

North Carolina's Medicaid Managed Care Quality Measurement Technical Specifications Manual

North Carolina Department of
Health and Human Services

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I. Introduction

The North Carolina Department of Health and Human Services (the Department) is dedicated to designing a comprehensive Medicaid managed care program that optimizes health and well-being for all North Carolinians. Central to these efforts is a commitment to the delivery of high-quality health care through the development of a data-driven, outcomes-based, continuous quality improvement process that focuses on rigorous measurement against relevant targets, and appropriately rewards Prepaid Health Plans (PHPs) and providers for advancing quality goals. This document provides additional detail and updates to the [PHP Quality and Accountability paper](#) released in March 2018 and an overview of the Department's approach to quality improvement for standard plans, with a specific focus on quality measurement and reporting and incentives for improved quality performance.

The document includes:

- (1) the Department's vision for advancing quality through PHPs;
- (2) detailed information about how the Department will measure PHP quality and promote quality improvement; and
- (3) an appendix containing technical specifications for new measures related to low birth weight.

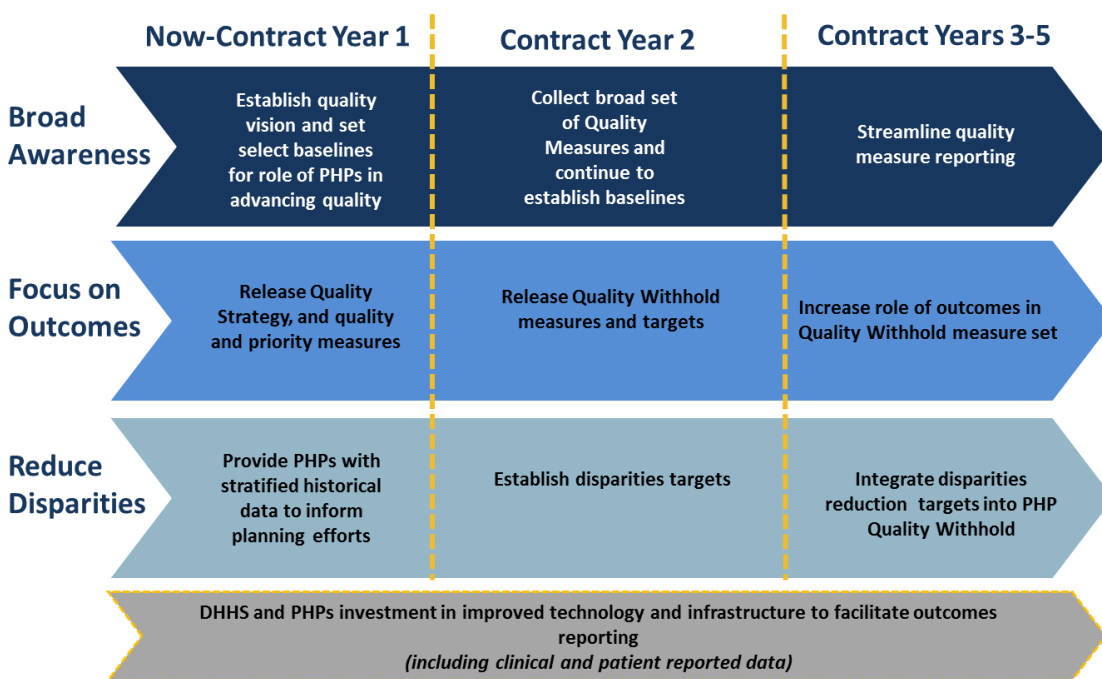
II. Vision for Advancing Quality through PHPs

As noted in the Quality Strategy, the Department seeks to develop a data-driven, outcomes-based continuous quality improvement process that rewards PHPs for advancing quality outcomes in targeted areas that support three central Aims: 1) Better Care Delivery; 2) Healthier People, Healthier Communities; and 3) Smarter Spending. Goals and Objectives are tied to each of these Aims, along with a series of interventions, including [advanced medical homes \(AMHs\)](#) and a [social determinants of health strategy](#), outlined in more detail in previous papers and specifically designed to improve quality outcomes in North Carolina.

The Department is committed to rewarding PHPs that accurately report and demonstrate meaningful improvement against specified quality targets. Working with PHPs, the Department will collect a robust set of quality data, which will paint a clear picture of service delivery and clinical care at a statewide and, eventually, a regional level, and across demographic measures, such as age, gender, disability status, race and ethnicity. The Department will require PHPs to quickly establish working relationships with providers and other community stakeholders to support accurate plan and provider-level reporting for Quality Measures, including selected clinical outcomes. Later years will build on these relationships to both attain increasingly ambitious quality performance targets focused on priority outcomes specified by the Department (figure 1) and include financial accountability for PHPs to improve those outcomes. The Department will also collect and report on select public health measures to link PHP quality improvement efforts to larger state public health initiatives and goals.

The Department will support this vision through investments in initiatives to improve outcomes (e.g. pilots to provide services for members with food insecurity and housing needs) and advancement of required infrastructure to facilitate public reporting of quality performance and assessment of state-level health improvements that result from improved care in the Medicaid program. In turn, the Department expects PHPs to establish the staffing plans, tools, IT infrastructure, and data analytics capabilities required to measure quality performance, embed continuous quality improvement efforts to improve outcomes, and possess the capabilities to execute successful strategies to reduce and eliminate health disparities. Recognizing the substantial investments PHPs must make to meet quality reporting requirements, the Department intends to invest in improved technology and infrastructure to support PHP reporting and will streamline reporting requirements when feasible, based on the results of reporting in early years.

Figure 1: The Quality Vision Over Time



Over time, PHPs should plan for an increasing proportion of provider contracts to be in advanced payment models that may require alternative approaches to contracting, data sharing, and provider and beneficiary engagement. These contracts will drive accountability, for quality outcomes not just at a state level, but at a regional level and extending across populations.

