Transcription for Quality Management in Medicaid Managed Care

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5:30-6:30pm

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Hugh Tilson

Good evening everybody and thank you for participating in tonight's webinar for Medicaid providers, our webinar tonight is part of a series of informational sessions put on by North Carolina Medicaid and North Carolina AHEC to support providers during the transition to Medicaid managed care. We'll put on these fireside chat webinars on the first Thursday of the month on managing Medicaid. And on the third Thursday of the month, Tom Ross, president of CCNC will join us to discuss relevant clinical and quality issues. North Carolina Medicaid and North Carolina AHEC have partnered to ensure that healthcare providers across all 100 North Carolina counties have the information and support they need to adapt to and thrive under managed Medicaid. This collaboration will produce informational webinars like these and virtual office hours across a variety of relevant topics. In addition, the partnership will make AHEC practice for coaches available to provide one to one assistance directly to practices. Tonight we're focusing on quality management and Medicaid managed care. I'm Hugh Tilson and I'll moderate tonight. Before I turn it over to Dr. Dowler, let me run through some logistics. First is, you can adjust the proportions of the slides in the speaker by clicking on the gray bar just to the right of the slides and dragging it to either side to adjust the size of the slide. That way you can control the proportions, the way you want them to be. To remind you, we will also have time for questions at the end. Everybody other than our presenters is muted. So you can submit questions two ways. One is by using the q&a feature in the black bar at the bottom of the screen, or if you're dialing in, send us an email to questionsCOVID19webinar@gmail.com. That's questionsCOVID19webinar@gmail.com. We've learned in the past, the presenters will often address your questions during their presentations. In fact, we've gathered questions in advance that we will ask to respond during the portions of these webinars. I

encourage you to wait till the presenters are through their presentation before submitting a question, and please note, we'll send any questions we don't get to Medicaid, so they can respond directly to you. Lastly, we've posted the slides on the NC AHEC website. A link is in the q&a. We'll record this webinar and will add that recording and a written transcript of it with the slides on the website as soon as possible. Now let me turn it over to Shannon.

Dr. Shannon Dowler

All right, thank you. Hey friends, it's great to see all of your virtual faces on our fireside chat. We've got a nice showing tonight, which is great. That means you guys are as excited about quality as I am. I think I can probably blame most of my love of all things quality on one of my first mentors and teachers. I was an intern at the NC AHEC residency program and Dr. Suzanne Landis was passionate about continuous quality improvement. And even though she drove me a little crazy, she kept me kind of excited about it too, so I'm glad to be here tonight with a large group from our team that really loved quality, just as much. To tell you a lot and get you ready for quality and managed care.

So I think this is a question everybody wants to know right, the times they're changing, and I couldn't get Bob Dylan on the call, but I got a sort of Dave Richard-Bob Dylan mashup. And so here's the question Kelly, how is quality management, how is it going to feel to the provider on July, 1 compared to how it feels today.

Kelly Crosbie

Yeah, I mean, there's no getting around the fact that you're going to have five different entities that you're going to get data and quality scores from, but I think we really tried to build a quality management program that builds on the foundation we already have here in North Carolina, and also aligns with other quality management programs with other insurers and quality measures with other insurers. So, things will come from different places but we try to align with the other lines of business as much as we could.

Dr. Shannon Dowler

That's awesome. So for the next section Kelly is going to tell you all about our quality vision.

Kelly Crosbie

All right, if you could go to the next slide please. A lot of you may have seen this diagram before, but this is the diagram that describes our North Carolina Medicaid Quality Strategy. So our Medicaid Quality Strategy talks about the aims, goals, and objectives of the Medicaid program. It also talks about how we're going to measure our progress towards those aims, goals and objectives. It describes the program interventions that we've put in place that we think will improve quality of care. And it also talks about the accountability and oversight that we'll use for quality management here in North Carolina. Super

quickly our first aim for better care really looks at making sure we have appropriate access to care. We have engaged patients, we have satisfied providers, and we have access to care. It also looks at things like coordination of care. So to individuals, physical health care and behavioral health care-- is it being coordinated.

The second aim is looking at healthier people and communities, so really that's three big buckets of work. Are we promoting wellness and prevention, how are we measuring that and how are we measuring community integration. Are we doing a good job at taking care of the chronic conditions for members of Medicaid. And lastly, how are we improving population health and that's where we really look at issues of promoting health equity and addressing unmet resource needs or social determinants of health.

And the last name of our Quality Strategy is making sure we're paying for the right things, so we're investing where we need to invest and we're not spending a lot of money on avoidable things.

