PROVIDER TRANSITION TO MANAGED CARE QUALITY AND VALUE-BASED PAYMENT WEBINAR

Earl

Welcome everyone. Thank you for joining today's webinar. My name is Earl, and I'm the WebEx producer, and I will be your organizer for today's webinar presentation on North Carolina Medicaid Transformation Value-Based Payment and Quality Measurement and Medicaid Managed Care. Today's presentation is the third in a series of eight provider education modules that are planned on Medicaid transformation. Notifications on additional provider education modules will be forthcoming and posted to the Medicaid transformation website.

We, we have a few housekeeping items before we get started. If you experience technical difficulties joining the WebEx session, please dial 1-866-779-3239, or you can message me using the QA panel. During the presentation, all participants will remain in listen-only mode and as a reminder this event is being recorded. We will be holding a Q&A session. We encourage you to submit written questions at any time during the presentation using the Q&A panel at the bottom right of your screen. Please type your questions into the text field and hit send. Please keep the drop down as "all panelists."

I will now turn the event over to Emily Carrier, senior manager at Manatt Health to make opening remarks. Emily, you have the floor.

Emily Carrier

Hi, everyone, I'm Emily Carrier from Manatt Health. We've been working with North Carolina on the Medicaid transformation project. And today's webinar is on value-based payments and quality measurement and Medicaid managed care, and it's intended to give providers initial guidance on value-based payments, which are commonly referred to as VBP, with a focus on the early standards that the Department of Health and Human Services is using to assess VBP. And the webinar will also provide a deep dive on the state's approach to quality measurement and managed care. You're going to hear from a number of folks from the North Carolina DHHS who are overseeing this work. During the next hour, you'll hear from Amanda Van Vleet and Jamica Wilkins to discuss VBP and quality, in turn. And then you'll hear from Lynne Testa, who's going to talk about upcoming opportunities for engaging with the state on these topics. And I'll be back again for the Q&A, because we do have a lot of participants. Again, rather than open the lines, we'll ask everyone to submit their questions via the chat window. You can do that at any point during the talk. We may not be able to get to everyone's questions -- we are planning to release an FAQ document that should address most of the questions we didn't get to, and there'll also be some information during the presentation about where to go if you want to follow up further. And to address one frequently asked question right now, the deck that you're seeing will be posted by early next week to the Medicaid transformation website, which is the same place you went to to register for this webinar.

So I would now like to introduce Amanda Van Vleet, who is Senior Program Analyst for Quality and Population Health at North Carolina Medicaid, who will provide the content overview for the presentation and will then cover North Carolina's vision for value-based human and managed care.

Amanda Van Vleet

Great. Thanks, Emily. So, as Emily mentioned today we'll be talking about North Carolina's vision for promoting quality and value in Medicaid managed care. I'll provide an overview of our initial guidance on payment, on paying for value, and then my colleague Jamica Wilkins will go into more detail on our quality strategy and measures. And, finally, Lynne Testa will review some opportunities for engagement and resources before we turn to Q&A. Also, you'll notice in the presentation there are some dotted call-out boxes, like at the bottom right-hand corner of the slide here. Those contain some key takeaways or detailed examples that may be helpful for you to reference throughout the presentation.

Next slide. So, North Carolina Medicaid's increasing focus on value-based payments is a part of a broader shift in payment models in North Carolina, and nationally, across payers. Payers are shifting from paying for the volume of services provided to paying for health outcomes, improved quality of care and curbing the cost of care. Nationally, the amount of value-based healthcare payments has increased in the past few years. Value-based payment arrangements are most common in Medicare but are really widespread across payers. And in Medicaid specifically, a quarter of all payments are valued based. And then in North Carolina specifically, there is currently a really big shift to value-based care across payers. For example, five major health systems recently signed contracts with value-based arrangements with Blue Cross North Carolina to share in those savings and losses. The UNC Health Alliance signed a value-based agreement with Blue Cross North Carolina in relation to their ACA plans. That allowed their ACA rates to decrease statewide by an average of over four percent. And Duke Connected Care, which is Duke's physician-led accountable care organization, last year exceeded their quality, their targeted quality standards while saving over $21 million. So, there really is a great opportunity here to improve quality and provide better care while working on affordability.

