North Carolina Medicaid Transformation: Value Based Payments and Quality Measurement in Medicaid Managed Care

April 25, 2019
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Promoting Value and Quality in Medicaid Managed Care
Initial VBP Guidance
Overview of North Carolina Medicaid Quality Approach
Deep Dive on Select Quality Measures
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Key takeaways for providers and detailed examples can be found in these boxes.
Shift to Value-Based Payment is Well Underway Nationally and in North Carolina

North Carolina Medicaid’s increasing focus on value-based payment (VBP) is part of a broader shift in payment models across payers.

**National Landscape**

- **34%** of U.S. healthcare payments were “value-based” in 2017, up from **23%** in 2015, according to research conducted by the Healthcare Payment Learning and Action Network (HCP-LAN).*

- Value-based arrangements were most common in Medicare but are widespread across payers.

**North Carolina**

- Major NC health systems are signing value-based arrangements across payers.

*Payments categorized as level 3 (alternative payment models built on FFS architecture with upside/downside risk) or 4 (population based payment) under the Healthcare Payment Learning and Action Network (HCP-LAN) alternative payment model framework.

**Source:** “APM Measurement: Progress of Alternative Payment Models”, HCP-LAN, 2018. Survey responses were voluntary.
The Importance of VBP and Quality in Medicaid Managed Care

VBP in managed care focuses on promoting **quality** and **value** in how care is delivered.

DHHS will promote PHP’s use of VBP through *withholds* and will establish guidelines for what VBP arrangements should look like.

PHPs will be responsible for developing and implementing VBP arrangements and engaging with providers to ensure delivery of high quality care.

Today’s webinar will focus on early standards DHHS is using to assess VBP, as well as plans for measurement of quality within managed care.

Managed care is about interaction between state and health plans. Quality/VBP ensures that **providers** share in the rewards for the work they do to improve quality and reduce utilization in a meaningful way.

*Withholds will be effective in Contract Year 3*
Defining VBP

The state sets guidelines for VBP arrangements, but does not prescribe specific types of arrangements PHPs must use. As such, each PHP may have a different approach to VBP.

VBP Arrangement

- Arrangements that fall under categories 2-4 of the HCP-LAN APM framework qualify as VBP.
- PHPs may establish different types of arrangements that fit within these categories.
- Providers are not required to engage in these models, but are encouraged to do so as they reflect opportunities to gain additional funding based on reporting or performance on quality measures.
  - Payments to AMH Tier 3 practices will count as VBP under this definition.
DHHS requires that by the end of Contract Year 2, the portion of each PHP’s medical expenditures governed under VBP arrangements will increase by 20 percentage points or represent at least 50 percent of total medical expenditures.

**VBP Targets**

**Numerator:** All payments that flow from PHPs to providers under a VBP payment arrangement, or, in the case of a total cost of care model, the total cost of care for the patient population assigned to the model.

**Denominator:** Total medical expenditures, with only two categories of directed payments excluded.

Year 2 target is either an increase of at least 20 percentage points in VBP expenditures or at least 50% of total medical expenditures under VBP arrangements.

- PHPs do not have to meet the higher of these two target measures.
- Baseline for the 20 percentage point increase will be set at the end of Contract Year 1, when first data on VBP payments is available.
- No withholds will be applied to the Year 2 target, per CMS rules and State law, but target is a contract requirement.

Early on, VBP targets likely will not drive significant changes for providers. **Over time, providers can expect that their contracts with PHPs will require greater accountability** for cost and quality of care.
A longer-term process to develop the NC Medicaid “VBP Roadmap” is underway. The Roadmap will identify ambitious but achievable PHP VBP targets, standards, and requirements for years 3 - 5. This Roadmap will help providers understand how their VBP contracts with PHPs might change over time.