Programmatic Requirements for Quality Improvement

The Department will use a variety of programmatic requirements to ensure PHPs move towards plan-level accountability for health outcomes, and will offer resources to support PHPs and providers in their quality improvement efforts. Most directly, the Department will set goals for

PHP quality improvement efforts through the establishment of **quality measure sets**, which PHPs will be required to report, and calculation of baselines, targets and benchmarks for these measures. These requirements are likely to be a major focus of PHP efforts, and (through the **quality withhold program**, described in greater detail in Section V.) will give PHPs direct financial accountability for a subset of overall quality performance improvement and reduction or elimination of disparities.

The Department will require additional program elements related to quality improvement, including the following:

- The Department expects PHPs will work with their contracting providers to improve quality through PHP Performance Improvement Projects, for which the Department will provide broad guidelines. PHPs will submit an annual Quality Assessment and Performance Improvement (QAPI) plan, delineating their plans for Performance Improvement Projects and other quality improvement efforts.
- The Department requires PHPs to engage with external entities to improve quality, including an Accrediting body that will assess quality management processes and offer additional guidance and an External Quality Review Organization (EQRO) that will validate quality performance, assess quality improvement efforts, and provide feedback to PHPs, including a separate report on health disparities.
- The Department has established requirements for PHP deployment of Value-based Payments (VBP), and Provider Incentive Programs to incentivize quality improvement among contracting providers. These elements are discussed in detail in the PHP Quality and Accountability paper.
- The Department expects PHPs, contracting providers, enrollees and other community stakeholders to share feedback on quality improvement through the MCAC Quality Committee and offer suggestions that can lead to better processes and outcomes.

Many of these elements have been described in detail in the PHP Quality and Accountability paper and other documents. Further information regarding VBP can be found [here](#). Further information regarding PIPs and QAPI, as well as additional details on the EQRO and Accreditation are provided in the accompanying Quality Strategy.

The remainder of this document focuses on quality measure reporting, DHHS' use of these measures to assess PHP performance, and PHPs' use of these measures in their contracts with Advanced Medical Home practices.

III. Quality Measurement and Improvement

To ensure that all North Carolina Medicaid managed care beneficiaries receive high-quality care, PHPs will be expected to report, and ultimately be held accountable for performance against, measures aligned to a range of specific Goals and Objectives used to drive quality improvement and operational excellence. The Department's use of specific quality

requirements to advance toward these Goals and Objectives will evolve as PHPs' and providers' infrastructure and experience increase, with greater rewards for excellence and more significant penalties for poor performance.

PHPs will be held accountable for all 67 quality measures reported at the plan level (“**Quality Measures**”), some of which will be self-reported and some of which will be reported by the Department. The Quality Measures are meant to provide the Department with a complete picture of the PHPs' processes and performance, in a format that will be specified by the Department.¹ These measures were selected from a variety of sources, including [HEDIS measures](#), [NCQA health plan accreditation requirements](#)², and CMS [adult](#) and [child](#) core measure sets. The Department will update its measures annually to reflect changes in these sets. In one case, measurement of low birth weight, the Department has modified an existing measure for use in the managed care setting. In addition, for quality purposes, PHPs will be required to self-report a small number of administrative measures developed by the Department to support activities that are unique to the North Carolina Medicaid program. The sections below discuss the Department's overall approach to Quality and Administrative reporting, and review approaches to specific areas of measurement that the Department would like to highlight. Those areas include:

- Modified Measures
- Utilization Management Measures
- Select Administrative Measures
- Survey-Based Measures; and
- Public Health Measures

The technical specifications for all quality and select administrative measures are shown in The Department has emphasized measures that can be reported using only administrative data, but will accept a hybrid reporting approach for measures for which hybrid reporting is appropriate, as well. The Department encourages PHPs pursuing hybrid reporting to develop consistent reporting approaches that minimize burden on providers.

A. Quality and Administrative Measure Reporting

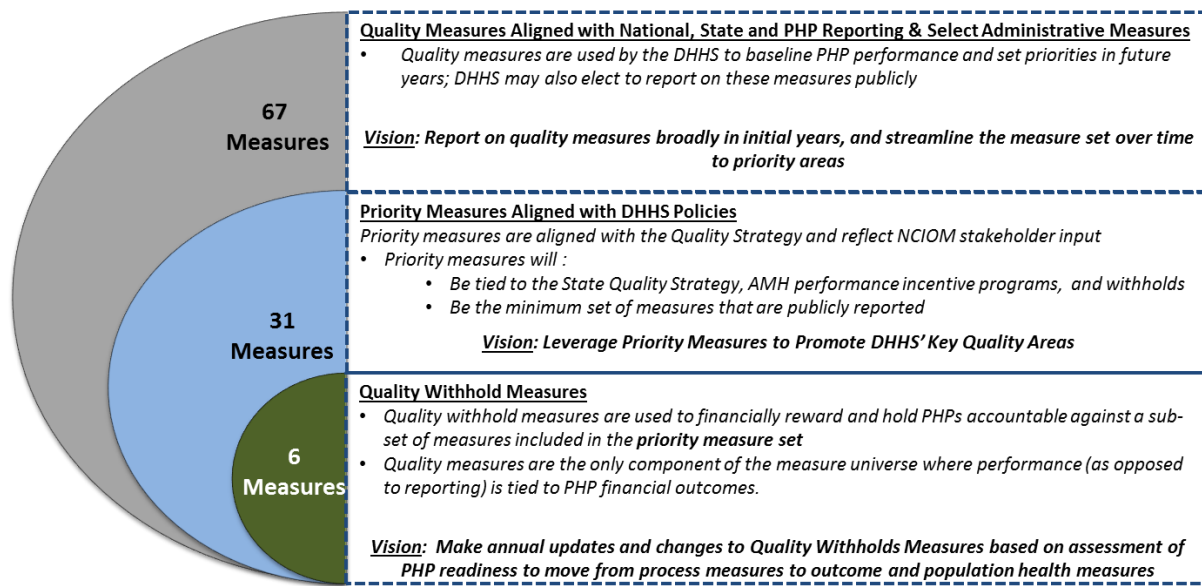
The **Priority Measures** are a subset of the larger measure set that is most closely aligned with North Carolina's aims, goals and objectives. Beginning in the third contract year, the Department will hold PHPs financially accountable for their performance on a set of **withhold measures**, which the Department will draw from the Priority Measure set, in the corresponding calendar year. (See Figure 3 in Section IV for further information on the timing of financial accountability.) The Department will also draw from the Priority Measures to establish a list of

¹ The EQRO will report CAHPS measures at the PHP level.

