



Quality Management in Medicaid Managed Care

February 4, 2021

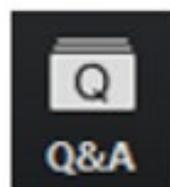
RCC (Relay Conference Captioning)

Participants can access real-time captioning for this webinar here:

<https://www.captionedtext.com/client/event.aspx?EventID=4708136&CustomerID=324>

Logistics for today's COVID-19 Forum

Question during the live webinar



Technical assistance

technicalassistanceCOVID19@gmail.com

Agenda

- NC Medicaid Quality Vision: Quality Strategy & Quality Management Program
 - Kelly Crosbie, MSW, LCSW
Director, Quality and Population Health
Division of Health Benefits
 - Taylor Zublena, RN, MSN, CCM, CPHQ
Program Manager, Quality Measurement,
Division of Health Benefits
- Quality Measurement Timeline and Targets for Year 1 & 2
 - Sam Thompson, MSW
Senior Program Manager, Evaluation,
Division of Health Benefits
- Quality Management & Improvement
 - Jaimica Wilkins, MBA, CPHQ, ICP
Senior Program Manager, Quality
Management
Division of Health Benefits

The Times, They Are A'Changin'...

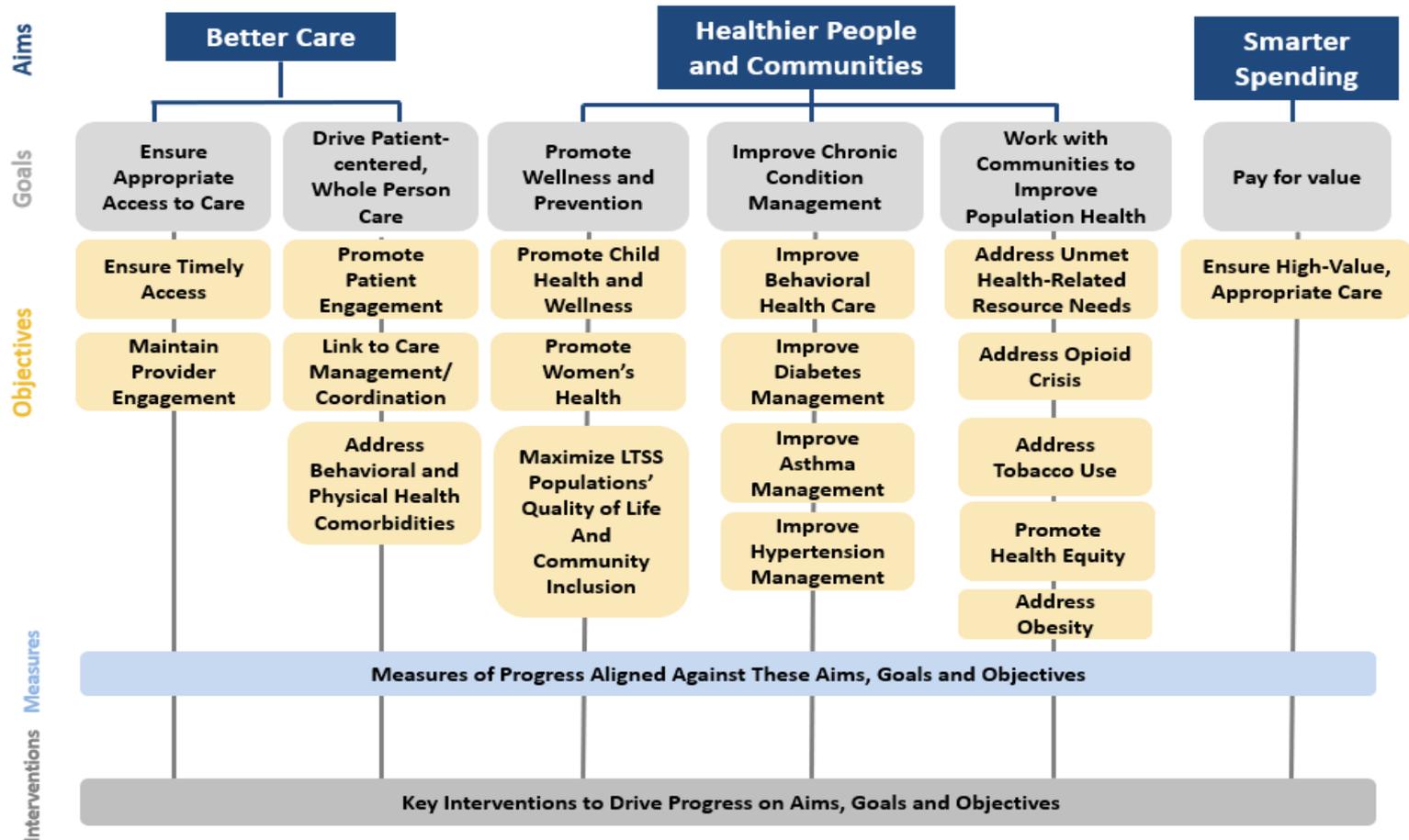
How will quality
management feel
different to you as a
Medicaid provider after
July 1st?



**NC Medicaid Quality Vision: Quality Strategy & Quality
Management Program**

North Carolina Medicaid Quality Strategy

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



Medicaid's Quality Management Program

1 Quality Measure Reporting

- Claims-based, clinical data (NC HealthConnex), Surveys (member & provider)

2 Measures/Disparity Analysis, Setting Targets, Amend/Adopt/Abandon

- Expect measures & targets to flow to providers in value-based arrangements
- DHB will standardize measure sets for certain programs (Advanced Medical Homes)

3 Quality Performance Improvement

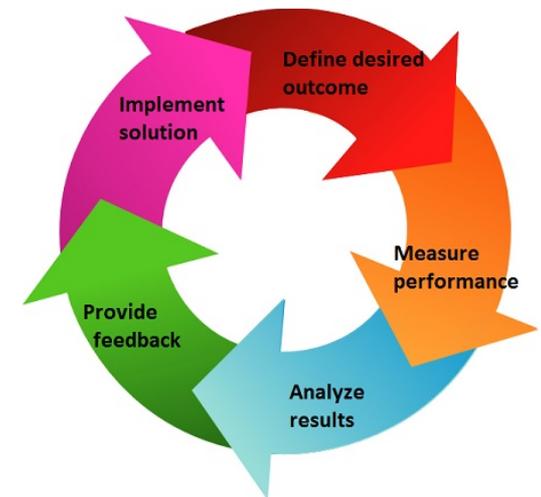
- Plans are required to have an annual assessment & improvement plan
- DHB will oversee 3+ clinical performance improvement projects
- DHB will support alignment and state-led provider supports