Next slide. So, paying for quality and value is really important to the state of North Carolina in our transition to managed care. Since, in the managed-care environment, providers will be contracting with health plans, the state's VBP strategy ensures that providers share in their rewards for the work that they do to improve quality and use their resources in a meaningful way. So, under our VBP strategy, the department will encourage PHPs to enter into VBP arrangements, and will establish general guidelines and framework for PHPs on what these value-based payment arrangements should look like. However, we're still leaving a lot of flexibility for both PHPs and providers to find arrangements that work for them and can be tailored to each provider.

We understand that providers in North Carolina has very different resources and serve very different populations, so we want to ensure that providers can use these alternative payment arrangements in ways that help them. They really are meant to encourage flexibility and innovation. So we encourage providers to think about what they need and go to PHPs with that ask. So, for example, if you could use more payments and are willing to report some of your quality measures to your PHPs, or if you're doing well and meeting quality metrics, there's an opportunity to get some incentive payments for that. Maybe you could use a PM PM to ensure that you're, you can coordinate some additional care for your patients. So, we encourage you to think about what you need and try to use the flexibility and innovation to try to set up payment arrangements that can help support that.

Next slide. So now I'll walk through the initial guidance that we've put out on VBPs. I will note that this is a developing process that, if you have feedback on any of the guidance, we encourage you to weigh in. We want to hear from you, and I just want you to know that this will be an iterative process, as we seek feedback from stakeholders over time.

So, our initial guidance lays out guidelines for VBP arrangements in the first two contract years of managed care. Primarily, it specifies how the state will define VBP for these first two years. We're basing our definition of value-based payments on the healthcare payment Learning and Action Network, or the LAN framework. The LAN is a public-private partnership, with the mission of accelerating VBP models and is a common framework for defining VBP that's used across payers. So, if you look at the categories on the slide, if you start at the left, you start at fee for service and as you move to the right, you move towards increasing levels of risk and increasing levels of value. So, the state is defining VBP in the first two years as managed care, as any arrangement that falls in categories two through four of the LAN framework. So, this includes arrangements such as pay for reporting or pay for performance, all the way through population-based payments or global budgets. So a wide range. And PHPs and providers can establish different types of arrangements that fit into these, these three categories.

Providers are not required to engage in these models, but they are encouraged to do so, because again there's opportunity for you here. So again, think about opportunities to gain additional funding. If you report performance or meet certain quality measures, etc. And, additionally, all payments to AMH Tier 3 practices will count as value-based payment under this definition, because all AMH Tier 3 contracts must have a performance-based payment included. So, payments to a AMH Tier 3 practices count as VBP.

Next slide. So that's what we mean when we talk about VBP. Now let's talk about what targets need to be met on VBP. So, the state's requirement is four RPHPs. So, by the end of contract year two, the portion of each PHPs medical expenditures that are under VBP arrangements must increase by 20 percentage points, or represent at least 50% of total medical expenditures. The target is defined by all payments that flow from PHPs to providers under a VBP payment arrangement or in a total cost of care model, the total cost of care for the patient population assigned to the model, and the denominator of that is the PHP's total medical expenditure.

I'll note that PHPs do not have to meet the higher of these two targets. The baseline for the increase will be set at the end of Contract Year 1, which is when the first data on VPB payments is available. And there won't be any with withholds for PHPs in the first two years, but the target is a contrast requirement. So, based on this, I'll say that early, on VBP targets will likely not drive significant changes for providers. However, over time, providers can expect that their contracts with PHPs will require greater accountability for cost and quality of care. So, we encourage providers to begin preparing for the string this time and setting up any system processes that will be needed to drive towards more accountability.

Next slide. So, that's VBP in the first two years of managed care. What about after that? We'll continue to release guidance on the state's strategy for value-based payment arrangements over time. We're planning to release our next guidance, which is a VBP roadmap, this summer, which will overview the state's VBP strategy over years three through five of managed care. The Department's vision is that providers will grow in accountability for patients health over time, so the roadmap will reflect that. It will identify ambitious but achievable VBP targets for PHPs' standards and requirements during some of these later years in managed care and will help providers understand how their VBP contracts with PHPs might change over time.

We'll be releasing this guidance for public comment, so please keep an eye out for it and provide us your feedback when it's released. We'll continue to update our guidance over time based on public comment, as well as looking at PHP performance and seeing what may need to be adjusted or what's

going well. We're also planning to convene stakeholders to look at VBP performance and penetration in the market over time, and using those learnings to update our guidance over time as I said, so it'll be an iterative process.

And now I will turn things over to my colleague Jamica Wilkins, who will go into the quality side of paying for quality and value, and she'll provide an overview of North Carolina Medicaid quality approach and do a deep dive on some select quality measures.

