immunization combo 10 by their second birthday.

- While still below the national median, the rate increased from 2018 to 2019.

Maternal Health Indicators

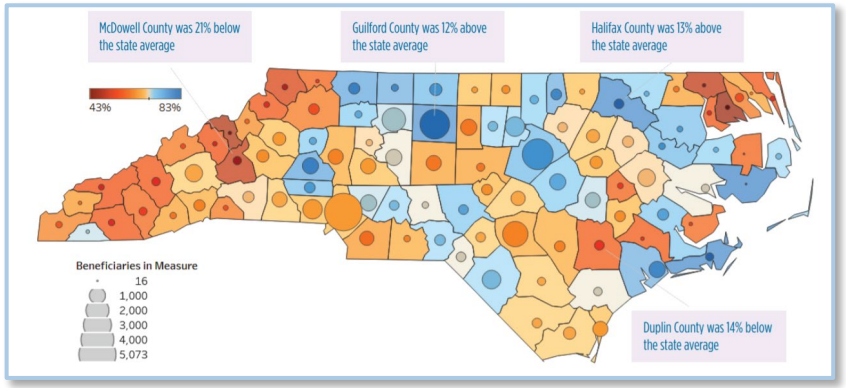
Includes the goal of **promoting wellness and prevention for women's health**.

Measure Name	2016 Rates %	2017 Rates %	2018 Rates %	2019 Rates %	Comparison to 2019 National Median
Breast Cancer Screening	49.67	46.76	43.64	41.35	★
Cervical Cancer Screening	52.44	49.83	46.47	43.82	★
Chlamydia Screening	58.19	58.2	57.86	58.22	★★
Contraceptive Care for Postpartum Women: Most & Moderately Effective Methods (Ages 15-20) CCP[38]					
3 Days Postpartum Rate 1 (Most or moderately effective FDA-approved)	5.5	3.6	7.9	9	N/A
60 Days Postpartum Rate 1 (Most or moderately effective FDA-approved)	41.1	47	48.4	46	N/A
3 Days Postpartum Rate 2 (LARC)[39]	1.2	0.5	1.9	3.6	N/A
60 Days Postpartum Rate 2 (LARC)	16.4	21.1	18.9	18	N/A
Contraceptive Care: Most & Moderately Effective Methods (Ages 21-44) CCP					
3 Days Postpartum Rate 1 (Most or moderately effective FDA-approved)	13.2	10.8	15	15	N/A
60 Days Postpartum Rate 1 (Most or moderately effective FDA-approved)	38.4	43.7	44.4	43.2	N/A
3 Days Postpartum Rate 2 (LARC)	0.6	0.3	0.75	2.2	N/A
60 Days Postpartum Rate 2 (LARC)	11	14.9	12.5	13	N/A
Percentage of Low Birthweight Births[40]	8.9	9.1	9.2	9.4	◇ 8.2
Prenatal and Postpartum Care (Both Rates)					
Timeliness of Prenatal Care (HEDIS)	37.66	36.92	36.37	35.53	★
Postpartum Care (HEDIS)	59.03	59.36	58.89	68.77	★★
Timeliness of Prenatal Care[41] (HEDIS-like)	—		77.48		
Postpartum Care (HEDIS-like)	—		71.36		
Rate of Screening for Pregnancy Risk	78.2	78	77.9	77.5	N/A

More than **85%*** of the NC Medicaid population are women and children. Medicaid's continued focus on these populations is evident through the NC DHHS aligned:

- Early Childhood Action Plan
- Perinatal Health Action Plan
- Maternal Health Strategic Plan

Postpartum Care by Geography



The proportion of deliveries that had a postpartum visit on or between 21 and 56 days after delivery by geography.

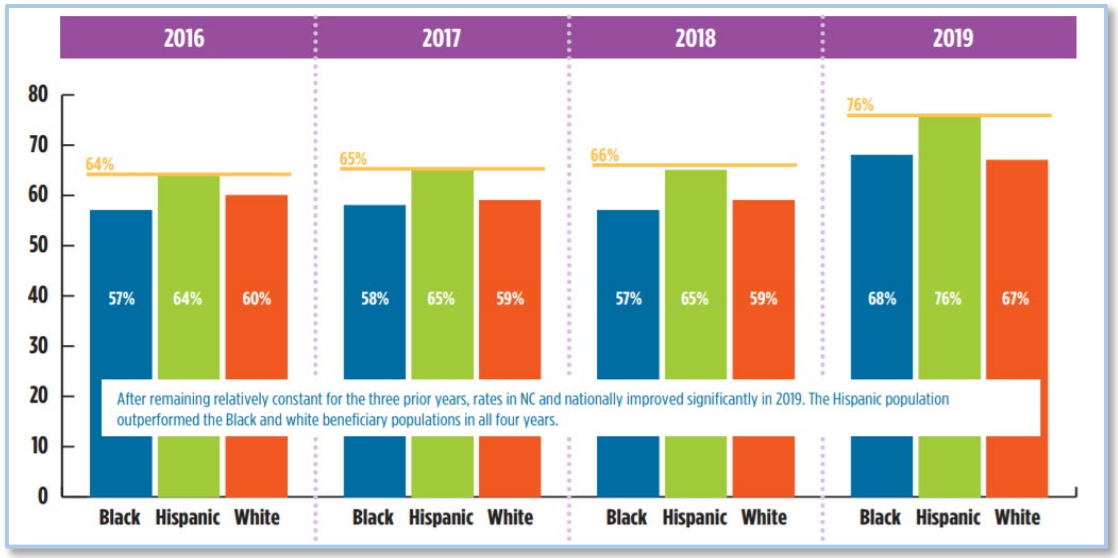
* https://files.nc.gov/ncdma/documents/AnnualReports/AnnualReport_SFY2017_20171230.pdf