4 External Quality Assurance

- Governance: MCAC Quality Subcommittee & Medicaid Quality Strategy
- External Quality Review Organization (oversight of key contract areas, quality programs & reporting)
- Health Plans are required to be NCQA accredited by Year 3

5 Program Evaluation

- Care Management, Healthy Opportunities Pilots, Access to Care



Medicaid Quality: Public Reporting of Performance

- ✓ ***Annual Quality Report***—Statewide + Plan Performance
- ✓ ***Quality Rating Scale (QRS)***—Member-Facing Plan Report Cards
- ✓ ***Health Equity Report***
- ✓ ***Provider Survey Results***
- ✓ ***Member Survey Results***
- ✓ ***Network Accessibility Reports***
- ✓ ***Accreditation Progress and Results & EQRO Reports***
- ✓ ***Evaluation Results***

Medicaid Quality Management Webpage

The screenshot shows the NCDHHS website interface. At the top left is the NCDHHS logo with the text "NCDHHS NC Medicaid Division of Health Benefits". To the right is a search bar and navigation links: "ABOUT US", "NC DHHS", "NC.GOV", "SERVICES", and a notification bell with the number "1". Below this is a blue navigation bar with links: "Home", "Beneficiaries", "Transformation" (with a dropdown arrow), "Meetings & Notices", "Find A Doctor", "Providers", "Counties", and "Reports". A prominent orange banner reads "COVID-19 RESPONSE · Resources, information and assistance from across state government. Go to COVID19.NC.gov" with a close button. Below the banner, breadcrumb navigation shows "NC DHHS" > "Transformation" > "Quality Management and Improvement". The main heading is "Quality Management and Improvement" with a green underline. The text below states: "The Department's goal is to improve the health of North Carolinians through an innovative, whole-person centered, and well-coordinated system of care and measurement of quality, which addresses both medical and non-medical drivers of health." It continues: "As North Carolina transitions to NC Medicaid Managed Care, the Department will work with Prepaid Health Plans (PHPs) to develop a data-driven, outcomes-based continuous quality improvement process. This will:" followed by a bulleted list: "• Focus on rigorous outcome measurement compared to relevant targets and benchmarks.", "• Promote equity through reduction or elimination of health disparities, and", "• Appropriately reward PHPs and, in turn, providers for advancing quality goals and health outcomes." The section "Quality Strategy" is partially visible at the bottom.

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

NC Medicaid Annual Quality Report COMING SOON

- Annual Report assessing performance on and accountability for quality measures related to aims and goals of the Quality Strategy
 - 1) **Better Care Delivery, 2) Healthier People and Communities, and 3) Smarter Spending**
 - Measures are organized by Aims/Goals
 - Measures from 2015-2019 are included
 - Measures are claims and survey-based
 - Measure rates are stratified with key disparities highlighted
 - NC statewide rates are compared to National Medicaid median where available
 - DHB assigned a statewide performance score (★) based on measure performance in an AIM/GOAL area

Summary of NC Medicaid Quality Performance 2019

Aims	Goals	Overall Performance
Aim 1: Better Care Delivery. <i>Make health care more person-centered, coordinated, and accessible.</i>	Goal 1: Ensure appropriate access to care	★★★
	Goal 2: Drive patient-centered, whole-person care	★★★
Aim 2: Healthier People, Healthier Communities. <i>Improve the health of North Carolinians through prevention, better treatment of chronic conditions, and better behavioral health care, working collaboratively with community partners.</i>	Goal 3: Promote wellness and prevention	★★★
	Goal 4: Improve chronic condition management	★
	Goal 5: Work with communities to improve population health	★★★
Aim 3: Smarter Spending. <i>Pay for value rather than volume, incentivize innovation, and ensure appropriate care.</i>	Goal 6: Pay for value	★★★

★★★★★	Performance across all measures in the group was above the national median.
★★★	Performance across all measures in the group was around the national median.
★	Performance across all measures in the group was below the national median.

NC Medicaid Physician Leadership



Dr. Abigail DeVries,
Family Physician,
Associate Medical Director



Dr. Janelle White,
Pediatrician,
Associate Medical Director



Dr. Velma Taormina,
OB-Gyn,
Women's Health Consultant

Standard Plan Measures: Adult

Measure	NQF #	Overall 2019 Performance
Cervical Cancer Screening (CCS)	0032	★
Chlamydia Screening in Women (Total Rate) (CHL)	0033	★★
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPC)	0059	-
Concurrent Use of Prescription Opioids and Benzodiazepines (COB)	3389	◆ 14.86
Controlling High Blood Pressure (CBP)	0018	-
Follow-Up After Hospitalization for Mental Illness	0576	
7- Day Follow-up (Age 21+)		★★
30-Day Follow-up (Age 21+)		★★
Flu Vaccinations for Adults (FVA)	0039	★★
Medical Assistance with Smoking and Tobacco Use Cessation (MSC)	0027	★★
Advising Smokers and Tobacco Users to Quit		★★
Discussing Cessation Medications		★★
Discussing Cessation Strategies		★★
Plan All-Cause Readmissions - Observed to expected ratio (PCR)	1768	◆ 0.93
Use of Opioids at High Dosage in Persons Without Cancer (OHD)	2940	-

◆ Star indicator not feasible due to limitations of calculation and national comparison availability

Highlight Indicates measure which Standard Plan Health Plans will be accountable for through DHHS calculated measure targets to achieve to receive some or all of their withhold amount beginning year 3 of Managed Care. Measures selected for withhold subject to change.

Standard Plan Measures: Pediatric

Measure	NQF #	Overall 2019 Performance
Adolescent Well-Care Visit (AWC)*		★
Childhood Immunization Status (Combination 10) (CIS-CH)	0038	★★
Percentage of Low Birthweight Births	N/A	◆ 11.5
Follow-Up After Hospitalization for Mental Illness	0576	
7- Day Follow-up (Ages 0-18)		-
30-Day Follow-up (Ages 0-18)		-
7- Day Follow-up (Ages 19-20)		◆ 29
30-Day Follow-up (Ages 19-20)		◆ 47
Immunization for Adolescents (Combination 2) (IMA)	1407	★★
Percentage of Eligible Who Received Preventive Dental Services (PDENT-CH)	N/A	◆ 52.1 ¹
Screening for Depression and Follow-Up Plan (DSF)	0418/ 0418e	-
Total Eligible Receiving at least One Initial or Periodic Screen (Federal Fiscal Year)	N/A	◆ 52.98 ²
Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)	2801	★★
Well-Child Visits in the First 15 Months of Life - 6 or More Visits (W15)*	1392	★★
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)*	1516	★★

*Measure included here to report historical rates. Health Plans will report the revised NQQA measures, W30 and WCV; will be AMH measures.