**VBP Targets**

**Launch VBP Roadmap Process**
- Discuss internally goals and vision for VBP and set targets and requirements for years 3-5
- Incorporate/align with provider incentive programs (e.g. AMH program)
- Determine level of stakeholder engagement (e.g. AMH TAG, other groups) and begin stakeholder engagement
- Release draft VBP Roadmap white paper and solicit public feedback *(Summer 2019)*

**Update VBP Roadmap Using Performance to Date**
- Review PHP VBP assessment data and other data on PHP spending and contracting, as available
- Update VBP Roadmap *(Fall 2019)*

**Update VBP Roadmap on Ongoing Basis**
- Regularly convene stakeholders to assess ongoing VBP penetration in NC Medicaid
- Update Roadmap, including to address public feedback

**Development of provider and PHP infrastructure to support VBP, including encounter data sharing and reporting, quality measurement and reporting, and population health management.**
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Overview of quality approach
- Quality measures
- PHP accountability for quality
- Addressing disparities and public health outcomes
North Carolina Medicaid Quality Approach

Secretary Cohen’s Charge for Medicaid Transformation

1. Robust measure set and measure reporting that allow NC to track progress against quality priorities at a stratified level

2. Accountability for quality from Day 1

3. Immediate attention to improving public health priorities, including low birth weight, and promoting health equity

Legislative and Other Factors Shaping Quality Approach

- NCSL passed an amendment to Section 5(a) of S.L.2015-245, stating that withholds could not be implemented until at least 18 months after managed care launch
- DHHS expects providers will require time to update documentation and coding processes for managed care environment
- Public health priorities (particularly low birth weight) require new approach for managed care

For more information, see the Technical Specifications Manual
The Quality Framework defines and drives the overall vision for advancing the quality of care provided to Medicaid beneficiaries in North Carolina.

North Carolina Medicaid Quality Framework

The Quality Framework defines and drives the overall vision for advancing the quality of care provided to Medicaid beneficiaries in North Carolina.
North Carolina Medicaid Quality Measures: Overview

PHPs will be required to report on a robust measure set, but must focus on narrower subset of measures reflecting DHHS priorities in contracting with providers. DHHS expects PHPs will incorporate these measures into their contracting and other engagement with practices.

PHPs must report all of these measures to DHHS annually.

PHPs could include any of these measures in provider incentive programs*

DHHS will hold PHPs financially accountable for these measures starting in Year 3 (July 2021)

The slides that follow provide further detail on select measures from these lists. For a full list of quality measures, please see https://files.nc.gov/ncdma/documents/NC-Medicaid-Managed-Care-Quality-Measurement-Technical-Specifications-Public.pdf

*AMH performance incentive programs must be based on a subset of the priority measures and will be discussed later
Measures to Assess Advanced Medical Home Performance

PHPs will 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.

The state has selected this smaller group of measures to standardize the metrics PHPs uses to assess AMHs. PHPs are not required to use all measures listed, but all AMH measures PHPs select must come from this list.

<table>
<thead>
<tr>
<th>NQF#</th>
<th>Measure Title</th>
<th>Relevant Population</th>
<th>Adult</th>
<th>Pediatric</th>
</tr>
</thead>
<tbody>
<tr>
<td>0038</td>
<td>Cervical Cancer Screening</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>0032</td>
<td>Childhood Immunization Status (Combination 10)</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>0059</td>
<td>Comprehensive Diabetes Care: HbA1c poor control (&gt;9.0%)</td>
<td></td>
<td>X</td>
<td>*</td>
</tr>
<tr>
<td>1800</td>
<td>Asthma Medication Ratio</td>
<td></td>
<td>X</td>
<td>*</td>
</tr>
<tr>
<td>0576</td>
<td>Follow-up After Hospitalization for Mental Illness</td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>0027</td>
<td>Medical Assistance With Smoking and Tobacco Use Cessation</td>
<td></td>
<td></td>
<td>*</td>
</tr>
<tr>
<td>1516</td>
<td>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>1407</td>
<td>Immunization for Adolescents</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>0024</td>
<td>Weight Assessment and Counselling for Children and Adolescents</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>0018</td>
<td>Controlling High Blood Pressure</td>
<td></td>
<td>X</td>
<td>*</td>
</tr>
<tr>
<td>N/A</td>
<td>Total Cost of Care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N/A (NYU/Billings)</td>
<td>Avoidable/Preventable ED Utilization</td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>N/A (AHRQ)</td>
<td>Avoidable/Preventable Inpatient Utilization</td>
<td></td>
<td>X</td>
<td>*</td>
</tr>
<tr>
<td>1768</td>
<td>Readmission Rates</td>
<td></td>
<td>X</td>
<td>*</td>
</tr>
</tbody>
</table>

* = Likely low rate for pediatric-only practices
North Carolina Quality Measures: Key Takeaways

- **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 PHPs. PHPs will, in turn, work with providers to improve quality performance.**

- **PHPs will design their own quality improvement programs using the priority measures. Providers will assess quality improvement programs for participation.**

- **Most quality measures will require only claims data, but PHPs and providers may mutually agree to use a hybrid* reporting approach where appropriate.**

- **Providers will have a number of opportunities to offer feedback on how DHHS and PHPs can make reporting more efficient and meaningful.**

* In hybrid reporting, PHPs will use clinical data to supplement information available in encounter data.
Public Reporting

- Plans will be required to report performance on a wide range of quality measures. This performance will be publicly reported on an annual basis.