² PHPs will be required to secure NCQA accreditation by Year 3

measures PHPs can use for developing performance payments to [Advanced Medical Home](#) practices (described further in Section V.D, below), and PHPs should use Priority Measures for any non-AMH performance improvement programs and value-based contracting arrangements.

Figure 2: Quality and Administrative Measure Reporting Framework



The following subsections outline quality measures of particular interest to stakeholders, including measures that are unique to North Carolina, measures that have changed based on public and stakeholder feedback, and select administrative measures that PHPs will be required to report.

B. Modified Measures

Live Births Weighing Less than 1,500 or 2,500 Grams (measure reported by DHHS):

This measure assesses the proportion of eligible births that are low birth weight. As of 2017, North Carolina ranked 8th in the nation in low birth weight³ (a rank closer to 1 indicates poorer performance). Given the importance of low birth weight as an indicator of future health, the Department wants to ensure that all Medicaid stakeholders have incentives to pursue the full range of interventions aimed at reducing low birthweight among Medicaid enrollees. The Department will measure low birth weight at the PHP level. Because the low birthweight

³ Stats of the States. National Center for Health Statistics. January, 2019. Retrieved from https://www.cdc.gov/nchs/pressroom/sosmap/lbw_births/lbw.htm

measure used by the CDC (NQF # 1382) is specified for regional measurement, the Department has modified this measure in consultation with the measure steward and North Carolina experts on prenatal care and the measurement of low birthweight. In this effort, the Department has been particularly concerned to avoid creating incentives for PHPs to discourage members they may consider at elevated risk for low birthweight, and will closely monitor member enrollment and disenrollment trends.

DHHS The Department will pursue two approaches to PHP accountability for LBW: both an outcome measure, which is a modified version of NQF# 1382, and a process measure.

- The outcome measure will address the percentage of LBW births among members who have been covered continuously by a PHP from at least 16 weeks of their pregnancy.
- The process measure would address the percentage of pregnant smokers who are screened and treated for tobacco use.

C. Measures of Utilization

Measures of Avoidable or Preventable Utilization:

The Department has added measures of avoidable or preventable utilization to the priority/quality measure set to assess the degree to which PHPs' care management and utilization management efforts are able to reduce avoidable and preventable utilization. These measures are meant to reflect access to needed primary and preventive care, and are not intended for use in adjudicating payment for individual services. PHPs will be required to use publicly available specifications to report the following outcomes for their assigned measures:

- Hospital readmissions (measured using NQF# 1768, Plan All-Cause Readmissions)
- Avoidable or preventable emergency department visits (measured using the [NYU/Billings algorithm](#)). Further guidance will be made available on reporting this measure prior to the first contract year.
- Avoidable or preventable inpatient hospitalizations (measured using AHRQ [PQI](#) and [PDI](#) individual and composite measures). The Department will introduce additional PQIs and PDIs that PHPs are required to report each year as follows:

	Contract Year 1	Contract Year 2	Contract Year 3
Adult (PQI)	<ul style="list-style-type: none"> • 01: Diabetes Short-term complication admission rate • 05: COPD or Asthma in older adults admission rate • 08: Heart failure admission rate • 15: Asthma in younger adults admission rate 	All Year 1 PQIs plus those required for the acute composite PQI: <ul style="list-style-type: none"> • 10: Dehydration admission rate • 11: Bacterial pneumonia admission rate • 12: Urinary tract infection admission rate 	All Year 1 and Year 2 PQIs plus those required for the chronic composite PQI: <ul style="list-style-type: none"> • 03: Diabetes long-term complications admission rate • 07: Hypertension admission rate • 14: Uncontrolled diabetes admission rate • 16: Lower-extremity amputation among patients with diabetes
Pediatric (PDI)	<ul style="list-style-type: none"> • 14: Asthma admission rate • 15: Diabetes short-term complications admission rate • 16: Gastroenteritis admission rate • 18: Urinary tract infection admission rate 	All Year 1 PDIs plus additional measures as determined by the Department	All Year 1 and Year 2 PDIs plus additional measures as determined by the Department

D. Select Administrative Measures

Screening for Social Determinants of Health:

This measure assesses whether PHPs are screening all members to determine whether they have needs in the areas of housing, safety, transportation and food insecurity. The denominator captures all members in a PHP's enrolled population, and the numerator is all members who have been screened within 90 days of enrollment as per contract requirements. The Department has provided the specific questions to be used in this screening. To report this measure, PHPs will need to capture the dates on which screenings are completed so that they can calculate the number of days' difference between successful screening completion and member enrollment. While the PHP contract requires only that PHPs make at least two attempts to screen within the 90-day period, this measure captures how many screenings the PHP has successfully completed.

Screening for Pregnancy Risk:

This measure captures whether PHPs' contracted pregnancy care providers are administering pregnancy risk screenings in a timely manner. The denominator includes all of a PHPs' enrolled population with a reported pregnancy during the measurement year, excluding those with a documented nonviable pregnancy at the first prenatal visit (since administering a pregnancy risk screening would be inappropriate under those circumstances). The numerator is all members for whom the PHP's contracted providers (including obstetricians, local health departments or other designated providers) administers a pregnancy risk screening form and bills the PHP.