¹ ◆ Star indicator not feasible due to limitations of calculation and national comparison availability. Federal Fiscal Year 2019 Form CMS-416 report Federal Fiscal Year 2019. Calculated national rate from lines 1b and 12b. <https://www.medicaid.gov/medicaid/benefits/early-and-periodic-screening-diagnostic-and-treatment/index.html>

² ◆ Star indicator not feasible due to limitations of calculation and national comparison availability. Federal Fiscal Year 2019 Form CMS-416 report Federal Fiscal Year 2019. Calculated national rate from lines 1b and 9. <https://www.medicaid.gov/medicaid/benefits/early-and-periodic-screening-diagnostic-and-treatment/index.html>.

Standard Plan Measures: Maternity and Other

Measure	NQF #	CY2019 NC Rate
Percentage of Low Birthweight Births (modified measure)	N/A	◆ 11.5
Prenatal and Postpartum Care (Both Rates) (PPC)	1517	
Timeliness of Prenatal Care		★
Postpartum Care		★★
Pregnancy Tobacco Screening and Cessation	N/A	-
Rate of Screening for Pregnancy Risk	N/A	◆ 77.5 ¹
Rate of Screening for Unmet Resource Needs	N/A	-
Total Cost of Care	N/A	-

◆ Star indicator not feasible due to limitations of calculation and national comparison availability

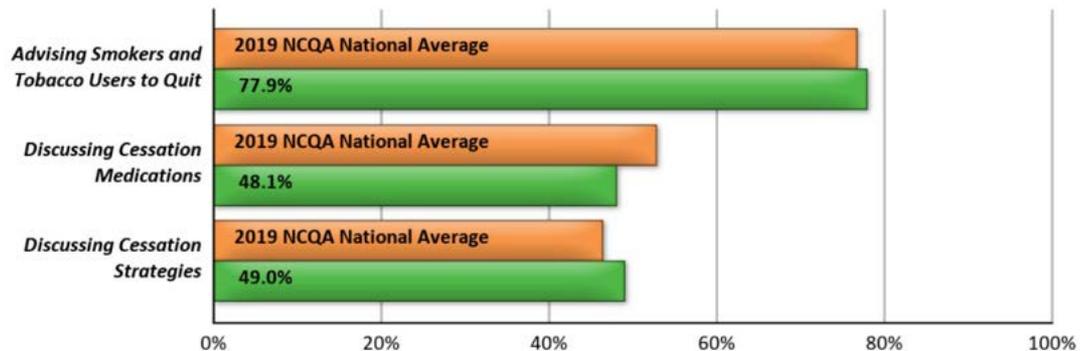
¹ Obstetrics providers are paid an incentive rate to perform a uniform Pregnancy Risk Screening. This rate reflects the % of Obstetric providers performing the screening over year

Standard Plan Measures: Survey Measures

1. Provider Survey (PCP and OB) - DHB will distribute an annual survey to providers assessing their satisfaction with each Health Plan.
 - a) with support for healthcare quality
 - b) with administrative process

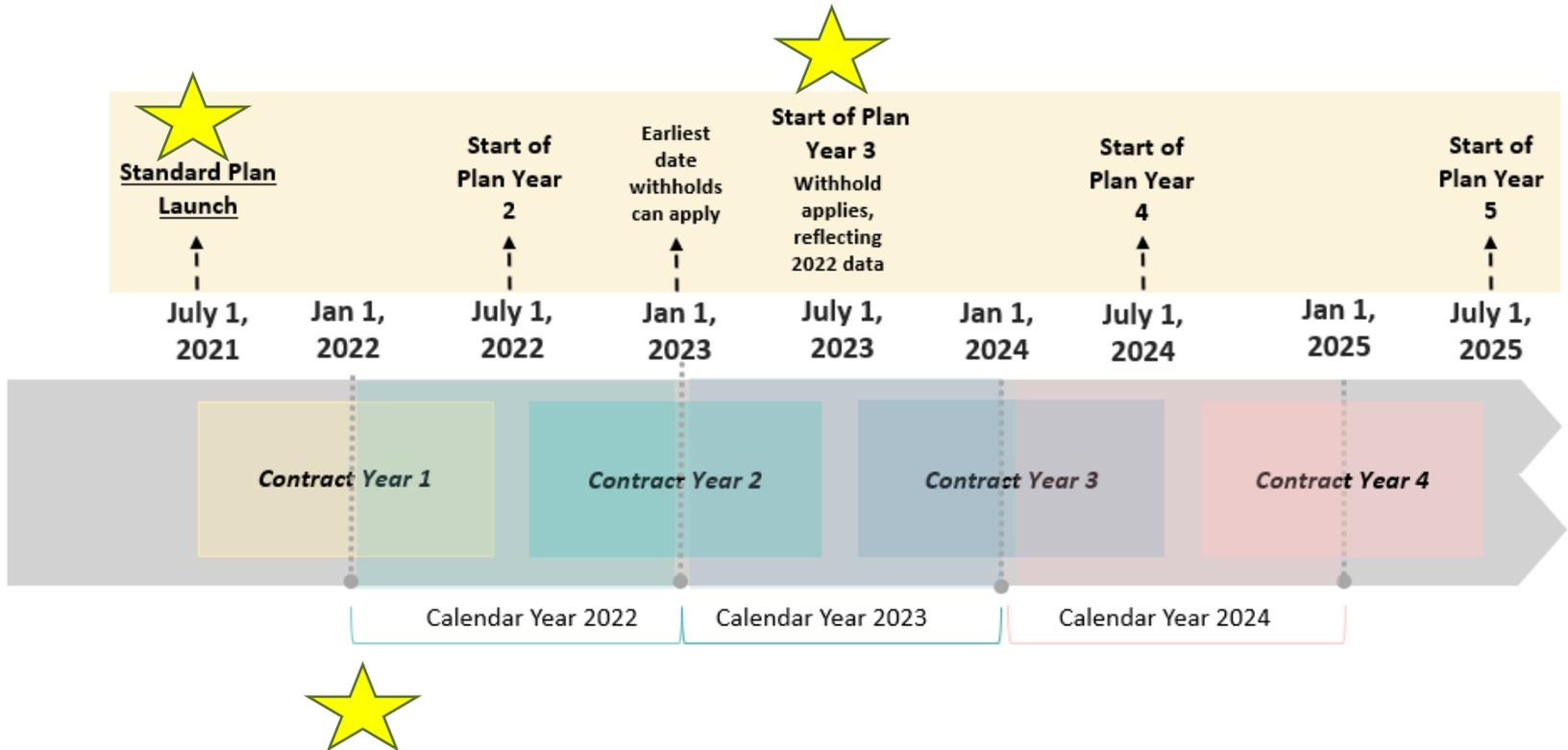
Implementing baseline in spring 2021 for comparison against health plan performance in future years.

