Chris Weathington:

It is 12 o'clock. Let's get started. Happy Wednesday everyone and thank you for participating in our third annual virtual statewide quality forum. I'm Chris Wellington, director of Practice support at North Carolina AHEC. Our Quality forum is produced by North Carolina Medicaid and NC AHEC to help providers and practices across all 100 counties. Learn and thrive with Medicaid Managed Care. We have a great team of people with us today who are subject matter experts at North Carolina Medicaid AmeriHealth, Caritas Carolina Complete Health, healthy Blue United Healthcare, WellCare, and the North Carolina Health Information Exchange. Please note that the health plans and NC AHEC Practice Support are available to assist you with your quality improvement efforts as you strive to provide the best care possible to North Carolina Medicaid beneficiaries. We will have more information on those resources during our webinar.

Everyone other than our presenters is muted and the chat function is turned off. You can ask questions or make comments by using the Q and A feature on the black bar at the bottom of your screen. And if you need closed captioning, please click on the closed captioning box at the bottom of your screen as well. The slides for today's presentation are available on the Medicaid Managed Care section of our website at NCAHEC.net. There will also be a link to them put in the Q and A box in just a few minutes. We will provide a recording and written transcript of today's presentation on our website tomorrow. We've learned in past webinars that the presenters will often address your questions during their presentations and we encourage you to pause until the presenters are through before submitting your question. Again, thank you for joining us and please know how much we appreciate the hard work and service to your Medicaid patients in the communities you serve across North Carolina.

The first agenda item will be our 2023 AMH or Advanced Medical Home measure set review. We will also have a review of the North Carolina Medicaid performance improvement projects, which are the priority quality measures. We'll go in more detail around the AMH or the Advanced Medical Home priority measures as it pertains to diabetes and pediatric immunizations and prenatal postpartum care. We'll talk also about our strategic plan to leverage the HIE or the Health Information Exchange, the CAPS survey and the provider survey results that we've received. And then finally, Dr. Bill Lawrence will go over the administrative simplification efforts that the health plans have undertaken and continue to undertake in order to maximize the provider and patient experience. And then finally, we will go into questions at the meeting close. So now I will turn this over to Sam Thompson at North Carolina Medicaid.

Sam Thompson:

Good afternoon y'all. As Chris said, my name is Sam Thompson. I'm the Deputy Director for program evaluation at North Carolina Medicaid, and I'm just going to very briefly walk you through our 2023 AMH measure set. So if you put that up. Yeah, thank you. So not a lot of changes in this. Y'all might be familiar. Our AMH measures are the set of measures that we allow the plans to use in incentive-based value-based arrangements with AMHS. And so you see we have a pediatric set and an adult set and the plans can use any of these measures in those arrangements. They can't use measures that are not in this set and they don't have to use all the measures in this set. So, you should be able to negotiate on specific measures as it relates to your arrangements with the plans.

I think the big news here is the item at the very bottom, prenatal and postpartum care, we added that that can be used as an incentive measure starting at the beginning of 2024. We are aware that some AMHs don't feel they can directly affect rates of prenatal and postpartum care. I think there's all kinds of discussion happening around that to determine how plans and PHPs can support those AMHs in that area. And certainly it's within your power to negotiate with the plants around which measures are included in your contracts. That's an important measure and we've added it because along with childhood immunization status, which is at the top, those are going to be plan withhold measures in 2024, which is to say that DHB will be withholding some of the PHPs money based on their performance on those measures. That does not directly, no money will be withheld from providers, although it may become a higher priority for the plans to work with you on those measures.

So, here's a look at our quality measurement timeline and just to give you a sense of where we are in things, calendar year 2022 was our first full quality measurement year. So the plans were on board that whole year and had members enrolled, and so we just got our 2022 quality measure results. We're very excited to see those and give us a real sense of how managed care is going so far compared to Medicaid direct and fee for service prior. As you can see in calendar year 2024 down there at the bottom, that will be the first year we implement these financial withholds. So withholding a portion of plans, capitation depending on their performance on some quality measures. And we talked on the last slide about which measures those would be. Alright, I am going to hand it off to the next speaker, Chelsea.