E. Select Survey-Based Measures

Clinician Satisfaction with PHP:

The Department, in partnership with a third party, will distribute an annual survey to providers assessing their satisfaction with their PHP. This survey will include a question assessing overall satisfaction using a five-point scale, which will be the source of the information that will be reported in this measure; other questions meant to inform Department policy and operations may be included in the survey as well. The Department will request PHPs' support in developing a sampling frame and conducting outreach for this survey.

The Department will use the CAHPS Adult v5.0, Children v4.0, Chronic Condition Supplemental and Home and Community Based Services surveys to assess patient experience in receiving care. The Department will evaluate survey responses related to patients' ability to obtain needed care, ability to get care quickly, coordination of care, customer service, patients' rating of the health plan, rating of their personal doctor, and rating of the specialist seen most frequently.

F. Public Health Measures

The Department envisions PHPs serving as active partners in meeting Healthy NC 2020 and 2030 goals. To advance this vision, the Department will review a select set of public health population-level outcomes measures that it expects will be impacted by PHP activities. These measures are meant to assess the association between PHP-level efforts around [Healthy NC 2020 priorities](#) and health improvements at the population level. The Department will report selected survey-based public health measures at the population level and at the level of the Medicaid program, and review them against related PHP performance measures. See Table 1 for the PHP performance measures linked to each public health measure. For Y1, the Department will report the following measures, based on the [Behavioral Risk Factor Surveillance System](#) Survey:

- Percentage of adults who are current smokers

- Percentage of high school students using tobacco
- Percentage of women who smoke during pregnancy
- Exposure to second hand smoke in the workplace
- Fruit and vegetable consumption among adults
- Percentage of adults getting the recommended amount of physical activity
- Unintentional poisoning mortality rate

Table 1. The Relationship Population Health Objectives and PHP Performance Measures

Category	Public Health Objective	Relevant PHP Measure
Tobacco Use	Decrease the percentage of adults who are current smokers	Medical Assistance with Smoking and Tobacco Use Cessation
	Decrease the percentage of high school students using tobacco	
	Decrease the percentage of women who smoke during pregnancy	
	Decrease exposure to second hand smoke in the workplace	
Nutrition and Physical Activity	Increase fruit and vegetable consumption among adults	Adult BMI Assessment
	Increase percentage of adults who get recommended amount of physical activity	
Opioid Use	Reduce the unintentional poisoning mortality rate	Initiation/Engagement of Alcohol and Other Drug Treatment; Use of Opioids in High Doses in Persons without Cancer; Concurrent Use of Prescription Opioids and Benzodiazepines; Follow-up After ED Visit for Mental Health or Alcohol/Other Drug Treatment; Follow-up After Hospitalization for Mental Health or Alcohol/Other Drug Treatment

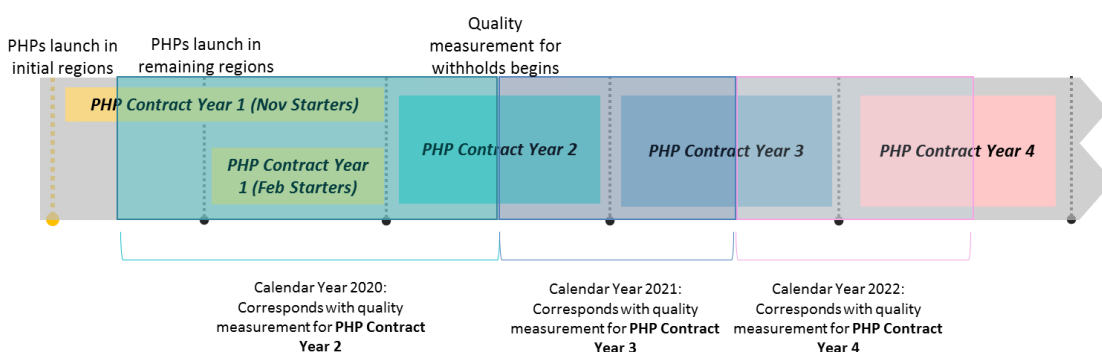
IV. Required Reporting Activities for PHPs

PHPs will be required to report all of the measures in Appendix A as part of their contractual obligations under managed care, including annual, interim and gap reporting as described below. These PHP reports will support a wide range of activities including ongoing Department

quality monitoring and state submission of quality measure sets to CMS. As noted in section V, the Department will make these reports public, identified by PHP, beginning with reports that include PHPs' performance in calendar year 2020.

Quality measure reporting will begin with the launch of managed care. Because quality measures are typically specified for measurement based on a calendar year, while the Department will contract with PHPs for years beginning on July 1st, each contract year PHPs will submit quality performance data measured during the calendar year beginning immediately before the contract year. That is, for the contract year extending from July 1st, 2021 to June 30th 2022, PHPs would report their performance on quality measures reflected during the calendar year extending from January 1st 2021 until December 31st 2021. Figure 3 provides a detailed comparison of quality performance years and contract years.

Figure 3: Timeline for quality measurement and contracting



The remainder of this section discusses the timing and types of required reporting.

A. Interim and Gap Reporting Requirements

In addition to annual reporting of final measure results, PHPs are required to provide **interim (monthly) reports** for selected measures, as indicated in Appendix A. These monthly reports should include monthly and year-to-date results for the measure, and should be provided both to the Department for performance at the PHP level and to the individual practices with which the PHP is contracting showing performance at the practice level. Not all measures are appropriate for interim measurement. For example, a measure with an obvious seasonal component would not be included in interim measurement.