Jaimica Wilkins

Thank you, Amanda. We will now go over the overview of North Carolina Medicaid's equality approach, including the overview of the approach, quality measures, PHP accountability for quality, and addressing disparities and public health outcome.

Next slide. The next slides will cover North Carolina's approach to quality and the quality measures. We have three charges from Secretary Cohen for Medicaid transformation. Charge 1: a robust measure set and measure reporting that will allow North Carolina to track progress against quality priorities at a stratified level. Charge 2: accountability for quality from day one, and Charge 3: immediate attention to improving Public Health priorities including low birth weight and promoting health equity. Some of the legislative and other factors shaping our quality approach includes legislation stating that withholds could not be implemented until at least 18 months after managed care launch. Also, the Department expects providers will require time to update documentation and coding processes for the managed care environment. The public health priority, particularly low birth weight, require new approaches for managed care. For more information, we encourage you to see the technical specifications manual, which was released on April 18, 2019. It is located on the Medicaid transformation website, under the quality management and improvement page.

Next slide please. North Carolina's quality strategy is built on this quality framework, around the desire to build an innovative whole person, well-coordinated system of care, which addresses both medical and non-medical drivers of health and promotes health equity. This quality strategy and its objectives recognize that significant process and are aligned closely with the measures the North Carolina Institute of Medicine Task Force put forth. As you can see on the slide, we have three aims and six goals which are aligned with the CMS national quality strategy, with the goals and objectives aimed at driving improved and sustained population health outcomes. The 18 objectives set forth are similarly aligned to ensure beneficiary access to services, particularly in the context of the state's transition to managed care

Goal 1: Ensure appropriate access to care, recognizes the need to maintain North Carolina's historically high rate of provider participation in Medicaid and to fully meet beneficiaries' needs including convenient access to appropriate range of providers in a timely manner.

Goal 2: Drive patient-centered whole person care, seeks to ensure that beneficiaries are engaged in their health care and are satisfied with their prepaid health plan. In addition, ensuring that they are linked to an advanced medical home provider is also key.

Goal 3: Promote wellness and prevention, reflects the continued emphasis on improving the health of children and women, which are large populations represented in North Carolina Medicaid, respectively 60 percent and 58 percent of Medicaid beneficiaries.

Goal 4: Improve chronic condition management, focuses on conditions that heavily impact North Carolinians' Medicaid population, including asthma, diabetes, behavioral health, and hypertension. While other chronic conditions were also consider for inclusion, the department focused on select targeted priorities that allow for demonstrated progress reinforced by recommendations and a relevance to existing and newly covered populations in the managed care environment.

Goal 5: Work with communities to improve population health. This objective emphasizes areas where community engagement is important and critical to advancing a high-quality health system, such as meeting unmet resource needs and combating the opioid epidemic.

Goal 6: Focuses on pay for value and will ensure high value appropriate care as we move into advanced payment models and value-based payments and purchasing.

Next slide, please. North Carolina Medicaid Quality Measures are a robust measure set that the plans will be required to report on an annual basis. This robust measure set includes 67 measures from national measure stewards that focus on quality and select administrative measures aligned with national, state, and plan reporting. PHPs must also narrow their focus to reflect the department's priorities in contracting with providers, so we also have a 31 priority measure set that can be used in provider incentive programs. For all 67 measures, the PHPs must report on these annually to the Department. For the 31 measure priority set, PHPs could use any of these in the provider incentive program. For the six measures included in our quality withhold measure set, the Department will hold prepaid health plans accountable financially for these measures, starting in year three, July 2021.

Next slide. The PHPs will also use a subset of priority measures selected for their relevance to primary care and care coordination to assess AMH performance and calculate performance-based payment. The state has selected this smaller group of measures to standardize the metric plans used to assess advance medical homes. Plans are required to use all measures listed, for all AMH measures, PHP selects must come from this list. As you can see, there are adult and pediatric measures relevant to the population. These are also measures from national measure stewards and key performance indicators.

Next slide. Some of the key takeaways for the North Carolina quality measures are as follows. Under Medicaid managed care, providers have an opportunity to receive higher payments for delivering and documenting high quality care. The state will focus on driving quality improvement through the PHPs, and PHPs will in turn work with providers to improve quality performance. PHPs will design their own quality improvement programs using the priority measures, the 31 measures that we mentioned on the previous slide. Providers will also assess quality improvement programs or participation. Most quality measures will require only claims data, but PHPs and providers may mutually agree upon using hybrid reporting approaches where appropriate. In hybrid reporting, PHPs will use clinical data to supplement information available in the encounter data. Providers will also have a number of opportunities to offer feedback on how the department and the PHPs can make reporting more efficient and meaningful, and we encourage you to provide that feedback to us, as requested. There's also a Medicaid transformation email address where you can provide other feedback or send in questions.