- PHPs’ data collection for submission to DHHS will begin with the first calendar year after managed care implementation (January 1, 2020).

- Benefits: Public reporting promotes improved performance. Public comparison, stratified to avoid penalizing plans serving higher-need members, is an incentive to improve quality performance.

Financial Accountability

- Financial accountability will be implemented through the quality withhold.

- Because of the legislatively-mandated delay, financial accountability, via withholds, will begin in Contract Year 3 (corresponding to quality performance in calendar year 2021).

- Benefits: Financial accountability will more closely reflect state needs. Allows DHHS opportunity to establish quality withhold measure set and targets based on current assessment of performance gaps.

- PHPs will consider public reporting as an incentive to improve performance even in the absence of financial penalties.

- Providers should expect to be engaged by PHPs around performance and documentation more broadly.
Interim and Gap Reporting

To facilitate quality improvement throughout the year, PHPs will be required to share interim and gap reports with AMH providers on select quality measures.

**Interim Reports**

Interim reports 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.

**Gap Reports**

Gap reports identify specific members who are not listed as receiving recommended care based on PHP records. PHPs will deliver these reports to AMH practices, as appropriate.

Providers can use these reports to support care planning for listed individuals, population health management efforts, and changes in documentation practices.
Stratified Reporting

**PHPs will report stratified data to ensure improvements in quality performance maintain or promote health equity.**

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

Most of these stratifications rely on administrative data generated at enrollment, and providers will not need to collect additional information to inform stratification.

If providers notice a PHP reporting incorrect information about one of their patients, they should work with the PHP to correct it.
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.

- 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.

### Example Benchmark Calculation

<table>
<thead>
<tr>
<th>NCQA Medicaid Managed Care Percentile Score</th>
<th>NC Prior Year Percentile Score</th>
<th>Performance Year Benchmark Percentile Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measure A</td>
<td>35</td>
<td>50</td>
</tr>
<tr>
<td>Measure B</td>
<td>70</td>
<td>90</td>
</tr>
</tbody>
</table>

Benchmarks are set at the PHP level and will not likely affect individual providers. Benchmarks will not be posted publicly.

Benchmarks are informational only and are not used to calculate performance for quality withholds, which will begin in the third contract year of managed care.
Timeline for Quality Measurement and Contracting

Quality measure reporting will begin with the launch of managed care. For each contract year, PHPs will submit quality performance data measured during the *calendar* year that began in the January before the beginning of that *contract* year.

Example

For Contract Year 3 (extending from July 1, 2021 to June 30, 2022), PHPs would report performance on quality measures reflected during the calendar year extending from January 1, 2021 to December 31, 2021.

Although withholds aren’t implemented until Contract Year 3, *providers should expect PHPs to implement performance incentive programs earlier* to prepare for the withhold period.
Disparities

• PHPs will report stratified data for quality measures and EQRO will draft disparities report starting with first quality performance year (calendar year 2020).
• Disparities in low birth weight can be focus for DHHS engagement with PHPs around modified LBW accountability measure.

Public Health

• Healthy NC 2020 goals correspond to several areas of intended PHP quality focus
• DHHS will report state-level and program-level data from BRFSS related to smoking cessation, diet and exercise, and opioid-related mortality and compare against PHP-level performance.
• Benefits: Linking PHP performance and state-level or program-level outcomes can inform state public health efforts. PHP activities may have ripple effects that affect health beyond the Medicaid population. DHHS 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 reducing disparities at the practice level.
Measuring Quality of Diabetes Care

Given diabetes’ role in morbidity and mortality among NC residents, DHHS has included diabetes as a priority area of care and will assess diabetes care against a range of indicators.

Working from a larger measure set that included Adult/Child Core measures and NCQA accreditation measures, NC identified 5 diabetes measures.

One of the 5 (HbA1c results) provides the most direct insight into diabetes control, and will be a priority measure.