PHPs are also required to provide **gap reports** for selected measures, as indicated in Appendix A, to contracting practices. Unlike interim reports, which show interim performance aggregated in the same format as would be used for the final measure report, gap reports are meant to provide practices with actionable information about which members have gaps in care. Gap reports are meant to identify specific patients who are out of compliance for each indicated

measure. As with interim measures, not all measures are appropriate for gap reporting. For example, a measure assessing blood pressure control would be considered appropriate for gap reporting because a practice can take steps to improve an identified member’s blood pressure on subsequent measurements to bring them into compliance, but a measure assessing appropriate management of acute pharyngitis would not be, because a practice cannot go back and change the initial management that was assessed. Because gap reports, unlike interim reports or other quality or administrative measures, contain protected health information, PHPs are expected to identify secure modes of transmission and to notify the Department immediately in the event of a privacy breach.

B. Stratified Reporting Requirements

The Department aims to promote equitable health outcomes for North Carolina Medicaid enrollees. PHPs are expected to report results that are stratified, where applicable, using the stratified reporting details indicated in each measure’s technical specification. For measures lacking stratification details, PHPs should use the distinctions outlined below in Table 2.

Table 2. Stratified Reporting Elements

Stratification Element	Strata	Source
Age	For pediatric measures: 0-1, 2-3, 4-6, 7-10, 11-14, 15-18, 19-20, 21 For maternal health:<19, 19-20, 21, 22-24, 25-34, 35+ For adult/full pop. measures: 0-18, 19-20, 21, 22-44, 45-64, 65+	DHHS enrollment data
Race/ethnicity	Hispanic, Non-Hispanic Black, Non-Hispanic White, American-Indian/Alaska Native, Asian/Pacific Islander, Other	DHHS enrollment data (self-reported where possible)
Gender	Male, Female, Third Gender (Other)	DHHS enrollment data (self-reported where possible)
Primary Language	English, Spanish, Other	DHHS enrollment data (self-reported where possible)
LTSS Needs Status	Aged/Blind/Disabled, Non-Aged/Blind/Disabled	PHP screening
Disability Status	Disability, No disability	DHHS enrollment data
Geography	Rural, urban	DHHS enrollment data
Service Region	1-6	DHHS enrollment data

V. Assessing Performance

The Department will assess PHPs' and providers' quality performance in several ways. This section details how PHPs will be held accountable, as well as which measures PHPs will be able to deploy at provider level to also reward providers for high quality outcomes. This section also describes the Department's public reporting process, which will support statewide engagement (including PHPs) around population health goals.

A. How the Department will assess PHPs' performance on quality measures

PHPs will be given historical **baselines**, calculated by the Department, for all measures for which comparable historical data are available at the state level. The Department will also calculate **benchmarks**, representing *optimal performance levels*, for all Priority Measures. These targets are meant to help the Department identify particularly high-performing PHPs, and to support PHPs' quality improvement efforts, but are not linked to financial accountability. Beginning in Contract Year 1, the Department will monitor PHP progress towards meeting priority measure benchmarks in each contract year. The Department expects to see annual progress towards meeting priority measure benchmarks, and priority measure performance improvement will serve as the focus of PHPs' quality assessment and performance improvement (QAPI) programs and performance improvement projects (PIPs). PHPs will be held financially accountable for performance measured against a different target for a smaller subset of measures beginning in the third contract year; these targets will reflect a performance level that ensures meaningful improvement for North Carolina Medicaid enrollees, while the benchmarks are meant to be aspirational in nature. Further discussion of these measures and targets can be found in Section C below.) Upon reviewing each year's quality data, DHHS will determine whether to publish benchmarks as part of its public reporting.

In Year 1, benchmarks for each measure will be calculated in one of three ways:

- For measures for which North Carolina's prior-year average performance as measured against the NCQA Medicaid managed care national average fell below the NCQA national 50th percentile or equivalent national median, the benchmark will be set at the NCQA national 50th percentile or equivalent national median.
- For measures for which North Carolina's prior-year average performance was above the NCQA national 50th percentile or equivalent national median, the benchmark will be set at twenty percentile points above North Carolina's prior year average.
- For measures for which North Carolina does not have prior performance data, the benchmark will be set at the NCQA national 50th percentile or equivalent national median.

In future years, the Department may shift to calculating baselines and benchmarks at the regional level. See Figure 4 for an example benchmark calculation.

Figure 4. Example Benchmark Calculation

	NCQA Medicaid Managed Care Percentile Score	
	NC Prior Year Percentile Score	Performance Year Benchmark Percentile Score
Measure A	35	50
Measure B	70	90

B. Promoting equity in care and outcomes

DHHS expects that PHPs will ensure improvements in quality will be equitably distributed, with no group of members ignored. In support of this goal, DHHS will require PHPs to participate in activities around disparities reduction, and beginning in the third contract year will hold them financially accountable for ensuring equity in improvements for selected measures. PHPs are expected to engage with the Department’s designated EQRO, which will develop an annual disparities report. The Department will use this report to guide development of a health equity promotion strategy, which will begin with systematic identification of disparities in the Medicaid program and progress through rewarding PHPs that can generate more equitable improvement in outcomes for their enrolled members. In Year 1, the requirement is limited to stratified reporting.

North Carolina has clear disparities in health outcomes at the population level, but additional data is required to identify specific Medicaid quality metrics, many of which measure processes or intermediate outcomes, for which promotion of equity has the greatest potential to reduce disparate rates of morbidity and mortality. The Department and the Department’s designated EQRO will work with PHPs to clarify the significance of inequitable quality performance on individual measures, with the goal of rewarding increased equity. Each year the EQRO will prepare a public disparities report documenting progress toward this goal and sharing PHPs’ stratified quality performance. The EQRO will identify disparities most closely associated with disparate health outcomes and will incorporate them into the withhold measure set as soon as feasible, likely beginning in the third or fourth contract year, assuming data shows consistent trends in prior years.