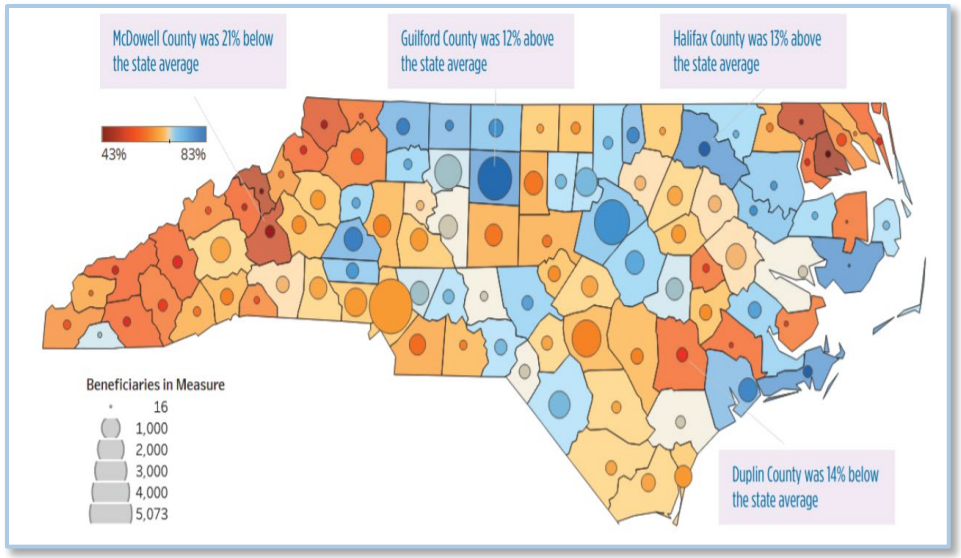
Maternal Health Indicators

Postpartum Care by Race and Ethnicity

Postpartum Care by Geography

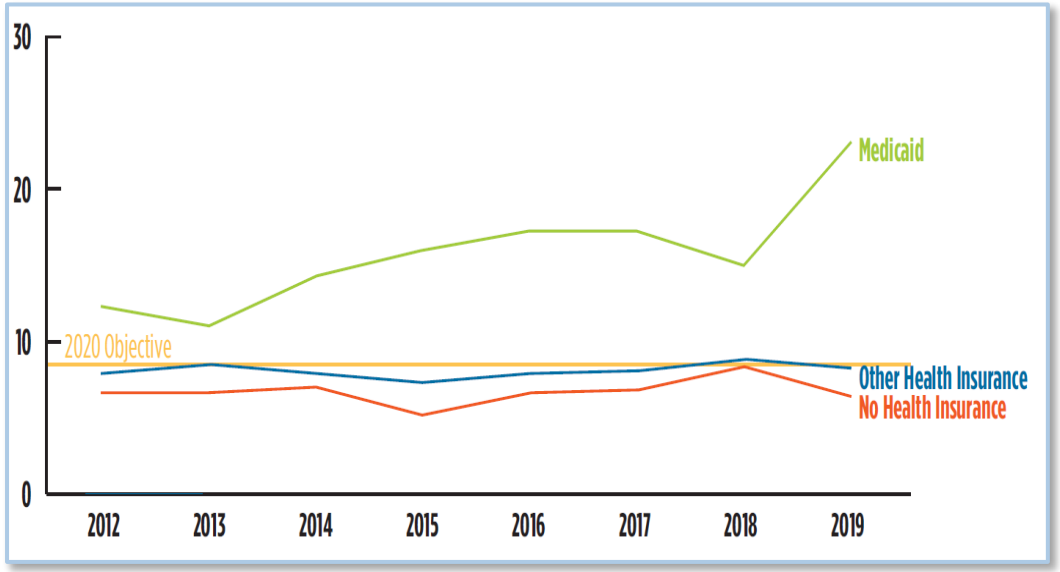
The proportion of deliveries that had a postpartum visit on or between 21 and 56 days after delivery by race/ethnicity and geography.





Diabetes Prevention and Control

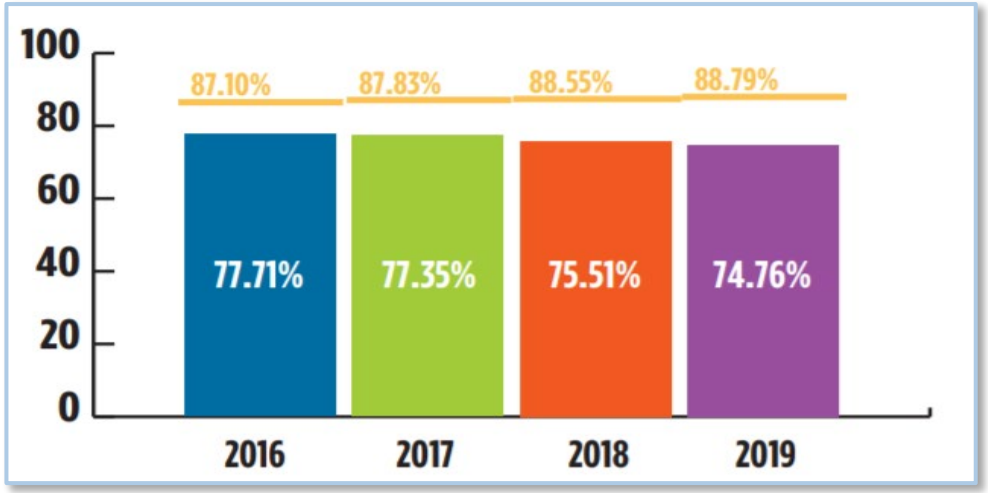
Diabetes by Insurance Type



The percent of North Carolina adults with diabetes by insurance types based on the BRFSS questionnaire.

* https://schs.dph.ncdhhs.gov/data/brfss/medicaid/docs/Medicaid_2018_tables.pdf

HbA1c Testing



The proportion of individuals ages 18 to 75 in NC Medicaid with diabetes who received an HbA1c test.

- **Almost a quarter of individuals did not receive this test, despite it providing critical information about glucose control and disease management.**
- **NC remains below the national median.**

Diabetes Prevention and Control

Measure Name	2016 Rates %	2017 Rates %	2018 Rates %	2019 Rates %	Comparison to 2019 National Median
Asthma Medication Ratio (Total Rate)	62.97	63.5	64.53	65.30	★★
Hemoglobin A1c (HBA1c) Testing	77.71	77.35	75.71	74.76	★
Plan All-Cause Readmissions - Observed to expected ratio	—	0.82	0.82	0.93	◊ 0.83
PQI-01: Diabetes Short-Term Complication Admission Rate	19.26	23.1	24.4	27.8	★★ 19.1[48]
PQI-05: COPD or Asthma in Older Adults Admission Rate	94.37	103.4	71.91	92.7	★★ 71.9[49]
PQI-08: Heart Failure Admission Rate	39.19	42.57	40.79	43.5	★★ 26.4[50]

Includes the goal **of improving chronic condition management**. Over **40%*** of NC Medicaid beneficiaries have a chronic condition.

Utilization Measures

Most of these measures are prevention indicators aimed at identifying potentially preventable utilization, thus a lower rate is better.

Measure Name	2016 Rates %	2017 Rates %	2018 Rates %	2019 Rates %	Comparison to 2019 National Median
PDI-14: Asthma Admission Rate[69]	103.01	98.75	93.81	90.3	◊ 80.57[70]
PDI-15: Diabetes Short-Term Complications Admission Rate	39.88	44.59	40.09	40.87	◊ 25.09
PDI-16: Gastroenteritis Admission Rate	23.55	24.65	21.59	27.37	◊ 36.26
PDI-18: Urinary Tract Infection Admission Rate	24.14	22.83	17.17	20.07	◊ 20.55
PQI-01: Diabetes Short-Term Complication Admission Rate	12.2	23.38	24.43	27.8	★★ 19.1[71]

Quality Initiatives within the AMH Program

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

- All practices will be eligible to earn negotiated Performance Incentive Payments based on the set of measures in the AMH measure set, **which were selected for their relevance to primary care and care coordination.**
  - Performance Incentive Payments are optional for Tier 1 and 2 AMHs.
  - Standard Plans are required to offer opportunities for such payments to Tier 3 AMHs.
- Standard Plans are not required to use all the AMH measures, but **any quality measures they choose must be drawn from this set;** plans are not permitted to use measures drawn elsewhere.