Chelsea Gailey:

Good afternoon everyone. I am going to speak briefly about the performance improvement projects that are occurring at a state level. So, in general, states must require the managed care organizations to implement performance improvement projects or pips as a part of a comprehensive quality assessment and performance improvement plan. The purpose of these projects is to achieve significant improvement in measurement of quality performance with objective indicators as well as to sustain the improvement over time. And, so the managed care organizations and PHPs must conduct clinical and nonclinical performance improvement projects. To examine access and quality of care, they need four elements, performance measurement, implementation of interventions, evaluation of the interventions impact using the performance measures and activities to increase or sustain the improvement.

There are 3-year life cycles that DHB has elected to complete. The first year of a performance improvement project includes six components where the topic is established, an AIM statement is completed and the eligible population is determined. Sometimes there's sampling methodology depending on the population, and then there are performance indicators that are also determined for years two and three, the actual improvement strategies are put in place and then the final year is a REM measurement year to determine the impact of these strategies. Next slide. For the standard plans, there are four total performance improvement projects, three clinical PIPs and one nonclinical PIP. A clinical PIP refers to the process of managing the patient or member most often relating to or pertaining to the treatment or management of a condition or disease state. That includes A1C control blood pressure and really is related to providers, clinicians, and nurses measuring clinical issues.

For non-clinical performance improvement projects, there are the administrative management of the patient and member which measures the effectiveness of policies and procedures and workflows that surround clinical management. These include scheduling, patient outreach and other internal organizational practices that help in coordinating the care. So now we're going to dive into a little bit

more detail. The indicator goals are 5% increase from baseline. The topics and indicators follow H IDIs technical specifications. There are quarterly progress reports and DHB is doing learning collaboratives. Currently there is a child health learning collaborative and then in 2024 there will be learning collaboratives focused on women's health and maternal health as well as care needs screening and chronic disease management.

So, for the PIP topics this year, we're going to dive into the three clinical PIP topics. One is childhood immunization status. The significance of this topic is that childhood vaccines protect children from a number of serious and life-threatening diseases, and getting these vaccines in a timely manner helps prevent getting these life-threatening illnesses in general. In this slide, you'll see a key that indicates what the trends are within Medicaid for the rates and also how we compare to the national median. You'll also see if there were any specification changes to the measure, if there are any equity considerations or results. And then you'll see generally some other thoughts around how this measure aligns with other states or CMS. And for CIS combo 10 in Medicaid we're seeing a flat trend and with the national trend we're seeing a flat trend as well.

This slide outlines the year after year trends from 2017 to 2021. And like I mentioned in the previous slide, there is a flat trend for the two colorful bars at the end. You will see the standard plan population target for 2023 and the tailored plan eligible population target for 2023, and these are based on their 2021 rates and adding a 5% relative increase.

This is a breakdown of the measure by vaccine. So you can see the rate per vaccine influenza being the lowest rate of all of the vaccinations at 44.2% driving the rate down and you'll see the combo 10 that is encompassing of all of these rates as being the lowest rate. And so we're really focused on improving this rate. Next slide for this slide, it is a breakdown of the childhood immunization by vaccine and by race. So, we can really look at the disparities that are occurring for flu.

Again, you'll see that the lowest rate and the largest disparity between black and non-black beneficiaries. Next slide. The next measure we wanted to look at is prenatal and postpartum care. Each year, 4 million women in the US give birth with 1 million having one or more complications during their pregnancy, during the delivery or postpartum period as many of 60% of all pregnancy related deaths could be prevented if they had better access or better timely care. This sets the stage for the long-term health and wellbeing of new mothers and their infants, and we have seen a flat trend in North Carolina year after year. And also that we are below the average rate as compared to the national median for some equity considerations. There are some small disparities that are less than 5% in some of the more plan specific rates. And we will go ahead and hop into the next slide.