2. DHB will use the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Adult v5.0 and Children v4.0 to assess patient experience in receiving care.
 - a) Results will be stratified by health plan, race and ethnicity.
 - b) Flu vaccination and tobacco cessation measures will be drawn from CAHPS.

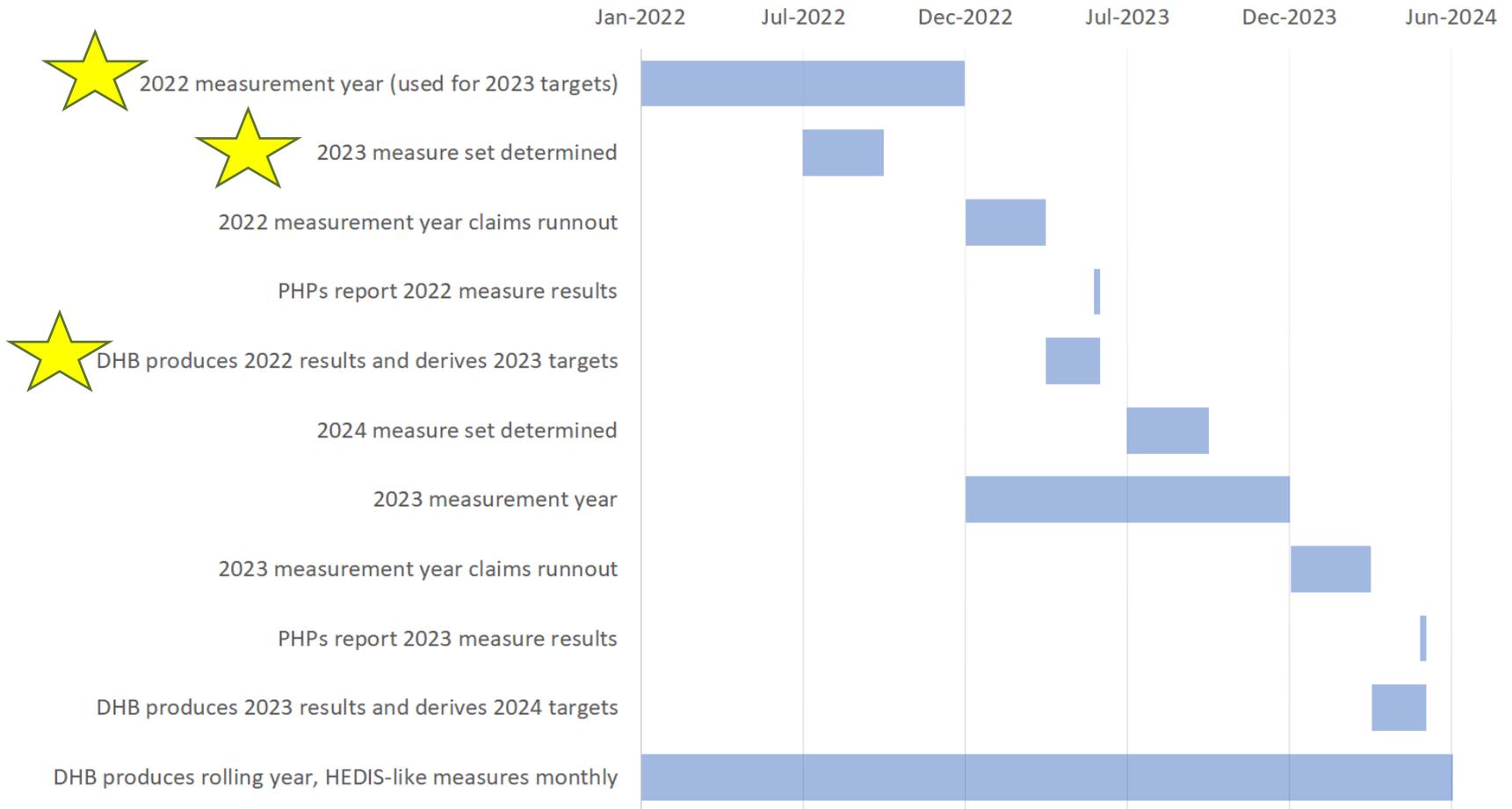


Quality Measurement Timeline

Standard Plan Quality Measurement Timeline



Standard Plan Quality Measurement Cycle



Quality Measure Targets for Year 1 & 2

Incremental Quality Measure Targets

- *For the first two years of managed care implementation, the Department's benchmark for each measure will be a 5% relative improvement over the prior year's North Carolina Medicaid statewide performance for that measure.*
 - *Example: health plan A has 1000 women who qualify for Chlamydia screening. In 2019, 500 got screening for a 50% performance. For the next measurement year, the health plan would need to screen an additional 25 women to achieve a 5% increase over baseline.*
- *Health plans will be compared against their program's historical performance and expected to show year-over-year improvements.*

Incremental Quality Measure Targets

Each year the proportion of eligible women in health plan A that receive a Chlamydia screening increases by 5%. Each blue icon represents 10 women that received their screening. Health plan A's performance goes from 50% (500/1000) in 2019 to 59% (590/1000) in 2022.



Disparity Definition

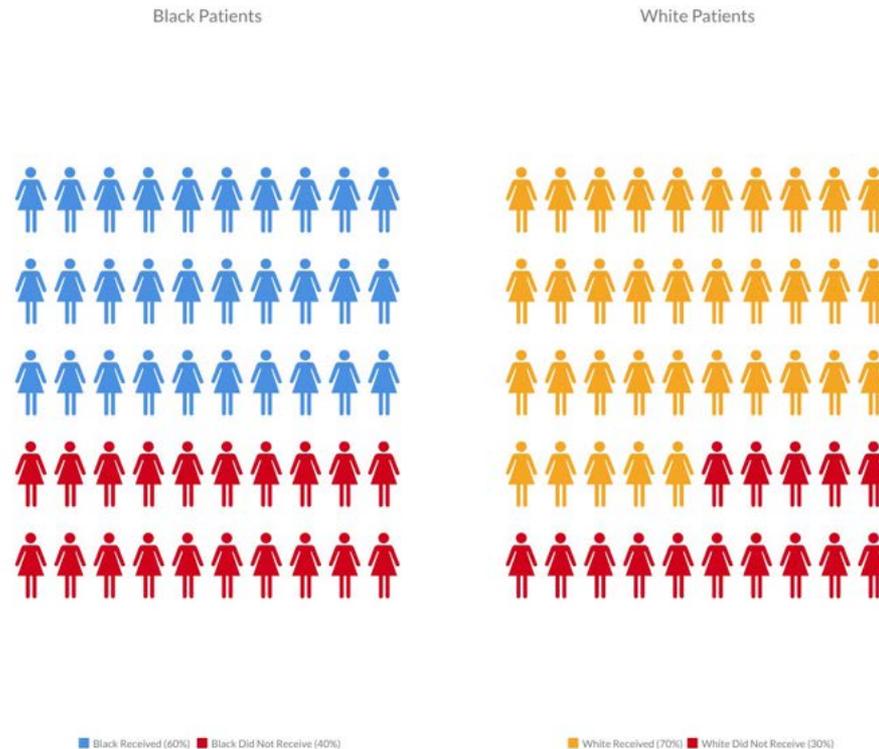
The Department will identify quality measures with significant disparities, defined as a greater than 10% relative gap in performance between a subgroup and a reference group. *This disparity definition was developed by AHRQ as outlined in the 2019 National Healthcare Quality and Disparities Report.*