CY2022 = First Measurement Period
CY2019 = Baseline Statewide Rates

Advanced Medical Home Measure Set

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

*Monthly gap measure reports are also required.

Performance Improvement Projects (PIPs)

FY2022 Medicaid Performance Improvement Priorities

Standard Plans are required to conduct Performance Improvement Projects (PIPs) that:

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

FY22 PIPs

- **Diabetes prevention and control**
- **Childhood Immunizations**
- **Maternal Health- Timeliness of Prenatal Care**

FY2022 Medicaid Performance Improvement Priorities

Measure Name	2016 Rates %	2017 Rates %	2018 Rates %	2019 Rates %	Comparison to 2019 National Median
Childhood Immunization Status (Combination 10)[28]	32.81	34.16	30.29	35.02	★★
Timeliness of Prenatal Care (HEDIS)	37.66	36.92	36.37	35.53	★
Hemoglobin A1c (HBA1c) Testing ★	77.71	77.35	75.71	74.76	★

★ While historical rates for this measure are not available for HbA1c Control, secondary indicator rates of hemoglobin A1c (HbA1c) testing provide historical performance on diabetes care in NC Medicaid

* https://files.nc.gov/ncdma/documents/AnnualReports/AnnualReport_SFY2017_20171230.pdf

Childhood Immunization Status (CIS) Combo 10

Childhood Immunizations Combo 10 PIP
Measure Steward: National Committee for Quality Assurance

Clinical Guidelines: Centers for Disease Control and Prevention Advisory Committee on Immunization Practices (ACIP)

- 2021 Recommended Child and Adolescent Immunization Schedule (cdc.gov)
- www.cdc.gov/vaccines/hcp/acip-recs/general-recs/downloads/general-recs.pdf

Measure Overview:

- Improve the rate of compliance for childhood immunizations among children in North Carolina receiving Medicaid, EPSDT or Health Choice benefits
- The "combination 10" vaccine measurement consists of the following series which aligns with the American Academy of Pediatrics (AAP) Bright Futures Periodicity Schedule

4	DtaP (Diphtheria, tetanus, acellular Pertussis
1	MMR (Measles, Mumps, Rubella)
4	PCV (Pneumococcal Conjugate)
1	VZV (Varicella Zoster Vaccine)
3	HiB (Haemophilus Influenza type)
1	Hep A (Hepatitis A)
3	Hep B (Hepatitis B)
3	PV (Polio)
2	Influenza (flu)
2 to 3	Rotavirus

Childhood Immunizations Combo 10 PIP

Measure Steward: National Committee for Quality Assurance (NCQA)

NC MEDICAID FFS Rates & Comparisons to Targets

US Medicaid FFS Median CY2019	NC Medicaid FFS Rate CY2019	NC DHHS + 5 Percentage Points	NC Medicaid FFS Rate CY2020	NC DHHS + 5 Percentage Points
37.47*	35.02	36.77	36.16	37.97

Impact Questions:

- Does the implementation of targeted education and awareness campaigns increase the rate of compliance with childhood immunizations combo 10 (from a baseline of 35.07 percentile in CY2019) for eligible members as measured by HEDIS?
- Are we addressing social determinants of health to improve childhood immunization compliance?

**Source: NC DHHS, 2016-2019 Standard Plan Measure Set, 8/11/2021*

Childhood Immunizations Combo 10 PIP
Measure Steward: National Committee for Quality Assurance (NCQA)

Awareness:

- Data capture impacting provider VBP results and payout:
  - Importance of billing correct codes and/or provider reporting to NCIR
  - Remember to include correct codes when billing for administration of vaccines from federal Vaccines for Children (VFC) immunization stock

Potential Interventions:

- Offer drive-through vaccination clinics
- Provide handouts for parents in clinics/practices
- 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 child care 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

Childhood Immunizations Combo 10 PIP
Measure Steward: National Committee for Quality Assurance NCQA)

Suggested Practical Strategies for Improvement:

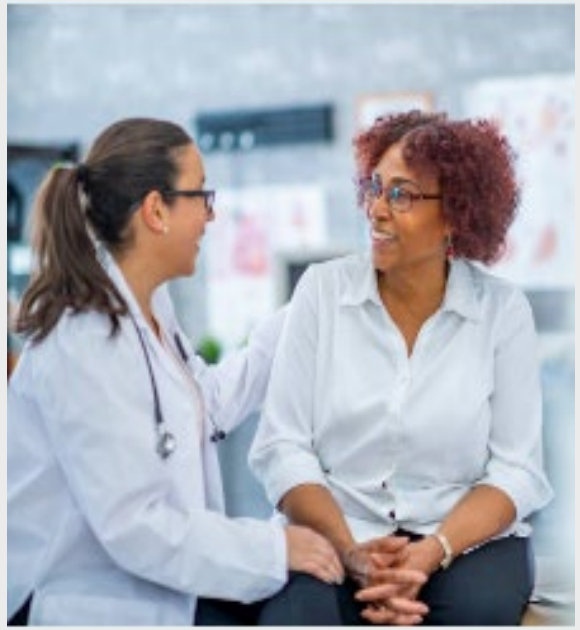
- Target disparate populations by generating a list from Electronic Health Record (EHR) systems (Ex: families in rural areas and/or those with transportation issues)
- Document in the EHR and NC Immunization Registry if immunizations were received elsewhere
- Develop a workflow document to determine 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)
- Use already developed handouts for parents related to importance of vaccines (www.immunize.org/catg.d/p4314.pdf)
- Partner with local Health Departments and PHPs to ensure communication/coordination flow
- Utilize NCCARE360 to streamline information for community connections
- Partner with school systems to advertise immunization clinics/dates being provided
- Run kid-friendly videos in well child clinics on importance of vaccinations

Comprehensive Diabetes Care (CDC) HbA1c >9.0

Comprehensive Diabetes Care (HbA1c) Poor Control > 9.0
Measure Steward: National Committee for Quality Assurance (NCQA)

Clinical Guidelines:

NCQA HEDIS measures are based on industry guidelines, such as the *American Diabetes Association (ADA) Standards of Medical Care in Diabetes*



Measure Overview:

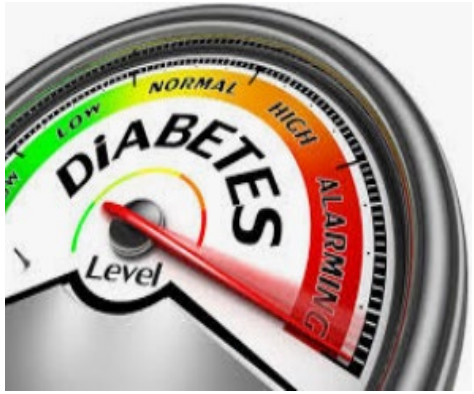
- Diabetic patients diagnosed with Type I or II Diabetes whose most recent HbA1c results indicate poor control > 9.0
- A "reverse measure" focused on improving evidence of diabetes population glucose control by lowering overall HbA1c results
- HbA1c lab results ideally identified through --
  - Submission of CPTII codes or
  - Connection with electronic data exchanges, such as NC HealthConnex