So our quality management program at Medicaid is the cycle, like all quality cycles are. And these are the five things that we do every year. So first we do quality measure reporting, you'll hear about that next. A lot of our reporting is claims based, but we also do surveys, member and provider, and we will be collecting clinical data. We'll be working very closely with the HIE to collect clinical data, so we can do clinical measure reporting. You know, once we collect all these measures we do analysis, we also do disparity analysis. Then we set targets for measure performance, and we go through our amend adopt and abandon cycle, meaning we see measures where we're topped out or we see measures we need to add, and we add this into our measure sets year over year. Expect the measures that we talked about tonight. And the targets that we talked about tonight to flow down into your contracts as a provider, and those should be the measures to show up in any value based arrangements that you have between you and the plans. We will standardized measure sets for certain programs, for example the advanced medical home program. So we want all providers working towards the same statewide quality measures. Then we'll work on performance improvement, we will talk about that a little bit later. Our health plans are required to have an annual assessment and improvement plan that we approve. They'll also have a variety of clinical performance improvement projects. We will ensure that we have alignment across those performance improvement projects and Jamaica will tell you about kind of a little bit later. And we'll also support at the state level, alignment, but also some state led provider support for this particular clinical projects through AHEC. So you see some statewide leadership of those performance improvement projects. We also have external quality assurance. We're required to have this so we have things like governance committees so we have our MCAC quality subcommittee that's made of a large group of physicians and quality experts across the state, it is open to the public and we encourage you to come. And we also have our governing document which is the quality strategy. We also have something called an external quality review organization that will review the health plans every year. So we'll do things like validate their quality measures, they'll perform surveys for us, and they'll oversee key contract areas to make sure that PHPs are compliant-- it really is a quality assurance step that we're required to have by the federal government. We also require our health plans to be accredited by NCQA by the third year of operation so for us that's another quality assurance step. And the last thing that we do every year is program evaluation. So besides all these standard quality measures, how are we evaluating the program overall? Some of the key things we'll do is we'll be evaluating our healthy opportunities pilots, will be evaluating our care management programs, did we set them up right and do

they achieving what we hope they do, and will of course be evaluating things like access to care, which is, which is a complex thing but we'll be evaluating that every year.

We want to be incredibly transparent about quality performance. Every year, we're going to publish an annual Quality Report, which will feature statewide and plan performance. Taylor's going to tell you about our quality report this year which will be statewide baseline performance. We're developing a quality rating scale, which is a member facing plan report card. So what are what are some really important quality members. We;ll get member feedback on what they want to know about their plans. We'll publish an annual health equity report. We'll publish this provider and member surveys that I mentioned. We'll also do a network accessibility report every year, we'll be very transparent with those accreditation and EQR reports that we get, we will publish this as well. And of course we'll publish the results of our evaluations.

This is our quality management webpage, I don't know if folks have seen it, but again this is where you're going to find the Quality Strategy, you'll find the technical specifications for our measures, you'll find a paper on value based purchasing and our value based purchasing plan for year one, you'll see quality reports posted there as well survey results. So please go on and visit the quality management webpage.

So now I'm going to turn things over to Taylor Zublena who's going to talk about our annual quality reports this year.

Taylor Zublena

Good evening everyone. I wanted to introduce you to our North Carolina Medicaid annual report,it is a very comprehensive and detailed evaluation that provides performance and evaluation on the goals and objectives of our three aims that Kelly discussed from the quality strategy as our navigation for improving the health and outcomes for our beneficiaries. In maintaining alignment and focus with our key department initiatives, the Quality Strategy and the measures throughout this report do provide an evaluation of our performance. Our bright spots where we excel, in areas we need to continue to focus on to improve health equity and quality of care through transformation to manage care over time. The report will be posted in the coming months, and some of which we'll be able to highlight this evening with you all. You'll find the history of performance in Medicaid in North Carolina over the last few years, to 2019, to guide and carry our focus into managed care in the future years noting, one of the key objectives being to partner with you all in reducing health disparities and promote health equity, as well as goals to close, identify gaps, and improve over time.

In summarizing our performance over the report years through 2019, we've utilized a star system. This is a widely used star system, and it uses a specific rate-- we'll use North Carolina specific rates as well that you'll see in tonight's presentation slide appendix to provide overall performance categorized by our goals and aims of our quality strategy as our navigational course. Where we have continuous high quality of care and outcomes in areas we continue to focus on to support improvement over time. Most of the measures that you'll see tonight are nationally recognized and aligned such [indiscernible], which is a widely used set of performance measures developed and maintained by NCQA: National Committee for Quality Assurance, as well as our caps member experience survey measures that Kelly mentioned on

the previous slides, which we will show later on tonight's slides, along with public health align measures developed by the CDC pharmacy quality alliance and other state public health sources. As well as alignment where appropriate with the CMS scorecard measures and CMS adult and child court measure sets which will be mandatory by 2024. This allows us to compare our performance and drill down into areas for improvement, as well as sustaining and improving all domains of high quality care. So wanted to introduce our star system, our domains of care. And with that, I'll hand it over to Dr Dowler and our physician leaders to guide us into taking a closer look at these domains of measures.

Dr. Shannon Dowler

So first I want to say that I am so, so excited to have new colleagues join me on the Medicaid team. They all have other day jobs, they're doing this because they really care about the work of Medicaid and many of you have worked with them or continue to work with them and they are there to help our whole team make sure that we've got clinical insight into the decisions we're making. So Dr Abby DeVries, you've heard from her in some of our other fireside chats. She's a family physician and she joined the team in the beginning of January. Dr. Janelle White joined the team as of this week. She's a pediatrician, and then Dr Velma Taormina, who has also been on some prior presentations is our women's health consultant who joined the team a few months ago and so I feel so lucky to have them as part of the team. And before they go on to tell you about how our performance has been, I just want to throw in my bias, on the star reportings. We have one, two or three stars, if you're two stars, you're are average. So when I correlate that to my life, I think about my kids and if they came home with a grade from school that was average. I would be like, probably not good enough. And I would say we've got to do this differently and so unfortunately a lot of our scores in North Carolina for our care of our Medicaid beneficiaries is average we have some that are even below average. We do have some that are above average, I believe chlamydia is one of them which is gratifying. But I do want us to really pay attention to how our performance has been, and make sure that we certainly don't lose ground in managed care but if anything we get better. The other thing I want to say is I get the optics of quality metrics. A lot of the times there are things that are happening behind the scenes when you're taking care of patients that don't show up in the measures, and I commit to you that we are doing everything we can to mitigate the sort of fake measures because nobody likes them. So with that, let me turn it over to our first scorecard, which Dr. DeVries is going to tell you about.