EXAMPLE:

- *Health plan B provides flu vaccines to 65% of all eligible patients (650/1000).*
- *When broken down by race, 70% of their white patients (350/500) get the flu vaccine.*
- *While only 60% (300/500) of their Black patients get the flu vaccine.*
- ***This would become a focused measure for health plan B related to health equity.***

Disparity Definition

60% (300/500) of Black patients in health plan B receive the flu vaccine; blue icons=10 vaccinated Black patients. While 70% (350/500) of white patients in health plan B receive the flu vaccine; orange icons=10 vaccinated white patients. This 50-patient difference equates to a 14% disparity.



Incremental Disparity Targets

DHB will set performance improvement targets for groups experiencing a disparity, in addition to setting performance improvement targets for each health plan's total population. **Disparity targets will be a 10% relative increase for the group of interest for at least two years AND until the gap between a group of interest and the overall population is less than a relative 10%**

EXAMPLE: health plan B launched an equity initiative to improve vaccination rates.

- *Health plan B provides flu vaccines to 65% of all eligible patients (650/1000).*
- *70% of their white patients (350/500) get the flu vaccine.*
- *60% (300/500) of their Black patients get the flu vaccine.*
- ***Because of the disparity, health plan B needs to increase performance within the black population by 10% to 66% (330/500) the next year.***

Incremental Disparity Targets

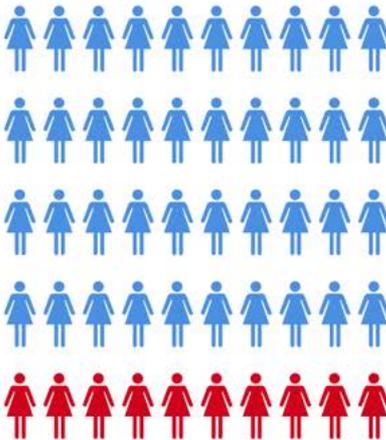
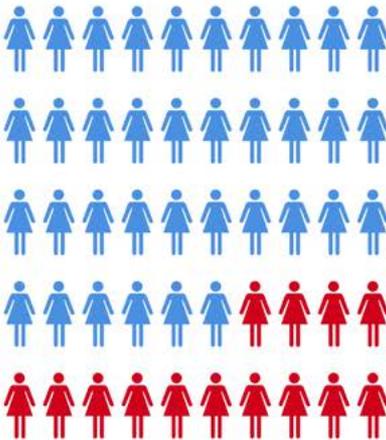
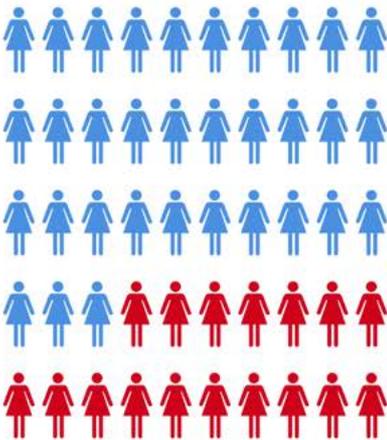
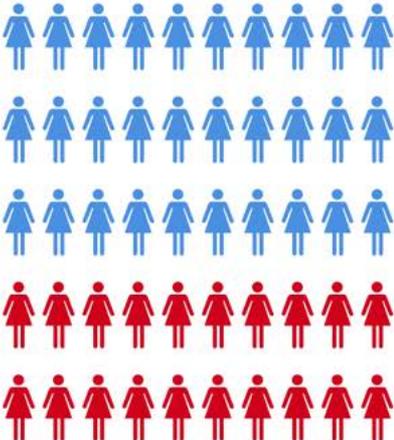
Each year the proportion of Black patients in health plan B that receive the flu vaccine increases by 10%. Each blue icon represents 10 vaccinated patients. Performance within health plan B's Black population goes from 60% (300/500) in 2019 to 80% (400/500) in 2022.

2019

2020

2021

2022



■ Received (60%) ■ Did Not Receive (40%)

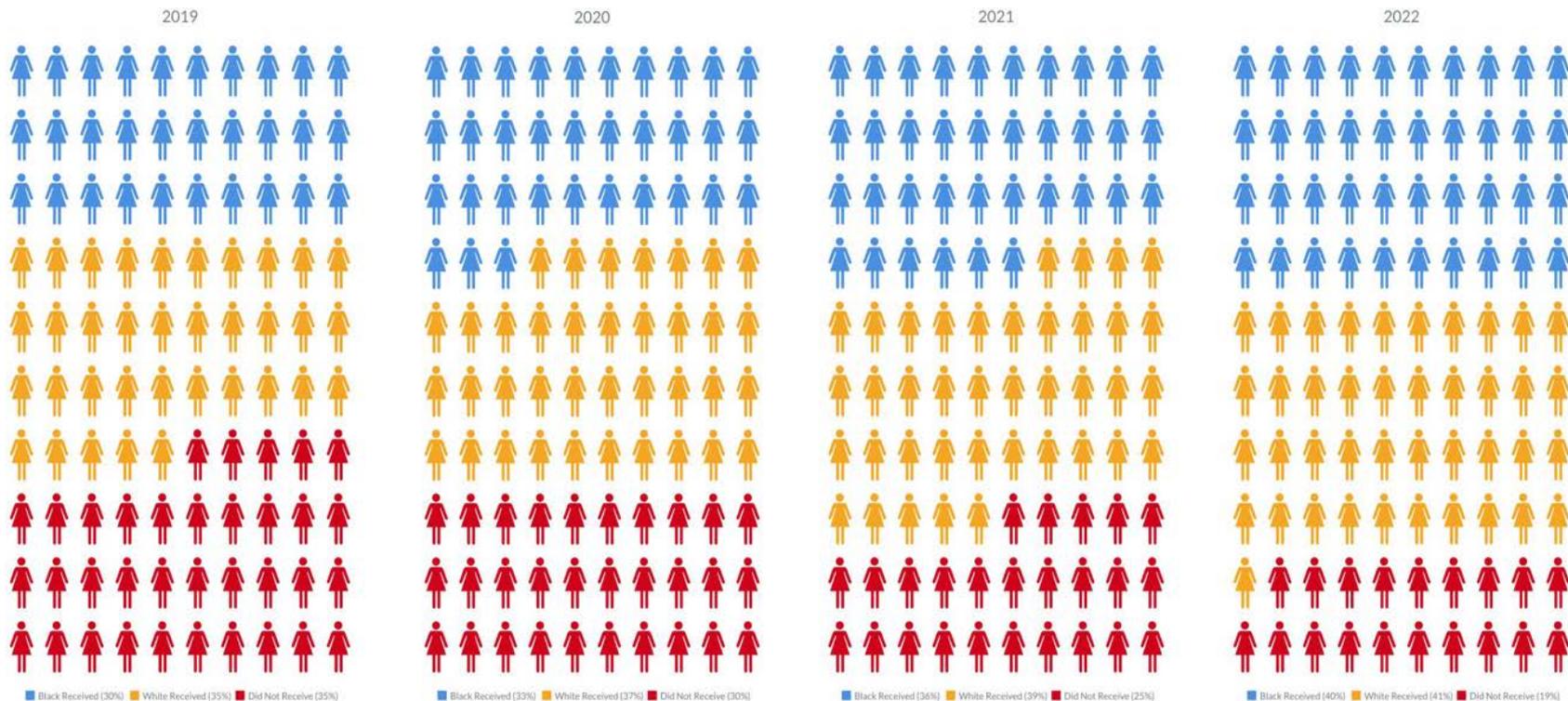
■ Received (66%) ■ Did Not Receive (34%)