Awareness:

- Data capture impacting provider VBP results and payout:
  - Consistent billing CPT II codes reflecting HbA1c results
  - Electronic submission choices (1) connection to HealthConnex or (2) direct submission of electronic files to Standard Plans

Comprehensive Diabetes Care (HbA1c) Poor Control > 9.0

Measure Steward: National Committee for Quality Assurance (NCQA)



NC MEDICAID FFS Rates & Comparisons to Targets

- CDC HbA1c > 9.0 (Lower is Better)
- CDC HbA1c Test Completed

Measure	US Medicaid FFS Median CY2019	NC FFS Medicaid Rate 2019	NC DHHS Target CY 2019 + 5 Percentage Points	NCQA HEDIS 25th Percentile 2019	NCQA HEDIS 50th Percentile 2019	NCQA HEDIS 75th Percentile 2019	NCQA HEDIS 90th Percentile 2019
HbA1c > 9.0	Unavailable	Unavailable	NA	46.72	38.52	32.85	27.98
HbA1c Test	Unavailable	74.76	78.50	85.16	88.55	90.51	92.94

**Source: NC DHB Quality & Population Health and NCQA Quality Compass 2019*

CY 2020 US Medicaid FFS Rates or NC Medicaid FFS rates not available

Comprehensive Diabetes Care (HbA1c) Poor Control > 9.0

Measure Steward: National Committee for Quality Assurance (NCQA)

Healthy Opportunities Considerations:

The American Diabetes Association (ADA) reports that health inequities related to diabetes and its complications are well documented and have been associated with greater risk for diabetes, higher population prevalence, and poorer diabetes outcomes.

ADA Recommendations for Tailoring Treatment for Social Context:

- Assess food insecurity, housing insecurity/homelessness, financial barriers, and social capital/social community support and apply that information to treatment decisions.
- Refer patients to local community resources when available. Utilize North Carolina resource NCCARE 360.
- Provide patients with self-management support from lay health coaches, navigators, or community health workers when available

American Diabetes Association. Diabetes Care

Comprehensive Diabetes Care (HbA1c) Poor Control > 9.0

Measure Steward: National Committee for Quality Assurance (NCQA)

Best Practices: ADA Chronic Care Management Model – Six Core Strategies to Optimize the Care of Patients with Chronic Disease

"Redefining the roles of the health care delivery team and empowering patient self-management are fundamental to the successful implementation of the Chronic Care Management. Collaborative, multidisciplinary teams are best suited to provide care for people with chronic conditions such as diabetes and to facilitate patients' self-management."

Delivery system design --- move from a *reactive* to a *proactive* care delivery system where planned visits are coordinated through a team-based approach

Self-management support --- consistent effort to educate patients/caregivers to manage their illness

Decision support --- base care on evidence-based, effective care guidelines

Clinical information systems --- use registries that can provide patient-specific and population-based support to the care team

Community resources and policies --- identify or develop resources to support healthy lifestyles

Health systems --- create a quality-oriented culture

American Diabetes Association. Diabetes Care

Comprehensive Diabetes Care (HbA1c) Poor Control > 9.0

Measure Steward: National Committee for Quality Assurance (NCQA)

ADA Strategies for Improvement: Utilizing A Systems Approach

- **Maximize Multi-Disciplinary Care Team** – advise to focus on prioritizing timely, appropriate intensification of lifestyle and/or pharmacologic therapy for patients who have not achieved the recommended metabolic targets

- **Use of Telemedicine** – Increasingly, evidence suggests that various telemedicine modalities may be effective at reducing A1C in patients with type 2 diabetes compared with usual care or in addition to usual care.

- **Patient Behavior Change** – Implementation of quality diabetes self-management education and support (DSMES).

  https://diabetesmanagementnc.com/learn-about-dsmes

DSMES
Diabetes Self-Management Education and Support

Timeliness of Prenatal Care

Timeliness of Prenatal Care PIP

Measure Steward: National Committee for Quality Assurance (NCQA)

Measure Overview:

- **Type:** process measure which means that it is captured when an activity has been accomplished.
- **Description:** The percentage of deliveries of live births between October 8 of the year prior to the measurement year and October 7 of the measure year. For these women, 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 as a member of the organization in the first trimester or within 42 days of enrollment in the organization.

Timeliness of Prenatal Care PIP
Measure Steward: National Committee for Quality Assurance (NCQA)

Clinical Guidelines:

NCQA HEDIS measures are based on industry guidelines, such as the following:

- 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

Timeliness of Prenatal Care PIP

Measure Steward: National Committee for Quality Assurance (NCQA)

Healthy Opportunities Considerations:

The ACOG Committee on Health Care for Underserved Women issued a white paper and released a collective opinion (reaffirmed in 2018) ---

"Projections suggest that people of color will represent most of the U.S. population by 2050, and yet significant racial and ethnic disparities persist in women's health and health care. Although socioeconomic status accounts for some of these disparities, factors at the patient, practitioner, and health care system levels contribute to existing and evolving disparities in women's health outcomes."

"Although the existing literature is replete with examples of differences in outcomes in black and white women, more work is needed to explore disparities among American Indian, Alaska Native, and Asian women. In addition, more granular data collection on ethnicity would help to elucidate the heterogeneity of health outcomes within the broad categories of Asian, Hispanic, and other groups.

Details can be accessed at the web-link below which includes national disparity rates for prenatal care in the first trimester:

https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2015/12/racial-and-ethnic-disparities-in-obstetrics-and-gynecology

Timeliness of Prenatal Care PIP

Measure Steward: National Committee for Quality Assurance (NCQA)

NC MEDICAID FFS Rates & Comparisons to Targets

US Medicaid FFS Median CY2019	NC Medicaid FFS Rate CY2019	NC DHHS + 5 Percentage Points	NC Medicaid FFS Rate CY2020	NC DHHS + 5 Percentage Points
89.05	35.53	37.31	39.98	41.98

**Source: NC DHHS, 2016-2019 Standard Plan Measure Set, 8/11/2021*

Timeliness of Prenatal Care PIP

Measure Steward: National Committee for Quality Assurance (NCQA)

Awareness:

- Data Capture**:** If submitting a global bill for payment, the prenatal visit is not included. Make sure to submit a separate claim.