DHHS is currently unable to calculate accurate performance on the HbA1c: Poor Control due to limited availability of clinical data or encounter codes describing A1c results.
Measuring Quality of Diabetes Care

Given the importance of diabetes management and its relevance to primary care, HbA1c: Poor Control as an Advanced Medical Home measure.

Practice-level HbA1c Reporting

- PHPs are not required to use all AMH measures. If PHPs choose to use HbA1c: Poor Control in AMH assessment in their provider contracting, they may only use it as a pay-for-reporting measure.
- Recognizing the challenges in reporting on glycemic control, DHHS will support group efforts to coordinate reporting strategies.

Glycemic control is important for population health management, but providers may face challenges reporting clinical data.

Practices can report this measure in a variety of ways; CINs and other partners can also add value. DHHS will work with PHPs and AMH providers to implement reporting processes.
DHHS modified CDC measure of low birthweight to permit assessment of PHP-level accountability

- NC expert workgroup drove LBW recommendations.

- **Outcome measure sets broad accountability for LBW:** Of all pregnant members with continuous coverage by a PHP from 16 weeks’ gestation, what proportion delivered low birthweight (<2500 g) and very low birthweight (<1500 g) babies?*

- **Process measure focuses on high prevalence of tobacco use, a LBW risk factor, among pregnant Medicaid enrollees:** Of all pregnant members who screened positive for tobacco use, what proportion engaged in tobacco cessation activities?

- DHHS will report both measures and experiment with different risk stratification approaches to finalize approach before Contract Year 3.

- DHHS will engage PHPs 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, DHHS will identify additional exclusion criteria. Providers should continue to track DHHS guidance to learn more about these exclusions.

*Excludes multiple gestations
# Measures of Avoidable/Preventable Utilization

These measures will assess the degree to which care management and utilization management efforts reduce avoidable and preventable utilization.

PHPs are **not** permitted to use these metrics as utilization management criteria for adjudicating individual visits; these measures are meant to assess access to and quality of primary care. Providers should contact DHHS if they see these designations used to limit coverage.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Measurement Methodology</th>
</tr>
</thead>
<tbody>
<tr>
<td>Avoidable/Preventable ED Visits</td>
<td>Measured using the NYU/Billings Algorithm</td>
</tr>
<tr>
<td>Avoidable/Preventable Inpatient Hospitalization</td>
<td>Measured using AHRQ Prevention Quality Indicators and Pediatric Quality Indicators</td>
</tr>
<tr>
<td>Hospital Readmissions</td>
<td>Measured using NQF #1768, Plan All-Cause Readmissions</td>
</tr>
</tbody>
</table>

Measures are meant to ensure PHPs focus on reducing utilization through improved access and disease management, rather than increasing barriers to care.

Reporting for these measures will be phased in over time. See the Technical Specifications Manual for details.
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More Opportunities for Engagement

DHHS values input and feedback and is making sure stakeholders have the opportunity to connect through a number of venues and activities.

Ways to Participate

- Regular webinars, conference calls, meetings, and conferences
- Comments on periodic white papers, FAQs, and other publications
- Regular updates to website: [https://www.ncdhhs.gov/assistance/medicaid-transformation](https://www.ncdhhs.gov/assistance/medicaid-transformation)
- Comments, questions, and feedback are all very welcome at Medicaid.Transformation@dhhs.nc.gov

Providers may use the following forums to provide feedback on the Medicaid Managed Care Quality measurement Approach:

- AMH Technical Advisory Group: [https://medicaid.ncdhhs.gov/amh-technical-advisory-group](https://medicaid.ncdhhs.gov/amh-technical-advisory-group)

Providers will receive education and support during and after the transition to managed care.
Upcoming Events

**Upcoming Managed Care Webinar Topics**

- Behavioral Health Services: Standard Plans and Transition Period (5/23)
- Clinical Policies (5/30)
- Healthy Opportunities in Medicaid Managed Care (6/13)
- Beneficiary Policies (6/27)

**Other Upcoming Events**

- Virtual Office Hours: Weekly, beginning in Spring, 2019
- Provider/PHP Meet and Greets: beginning in Spring, 2019

Look out for more information on upcoming events and webinars distributed regularly through special provider bulletins
Additional Quality Resources

Resource Links

- **HEDIS:** [https://www.ncqa.org/hedis/measures/](https://www.ncqa.org/hedis/measures/)
Q&A
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Appendix: Links to Avoidable/Preventable Utilization Measures

- Avoidable ED Visits: https://wagner.nyu.edu/faculty/billings/nyued-background