■ Received (72%) ■ Did Not Receive (28%)

■ Received (80%) ■ Did Not Receive (20%)

Combining Overall and Disparity Targets

Each year the proportion of Black beneficiaries in health plan B that receive the flu vaccine (blue icons) increases by 10% while the proportion of white beneficiaries that receive the flu vaccine (orange icons) increases by 5%. Health plan B's performance goes from 65% (650/1000) in 2019 to 81% (810/1000) in 2022 and the disparity has been reduced.



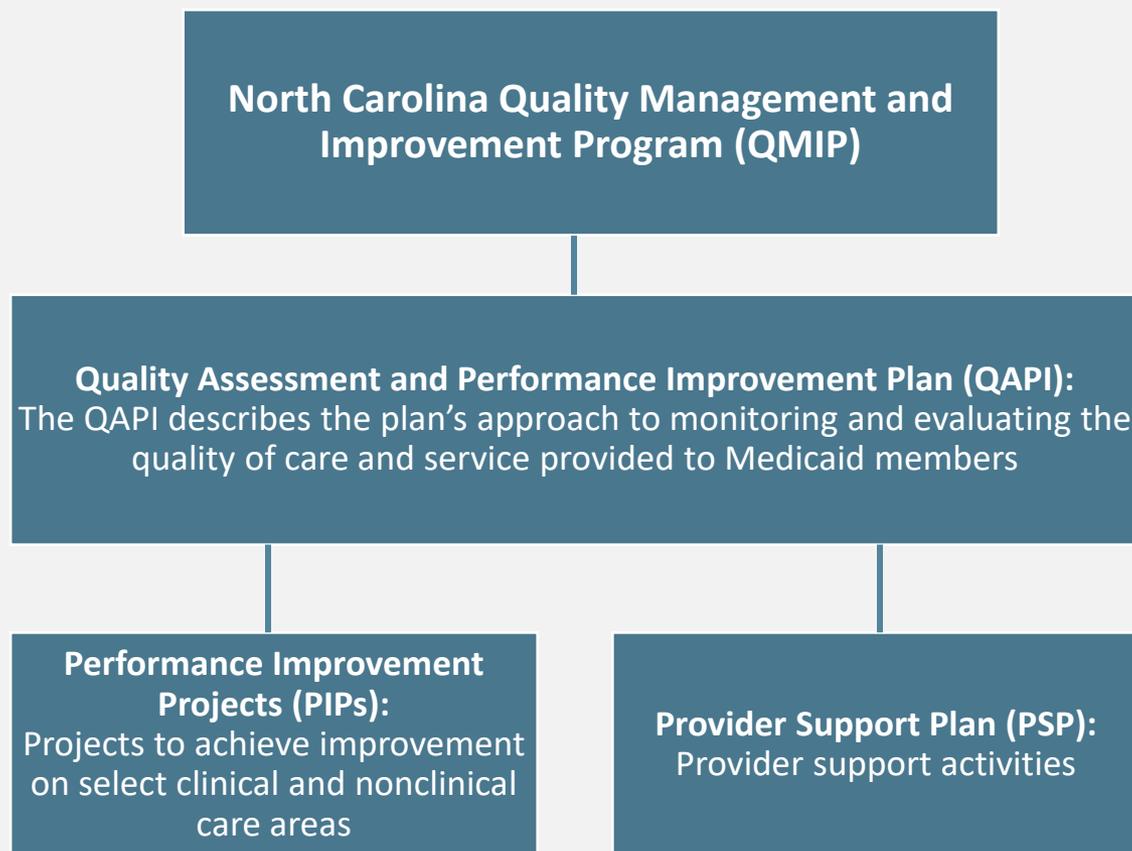
Additional Details

- *For the third managed care plan year and beyond, the Department may adjust the benchmarking methodology based on information gathered in the first two years.*
- *Using state-level, program-specific data to inform the benchmark will be more reflective of the state's strengths and quality improvement needs than benchmarks derived from national data.*
- *Measures will be risk-adjusted where appropriate based on the specifications of each measure.*

Quality Management and Improvement

Quality Management and Improvement Program (QMIP)

Managed care plans shall have a robust Quality Management and Improvement Program (QMIP) that will focus on health outcomes, rather than only health care process measures.



The Department's Commitment to Health Equity: Promoting health equity through reduction of health disparities will be a focus within North Carolina's QMIP. Managed care plans will identify disparities and implement interventions through their population health management programs to reduce disparities.

Performance Improvement Projects

Standard Plans and BH I/DD Tailored Plans are required to conduct PIPs that:

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



Provider Implications: Plans will be working with you to develop and implement PIPs.



Patient Implications: Plans and providers are focused on continually improving the quality of care.

Performance Improvement Project Standardization

- Alignment of Performance Improvement Projects (PIPs) statewide for all Prepaid Health Plans (health plans)
- 3 PIPs standardized in Contract Year 1
 - **1 Clinical Adult PIP** -Comprehensive Diabetes Care: HbA1C Poor Control (>9.0%)
 - **1 Clinical Child PIP** - Childhood Immunization Status- CIS (Combo 10)
 - **1 Clinical Maternal Health PIP** – Prenatal and Postpartum care measure focused on Timeliness of Prenatal Care
- PIPs support Quality Strategy Aims, Goals and Objectives

Provider Support Plan

Each plan must develop a report detailing:



All planned technical support activities.