Potential Interventions:

- Establish Peer Supports
- Engage Doula Supports
- Engagement with Pregnancy Care Management
- Schedule post-partum care visit late in the third trimester or before discharge
- Perform outreach within a week after discharge (identifies issues with feeding, anxiety, depression, and connect to supports if needed)
- SDOH, Depression and PPD Screening
- Reproductive Life Planning

Timeliness of Prenatal Care PIP

Measure Steward: National Committee for Quality Assurance (NCQA)

Strategies for Improvement:

- Group Prenatal Care
- Peer Support Networks
- Creative Scheduling
- Implicit Bias Trainings
- Targeted Interventions With Sub-Populations
- Expand pregnancy care management
- Member and Provider Incentives
- Incorporate primary care providers; pre-conception health discussion at every wellness visit

COVID-19 Strategies

COVID-19 Strategies for Care Gap Closure

- Providers access the Health Plan provider portals to identify care gaps https://medicaid.ncdhhs.gov/media/9521/open or review entire patient panel via EHR to identify opportunities.

- Make outreach to members in an effort to gauge receptiveness to in-person visits (Practice level only).

- Schedule appointments and transport to begin to move the needle.

COVID-19 Vaccine

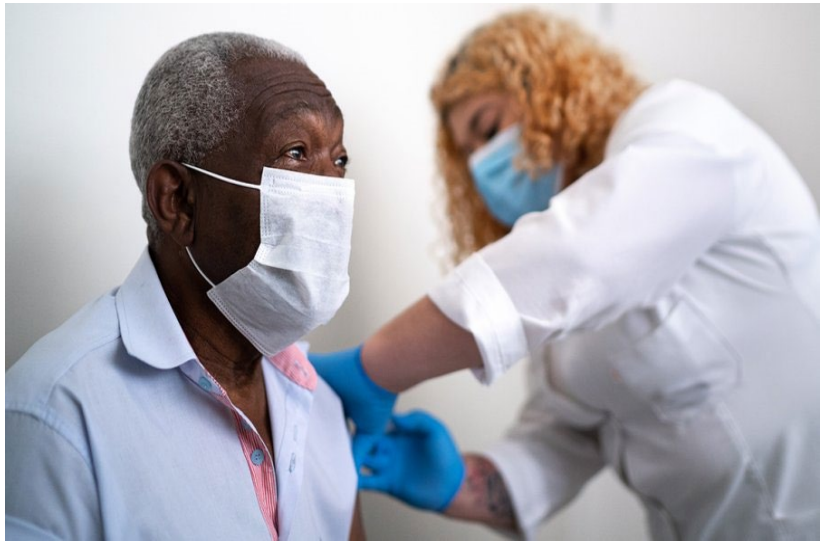
- **Toolkits** are available for practices that wish to become a vaccination site on NC DHHS website:

  https://covid19.ncdhhs.gov/media/3142/download?attachment

- NC DHHS host **COVID-19 Vaccine Management System (CVMS):** https://covid19.ncdhhs.gov/vaccines/info-health-care-providers/covid-19-vaccine-management-system-cvms.

COVID-19 Vaccine

- **Use CPT code 99401 counseling code with modifiers to indicate a PHE code.**
  - 25 modifier for OV and E&M services
  - CR and GT modifier for telehealth services
  - CR and KX modifier for telephonic services



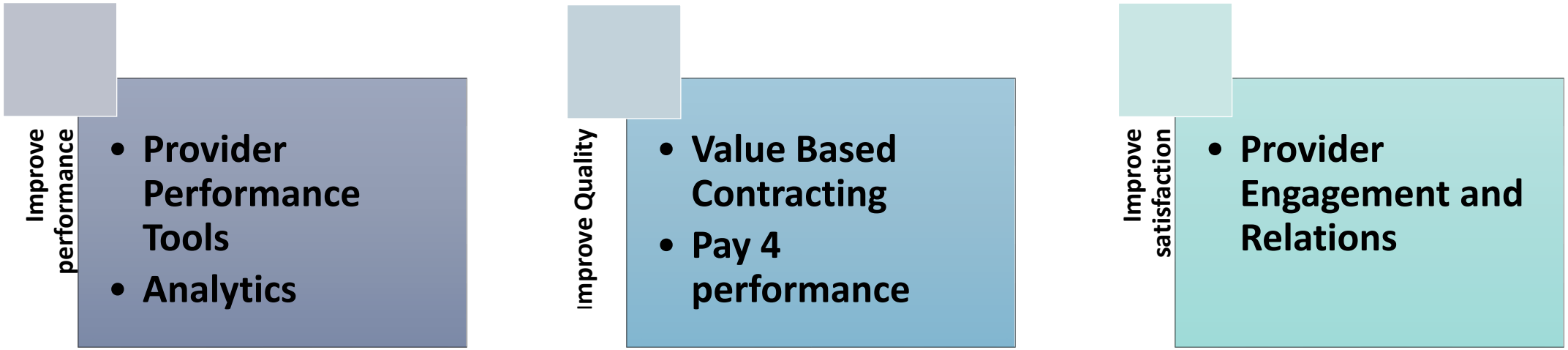
- **Reimbursement rate range**
  - $21.10 for Facility,
  - $32.94 for Non-Facility

- **Administration COVID-19 CPT codes:** 91300 Pfizer, 91301 Moderna, 91303 J&J
- Consistently report vaccine administration to the COVID-19 Vaccine Management System (CVMS)
- Providers will also be able to access COVID-19 vaccination status at the patient level after 10/20/2021 in the North Carolina Immunization Registry

Practice Support

Health Plan and AHEC Practice Support

- Dedicated Provider Support & Connection teams
- Health Plans, AHEC and CINs/ACOs collaborate to support practice needs
- Customized engagement strategy based on needs of the practice
- Embedded local boots-on-the ground support with onsite or virtual visits
- Focus on administrative simplification and provider satisfaction
- Health Plans are able to assist practices with health plan specific needs
- AHEC is able to assist practices across a broad spectrum of practice support needs



Health Plan Provider Support

Each health plan offers provider support that includes but is not limited to:

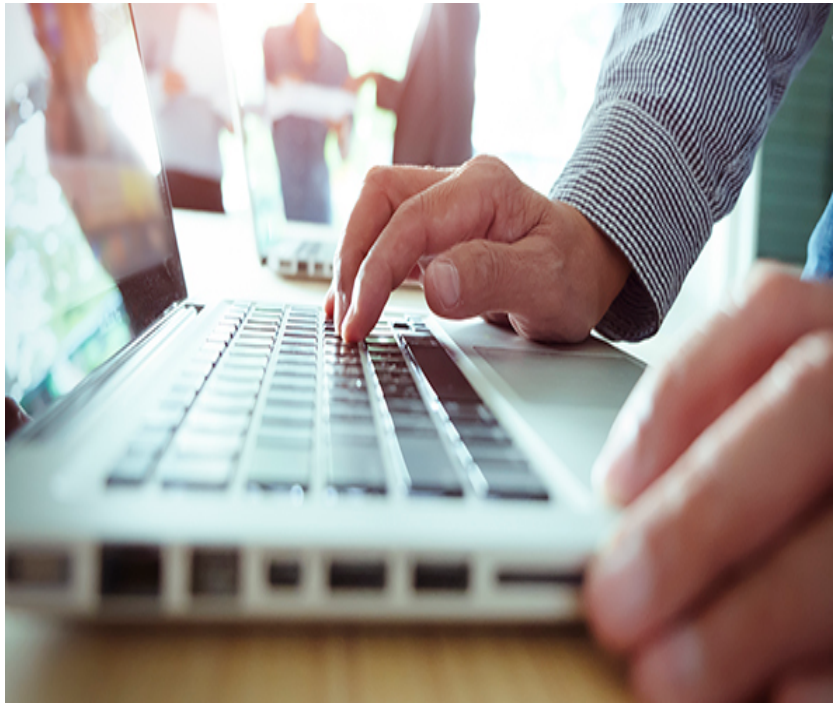
- Linking providers to wrap-around support
- Enhancing the member experience
- Individualized provider training