Next slide. PHPs will be held accountable for their performance and required to report it. For public reporting, plans will be required to report performance on a wide range of quality measures. These performance measures will be publicly reported on an annual basis. PHP's data collection for submission to the Department will begin the first calendar year after managed-care implementation, January 1, 2020, Public reporting for most improved performance. Public comparisons stratified to

avoid penalizing plans serving high-need members is an incentive to improve quality performances. PHPs will consider public reporting as an incentive to improve performance in the absence of financial penalties. Providers should expect to be engaged by PHPs around performance and documentation more broadly. For financial accountability, it will be implemented, implemented through the quality withholds program. Because of the legislatively, legislatively mandated delay, financial accountability via withholds will begin in Contract Year 3 corresponding to quality performance in calendar year 2021. Financial accountability will more closely reflect the state's needs, and this allows the Department opportunity to establish the quality withhold measure set and targets based on current assessment of performance gaps.

Next slide. The PHPs will also be held accountable for interim and [Gap] reporting on select quality measures to facilitate quality improvement throughout the year. Interim reports will provide information on quality measure performance trends throughout the year. Providers can use these reports to assess performance throughout the year, and identify areas for improvement. [GAAP] reports will identify specific members who are not listed as receiving recommended care on the PHP record. PHPs will deliver these reports to the advanced medical homes as appropriate. Advanced medical homes can use these reports to support care planning for listed individuals, population health management efforts, and changes in documentation practices.

Next slide. PHPs will also report stratified data to ensure improvements in quality performance and maintain or promote health equity. The stratifications include age, race and ethnicity, gender, primary language, long-term services and support needs, disability status, geography, and service region. Most of these stratifications rely on administrative data generated at enrollment , and providers will need to collect additional information to inform stratification -- will not need to collect additional information. If providers notice a PHP reporting incorrect information about one of their patients, they should work with the PHP to correct it.

Next slide. PHP performance will be assessed against annual benchmarks. 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 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. See Measure A example below.

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 the 20 percentile points above North Carolina's prior year average. Please see Measure B example below.

For measures for which North Carolina does not have prior performance data, the performance benchmark will be set at the NCQA national 50th percentile or equivalent national median. The benchmarks are set at the PHP level and will not likely affect individual providers, and benchmarks will not be posted publicly. Benchmarks are for informational only purposes and are not used to calculate performance on quality withholds, which will begin in the third contract year of managed care.

Next slide. On this slide, you'll see the timeline for quality measurement and contracting. Our quality measure reporting will begin with the launch of managed care. For each contract year, the PHPs will submit quality performance data measured during the calendar year that began in the January prior to the beginning of that contract year. Although withholds aren't implemented until Contract Year 3, providers should expect the PHPs to implement performance improvement programs earlier, so that

they can prepare for the withhold period. PHPs launch in initial regions 2 or 4 in November of 2019 in the remaining regions 1, 3, 5, and 6, in February of 2020. calendar year 2020 corresponds with quality measurement for PHP Contract Year 2. calendar year 2021 with PHP Contract Year 3, and calendar year 2022 with Contract Year 3. Please see the example at the bottom of the slide. For Contract Year 3, extending from July 1, 2021 to June 30 of 2022, the PHPs would report performance on quality measures reflected during the calendar year extending from July 1, 2021 to December 31, 2021.

Next slide. In addressing disparities and public health outcomes, for disparities, PHPs will report stratified data, which we talked about earlier for the quality measures, and the external quality review organization will drive disparity reports, starting with the first quality performance year, which is calendar year 2020. Disparities in low birth weight can be the focus for the Department with PHPs around modified low birth weight accountability measures. The department also welcomes providers' input on how to identify health disparities through the use of quality and encounter data.

For public health, Healthy NC 2020 goals correspond to several areas of intended PHP quality focus. The Department will report state-level and program-level data for the behavioral risk factor surveillance system, or BRFSS, related to smoking cessation, diet and exercise, and opioid-related mortality and compare against PHP level performance. Linking PHP performance and state-level or program-level outcomes can inform state public health effort. PHP activities may have ripple effects that affect health beyond the Medicaid population. The Department can leverage these efforts to advance public health goals. Over time, withholds will focus on reducing health care disparities. Providers should begin considering options for disparities at the practice level.