Detailed information regarding how its proposed provider supports activities will advance the aims, goals, and objectives outlined within the Department's Quality Strategy.



An overview of which metrics the Plan will use to evaluate its provider engagement progress over time.

Technical Assistance and Practice Support: Area Health Education Centers (AHEC)

AHEC will provide training and practice-level technical assistance for the transition to managed care, with a focus on safety net/essential and rural providers.

- Prior to Launch: AHEC will provide targeted training assistance to ensure providers are prepared to participate in Medicaid transformation initiatives.
- Prior to Launch: AHEC hosts Fireside Chats.
- Prior to Launch: AHEC leads the AMH Coaching Program.
- After Launch: AHEC will provider state-level webinars that highlight Statewide PIPs.
- After Launch: AHEC will host events and support health plan Regional Quality Forums.
- After Launch: AHEC will continue AMH Coaching Support.

We're here to help!!!



Provider Feedback Loop on Quality Improvement



Quality Forum Invitees

Primary Care Physicians and Advanced Medical Homes (all Tiers)

Obstetric/Gynecological Providers

Behavioral Health Providers

Local Health Departments

School-based Health Centers

Hospitals

Long-term Services and Supports Agencies

Clinical Integrated Networks

Local Department of Social Service (DSS)

Other relevant stakeholders based on the agenda and goals of the Forum

Wrapping It Up

What Should Providers Do Now?

- Pay attention to your contracts—are you agreeing to reasonable targets? 

- Start looking at your performance on the quality metrics now---get them from CCNC. 

- Focus on the "at risk" metrics coming down the road. Ask CCNC or AHEC for help. 

- If you didn't document it, it didn't happen. 

- Connect to the Health Information Exchange (HIE). 

- Communicate with us! 

- Panel management. 

Healthy Opportunities Screening, Assessment and Referral Payment (HOSAR) Overview

Effective January 1, 2021, NC Medicaid and NC Health Choice is temporarily covering **Healthy Opportunities screenings** to encourage providers to gain capacity for screening Medicaid beneficiaries for unmet health-related resource needs and referring them to appropriate community-based resources prior to the launch of Medicaid managed care.

Current Carolina Access (CAI) providers are eligible to bill code G9919 for positive healthy opportunities screenings using the Department's standardized screening questions. Coverage of this code will continue through June 30, 2021; continued coverage after managed care launch will be at the discretion of PHPs.

AMH Tier 3 Glide Path Payments

DHHS will implement a new \$8.51 PMPM payment stream to AMH Tier 3 practices 90 days prior to the launch of Managed Care to assist with and incent Tier 3 preparation

Tier 3 Glide Path Payment Eligibility Criteria

1. AMH Tier 3 within NC Tracks
2. Contracting completed with at least two PHPs
3. Data exchange testing successfully completed with at least two PHPs
4. Practice has completed attestation in NC Tracks provider portal that items 2-3 complete.

DHHS will release additional details on the above criteria prior to launch.

Payments will flow to practices in the same way as current CA II Payments. Qualifying practices will receive \$8.51 PMPM direct from NC Tracks for each month in which they meet the conditions shown at left, up to three times.

April 2021 — “Opportunity 1”

May 2021 — “Opportunity 2”

June 2021 — “Opportunity 3”

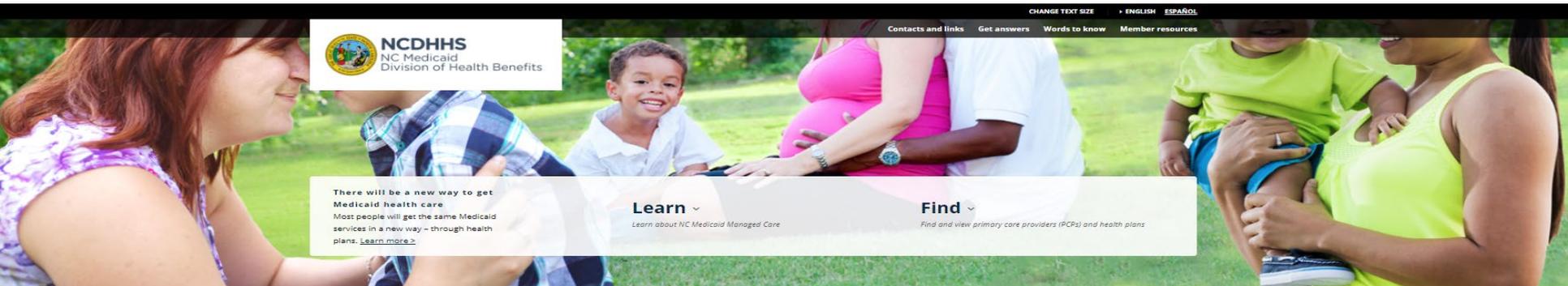
July 2021  Launch

Medicaid Managed Care Provider Directory and Health Plan Look Up Tool

The public version of the **Medicaid and NC Health Choice Provider and Health Plan Lookup Tool** is now available at: <https://ncmedicaidplans.gov/>. Providers are encouraged to use this tool to confirm the availability and accuracy of information contained in their NCTracks provider enrollment record.

The provider directory contains all active Medicaid and NC Health Choice providers, including primary care providers, specialists, hospitals and organizations. The authenticated portal will be available to beneficiaries beginning March 1, 2021.

For more information, please visit [NC Provider Directory – Medicaid and NC Health Choice Provider and Health Plan Look Up Tool Now Available](#).



NC Medicaid Managed Care restart

NC Medicaid Managed Care will start July 1, 2021. We will share more information soon, including when and how to choose a health plan.

For now, keep getting Medicaid and NC Health Choice services the way you do now. To learn more, go to ncdhhs.gov.

Get the free mobile app

You can get the free mobile app starting March 1, 2021 on Google Play or the App Store. We will share links to the app on this website when it is ready.

Use the app to find and view primary care providers (PCPs) and health plans for you and your family. Learn more about the free mobile app at [Get answers](#).

Find and view providers and health plans

This website has new tools to help you find and view primary care providers (PCPs) and health plans.

Medicaid and NC Health Choice Provider and Health Plan Lookup Tool
You can use the Medicaid and NC Health Choice Provider and Health Plan Lookup Tool to find a PCP. Our new provider search will help you find the best PCP for you and your family.

To search for a provider, go to [Find a provider](#).

Health Plan Choice Guide
You can use the Health Plan Choice Guide to view health plans. It will help you choose the best health plan to meet your health care needs.