- Focus on Driving Innovation & Education
- Resources/ tools regarding best practices and clinical outcomes
- Innovative Portal Features
- Provide Care Gap Closure Support and Provider Incentives

Health Plan Data and Analytic Support

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 Data and Analytic Support

Each health plan offers Provider Analytics via Dashboards or Reports

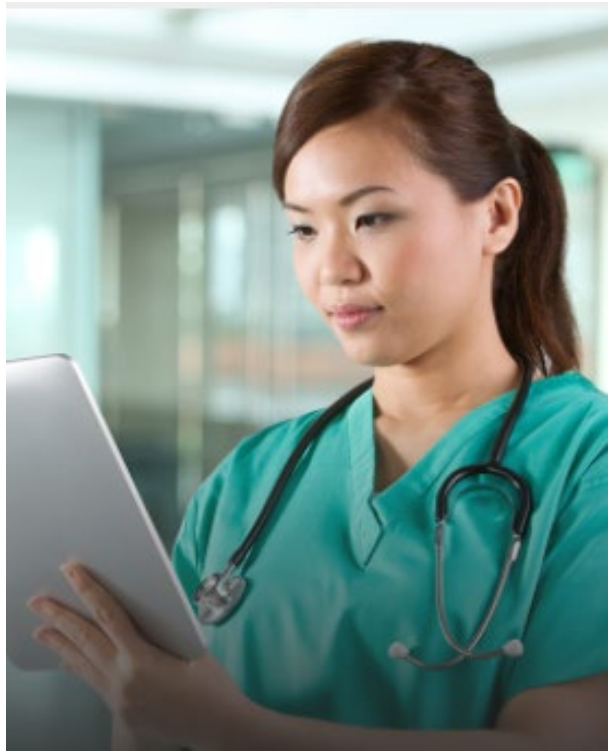
- Key Performance Indicators
- Cost and Utilization
- Emergency Room
- Pharmacy
- Quality performance
- Integrated Care Gaps
- Value-based Contracting
- Single member or practitioner drill-down functionality

Strategic Innovation and Performance Improvement

Innovation and Pilots with Community Stakeholders

Provider Support and Interventions

Member Outreach and Care Reminders



EPSDT Education and Outreach

Analyze Performance with Targeted Improvement

Reduce Health Disparities and Improve SDoH

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@healthyblue.com

United Healthcare Community Plan:
uhccommunityplan.com/NC

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

(TTY: 711)

Monday – Saturday 7am-6pm

WellCare:
wellcare.com/NC

NCProviderRelations@Wellcare.com

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

(TTY: 711)

AHEC Practice Support

- We are the contracted partner with NC Medicaid to provide practice support services and educational programming for providers across all 100 counties.

- AHEC has a 50-year history of serving the state's health workforce needs and a national leader in practice support.

- The aim is to help providers thrive with value-based care across entire patient panel including Medicaid and all other payors.

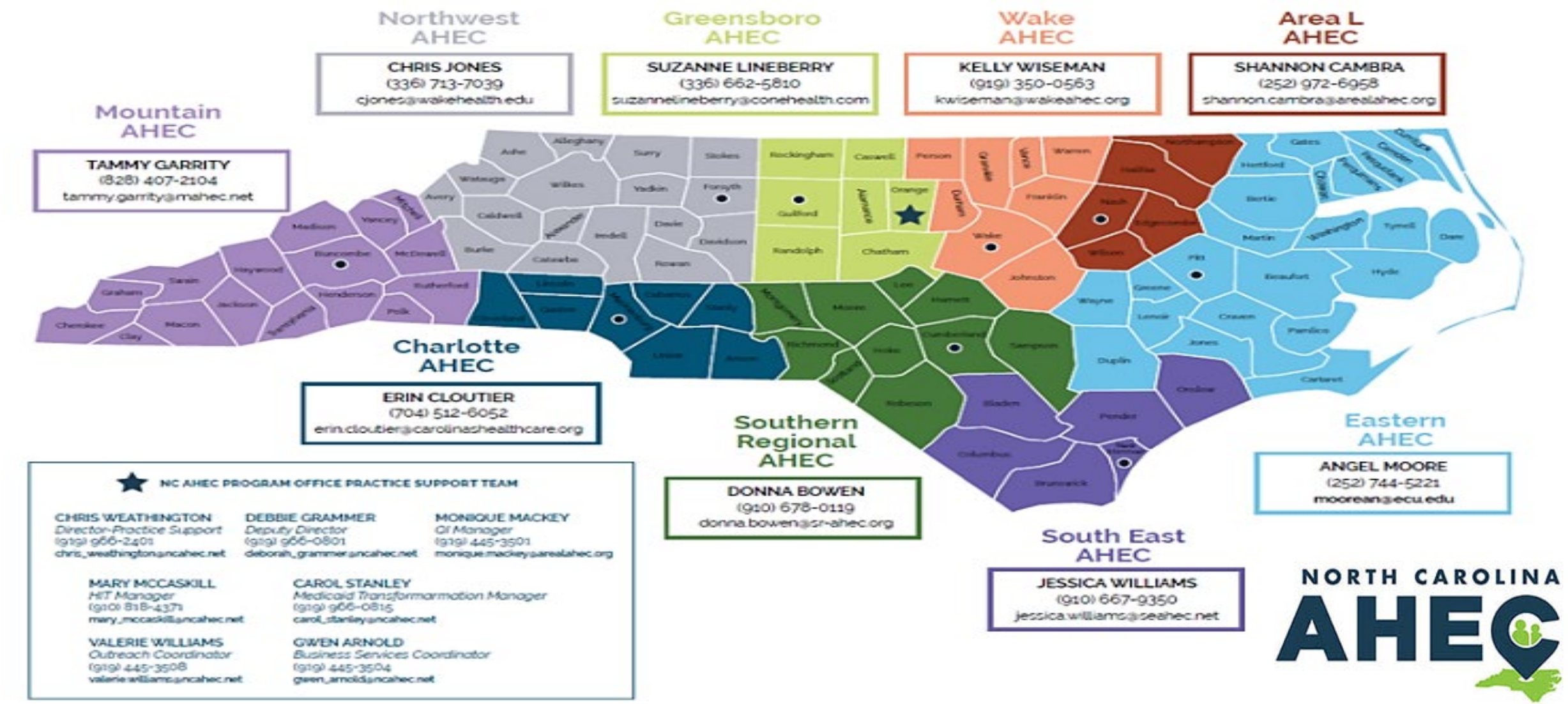
- This service is offered at no cost via a team of nearly 40 practice support coaches located at 9 regional AHEC centers across North Carolina.