Dr. Abby DeVries

Hi, good evening. So these are adult measures, and this list represents the approach of Medicaid of whole person care so includes physical health and behavioral health metrics, also includes a mix of preventive and chronic disease measures. So as Shannon was saying we know that we have some areas for improvement, specifically around some of the mental health measures, such as hospitalization follow up. And then also wanted to point out the highlighted measure here is the A1c poor control measure. And this one is one of the withhold measures for managed care which means it's a priority measure, it's one that we know we can do better on and want to work with providers and plans to do a better job. The other only other thing I'll point out is that both the hypertension measure, and the diabetes

measure are clinical measures so they show up. We need your data to be able to report those measures so just keep that in mind.

Dr. Dowler

Yeah, and I'm just noticing Abby that chlamydia is only two stars, which is devastating news. I thought we had gone to the three star world. But anyway, I'm sorry I'm distracted.

Dr. Abby DeVries

That is all I was gonna say and then I will happily turn it over to Dr. Janelle White.

Dr. White

Good evening everyone, I was on mute and I was talking, I apologize. So we will begin with our pediatric measures and I'll sort of just go back through the list if that's okay and starting with one: that adolescent will visit. You know as we can see here, we're performing at one star. So, we continue to be slightly below the national median. And it's really sort of just, you know, we need to highlight it just sort of underscores the importance of improvement, especially as we move to managed care and beyond. As pediatricians, this is sometimes a difficult age group to capture for well visits, because there aren't usually many immunizations tied to this age range and other factors so that's something that we certainly want to keep a close eye on. Our childhood immunizations, we tend to be in line with the National median for them. And just to keep in mind that these measures are 2019. So COVID, you know, impact is excluded, as performance listed on this slide because this is through 2019 only so just keep in mind that we are analyzing the impact that COVID has had at the department and partnering with some of our partners, Keeping Kids Well initiative to support improvement. For immunizations, for our combination 10 and also for our combination 2 for adolescence, sort of performing around and the National median. For our percentage of low birth weight of births, we are sort of higher. So the higher the number that's unfavorable, than the national mean for this measure, but we have seen year over year improvement. So this is something that we certainly want to be mindful of because as we know, common outcomes for infants who are low birth weight are likely to experience significant and costly health outcomes and also developmental concerns. For our follow up after hospitalization for mental illness. We don't have any national median at this time data to connect to. So what's reported here is just sort of our North Carolina performance through 2019. So keeping a close eye on that. Moving down the list, our percentage of eligibles, who have received preventative dental care and also access to dental services. We are slightly above the national median for 2019, so making some headway there. Next up is our screening for depression and follow up plan. So this is a CMS Child and Adult core measure, and this one utilizes both claims and clinical data to measure the screening rates and referral for treatment of depression. We don't have a baseline and this is something that we will discuss later in the fireside chat-- regarding the physical feasibility of gathering that clinical data for this measure. But again, just working with our health plans and providers on gathering the data that we need for this measure and just to point out for pediatrics this measure covers patients between the ages of 12 and 17. Next on our list is our Early and Periodic Screening diagnosis and treatment program so that's our EPSDT. And this is for children under 21, who are enrolled in Medicaid and making sure that these

children have their screening for preventative and treatment services and wanting to make sure that they receive at least one initial periodic screen for this so this is something that we are monitoring closely and again we see that we have room for improvement there. The next measure, use of first line psychosocial care for our children and adolescents on antipsychotic, so in North Carolina we're slightly below the main but we're in line with the National median  So, this measure here assesses the percentage of children and adolescents who were newly started on antipsychotic medications without a clinical indication, and had documentation of psychosocial care as first line treatment. Meaning if the child was prescribed an antipsychotic, we want to see if first line psychosocial treatment was also provided prior to or in conjunction with the medication. So our goal here is to avoid unnecessary medication if we can and looking to utilize safer and first line interventions. And then for our last couple of measures our well visits for our infants and young children. This here is for our children and historically well visits having for our patients up to six years of age have increased year over year through 2019, so again doing pretty well there but continuing to keep a close eye. Now, turning it over.

Hugh Tilson

**As y'all are doing that we got a question about what is NQF number?**

Taylor Zublena

And that number is not on my screen, I apologize. This is Taylor Zublena. It is the National Quality Forum. They are the ones who endorse national measures and alignment, along with stewards of NCQA and other measures stewards so it's a national forum where they endorse measures so that can be across the board.