To view health plans, go to [View health plans](#).

Questions?

We can help. Our call center opens **March 1, 2021**.

Until then, you can get answers to common questions at [Get answers](#).

QUESTIONS?



Appendix

Standard Plan Measures: Adult

Measure	NQF #	Measure Group	CY2019 NC Rate	CY2019 US Median	AMH Measure	PMP Measure	CMARC/CMHRP Measure	Survey Measure
Cervical Cancer Screening (CCS)	0032	Adult	43.82	61.31	x			
Chlamydia Screening in Women (Total Rate) (CHL)	0033	Adult	58.22	58.44	x			
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPC)	0059	Adult	-	-	x			
Concurrent Use of Prescription Opioids and Benzodiazepines (COB)	3389	Adult	14.86	-				
Controlling High Blood Pressure (CBP)	0018	Adult	-	61.8	x			
Follow-Up After Hospitalization for Mental Illness	0576							
7- Day Follow-up (Age 21+)		Adult	30	-				
30-Day Follow-up (Age 21+)		Adult	45	-				
Flu Vaccinations for Adults (FVA)	0039	Adult	42.9	43.44				x
Medical Assistance with Smoking and Tobacco Use Cessation (MSC)	0027							x
Advising Smokers and Tobacco Users to Quit		Adult	77.9	77.66				x
Discussing Cessation Medications		Adult	48.1	54.15				x
Discussing Cessation Strategies		Adult	49.0	47.92				x
Plan All-Cause Readmissions - Observed to expected ratio (PCR)	1768	Adult	0.93	-	x			
Use of Opioids at High Dosage in Persons Without Cancer (OHD)	2940	Adult	-	-				

Standard Plan Measures: Pediatric

Measure	NQF #	Measure Group	CY2019 NC Rate	CY2019 US Median	AMH Measure	PMP Measure	CMARC/CMHRP Measure	Survey Measure
Adolescent Well-Care Visit (AWC)*		Pediatric	43.4	57.18	x			
Childhood Immunization Status (Combination 10) (CIS-CH)	0038	Pediatric	35.02	37.47	x		x	
Percentage of Low Birthweight Births	N/A	Pediatric	11.5	9.5				
Follow-Up After Hospitalization for Mental Illness	0576							
7- Day Follow-up (Ages 0-18)		Pediatric	-	-				
30-Day Follow-up (Ages 0-18)		Pediatric	-	-				
7- Day Follow-up (Ages 19-20)		Pediatric	29	-				
30-Day Follow-up (Ages 19-20)		Pediatric	47	-				
Immunization for Adolescents (Combination 2) (IMA)	1407	Pediatric	31.55	36.86	x			
Percentage of Eligible Who Received Preventive Dental Services (PDENT-CH)	N/A	Pediatric	52.1	49.1			x	
Screening for Depression and Follow-Up Plan (DSF)	0418/ 0418e	Pediatric /Adult	-	-	x			
Total Eligible Receiving at least One Initial or Periodic Screen (Federal Fiscal Year)	N/A	Pediatric	52.98	-				
Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)	2801	Pediatric	52.09	64.89				
Well-Child Visits in the First 15 Months of Life - 6 or More Visits (W15)*	1392	Pediatric	67.71	67.88	x			
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)*	1516	Pediatric	70.48	74.7	x		x	

*Measure included here to report historical rates. health plans will report the revised NCQA measures, **W30 and WCV**; will be AMH measures.

Standard Plan Measures: Maternity and Other

Measure	NQF #	Measure Group	CY2019 NC Rate	CY2019 US Median	AMH Measure	PMP Measure	CMARC/C MHRP Measure	Survey Measure
Percentage of Low Birthweight Births (modified measure)	N/A	Maternity	11.5	9.5		x	x	
Prenatal and Postpartum Care (Both Rates) (PPC)	1517					x	x	
Timeliness of Prenatal Care		Maternity	35.53	89.05		x	x	
Postpartum Care		Maternity	68.77	76.40		x	x	
Pregnancy Tobacco Screening and Cessation	N/A	Maternity	-	-				
Rate of Screening for Pregnancy Risk	N/A	Maternity	77.5	-		x		
Rate of Screening for Unmet Resource Needs	N/A	Other	-	-				
Total Cost of Care	N/A	Other	-	-	x			

Medicaid Quality: Public Reporting of Performance

- **Annual Quality Report**—DHHS will share plan-level rates for the quality measures, to facilitate comparison among plans.
- **Quality Rating Scale (QRS)**—Member-Facing Plan Report Cards (development in 2021-2022).
- **Health Equity Report**—DHHS will assess disparities in care and outcomes and publish a report summarizing areas of care in which disparities have improved, persisted, or developed.
- **Provider Survey Results**—DHHS, in partnership with a third party, will field a survey to providers assessing their satisfaction with the health plan(s) with which they have contracted. The Department will publish overall satisfaction rates and other findings from this survey.
- **Member Survey Results**—DHHS, in partnership with a third party, will field surveys to assess patient experience in receiving care.
- **Network Accessibility Reports**-- DHHS, in partnership with a third party, will evaluate network adequacy—a combination of provider availability, realized member utilization, and patient perception of availability.
- **Accreditation Progress and Results**—DHHS will publish health plan progress toward receiving this accreditation and will report the accreditor’s findings for each health plan during its accreditation process.
- **Evaluation Results**—DHHS will publish results of monitoring and eval with our external evaluation vendor as well as results of other targeted evaluation (telehealth).
- **EQRO Reports**—DHS will publish results of annual evaluation of health plan performance from our external quality review organization.

Quality Assessment and Performance Improvement (QAPI) Plan: Components

The Quality Assessment and Performance Improvement (QAPI) plan must include the following elements:

Performance Measures	Mechanisms to Assess	Additional Plans
<p>Table including:</p> <ul style="list-style-type: none">• Measures performance against state benchmarks• Measures stratified as directed by DHB• Measures of focus for performance/quality improvement (all measures less than DHB-target must be addressed in the QAPI)	<p>Under/Overutilization: Managed care plans must provide feedback on quality scoring results to each AMH practice</p> <p>Special Health Care Needs: Assess the quality and appropriateness of care for members with special health care needs</p> <p>LTSS: Assess the quality and appropriateness of care including assessment of care between settings, services/supports received vs in the member's treatment/service plan, detect and remediate critical incidents including LTSS services and programs</p> <p>Disparities: Assess and process for identifying interventions to improve quality disparities based on age, race, ethnicity, sex, primary language, geography and by key population group</p> <p>Population Health: mechanisms to incorporate population health programs targeted to improve outcome measures</p>	<p>PIP: Performance improvement projects (see next slide)</p> <p>Provider Support: provider supports that relate to each PIP or quality improvement effort</p>