

February 4 Quality Fireside Chat

**Q: Help me understand what data from the HIE will help with the adolescent depression screen?
There is no current data mapping that works for that as far as I know**

A: We are currently working with HIEA to identify the correct approach to 1) identify the screening and follow-up in the data and 2) incentivize providers to document the screening and follow-up consistently.

Q: What is the minimal Medicaid patient panel a practice must have to follow these quality targets?

A: We do not have a minimum panel limit currently. However, we are still developing our policies around attribution.

Q: Will you provide more info later re: which measures will be risk-adjusted?

A: More information on our approaches to quality measure risk adjustment will be provided at a later date.

Q: I thought HIV was mentioned early in the call, but I didn't see anything related to HIV in the slides. Is that an area you are considering for a quality measure?

A: Not at this time.

Q: Other than HEDIS measure performance, what other metrics will plans be required to provide contracted providers on a quarterly basis?

A: See AMH measure information in DHB Technical Specifications - <https://files.nc.gov/ncdma/documents/NC-Medicaid-Managed-Care-Quality-Measurement-Technical-Specifications-Public.pdf> - Please note that an updated version of these specifications will be posted in March 2021

Q: Will the HIE be fully functional at launch?

A: The HIE is already functional. Many providers are already submitting data.

Q: What shows up on the HIE? To help with quality measures and gap closures? I've always found this app to be useless

A: Clinical data from electronic health records.

Q: What data is in the NCHIE? How and who places each data class there? How is data captured now at the practice level?

A: Providers submit electronic health record data to the HIE.

Q: How can we attend the MCAC Subcommittee that is open to the public?

A: Here is a link to the MCAC which has information about the meetings:
<https://medicaid.ncdhhs.gov/meetings-notices/committees-and-work-groups/medical-care-advisory-committee>

Q: One of the concerns I have regarding this transition of behavioral health providers is that now I only have to submit the claims to one (1) LME-MCO through AlphaMCS. But when this transition

occurs, I would have (5) LME-MCOs in which I would have to report claims. Is there a software that can link all these five (5) LME-MCO Medicaid claims processing into one?

A: Each Health Plan will have their own system to pay claims. Many providers choose to work with a coding/billing company who can navigate the different payment systems on their behalf.

Q: How will Medicaid factor the pandemic's effect on our ability to provide high quality care? COVID19 has affected our ability to effectively manage patients with chronic illness and perform consistent screenings, immunizations, etc. Just want there to be consideration for this sentinel event when evaluating our performance. It will take time to get back to where we used to be.

A: We agree. DHB is setting very small targets for improvement for year one (Calendar year 2022) and we are using Calendar 2021 rates as baseline. Rates will likely be low--and they will serve as the baseline for 5% relative improvement in CY 2022.

Q: For the chlamydia measure - how is the sexual history or status of patients established for denominator eligibility? This seems to be difficult to capture through claims.

A: Pharmacy and claims/encounter data are used to determine sexual activity and eligible population for this measure.

Q: Any measure that is not computable (i.e., having to do chart pulls and audits) will be very difficult to do- docs will drop Medicaid when it is just too hard.

A: Connection to and utilization of NCHHealthConnex, the HIE for NC, can support extraction for these difficult to capture measures such as Clinical Measures (eCQM) to reduce Provider burden as well as improved accuracy, along with EHR systems and data collection for the Health Plans.

Q: Can a PHP use a Quality Rating Score for Tier 3 practices and only provide quality performance incentive payments if the practice meets their established threshold for the QRS?

A: The Quality Rating Scale (QRS) which is a member facing document is still in development. We can certainly explore how to use the QRS to standardize performance improvement payments in the future.

Q: How will the quality improvement changes impact therapy services?

A: Good question. I don't know that any of our quality measures are attributable to therapy services. Most of the quality measure reflect standard of care in primary and OB care.

Q: Methodology makes sense. Why have withholds for primary care? It's hard enough to ensure we have adequate primary care supply. The money isn't in primary care, it's in long term care and hospitals with expensive procedures. Primary care providers are already saying no to at risk contracts with payors. We just can't tolerate financial penalties.

A: Withholds are designed to ensure Health Plan Accountability, not to the providers. Health Plans can enter Value Based Purchasing agreements with providers through AMH Tiered agreements and Physician Incentive Plans to allow upside risk to shared savings and risk individually.

Q: I can't even get my panel right- can we do that first before we make grand plans of quality projects?

A: We are working diligently with practices now to help practices know and understand their panels prior to launch.

Q: Will PHPs engage all practices in PIPs or only practices who have low performance in the PIP areas?

A: PHPs should engage all providers in a variety of ways, but we would expect PHPs to likely provide more or hands-on assistance to struggling practices.

Q: PHPs should engage all providers in a variety of ways, but we would expect PHPs to likely provide more or hands-on assistance to struggling practices.

A: We are actively working with PHPs and AHEC to try and align on a limited set of quality improvement initiatives.

Q: How do you suggest we implement and increase EPSDT initiatives?

A: We would suggest that you look at the EPSDT program on DHB's website. Essentially, we need providers to focus on getting children in for age-appropriate screenings, immunizations, and well-visits.

Q: Will dental providers remain a carve out?

A: Currently, yes. The carve-out is in legislation.

Q: What happens when a home health agent has patients that choose one of the agency you didn't contract with?

A: The Health Plan is responsible to help members find providers (including home health providers) within their contracted network.

Q: Will there be CIN performance outcome data shared so providers know how their selected CIN is performing compared against other CINs?

A: DHB is exploring that opportunity now.

Q: If we get our claims and quality data from the health plans, will the reports look consistent across all health plans? It's important for providers and staff to have one format to follow that is intuitive and easy to understand.