Dr. Taormina

Okay, so let's move on to the maternal health metrics. So as you can see on this screen we don't have as many as the other sections here but if you've been doing current work in our pregnancy medical home these metrics should be very familiar to you. I think the thing that's been educational for me is understanding the time periods that are associated with these metrics. So of note here. If you look at the prenatal and postpartum care metrics, the timeliness of prenatal care we're a little under on that but basically what you want to do is you want to work with your office staff and make sure that you're completing that  first prenatal visit before the end of the 13th week. So during that visit you also want to complete your pregnancy Risk Screening form, and any screening for unmet resource needs. And so when you couple that with the postpartum care metric. You know the postpartum care one is important and knowing that you want to complete that visit during the window of 14 to 56 days after delivery. So it's not the post op visit on day three or day five or day 10. It is a comprehensive visit that needs to occur between days 14 and 56, which is a little different than what we think of now, which is basically up to the 60th day. So, by our public health emergency we've had lots of impact on how we deliver pregnancy care. So we want you to continue to look at your workflow processes in your offices to make sure that, you know, all of these things-- whether you're covering tobacco screening-- making sure that you have

all the billing and problem list indications marked and entered into your system so that you know what work is being provided and then we can document that work. But of note, then just making sure that if you're not involved in this work right now, there are various time between now and July 1 to look at your workflows, and I encourage you to reach out to your OB champions to your nurse coordinators to ask us questions about how we can help you streamline that process. I'll turn it over to Taylor then.

Zublema

Thank you. So, to finally some of our measures that are on our annual Quality Report and measurement, moving forward. We want to further capture the domains of high quality care for adult pediatric and maternal health populations and more. We will continue to engage both providers and beneficiaries and their experience through both a provider facing and a beneficiary survey annually. For beneficiary experience and satisfaction we'll continue to use the CAHPS adult and child survey to engage them, and capture their experience of care, including perceptions of access to care, barriers to care and their experience with their provider and their health plan. A few questions you'll see on the slide here which are also quality measures we've selected for standard plans are drawn from the CAHPS survey including flu vaccination and tobacco cessation measures For 2019 responses performance for tobacco cessation indicates slightly higher the national average on advising smokers to quit and discussing strategies with some improvement needed on discussing medications to support cessation. It is certainly an important area for metrics to reduce tobacco use, and its adverse health effects both within our Medicaid population, as well as the larger scale of healthy North Carolinians as well. These measures are also on the CMS adult core set of health care quality for Medicaid as well. And also in recognizing the transformation and our transition from the current North Carolina Medicaid landscape to manage care, we through a third party will be engaging providers in the spring, likely in early April this year in capturing the experience with North Carolina Medicaid from the administrative process to data and healthcare quality support. We are very much so invested in hearing from you as our provider community and equipping providers with the support needed through transformation to manage care and in working with the health plans. We'll use these findings from the survey this year as a baseline, then to reevaluate, likely annually, the providers experience and working with the health plans as well. I do want to stress tonight our commitment to hearing from our providers in the experience and caring for our beneficiaries, and capturing areas where more support may be needed, both for successful transformation and continued improvement through managed care and beyond. Just wanted to let you know to please look for this survey to come out in spring, likely in April. And now I will hand it back over to Dr. Dowler.

Dr. Shannon Dowler

Thank you. All right, I want to make sure we have time for questions at the end, but I did do some questioning before this presentation and asked some folks out in the field what their questions were to make sure that we got things answered and so one question I have for Kelly is, **we talk about optics and clinical data is one of those places where sometimes it doesn't get through all the way, how are we in Medicaid helping to make sure PHPs have the best data?**

Kelly Crosbie

Right now we're working actively with the Health Information Exchange, and with the PHPs on being able to pull the clinical data from the HIE. So what you can do as a provider is make sure that you're submitting your patient lists and all your other data to the HIE because our goal really is to not do a bunch of chart reviews and have you not do a bunch of data entry. But for us to be able to mine that data from the HIE so stay tuned for more information about that but that really is our game plan for getting that clinical data.

Dr. Shannon Dowler

Awesome, and then Taylor, **talk a little bit about pediatrics the adult providers are used to all these Medicare Shared Savings plans we've had all these adult metrics we've been dealing with for several years now. How does it feel different for the, for the pediatrics world?**

Taylor Zublema

So for most of our pediatric measures, they are related, you can see in the slides tonight and in the course that they're related to primary care and preventative care. Many of these measures are a part of our advanced medical home program measure set, and they're tied to the advanced medical home incentive programs. And so health plans are responsible for providing the quality measure data, at least quarterly if not more often depending on the measure for these measures to pediatric practices and then I believe later tonight we'll be talking about attribution as well.

Dr. Shannon Dowler

We're going to shift it over now to Sam Thompson, who is going to talk through how we measure the quality and this is probably the part a lot of you really want to understand the most. What does it mean how do we show improvement and how are we measuring it, so Sam.

Sam Thompson

Good evening, y'all. Um, so this is a high level overview of our standard plan quality measurement timeline. And as you all probably already know, standard plans launch on July 1 2021. And what this illustration really gets at, is that contract years will be on, what we would probably refer to as a state fiscal year but from July 1 to June 30 of every year. Whereas our measurement here is on the calendar year, so the first measurement year that plans will be attending to is calendar year 2022.We won't start withholds, until the their third contract year which will be in the middle of calendar year 2023, and those targets will be based on their first measurement here in 2022.

We'll dive into this a little bit deeper and you'll kind of see our quality measurement cycle. So that first blue bar at the top is our 2022 measurement year. So the first measurement year. And you can see that in the third quarter of each year, we're determining the subsequent years measure set. And so as you go down you see all these new sort of milestones but what we really want to know for you, more than anything, is that sort of late spring early summer we're producing our previous year measure results and deriving the subsequent years target. There's a lot of detail on this slide, you'll be able to get into it if you pull them down.