So, this slide's a bit busy, but again, it's a breakdown of the Medicaid rates year after year from 2017 to 2021. Again, seeing that flat trend over time. On the furthest right you see the colorful bars and those are the breakdown of those targets per the standard plan population and the tailored plan eligible population for 2023. Next slide. The last one we're going to cover briefly is comprehensive diabetes care. This is the percentage of patients 18 to 75 with diabetes type one and two whose most recent HbA1C levels during the measurement year was greater than 9% poor control or was missing a result. Of course, this is a complex disease and left unmanaged can lead to some serious complications, so this is a priority for DHB.

There are some significant issues with the data collection for this specific measure and that is one of the priorities for DHB and for the performance improvement projects. This is a disparity sensitive measure determined by health and human services and in general, we are continuing to look at how we can improve data collection for this measure. And that concludes the general overview of the performance improvement projects and I will turn it over to the next speaker.

Jennifer Frazer:

Good afternoon. Thank you Chelsea. Good afternoon everybody. My name is Jennifer Frazer. I'm the director of quality at AmeriHealth Caritas North Carolina. Next up, we'll do a little bit of a deeper dive on those three priority AMH measures that correspond to the clinical pips that Chelsea just shared about. I will cover specifically childhood immunization status or combination 10. As Chelsea shared, this measure is classified as a prevention measure and it assesses the percentage of kiddos turning two years of age during the measurement year who are up to date on those recommended routine combination 10 vaccines which are outlined here on the slide. It's important to note that appropriate billing codes and especially North Carolina immunization registry data are key in our ability to understand which children have indeed received those combination of vaccines. From a historical performance perspective, we have included the 50th and the 75th percentile National Medicaid quality Compass benchmarks.

These were published in 2022 and it's important to note that they're actually based on the 2021 measure year performance. We've also included the North Carolina DHHS 2021 and 2023 targets that were issued to standard plans for this measure specifically for 2023, we're driving towards that 35.85% target, which is just above the 2022 50th percentile benchmark. It's also important to note that the targets the state targets displayed may differ from provider targets that may have been negotiated for any provider incentive programs. Next, I'd like to touch on a few practical tips for providers that might help in improving performance for this measure. These include some reminders for providers as well as considerations when interacting or engaging with patients or members to impact disparities. We recommend utilizing care gap lists form your electronic health records or that may be provided by PHPs. In order to focus on populations of interest or disparity for outreach and intervention, be sure to utilize opportunities at visits outside of well visits to administer vaccines if feasible, and use standing orders to empower members of the healthcare team to administer vaccines as appropriate. Hosting drive-through vaccine clinics, especially for flu and outreaching to members to remind them of the need for a visit for vaccinations has also been found to be helpful. At this time, I'll hand off to Tina Bronson who's the quality director with United who will cover prenatal and postpartum care. So thank you.

Tina Bronson:

Thank you, Jennifer. As she said, my name is Tina Bronson, the quality director for United Healthcare and I will be covering prenatal and postpartum care. So prenatal and postpartum care. The measure is called it's PPC, but it is comprised of two sub-measures and it is the percentage of deliveries of live births between October 8th of the year prior to the measurement year and October 7th of the measurement year. So this one does cross two years and it assesses prenatal and postpartum care. So we're looking for deliveries, the percentage of deliveries that received a prenatal visit within the first trimester. And we're also looking at postpartum care, the percentage of deliveries that had a postpartum visit on or between 70 and 84 days after delivery. And looking at this measure is, and when you're global billing for this particular measure, sometimes the codes for prenatal care or most times the codes don't come through. So what it requires is generally a manual collection of these records so that we are able to have the appropriate documentation of the care that has been provided to the members.

So there may be a request for these records both before the HEDIS project and during the HEDIS project season. And I do have listed here prenatal and postpartum care with the quality compass, as Jennifer noted for measurement year 2021 published in, excuse me, 2022, the 50 and a 70th percentile. And that is with the 2021 and 2023 DHHS targets. And these also may vary from anything that might have been negotiated in any type of arrangement.