C. Future Uses of Quality Withholds and Overall Quality Results

Beginning in the third contract year, corresponding to July 1 2021-June 30 2022, the Department will measure PHPs’ performance against select **withhold measures**, for which PHPs will be financially accountable. The withhold measures will be drawn from the **Priority Measure** set. For Withhold Measures, the Department will calculate **targets**, representing *the level PHPs much achieve to receive some or all of their quality withhold* amount. The Department aims to maintain a small withhold measure set, ensuring that each measure carries sufficient weight to influence PHP behaviors. The Department may also consider weighting measures, by assigning different percentages of the total withhold amount by measure, rather than assigning an equal percentage to each measure. The Department has identified the following as initial withhold measures, though this list is subject to change prior to withhold implementation:

- Prenatal and Postpartum Care
- Live Births Weighing Less than 1,500 or 2,500 Grams (with modifications)
- Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life
- Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)
- Follow-Up After Emergency Department Visit for Mental Illness or Alcohol/Other Drug Abuse
- Initiation Engagement of Alcohol and Other Drug Dependence Treatment

The withhold measure set will shift toward outcome measures over time, with an increasing focus on not only improving performance under a gap-to-goal assessment approach, but also on eliminating disparities. In later years, Withhold Measures will likely involve more outcomes measures and incorporate clinical data in addition to encounter, survey and administrative data.

In future years, the Department will also implement new uses for PHPs' quality scores that go beyond calculation of quality withholds. For example, the Department will expect PHPs to further incorporate quality scores into internal continuous quality improvement and value-based purchasing efforts. The Department will also use PHP quality scores in the PHP auto-assignment algorithm, allowing PHPs with higher quality scores to be assigned proportionally more new beneficiaries. If quality performance is unacceptably low over a continued period, the Department may decline to renew or terminate a PHP contract.

D. Practice-level quality measurement for Advanced Medical Homes

The Department requires PHPs to monitor the performance of AMHs in all tiers to ensure they deliver high-quality care, but expects PHPs' use of practice-level monitoring to be sensitive to limitations such as population size. For PHPs' contracting with their AMH practices, the Department requires that PHPs use a subset of priority measures, selected for their relevance to primary care and care coordination, to assess AMH performance and calculate performance-based payments. These measures are shown in Table 3. PHPs are not required to use all of these measures, but any quality measures they do choose to use must be drawn from this set and PHPs are not permitted to use measures drawn from elsewhere. If a PHP elects to use the measure of Diabetes Control HbA1c >9.0%, it may only use this as a pay-for-reporting measure in its contracting until the Department has determined data quality is acceptable.

Table 3: Measures Selected for Use in PHP Assessments of AMH Practice Quality

NQF#	Measure Title	Relevant Population	
		Adult	Pediatric
0038	Cervical Cancer Screening	X	
0032	Childhood Immunization Status (Combination 10)		X
0059	Comprehensive Diabetes Care: HbA1c poor control (>9.0%)	X	*
1800	Asthma Medication Ratio	X	*
0576	Follow-up After Hospitalization for Mental Illness	X	X

NQF#	Measure Title	Relevant Population	
		Adult	Pediatric
0027	Medical Assistance With Smoking and Tobacco Use Cessation	X	*
1516	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life		X
1407	Immunization for Adolescents		X
0024	Weight Assessment and Counselling for Children and Adolescents		X
0018	Controlling High Blood Pressure	X	*
1604	Total Cost of Care		
N/A (NYU/ Billings)	Avoidable/Preventable ED Utilization	X	X
N/A (AHRQ)	Avoidable/Preventable Inpatient Utilization	X	*
N/A	PQI-01: Diabetes Short-Term Complication Admission Rate	X	
N/A	PQI-05: COPD or Asthma in Older Adults Admission Rate	X	
N/A	PQI-08: Heart Failure Admission Rate	X	
N/A	PQI-15: Asthma in Younger Adults Admission Rate	X	
N/A	PDI-14: Asthma Admission Rate		X
N/A	PDI-15: Diabetes Short-Term Complications Admission Rate		X
N/A	PDI-16: Gastroenteritis Admission Rate		X
N/A	PDI-18: Urinary Tract Infection Admission Rate		X
1768	Readmission Rates	X	*

* = Likely low rate for pediatric-only practices

E. Public Reporting of Performance

The Department intends to report PHPs' quality performance publicly wherever feasible and appropriate, as an important step in promoting high-quality care and encouraging stakeholder awareness of PHPs' quality performance. The Department will publish a number of reports to apprise the public of PHP performance and promote transparency in the overall quality of the managed care system. These reports will include:

- *Accreditation Progress and Results*—All PHPs will be required to receive plan accreditation through NCQA. The Department will publish PHP progress toward receiving this accreditation, and will report the accretor's findings for each PHP during its accreditation process.

- *Annual Quality Measures at Plan Level*—The Department will share plan-level rates for the quality measures described in Section III, to facilitate comparison among plans. Beneficiaries and the public should have access to a reliable report on how plans are performing on specific elements. The Department will determine based on a review of performance data whether to publish benchmarks as part of each year’s report. To that end, the Department will produce a report that will share plan-level quality measures described in Section III. Over time, plan performance against quality rankings may be used to inform other state actions (e.g., auto assignment).
- *Disparities Report/Health Equity Report*—The Department will assess disparities in care and outcomes across the demographics described in section IV.B, and publish a report summarizing areas or care in which disparities have improved, persisted, or developed.
- *Provider Survey Results*—The Department, in partnership with a third party, will field a survey to providers assessing their satisfaction with the PHP(s) with which they have contracted. The Department will publish overall satisfaction rates and other findings from this survey.
- *CAHPS Survey Results*—The Department, in partnership with a third party, will field the CAHPS Survey to assess patient experience in receiving care. The Department will publish overall ratings of plans, overall ratings of all care received and other findings from this survey. The Department is also considering other methods of sharing PHP performance data, including plan report cards with aggregate quality data collected from each PHP. The Department will share additional details should they introduce these reports.
- *Access Report* – The Department, in partnership with a third party, will issue a report summarizing secret shopper findings and other metrics of access for each PHP.