So I'm also going to walk y'all through our quality measure targets for years one and two. So, the first two years of managed care implementation. Our benchmarks for each measure will be a 5% relative improvement over the prior year statewide performance for the measure. An example we're going to give you here, so if health plan A has 1000 women who qualify for chlamydia screening in 2019, 500 of them got screening at 50% performance. For the next measurement year the health plan would need to screen an additional 25 women to increase their baseline by 5% and help them to be compared against their program's historical performance and it's expected to show a year over year improvement. So we're going to illustrate this for you in the next slide. So, um, so here you can see that improvement occurring over four years for 2019 to 2022, and each year, the proportion of women in the health plan receiving chlamydia screening increases by 5% in this illustration with each blue icon representing 10 women that received their screen. So health plan A's performance goes from 50% in 2019 on the far left to 59% in 2022 represented on the far right.

So we're also working on disparities and to work on disparities we have to clearly define them. So we're going to define disparities as a greater than 10% relative gap in performance between a subgroup and a reference group. This is a disparity definition that we've drawn from the Association for Healthcare Research and Quality in their 2019 Health Care Quality and disparities report. An example here would be if Health Plan B provides flu vaccines to 65% of all eligible patients. But when we break it down, we see that 70% of white patients receive their flu vaccine only 60% of Black patients receive their flu vaccine. we would identify this as a disparity and make it a priority, or improvement. So here you see that illustrated. 60% of black patients, so 300 to 500 received the flu vaccine, and those patients are represented by the blue icons with each icon representing 10 patients. While 70% of white patients so 350 to 500 received the flu vaccine-- those are the orange icons, with each icon representing 10 vaccinated white patients. So, this 50 patient difference equates to a 14% disparity. I am going to stop right there and help you understand how we get there. The numerator, for calculating the disparity is the 50 patients, right that 50 patient difference between the group on the left and the group on the right, the denominator for calculating that 14% is the 350. So the numerator for the reference group.

So, now we need to talk about how we're going to improve that disparity, and so our disparity target is going to be a 10% relative increase for the group of interest for at least two years, and until the gap between the group of interest in the overall population is less than a relative 10%. So let me give you an example. Health Plan B provides flu vaccines to 65% of all eligible patients. This is the example you've seen before. 70% of my patients get the vaccine, 350 to 500 patients, and 60% of black patients get the flu vaccine, so 300 to 500. Because of this disparity, we need health plan B to increase performance, within their black population by 10% to 66% in the next calendar year. So let me see that next slide. We're going to illustrate what this looks like year over year for you. Each year the proportion of Black patients in health plan B that received the flu vaccine increases by 10%. With each blue icon

representing 10 vaccinated patients. Performance  in health plan B goes from 60% in 2019, so on the far left to 80% in 2022, on the far right.

So we use this slide to draw those concepts together, we will combine our overall target and our disparity target. Each year, the proportion of Black beneficiaries in health plan B that received a flu vaccine, so the blue icons increased by 10%, while the proportion of white beneficiaries in health plan B increased by 5%, the overall target. So in health plan B's performance goes from 65% in 2019 on the far left to 81% in 2022 on the right. At the same time, we see that by the time we get to 2022, the disparity has reduced and we have about the same number of blue people as we do orange. So that disparity has been equalized.

So, in the third managed care year and beyond, we're going to learn from what we've seen in the first two years, we may adjust our benchmarking methodology, based on the information we've gathered in those first two years. We strongly believe that state level program specific data to inform the benchmark will be more reflective of our state's strengths, and quality improvement needs than benchmarks derived from national data. And where we can, we'll use risk adjustment based on the specifications of each measure.

Dr. Shannon Dowler

Sam I got a couple questions for you. **First question is, what happened with the COVID year? So how are we going to set those quality measures? What years are we going to use?**

Sam Thompson

Well, so our big COVID year was 2020. I mean, we're still in COVID but we've come out of the big gap that we saw with the stay at home order and everything. And fortunately, even 2021, it will be used to set targets for 2022, but 2022 will really be the first planned measurement year. So they'll be held to those targets but there will be no withholds. And I think the thing I'd probably stress even more than that is if rates are depressed because of COVID and COVID goes away, that will inherently make your performance look better. It raises your floor, it is an advantage to you.

Dr. Shannon Dowler

Okay, one more question for you. **How do you count the [indiscernible] measure if you say you've got a patient that's in a practice, they're with Medicaid for a whole 12 months, but they change plans there? What happens with that?**

Sam Thompson

Okay, so this is a complicated one and we want to be really thoughtful about it. And attribution under Medicaid might look a little different than you all have experienced and under other ensures. Members are counted in primary care practice denominators based on auto assignment and any measure

parameters we have around continuous enrollment-- that would be a measure by measure determination. DHB will work with health plans on common attribution and enrollment standards to apply across health plans and for all provider types, and that's what I mean by us really trying to be thoughtful about this. This approach will also apply to newborns who will also be assigned to practice and health plans.

Dr. Shannon Dowler

Thanks Sam. All right, I'm going to turn it over to Jamaica to talk about quality management and improvement.