Next slide. Next, will be our take on a deep dive on select quality measures, including diabetes care, low birth weight, and avoidable preventable utilization.

Next slide. Based on most recent CDC data, diabetes is the seventh leading cause of death in North Carolina, and contributes substantially to heart failure, stroke, and kidney disease. These factors give the state compelling reasons to work with providers to improve diabetes outcomes. Also, given diabetes role in morbidity and mortality among North Carolina residents, the Department has included diabetes as a priority area of care and will assess diabetes care against a range of indicators.

With the 67 measures North Carolina identified five diabetes measures from the adult child core measures and NCQA accreditation measures. These measures are comprehensive diabetes care, hemoglobin A1C testing, hemoglobin A1C poor control, statin therapy for patients with diabetes, and comprehensive diabetes care. For the priority measure set of 31 measures, we have one of those, hemoglobin A1C for control, as our measure that provides the most direct insight into diabetes control and will be a priority. Please note, the Department is unable to calculate accurate performance on the hemoglobin A1C for control, due to limited availability of clinical data or encounter codes describing A1C results.

Next slide. In measuring the quality of diabetes care, the hemoglobin A1C poor control measure has been identified as an immense, as an advanced medical home measure. For practice level reporting, plans are not required to use all AMH measures. If the plans choose to use this measure in AMH assessment in their provider contracting, they may only use it for pay for reporting as a measure. Recognizing the challenges in reporting on glycemic control, the Department will support efforts to coordinate reporting strategies. Practices can report this measure in a variety of ways. CINs and other

partners can also add value to reporting with this measure. The department will work with the plans and the providers to implement reporting processes as we look at diabetes care.

Next slide. So, the department has a modified CDC measure for low birth weight to prevent assessment of the PHP level accountability. The North Carolina expert workgroup drove the low birth weight recommendation. The outcome measure sets broad accountability for low birth weight. Of all pregnant members with continuous coverage by a PHP from 16 weeks gestation, what proportion deliver low birth weight and very low birth weight babies? This excludes multiple gestation. And then we also have a process measure that focuses on high prevalence of tobacco use, a low birth weight risk factor among pregnant Medicaid enrollees. Of all pregnant members, this measure looks at who screened positive for tobacco use and what portion engaged in tobacco use cessation activities.

The Department will report both measures and will experiment with different restratification approaches to finalize the approaches for Contract Year 3. The Department will also engage plans to identify opportunities for meaningful intervention and monitor for concerning member disenrollment patterns. Providers should be prepared to clearly document significant history and comorbidities and accurately code claims for tobacco cessation services. During the first year of reporting, the Department will identify additional exclusion criteria, and providers should continue to track the Department's guidance to learn more about these exclusions.

Next slide. For measures of avoidable and preventable utilization, we will assess the degree to which care management and utilization management efforts reduce these avoidable and preventable utilization. PHPs are not permitted to use these metrics as utilization management criteria for adjudicating individual visits. These measures are specifically meant to assess access to and quality of primary care. Providers should contact the Department if they see these designations used to limit coverage. For avoidable and preventable ED visits, they are being measured using the NYU/Billing's Algorithm. For avoidable, preventable inpatient hospitalization, we are using the AHRQ Prevention Quality Indicators and Pediatric Quality Indicators Algorithm.

Hospital readmissions, we are using the NQF 1768 Plan All-Cause Readmissions and the measures are meant to ensure the PHPs focus on reducing utilization through improved access and disease management, rather than increasing barriers to care. Reporting for all of these measures will be phased in over time, and we encourage you to see the technical specifications manual. Again, that's listed on the Medicaid transformation website under the quality management and improvement webpage.

I will now turn the presentation over to Lynne Testa, who will discuss opportunities for engagement for providers.

Lynne Testa

Thank you, Jaimica. Let's transition now to cover suggested next steps for providers and where providers can find helpful resources on quality measurements.

Next slide, please. What is important for providers to know is that the Department values input and feedback from stakeholders and has created a number of opportunities for providers to connect with us in an array of venues and activities. A series of topic-based webinars will educate providers on key topics to effectively serve their patients in the transition to managed care. Fact sheets and FAQs will accompany each webinar. The Department periodically releases policy papers, and providers are encouraged to offer comment and feedback as part of our iterative process. The Department's

webpage will serve as a central hub for providers to access resources about the transition to managed care. On the screen, we have provided a quick link to help locate information, and providers are welcome to submit comments, questions, and feedback to us through email at the address provided on the screen.