VI. Conclusion and Next Steps

The Department will engage with PHPs as their quality measurement approach develops. The Department’s selection of quality measures will likely change annually, reflecting the evolution of quality priorities as the managed care transformation continues. In addition, the Department’s measure selection includes measures from a number of nationally-recognized measure sets, which are themselves evaluated annually. The Department aims to maintain a measure set that reflects the state of the art in quality measurement for Medicaid-enrolled populations, and will update measures to capture any changes in these sets. Over time, the Department intends to decrease the size of the overall measure set by retiring topped-out measures and measures that are no longer necessary to capture optimal care. Each year the Department will release a new list of measures required for reporting and ask for public feedback.

The Department will also convene a group of stakeholder PHPs to share feedback on aspects of Medicaid transformation policy and operations, and will continue to work with the quality measurement subgroup of the [MCAC](#). In particular, the Department will seek ongoing feedback

on quality measure sets, which will likely be updated annually. In addition, the Department has convened a Technical Advisory Group specific to AMH issues.

VII. Appendices

Appendix A: Table of Quality and Administrative Measures

NQF #	Measure Name	Priority Measure	AMH Measure	Interim Measure	Gap Measure
1879	Adherence to Antipsychotic Medications for Individuals With Schizophrenia			x	x
NA	Adult Body Mass Index (BMI) Assessment	x			x
0024	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (the total of all ages for each of the 3 rates)	x			
	Total BMI Percentile Documentation				
	Total Counseling for Nutrition				
	Total Counseling for Physical Activity				
1388	Annual Dental Visits (Total Rate)				x
2508	Dental Sealants for 6-9 Year Old Children at Elevated Carries Risk				x
1334	Percentage of Eligibles Who Received Preventive Dental Services	x			x
0105	Antidepressant Medication Management (Both Rates)			x	x
	Acute Phase Treatment				
	Continuation Phase Treatment				
0002	Appropriate Testing for Children With Pharyngitis			x	
0069	Appropriate Treatment for Children With Upper Respiratory Infection			x	
1799	Medication Management for People With Asthma (Medication Compliance 75% Rate only)			x	
	Age 5 -11: 75% of treatment period				
	Age 12-18: 75% of treatment period				
	Age 19-50: 75% of treatment period				
	Age 51-64: 75% of treatment period				
	Total Rate: 75% of treatment period				
1800	Asthma Medication Ratio (Total Rate)	x	x	x	x
0058	Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis			x	
2372	Breast Cancer Screening				x
0032	Cervical Cancer Screening	x	x		x
0038	Childhood Immunization Status (Combination 10)	x	x		x
0033	Chlamydia Screening in Women (Total Rate)				x
0061; 0575;	Comprehensive Diabetes Care (BP Control [$<140/90$], HbA1c Control [$<8.0\%$], Eye Exam)				x

NQF #	Measure Name	Priority Measure	AMH Measure	Interim Measure	Gap Measure
0055	Hemoglobin A1c (HbA1c) Testing (HA1C)			x	
	Hemoglobin A1c (HbA1c) Poor Control (>9.0%)			x	
	Eye (Retinal) Exam				
0059	Comprehensive Diabetes Care: HbA1c poor control (>9.0%).	x		x	x
0547	Statin Therapy for Patients With Diabetes (Both Rates)				x
	Received Statin Therapy			x	
	Statin Adherence 80%				
0731	Comprehensive Diabetes Care (CDC)			x	
0018	Controlling High Blood Pressure	x	x	x	x
1932	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)				x
0543 (adherence)	Statin Therapy for Patients With Cardiovascular Disease (Both Rates)				x
	Received Statin Therapy Total			x	
	Statin Adherence 80% Total			x	
2371	Annual Monitoring for Patients on Persistent Medications				x
	ACE/ARB				
	Digoxin				
	Diuretics				
	Total Combined Rate				
0039	Flu Vaccinations for Adults Ages 18-64				x
0576	Follow-Up After Hospitalization for Mental Illness	x	x	x	
	7- Day Follow-up				
	30-Day Follow-up				
0108	Follow-Up for Children Prescribed ADHD Medication (Both Rates)				x
	Initiation Phase				
	Continuation and Maintenance (C&M) Phase				
1391	Frequency of Prenatal Care (≥81 percent of expected visits only)				
1517	Prenatal and Postpartum Care (Both Rates)	x			
	Timeliness of Prenatal Care				
	Postpartum Care				x
2902	Contraceptive Care: Postpartum	x			
2903	Contraceptive Care: Most & Moderately Effective Methods	x			
1407	Immunizations for Adolescents (Combination 2)	x	x		x
N/A	Adolescent Well-Care Visit				x

NQF #	Measure Name	Priority Measure	AMH Measure	Interim Measure	Gap Measure
0004	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Both Rates)	x			
	Age 13-17 yrs: Initiation of AOD Treatment				
	Age 13-17 yrs: Engagement of AOD Treatment				x
	Age 18+ years: Initiation of AOD Treatment				
	Age 18+ years: Engagement of AOD Treatment				x
	Total Rate: Initiation of AOD Treatment				
	Total Rate: Engagement of AOD Treatment				x
0027	Medical Assistance With Smoking and Tobacco Use Cessation	x	x		x
2856	Pharmacotherapy Management of COPD Exacerbation (Both Rates)				x
	Systemic Corticosteroid				
	Bronchodilator				
1392	Well-Child Visits in the First 15 Months of Life				
	0 Visits				
	1 Visit				
	2 Visits				
	3 Visits				
	4 Visits				
	5 Visits				
	6 or More Visits				
1516	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	x	x		x
N/A	Children and Adolescents' Access to Primary Care Practitioners				
	12 - 24 months of age				
	25 months - 6 years old				
	7- 11 years old				
	12- 19 years old				
NA	Percentage of Low Birthweight Births	x			x
NA	Percentage of Pregnant Smokers Receiving Appropriate Screening/Treatment for Smoking	x			
2940	Use of Opioids at High Dosage in Persons Without Cancer				x
N/A	Current use of Prescription Opioids and Benzodiazepines	x			
2605	Follow-up After ED Visit for Mental Illness or Alcohol or Other Drug Abuse				
2607	Diabetes Care for People with Serious Mental Illness: HbA1c Poor Control (>9.0%)				
2950	Use of Opioids from Multiple Providers in Persons Without Cancer				