A: Health Plans can use their own formats to share data and quality performance with practices. Some practices are working within a clinically integrated network who can consolidate those reports on their behalf.

Q: Wouldn't it be a better plan to fix the panels BEFORE we start this?

A: Yes, it would. We have been working with practices for months on how to ensure patient panels are correct. We talked about some recent work to assist at the state level at the Fireside chat on 2/18/2021.

Q: Do members have to visit providers that have contacted with their plan/PHP?

A: Yes, beneficiaries will be auto assigned or can elect for assignment to Primary Care Providers enrolled in the selected health plan

Q: How will incentives "trickle down" from plan to providers? Will this be plan contract specific, or will Medicaid prescribe some consistent manner.

A: Withholds are designed to ensure Health Plan Accountability, not to the providers. Health Plans can enter Value Based Purchasing agreements with providers through AMH Tiered agreements and Physician Incentive Plans to allow upside risk to shared savings and risk individually.

Q: If we are a public health department who does not provide primary care could a beneficiary still choose us as a PCP?

A: Beneficiaries will need to select or be auto assigned to a participating/contracted Primary Care Provider with the Health Plan.

Q: Will providers still be able to use the care impact dashboard for data for all plans?

A: The Care Impact Dashboard is a proprietary Care gap tool and dashboard for CCNC. Health Plans will have similar IT tools and gap reports according to their contract with the Providers.

Q: If a patient is seen by a provider that is not their assigned PCP, will the provider receive reimbursement?

A: Each Health Plan's reimbursement policy will be in their Provider Manual. In general, members have access to in-network providers.

Q: With Medicare Advantage quality measures we (specialist) see requests for exam data to measure but we do not get incentives for data mining this for them - example Diabetic eye exam performed. Contracts are being worded that we will have to give any requested data, quickly and at no cost - will the state back us if we request limitations on numbers requested or compensation for staff time to gather data?

A: We support providers negotiating rates and terms that support the work that is being asked for by Health Plans.

Q: Can medical assistants and/or outreach staff perform the SDOH screening and referral service incident to a provider?

A: Yes. DHB does not specify the exact role of the person who assists with the SDOH screening.

Q: For eligibility for AMH+ Tailored Care Management, does the requirement for 100 Medicaid patients mean 100 qualified for Tailored Plans, or ANY Medicaid patients. Thanks.

A: Any Medicaid beneficiaries in Managed Care Plans (Standard and BH/IDD Tailored Plans).

Q: If we notice issues on the enrollment website, related to how we are listed, how do we fix that prior to go live? When we search the site by our DBA it does not show up.

A: The ability to search by DBA Name was deployed to production in mid-February - please try using this functionality again. Provider information displayed in the Tool is sourced from the provider NCTracks record and supplemented with health plan contract data. To ensure that accurate information is displayed, please review the NCTracks provider record, and make any necessary updates using the

Manage Change Request (MCR) process. Also, confirm that the information given to health plans during contracting is up to date.

Q: Similar to HOSAR, is there billing for EPSDT screening?

A: The Medicaid fee schedule has rates for a variety of screenings.

Q: How can AHEC or CCNC help behavioral health providers catch up in this world of value-based models and outcomes?

A: DHB will be looking to Tailored Plans to develop provider coaching models--just like we require Standard Plans to have coaching models. We will look at ways AHEC or other vendors can help BH providers as well.

Q: Will the race and ethnicity data for the health equity PIPs be made available publicly on a plan-specific basis?

A: Each Health Plan will be able to stratify data to identify any disparities for health equity. NC Medicaid will continue to measure, evaluate, and provide publicly through the Quality Strategy, Annual Quality, Health Equity reports and other public facing reports as indicated on the slide deck for this presentation.

Q: Kelly mentioned standard targets for the AMH Quality Metrics - where can I find these targets? Thanks.

A: DHB has set standardized AMH measure. DHB has also set a 5% relative improvement target for PHPs for those measures. PHPs can set their own targets for performance incentive payments though we do expect a certain degree of alignment with DHB statewide targets.

Q: Regarding Glide Path Payment. Can you further explain data exchange testing? Is that via HIE? and if we are not yet connected with HIE how do we do this? We have been deferred thus far due to EHR still working on connectivity. So how do we do this alternately.

A: NO--this is not reliant on the HIE. AMHs and PHPs have a list of required data sets/files that must be exchanged between them for the model. Glidpath requires the AMHs to successful test those mandatory data sets/files with PHPs.

Q: The tools do not seem to communicate well. Will NC Tracks provide training for providers?

A: NCTracks has several trainings posted on their Skillport website. Provider information displayed in the provider directory Tool is sourced from the provider NCTracks record and supplemented with health plan contract data daily. To ensure that accurate information is displayed, please review the NCTracks provider record, and make any necessary updates using the Manage Change Request (MCR) process. Also, confirm that the information given to health plans during contracting is up to date. If you continue to experience issues, you can use the "Report an Error" feature in the top right corner of the tool.

Q: What if your Provider Look-up Tool is very inaccurate? Do you use the report inaccuracies through the tool or the PHP?

A: Provider information displayed in the provider directory Tool is sourced from the provider NCTracks record and supplemented with health plan contract data daily. To ensure that accurate information is displayed, please review the NCTracks provider record, and make any necessary updates using the

Manage Change Request (MCR) process. Also, confirm that the information given to health plans during contracting is up to date. If you continue to experience issues, you can use the "Report an Error" feature in the top right corner of the tool.

Q: When will behavioral providers stop billing to LME's?

A: Providers will stop billing LMEs when members move to Standard Plans or Tailored Plans.