Our goal is to respond to provider inquiries within three to five business days. We also want to highlight that providers may use the Medical Care Advisory Committee Quality Subcommittee and the AMH Technical Advisory Group as a mechanism to provide feedback on the Medicaid Managed Care Quality Measurement approach. On the right-hand side of the screen, we have provided helpful Quick Links that will offer information on the calendar of upcoming meetings, as well as prior meeting materials and minutes.

Lastly, we just want to reiterate that providers can expect to receive education and support during and after the transition to managed care.

Next slide, please. A number of upcoming events are being calendared for the months of April, May, and June. During the next several weeks, we have five additional webinars scheduled to roll out in our Medicaid Managed Care Transformation series. These include Provider Policies, which will be held on May 9th. The registration for this webinar is now open and you can register for it on our website. We have planned to do a Behavioral Health Services Standard Plans and Transition Period webinar on May 23rd. A Clinical Policies webinar on May 30th. A Healthy Opportunities in Medicaid Managed Care, on or about June 13th, and covering a, last webinar in this series on Beneficiary Policies, we hope to have this scheduled and open for registration for a June 27th date.

In addition, we will be holding our first virtual office hours this Friday, April 26, from 12:30 to 2:00 p.m. Registration information for tomorrow's session can be found on our website. And during April, we kicked off our provider PHP meet-and-greet forums that will continue through managed care launch. These regional sessions will offer providers an opportunity to meet with health plan representatives, ask specific questions about provider network participation, and Medicaid managed care transition. Health plans and North Carolina subject matter experts will be on hand to respond to provider enquiries. The upcoming calendar for May and June events will be posted to our website very shortly. Again we encourage providers to check the Department's web page for additional information and opportunities to register for upcoming webinars and other provider events.

Next slide, please. This slide is intended to offer providers helpful resource links for the technical specifications for the North Carolina Medicaid managed care quality measurement, the North Carolina Medicaid quality strategy, the HEDIS quality measures from the National Quality forum, and the federal CMS adult and child core set quality measures.

Next slide, please. We have concluded the formal presentation for today's webinar. At this time, I would like to ask Emily to facilitate the question and answer segment of today's presentation. Thank you.

Emily Carrier

Thanks, Lynne. So, we had a quick request to go back to slides 18 and 19, so I'm going to do that quickly, so folks who didn't have the opportunity to see it will have it. And then, we had a question about the slides being posted. I just wanted to reiterate the slides will be posted probably by early next week, but I just wanted to, I'm going to go back to slides 18 and 19 quickly for people who didn't have the

opportunity. So, here's slide 18. And now I'll just go through to the next slide. Okay, so we had a number of questions, and we had a number of questions that were related to specific service lines. Probably most of those questions we're going to end up tackling in the follow-up document so that we can get a complete list out to folks. We're going to try to tackle the questions on the, general questions on this call. First let me just, have a reminder, some questions were about which providers are specifically addressed by the material in this call. So, just as a reminder, this call is for providers who are contracting with standard plans, and this could be any kind of provider contracting with standard plans. You could be a primary care provider, AMH or non-AMH, a behavioral health provider, anyone who's contracting with a standard plan. And we did have a question about whether this applied to the tailored plans as well. Those plans are going to have their own guidance that will coming out, be coming out for search of the tailored plan launch.

So, let me then start with VBP question. So, for Amanda, we had -- let me start with a sort of a high-up question. We had a question, can you say more about what a withhold is?

Amanda Van Vleet

Thanks. Yeah, sure. So a withhold is geared towards our PHPs. So, basically, the state pays our prepaid health plans a capitated rate each year, and if we implement a withhold, then we'll, then we'll withhold part of that capitation payment to the PHP, and then if the PHP meets certain performance measures related to quality or VBP, or anything that we set out for them, if they reach those goals then we'll proportionally give some of that withheld money back to them. If they don't meet those performance goals, then the state will hold on to that money. So the withholds are not for providers.

Emily Carrier

And then we had a question that, we had a question that's kind of related to that. The participation in VBP is voluntary, but is the withhold going to be mandatory? And that might be somewhat related to providers and somewhat related to plans. Amanda, can you talk more to that distinction in a little more detail?

Amanda Van Vleet

Sure. So, the withholds, the withholds will be mandatory for our PHPs beginning in year 3. Again, no withholds for providers, but since the withholds for PHP s will be mandatory, that will impact their contracting with providers. So, since the PHPs will need to meet certain performance goals for BBP, for example, then that will mean that they'll be incentivized through that withhold to contract with providers and incorporate value-based payment arrangements into their contracts with providers. Hopefully that helped clarify some.