NQF #	Measure Name	Priority Measure	AMH Measure	Interim Measure	Gap Measure
3175	Continuity of Pharmacotherapy for Opioid Use Disorder				
1664	SUB-3 Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge and SUB-3a Alcohol and Other Drug Use Disorder Treatment at Discharge				
0006	Getting Care Quickly	x			
0006	Getting Needed Care	x			
0009	Coordination of Care	x			
0006	Customer Service	x			
0006	Rating of Health Plan				
0006	Rating of All Health Care	x			
0006	Rating of Personal Doctor	x			
0006	Rating of Specialist Seen Most Often				
N/A	Overall Provider Satisfaction with PHP	x			
N/A	Screening for Social Determinants of Health				
N/A	Screening for Pregnancy Risk				
0052	Use of Imaging Studies for Low Back Pain				
1604	Total Cost of Care	x	x		
N/A	Ambulatory Care (AMB)*				
1598	Inpatient Utilization- General Hospital/Acute Care (IPU)*				
1768	Plan All-Cause Readmissions	x	x		
N/A	Measures of Avoidable Utilization				
	Avoidable Emergency Department Utilization	x	x		
	Avoidable Inpatient Utilization (Adults)	x	x		
	Avoidable Pediatric Utilization	x	x		
N/A	<p>Select Public Health measures</p> <ul style="list-style-type: none"> • Tobacco Use <ul style="list-style-type: none"> ○ Decrease the percentage of adults who are current smokers ○ Decrease the percentage of high school students using tobacco ○ Decrease the percentage of women who smoke during pregnancy ○ Decrease exposure to second hand smoke in the workplace • Nutrition/Physical Activity <ul style="list-style-type: none"> ○ Increase fruit and vegetable consumption among adults ○ Increase percentage of adults who get recommended amount of physical 				

NQF #	Measure Name	Priority Measure	AMH Measure	Interim Measure	Gap Measure
	<ul style="list-style-type: none"> activity • Opioid Use <ul style="list-style-type: none"> ○ Reduce the unintentional poisoning mortality rate 				

* = NCQA has proposed retiring measure in 2020

Appendix B: Specifications for New Low Birthweight Measures

Percentage of Low Birthweight Births

Descriptive Information

Measure Type

Outcome

NQF Number and Measure Steward

NQF # N/A; Measure Steward: CDC

Brief description of measure

The percentage of singleton births with low birthweight or very low birthweight

Measure rationale

N/A

If Paired/Grouped: What is the reason this measure must be reported with other measures to appropriately interpret result?

N/A

Measure-Specific Instructions

Measure-specific web page

N/A

Attachments

N/A

Numerator Statement

The number of singleton babies born weighing <2,500 grams or <1,500 grams at birth in the study population in a 12-month measurement year

Numerator Details

N/A

Denominator Statement.

All singleton births in the study population in a 12-month measurement year, for which mothers had continuous coverage with the same PHP from ≤ 16 weeks gestation through birth

Denominator Details

N/A

Denominator Exclusions

- Deliveries that did not end in a live birth (i.e., miscarriage, ectopic, stillbirth, or induced abortion)
- Deliveries classified as live births weighing < 300 grams
- Deliveries that resulted from multifetal gestations

Denominator Exclusion Details

N/A

Stratification Information

- Race (Black-White-Other)
- Maternal age (≤ 17 or ≥ 44)

Stratified Reporting Categories**Clinical Data**

- History of prior LBW pregnancy or personal history of LBW
- History of preterm birth/other poor pregnancy outcome

PHP Care Needs Screening Data

- Smoking status prior to coverage
- Drug and alcohol use that began prior to coverage
- Hypertension that began prior to coverage

DHB Data

- Existing Medicaid vs. Medicaid for Pregnant Women (MPW)

Risk Adjustment Type

N/A

Type of Score

Rate/Proportion

Interpretation of Score

Lower rate = higher quality

Calculation Algorithm/ Measure Logic

N/A

Sampling

N/A

Survey/Patient-reported data

N/A

Data Source

N/A

Data Source or Collection Instrument

N/A

Level of Analysis

Health Plan

Care Setting

N/A

Composite Performance Measure- Additional Specifications

N/A

Percentage of Pregnant Smokers Receiving Appropriate Screening/Treatment for Smoking

Descriptive Information

Measure Type

Process

NQF Number and Measure Steward

NQF # N/A (Modified from NQF# 0028); Measure Steward: TBD

Brief description of measure

Percentage of pregnant smokers receiving appropriate screening/treatment for smoking

Numerator Statement

The number of pregnant women who (a) are screened for tobacco use⁴ and (b) (of those who screen positive) engage in smoking cessation activities in the study population in a 12-month measurement year. Tobacco use screening should be identified using the following value sets:

- "Tobacco Non-User" using "2.16.840.1.113883.3.526.3.1189"
- "Tobacco Use Screening" using "2.16.840.1.113883.3.526.3.1278"
- "Tobacco User" using "2.16.840.1.113883.3.526.3.1170"

Smoking cessation activities should be identified using the following value sets:

- "Tobacco Use Cessation Counseling" using "2.16.840.1.113883.3.526.3.509"
- "Tobacco Use Cessation Pharmacotherapy" using "2.16.840.1.113883.3.526.3.1190"

Denominator Statement.

The number of women who are enrolled in a PHP and are pregnant during a 12-month measurement year

Denominator Exclusions

None

⁴ A paired screening measure is necessary to ensure that calculating the proportion of members who screen positive who go on to engage in smoking cessation activities does not inadvertently discourage screening.