Jamaica Wilkins

Excellent. So this is the most exciting part of the presentation for me because we've seen all of the measures that we use and how we address disparities, etc. So this section really talks about how we take those data metrics and make them actionable into improvement for our quality of care. All managed care programs are required to have a quality management and improvement program or a QMIP, that will focus on their health outcomes and not just on healthcare processes. So you'll see on the screen diagram of what it looks like so the quality management and improvement program or QMIP is an overall visioning document that they submit to us annually for us to review at the department. Nestled into that QMIP is a quality assessment and performance improvement plan. And this plan actually describes the health plans approach to monitoring and evaluating the quality of care service that they provide to their Medicaid members. It also includes areas where they address over and under utilization, long term services and supports, health equity, and population health. Within the QAPIP there are two component parts which include performance improvement projects or PIPs. Plans will have projects that achieve improvement in two areas of PIPs, including clinical which requires a minimum of at least two clinical PIPs and non clinical where we require at least one non clinical PIP. In addition, plans will also have EPSDT PIP if they do not meet their 75% rate. Also the second component part of the QUAPIP is a provider support plan which details their support activities to the providers that are contracted with the plan. We do want to make sure that we highlight the department's commitment to health equity we've talked about previously, but definitely in our quality management improvement program it's woven into identify all the disparities and implement interventions that will help reduce those disparities

So far our performance improvement projects all plans are required to conduct them. They must be designed to achieve significant improvement that is sustained over periods of time, including health outcomes and enrollees satisfaction; these performance improvement projects are submitted annually. And we do receive quarterly progress reports for them as well as the QAPIP. The performance improvement project should also include quality indicators that are objective, implementations of interventions that achieve improvement, both in access and quality of care, and evaluation of the effectiveness of those interventions, and planning and initiation of activities for increasing or sustaining those improvements. We do like to point out for providers that health plans will work with you collaboratively to make sure that they are developing and implementing these PIPS and patients or

beneficiaries Medicaid members should know that plans and providers are working to continually improve their quality of care.

In contract year one, we will be standardizing our clinical PIPs, we will have three in these domains including adult child and maternal health. For adults will focus on comprehensive diabetes care, hemoglobin A1c for control greater than 9. I won't give you the definition because we've talked about it previously in our measures. Also for a clinical child PIP, we will look at childhood immunization status, and for maternal health we'll look at prenatal postpartum care, specifically the timeliness of prenatal care and you'll note in our previous slides, these are all areas where we could use some improvement. All of these clinical performance improvement projects do align with our quality strategy angles and objectives.

So the second component part of the QAPIP is the provider support plan and within this, each plan must develop a report that details what they're going to do as Technical Support Activity. So whether that's one on one coaching, webinars, tip sheets, etc. All of that will be detailed within this provider support plan. They must also show how these activities will advance the quality strategies, aims, goals, and objectives, and then show how they evaluate providers engagement and progress over time.

So we start here in this particular slide where we're talking about how we're collaborating at the department with our area health education centers or AHEC to provide technical assistance and practice support. So AHEC will work to provide training and practice level technical assistance as we transition into managed care, with a focus and priority on safety net and essential and rural providers. We have prior to launch activities as well as after launch activities. AHEC will provide targeted training and assistance to providers to make sure that you are prepared to go into Medicaid transformation and to be able to function within the initiatives that are put forth. We will also continue to host webinars with AHEC with our fireside chats as this is today a fireside chat, and our clinical and quality updates and both of those occur on the first and third Thursdays. Also AHEC will work with our events medical homes or AMHs to provide a coaching program work with their AMH tier support tool, and make sure that you're able to maintain and live up to the requirements that you attested for the AMH program. After launch, AHEC will provide state level webinars that highlight our three clinical statewide performance improvement projects around chil, adult and maternal health. AHEC will also host events and support health plan regional quality forms, which we're working very closely departmentally as well with AHEC and the plans to make sure that we can reduce any provider abrasion or burden with you having to attend multiple regional quality forums across multiple health plans. So we're working to make sure that's going to be streamlined after launch. And lastly AHEC will continue to promote the AMH coaching program and provide one to one support.

Lastly, I just want to wrap up my slides with a provider feedback loop on quality improvement. So providers know that there is room for your voice at the table. Health plans are required to have platforms, whether that's virtual or that's in person, one on one, or in groups to raise challenges from the providers. Local challenges you're facing, regional challenges you may be facing. Also to have a brain tank where you can exchange best practices. Plans are also required to have quarterly clinical leadership meetings, and the annual Quality Forum that I previously mentioned on the last slide. And you can see on the right hand of this slide, where the Quality Forum of invitees are a multidisciplinary cross functional team of professionals. And lastly, as we close out the provider feedback loop. We will ensure and work collaboratively with health plans to make sure that all of this information is communicated

back to the department, and will solution internally to help address any of the local challenges you may be having, and also share information on the best practices. So that concludes my section. And we'll turn it back over to Shannon.

Dr. Shannon Dowler

All right, I got a couple questions for you. Um, so let's see the first one I'm going to throw out to Kelly. **Kelly will providers including freestanding behavioral health providers, be able to get incentive payments based on their quality performance?**

Kelly Crosbie

Yep. Yeah, absolutely. Behavioral health providers will, primary care providers will, OB providers will. Part of what we're sharing this from a plan perspective is so that you see the accountability. Everyone wants to know the quality accountability at the plan level so we're sharing that with you. But all of this flows down to practices, every bit of it. So every measure goes down to you as a practice and these are exactly the measures we want you to know about. We want to set reasonable targets. And these are the very measures that PHPs, health plans need you for. They need you as a provider to help move these measures forward. So, yes, that's exactly where things like incentive payments and value based arrangements come into play. So there's lots of behavioral health measures as behavioral health providers that you can help these plans achieve. And these are the exact kind of things you want to contract around for value based incentive arrangements.