Emily Carrier

And, we had another VBP question. How will the VBP targets be implemented for specialists that are not PCPs?

Amanda Van Vleet

Sure, so, as Emily stated, the VBP guidance as well in this presentation is related for all -- relates to all providers that are contracting with standard plans. So, that includes specialists and PCP use. And so,

the point, the targets, the definitions and targets that we have set forth relate to all providers, that's specialist, primary care, behavioral health, etc., that contract with a standard plan. So, I did use our Tier 3 AMHs as an example, since payment, we've specified that performance incentive payments needs to be included in their contracts. But basically, we've set targets, and our PHPs and providers can come towards those VBP arrangements and contracting. However, they can come to those arrangements as long as the PHPs meet their, meet those targets.

Emily Carrier

We have another question about sort of the primary care specialist distinction. For behavioral health providers, how should they think about how VBP will be implemented for them?

Amanda Van Vleet

Sure, so behavioral health providers, if you are contracting with a standard plan, then, then the VBP guidance would apply for you in your contracts with standard plans. If you also choose to contract with tailored plans once those are selected, then we'll have some different quality and VBP guidance that applies specifically to your contract arrangements with tailored plans. That will be coming at a later date.

Emily Carrier

And we had some questions about quality. So, for Jamica, we had a question about confirming that the quality benchmarks won't be posted publicly. Can you talk a little bit more about the benchmarks and how the state is viewing them and how they'll be used?

Jaimica Wilkins

Sure. the quality benchmarks will apply to the prepaid health plans, and therefore, they won't be posted publicly but will be communicated specifically to the plans, and the plans will use those benchmarks to address their performance and how they move forward with their contracting with the providers. So the benchmarks only apply to the plans, and therefore, they will be communicated directly to them and not posted publicly.

Emily Carrier

We had a question, how will the required, about how will the required metrics, not just the priority metrics but all of them, be reported? And will the reporting be done by claims for each plan?

Jaimica Wilkins

The, the measures will be reported in-house. We have templates that are already created where we'll communicate back and forth with the plans, and they'll submit that data to us on the claims data around the 67 measures, and we'll receive that. And then the other question was, how will it be reported? Emily, what was the other part of the question?

Emily Carrier

Yeah, will the reporting be done by, will plans report by claims for you each plan?

Jaimica Wilkins

Yes. Yes,

Emily Carrier

We had a question about the priority measures. How can folks find the list of the 31 metrics that are priority measures for plans to choose from, and do we know how many of the priority metrics would each plan mandate?

Jaimica Wilkins

So the priority measures are listed as a part of our quality strategy, in the revised quality strategy, the final version of that is posted on the quality management and improvement Web page that's off of the Medicaid transformation website. It was posted on April 18, 2019, along with the technical specification. So, between those two documents, you can find our whole measure set, as well as the priority measure set, and they're required to report those measures annually, and as far as the priority measures, those are the measures that they can choose whichever ones they would like out of that set to hold advanced medical holds accountable for. And there's a subset from that priority set for specifically for the measures for advanced medical homes. So, if you look at the advanced medical home subset, I think that's the question they're asking about, how many of the priority metrics which will be mandated? If you look at the advanced medical home subset of the priority measures, the plans will be choosing from there, which ones to apply to the providers.

Emily Carrier

So, we have a question. Are the measures posted in the quality strategy report, are they the final measures, or are they subject to change?

Jaimica Wilkins

They are the final measures at this point. However, we are looking at updating the quality strategy every three years, or if there's a change in legislation or a drastic change in the Medicaid population, we will also look at changing those measures. And then you also have to be aware that the adult and child core set with CMS has their own process of adopting, amending and abandon, abandoning measures. So, they're currently looking at measures now and which ones they're pulling in and out of the set that may also affect our measure set. So, long story short to your question is, for now that measure set is final, but it may change in upcoming years due to the factors that I've mentioned.

Emily Carrier

And we had a question, it seems like the, this is a, this is a lot of measures for plans to report. Can you talk more about the thinking behind the selecting the measure list?