- Our coaches work 1:1 with independent primary care and specialists, FQHCs and rural health centers, health departments with primary care services and behavioral health providers.

AHEC Practice Support Resources

- Quality & Health Equity Improvement (Medicaid, All Payors)
- Medicaid managed care education & issue resolution
- Clinical workflow redesign & process improvement
- 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 Support
- Tailored Care Management (AMH+/CMA) Support
- Community Health Worker optimization
- Social Determinants of Health Workflow Optimization
- Virtual Collaborative Educational Programming

AHEC Practice Support Direct Contacts



AHEC Practice Support Contacts

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

Other Resources

AHEC & NC Medicaid Webinars & Virtual Office Hours

Medicaid Managed Care Webinar Series for Providers | NC AHEC

NC Medicaid Quality Management and Improvement

https://medicaid.ncdhhs.gov/transformation/quality-management-and-improvement

Questions & Answers

Appendix

NC Medicaid Quality Measure Mechanics

- HISTORY: DHB selected the Standard Plan (SP) quality measure set to reflect key focus areas informed by prior performance.
- MCAC Quality Subcommittee
- NCIOM Task Force (Managed Care Metrics)
- Managed care plans given historical baselines for all measures for which comparable historical data are available at the state level.
- State rates (when available) back to 2016 were published in the AQR.
  - Performance on these measures has varied: some are above and others below the National Median.
  - In some cases, measure performance is difficult to interpret due to limitations in coding and documentation.
- Baselines for Plans/Providers: CY 2019 Statewide Rate
- The AMH set is a sub-set of health plan measures. *They were selected for their relevance to primary care and care management.*

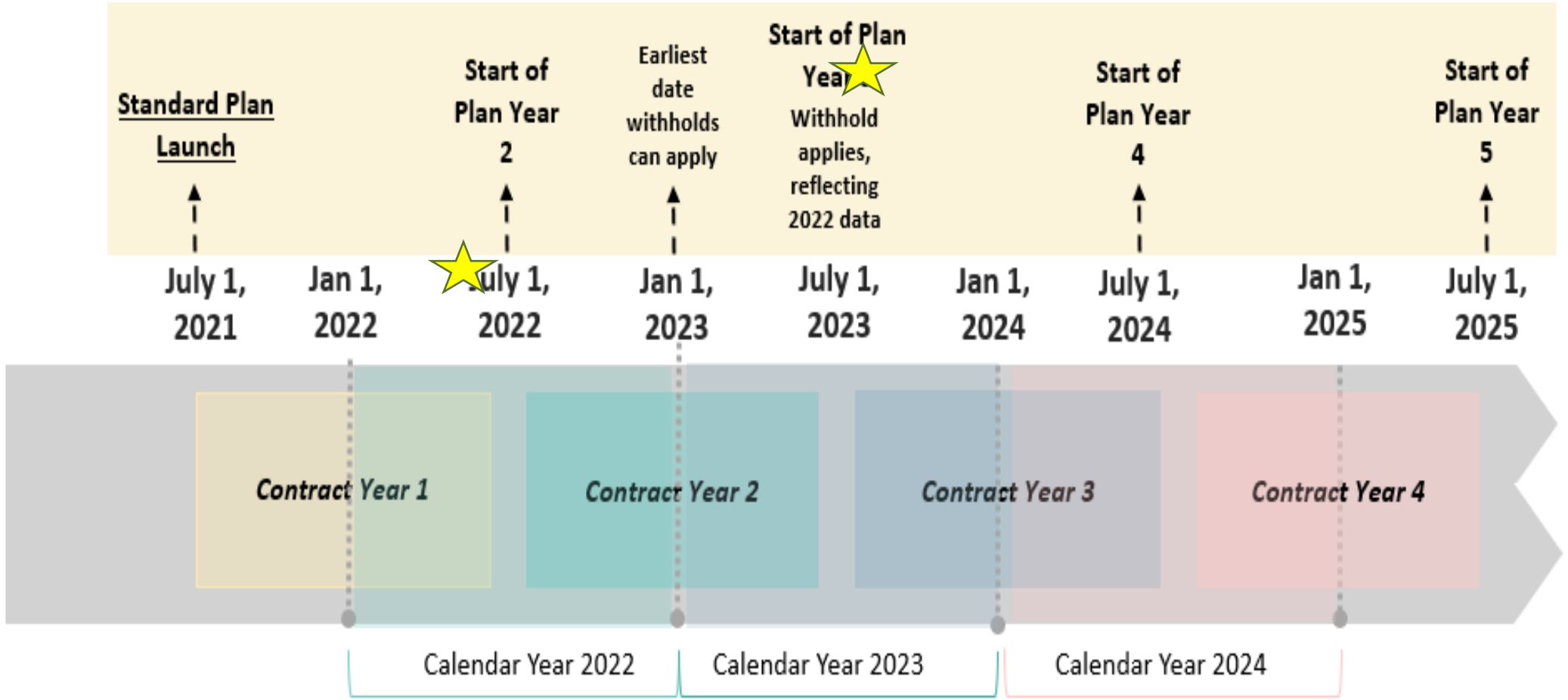
NC Medicaid Quality Measure Mechanics

Targets: *Benchmark for each SP measure will be a 5% relative improvement over the 2019 Statewide Rates*

- Targets to Promote Health Equity: *For measures with a race/ethnicity disparity (10% relative difference), the Plan target is a 10% relative improvement over 2019 Statewide Rates.*
- Withholds/Incentives: *18 months after managed care launch*
- Measure Specifications: technical specifications and targets
  - *DHB will calculate measure performance by Health Plan. Health Plans will calculate measures for providers.*
- Attribution: *DHB/SP working on a standardized attribution model that aligns with PCP assignment*
- FUTURE EVOLUTION: *DHB will update the quality measure sets and benchmarks annually to address:*
  - *Evolution of measure sets and technical specifications.*
  - *Disparate performance by region, plan, group*

Stay Tuned for Information on eMeasures in a future webinar

Standard Plan Quality Measurement Timeline



Continuous Quality Improvement: Benchmarking and Attention to Addressing Health Equity

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

Contract Year 1 and 2:

The Department's **benchmark for each plan-reported quality measure* will be a 5% relative improvement over the prior year's North Carolina Medicaid statewide performance for that measure.**

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

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

Contract Year 3 and Beyond:

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

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

The Department will **continue to promote accurate data collection.**

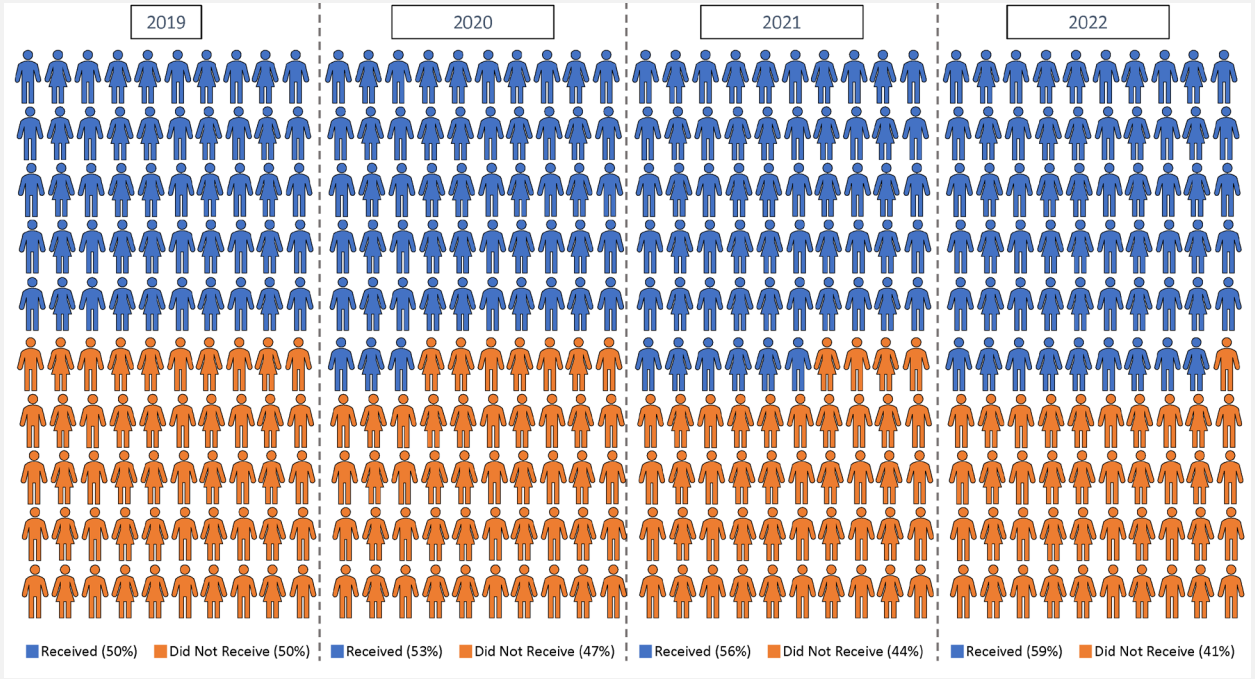
See the Next Slides for Further Detail

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

Contract Years 1-2: Incremental Quality Measure Targets

<u>Health plans</u> 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.

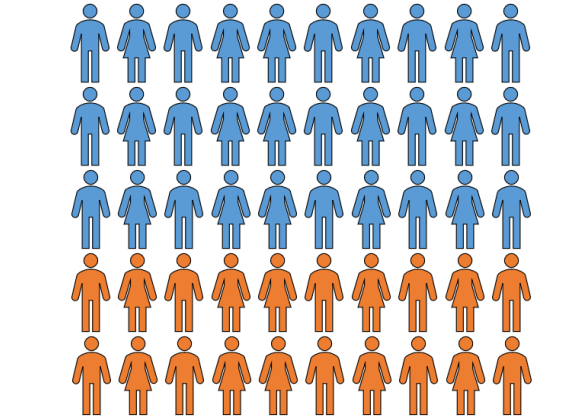
Example: Each year the proportion of eligible women in health plan A that receive a Chlamydia screening increases by 5%. Each blue icon represents 10 women who received their screening. Health plan A's performance goes from 50% (500/1000) in 2019 to 59% (590/1000) in 2022, meaning that health plan A 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 14% disparity, so the measure of influenza vaccination demonstrates a significant disparity.

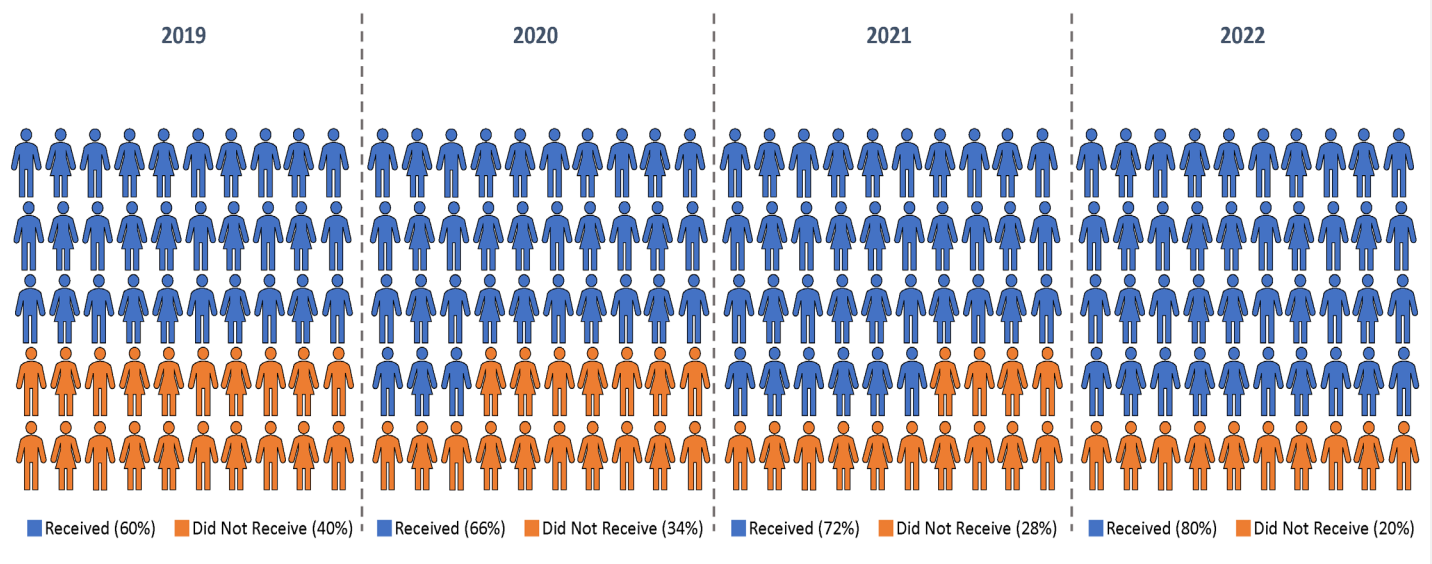


* This disparity definition was developed by AHRQ as outlined in the 2019 National Healthcare Quality and Disparities Report, available here: https://www.ahrq.gov/research/findings/nhqrdr/nhqdr19/index.html

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 Standard Plan or BH I/DD 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.