Dr. Shannon Dowler

Awesome! **Jamaica, so how do practices find out how they're doing, how are they going to know where they need to improve and where there are opportunities?**

Jaimica Wilkins

That's a great question. So health plans are required to share data with their practices that are contracted with them at minimum on a quarterly basis and that information will come to you so you can use it for QA purposes. It will come to primary care practices and maternal health providers, also any practices who have value based arrangements with the health plan. Additionally, advanced medical homes will receive monthly claim data that they can use for their quality analytics and also to understand that quality performance.

Dr. Shannon Dowler

Awesome, and Kelly I'm gonna throw a hard one at you. We've talked a lot lately about panel issues and challenges with panel management. **So what kind of adjustments will be made to correct for the panel issues, especially at the beginning?**

Kelly Crosbie

Yeah, that's a rough one, so like Sam mentioned, a lot but not all of our measures are attributed to primary care practices and Medicaid is different. You don't necessarily have to have seen the patient that is assigned to you. But our program is predicated on providers raising their hand and saying I'll get some assigned patients. So patients will be assigned to practices. That will be their attribution panel. But in other cases, like for maternal health measures, we will work with the health plans on attribution models. And we know that panels, transition is going to be rough! Especially for medical homes in the beginning so we're trying to take that into account with very reasonable targets. So we're not having grand targets because we know there's some panel fluctuation. And we'll be working on specific attribution issues with the plans and tried to come up with standardized ways to address this for primary care, OB care, all the other things that were mentioned earlier,

Dr. Shannon Dowler

Awesome and then it goes without saying that, probably the most important thing for panel accuracy is the beneficiary choosing you. You know, going into the open enrollment, selecting you as their provider, and then making sure they select a plan that you're in. And that will probably be the most important thing, but we know that historically across other states, only about 10% of beneficiaries actually go into open enrollment so we got a lot of work to do to make sure that's as perfect as possible before we go live.

I want to wrap this up really quickly so we can get some of the questions in the chat answered. **What are the things you can do now?**

So pay attention to your contracts. Are you agreeing to reasonable targets. That's important. Make sure you're signing on for the right stuff. Start looking at your performance on the quality metrics. We told you what we're focused on and what the priority measures are. We want you to know that-- It's not a gotcha situation so find out how you're doing now. Focus on that risk metric. So coming down the road, they're going to be metrics that are at risk. Obviously that's going to be really important for the plans and so go on and start thinking about that now and partnering with CCNC and AHEC to help set you up for success there. Just remember if you didn't document it ,it didn't happen. So, this is one of the toughest parts around our quality space and doing things that we have to do for some of these metrics, we are going to do as much as we can but getting connected to the health information exchange is really really important because a lot of that work you're doing that's harder to track will show up that way. And I think it will make it much more accurate. Communicate with us. This bi directional communication has been sort of my mantra the last year and a half I've been with Medicaid. We really do want to hear from you. We want to hear what your experience is on the ground so that we can make it better and partner together on these things. And panel management. It's going to take all of us to get this right between now and July 1. I mean every one of us: the beneficiaries, our practices, DHB, everyone's all in on getting this right. We've got two exciting things to tell you about and then we're gonna open it up to questions.

Kelly Crosbie

All right, super quick, I just want to tell you about two short term payment opportunities. Hopefully you've seen these in other meetings that we've presented on and hopefully you saw the Medicaid bulletins that came out earlier this week.

The first is our healthy opportunity screening assessment and referral Payment Program. It's temporary coverage, it's going to run January through June, and this is for medical home providers to bill a specific code for screening using our healthy opportunities screener or a comparable evidence based tool. If you get a positive screening we'd like you to please refer the individual for services, and then you can bill us for this screening. So we really want to encourage the use of the standardized screening tool. It is for food, housing, interpersonal safety, and transportation. And when you do get the positive and try to make a referral, we absolutely want to be able to incentivize that through this payment methodology.

The second, if you go to the next slide. Again this is short term because it's the Glide path to managed care. So our advanced medical homes, our tier three advanced medical homes, we really really want to support your success in becoming an advanced medical home. And we were trying to think of a way to help get some funding to you, quite frankly, to build the infrastructure in the staffing you needed to be successful at launch. So, the Glide path payments, that's what we're calling them, it will pay you $8.51 per member per month of your currently assigned panel and fee for service you'll get that every month. If you do two things. You've got to contract with PHPs and you've got to complete data testing. The bulletin gets into what data testing means, we tried to be pretty, pretty helpful on how we define data testing but you have to be able to adjust that data to do your advanced medical homework. If you do that, you can have up to three months of this $8.51 pm pm. So, if you have questions, the bulletin says how you can get in touch with us to follow up on this.

Dr. Shannon Dowler

All right, I think Hugh, why don't you throw out some of the questions from the chat and just remember if we can't answer all these we will get the answers afterwards. We always do that at the end of the panels, but as much as we can do live is better so we'll keep our answers quick.