Jaimica Wilkins

Yeah, so, here in North Carolina Medicaid, we serve a diverse population that includes pregnant women, children, duals and people with chronic diseases and illnesses. So, we wanted to make sure that we addressed all of those in our measure set and made sure that we had different types of measurement to

cover those care patterns. So, we keep a close eye on all of those populations and wanted to carry that over into our managed care transition. So, in future years, as, as previously mentioned, we may scale back those measures as part of our adopt, amend, abandon process for the measures, but we also encourage our plans and providers to focus on the smaller subsets that we talked about earlier including the priority measures and the subset of the priority measure set which is the advanced medical home measures.

Emily Carrier

And we had a question about the measures, like the A1C control or the blood pressure control that may require non-claims or encounter data. Can you talk a little bit more about what, how providers are expected to report those, and what kinds of resources they can draw on?

Jaimica Wilkins

So, they would need supplemental claims data for that. Basically, on electronic medical records or electronic health records. So we encourage the plans to negotiate any details around hybrid reporting with the practices that require clinical data, and the Department is requiring the plans to contract only on a pay for reporting basis for those hybrid measures, and we expect our advanced medical home technical advisory group and other groups to be able to weigh in on developing some common approaches to, to address that kind of reporting.

Emily Carrier

Okay. And we had a question, How will value-based purchasing affect public health departments that don't offer primary care services? I think that one's for you, Amanda.

Amanda Van Vleet

Thanks. So, I guess I would say similarly are the guidance that, that we've given so far is for our PHPs in relation to their contracting with all types of providers. So, that would include local health departments. But there's no guidance specifically tailored towards VBP arrangements with local health departments. And so, really that would be up to the contracting between the local health departments and the plan. And again, our only guidance is that the plans right now meet the targets by –Year that we have put out. So, that would really be up to your contract negotiations with the plan but no specific requirements.

Emily Carrier

We had a question about the avoidable preventable utilization measures and specifically the ED utilization measures. I'll actually tackle that. This is Emily talking. I'm actually an emergency physician, so this one is pretty close to me. So, the question was, are these really a measure of primary care access and quality, because people go to the emergency department for all kinds of reasons, and that comment is 100% true. People do go to the emergency department for all kinds of reasons, and that's why we made it very clear that these measures are not meant to adjudicate individual visits, because any individual visit could be related to any number of factors that are not directly connected to the person's clinical history and presentation. However, at the population level, there's good evidence to suggest that there are population level differences based on availability of primary care. So, we're thinking that these would be focused on sort of high-level looks at PHP populations and large populations. We would

also note that we welcome other feedback on the avoidable utilization measures. As Jamica mentioned, reporting for these measures will be phased in over time therefore.

Sorry, it was muted there for a second. We had a question, will the Department release benchmarks for the quality measures? Jamica, can you talk a little bit about what benchmark or historical data will be released?

Jaimica Wilkins

As previously mentioned, I think we just answered a question around benchmarks. We will, the benchmarks apply to the plans. And so, we will communicate those benchmarks to the plans. We will not post them publicly.

Amanda Van Vleet

Emily, I'll just add that we have some guidance on both quality and value-based payments on our website, as well as the value-based payments. Specifically, you can find more details about the guidance that I've been discussing that applies to Years 1 and on, on our website.

Amanda Van Vleet

We had another question about withholds, and I think this is going to be our last question because we're a minute away from the hour. We have many more questions that as I mentioned we'll plan to address in a document that will be posted on the Medicaid transformation site. So, if a PHP has a withhold in the third year because they haven't met their quality standards, does that affect the way that PHP pay their providers? That is, would that affect the claims payments from the PHP to their providers?

Amanda Van Vleet

Yes, it could. Also, I just wanted to note that the withholds are, are for future performance, and not based on past performance. And so, for example, the, starting in Contract Year 3, the PHP will get its capitated payment with a portion withheld, and then it's based on their performance for the upcoming year that determines whether they get a portion of that withheld amount back. And so, it would, that's the incentive for them to, to incorporate into their contracts with providers elements that would help them to meet those goals that we'll be measuring on that will help them to get that with health payment back. So, that's whether they have a certain percentage of VBP arrangements in place, whether they meet certain quality measures, and those will be coming from their relationships with providers, so it will affect provider contracts in that way.

Amanda Van Vleet

Great. And we're at the hour. I wanted to thank everyone for attending. These will be posted on the Medicaid transformation site beginning of next week, and there, the list of upcoming webinars is there, as well. And as I mentioned, we did get a number of comments that we couldn't speak to today. So, keep an eye out on that same site for a follow-up document that will adjust those questions in greater detail.

Thanks, everybody.

Earl

Ladies and gentlemen, thank you for attending today's webinar. This concludes today's presentation. You may now disconnect your lines, and have a nice day.