Hugh Tilson

Thanks. We got one comment that says this quality stuff is really hard. And that's not really a question but I thought ,you know, that's a lot of the reaction is this is a lot. **And maybe y'all could just respond to that and why it's a good thing and I think it's an important observation that they've made.**

Dr. Shannon Dowler

Yeah, I mean it's true it is hard and Medicaid has been more casual with this and you've seen with Medicare and other private payers and so really Medicaid is now just joining the fray of value based care. And we want to make sure that what we're paying for is the best care possible for our beneficiaries. And, unfortunately, sometimes our Medicaid beneficiaries don't get the best care possible and I think if you look at our performance for 2019, there are some areas where it's a little disappointing and so how can we move the needle, how can we get more breast cancer screenings, more colonoscopies, what are the things we need to do to help make that successful. And then what are the things our plans can do in managed care to help get some of these things done. Because we get new levers, with using managed care, and we hope we'll be able to close a lot of care gaps that way. Kelly I don't know if you want to add something inspirational.

Kelly Crosbie

No, that was it. I mean I think we tried to share a lot of information today, but, you know, if you cut to the chase as Shannon said, we're measuring things that probably other insurers are measuring you on. We're trying to make sure you get data. And we want the PHPs to work with you on incentive payments and data collection so you can improve these quality measures. That is the heart of it. And we think that these quality measures are indicative of if care is getting better, are people getting coordinated care, are we spending money on the right things.

Hugh Tilson

Thanks. Related to that, we got this question: **How will incentives trickle down from plans to providers? Will this be planned contract specific or Medicaid prescribe some consistent manner across all plans?**

Kelly Crosbie

Right now we've not been prescriptive about how much money has to flow down to providers. For example, in several programs like our advanced medical home program for example we have standardized this specific measure set. We've standardized the state target for performance. We said AMH tier threes absolutely need an incentive payment. We've not said how much that payment needs to be. But we could conceivably think of other value based models we would like to lead from this state in the future where we might be more prescriptive about things like that. Probably one of the things that, you know, Sam mentioned it in a star on one of his slides, but it is a withhold program. So in the future, we will withhold money from health plans for specific quality measures, and when they perform successfully, meaning providers perform successfully, that money will flow down. And so that's another opportunity for us to think really carefully about how much money we withhold, how much we incentive plans, and how that does flow down to the provider. So we've not been prescriptive about money right now and been more prescriptive about measures, but I think there's opportunities for us to, you know, to collaborate with you on things like that.

Hugh Tilson

Great. **Got a number of questions about the HIE and how the data will be pulled from the HIE. Can you respond to those questions?**

Kelly Crosbie

I mean, I noticed something on the depression screening, which I think was a great question. Actually that's been our first foray into trying to pull data from the HIE, and it's exciting. If you're into that. But yeah, how is depression screening and follow up captured in the HIE. So we've done all these amazing data rents to find it captured in a million different ways and we've actually had some conversations with CMS around does this count. Can we count this in the HIE, but that's just a really nerdy example. Sam. I don't know if you want to say something a little more concrete than my nerdy example?

Hugh Tilson

Do practices have to be connected to the HIE in addition to your.

Sam Thompson

So we certainly hope that they're connected to the HIE but they don't have to be, and there's all kinds of rules related to that. You can get a deferment and you can work with a team of Medicaid to receive that. There are also other kinds of practices that are not mandatory. But to calculate some of these measures, at least internally to Medicaid, we're planning to use HIE data and that's as opposed to sending a team out to collect those data directly from providers. We actually think that is a significantly lower burden. We're also, you know, a lot of the reason why we're working so hard to collaborate with the Health Information Exchange, is that we would rather all the plans go through one entity to pull provider clinical data than to go one by one to providers to pull that data. And so, it is in your best interest to connect to the HIE. It should ultimately be a lower burden and should also allow us to do more accurate measurement and allow the plan to do more accurate measurement on your behalf.

Hugh Tilson

Somebody just asked what the acronym HIE stands for? Its health information exchange. Dr. Dowler, I think we're just about out of time.

Dr. Shannon Dowler

Hi. All right, an hour always goes so fast. It may not feel like that to you all out there, but it goes real fast to me. Just a reminder that there is a lookup tool. The public version of the Medicaid provider and health plan lookup tool is online and available-- the websites there on the screen. It's important that you

look at that and make sure that your information is correct in there. We've been talking about this for four or five months saying, make sure you're getting an NCTracs make sure everything's accurate. Now it's time to make sure that everything crossed over accurately. We want to do that before. We need to have this information at the tip of our fingers, which is going to happen before we know it, so please make sure you're looking at that. This will be available to beneficiaries starting March 1 so the clock is ticking on that. So make sure that someone in your practice is verifying all that information. And we look forward to seeing you at the next one. Next week we've got an AMH, and then following that we've got a hot topic coming up on the third Thursday of February. So thanks everybody for joining us tonight. Hugh, I will let you say the parting words tonight.

Hugh Tilson

Well, Dr Dowler and team thank you so much for all this great work that you're doing. For those of you who participated tonight, we really hope that this information will help you as you work through managed Medicaid. Please know there are lots of us that are here to help you. Please do not hesitate to reach out and thank you for all that you're doing for your patients and your communities and we look forward to talking to you again in a week. That's all I got.