I just want to call out a few things for friendly reminders for the providers as also when talking to members, making sure that there's comprehensive care that is provided and also culturally competent care is provided because statistically African-American mothers have a higher morbidity and mortality rate then than non-blacks. So then we want to make sure that care is being provided at a culturally competent level and understanding the care that they need. And when talking to members, we want to make sure that we're prioritizing education regarding the importance of prenatal care. Some multiparous women will say, well, I don't need to go in to my postpartum visit because I've already had a lot of babies before, two or three, I know how it ends. So just educating them on the importance of having that prenatal and postpartum care, healthy lifestyle and any potential risk that could occur in that postpartum period. And I'm going to turn it over to our next speaker, Lauren Roberts.

Lauren Roberts:

Good afternoon. I'm Lauren Roberts. I am one of the program managers at WellCare of North Carolina, and I'm going to go over hemoglobin A1C control for patients with diabetes. So for this slide, just basically a quick review of the measure itself. And then on the right hand side, just some of the codes that we typically see. Of course that's not all inclusive. And again, just like the presenters before me, we do have the quality compass 2022 50th and 75th percentile scores as well as the 2021 and 2023 targets.

Just a couple things to hit on here, just ensuring our patient facing medical staff are aware of the A1C monitoring requirements for our diabetics. Just kind of knowing when those A1C checks should be just to kind of help those diabetics get in to the office as quickly as possible. Remember to document all A1C lab values with dates for all diabetic members no matter what the value is. Frequency of visits can depend on level of A1C control members with elevated A1Cs of course should be seen more often for point of care A1C testing document the date of the in-office test with the result, the office must complete the CPT code for the test performed. In addition to CPT two codes to report A1C result value, provide education to members regarding the need to monitor and manage their blood sugars. Provide a visual representation of a normal pre-diabetic and diabetic A1C reading range. Sometimes that's referred to as like a stoplight report. Stress the importance of how uncontrolled blood sugars can negatively affect the member's blood, or excuse me, body or help and assist members if needed to schedule lab visits for regular A1C testing to include transportation assistance if needed, and remind members of open care Caping care management calls for the best management of their diabetes. And I'll go ahead and turn it over to Jess. Thank you.

Jess Kuhn:

Awesome, thanks Lauren. So. my name is Jess Kuhn and I am the quality measurement lead at North Carolina Medicaid. Today I'm just going to give a brief overview of our strategic plan to leverage North Carolina's Health Information Exchange, which is known as NC HealthConnex for Quality and Population Health.

So just to lay a foundation, we want to talk about what is the problem or what are the challenges we're trying to solve? And we can think about them in three large buckets of challenges. So first are some of the key data elements are used for North Carolina. Medicaid programs are currently incomplete, non-standardized and duplicative across multiple sources. So this can look like not receiving adequate clinical information for quality measurement or not receiving beneficiaries, health related social needs screening data. So to be more precise in order to accurately monitor health outcomes for beneficiaries, we need access to actual blood pressure readings, hemoglobin A one C values or depression screening results for example. Second is that the exchange of data between the prepaid health plans and providers is often decentralized and requires many different interfaces. And this really contributes to the third problem, which is that providers and practices are facing increased administrative burdens related to paperwork, documentation, and data sharing.

And this burden has really only been heightened under managed care. So the question here becomes how can we provide actionable data to support care management and quality improvement while also reducing provider burden related to data exchange? So, to address those challenges and reach our goals of improvement in this space, we plan to rely on one vehicle and that vehicle is the Health Information Exchange or HIE. But just to give a little background on what is an HIE and that it a tool that allows for the linking of disparate systems and existing networks to deliver a more holistic view of patient records. And HIE allows for the real-time exchange of data across many different entities, which you can see on the slide here, and it's used by many different entities as well. But some examples are government agencies, health plans, providers, health systems labs, and more so under current regulations in North Carolina, certain providers that are receiving state funds for care such as Medicaid and the state health plan, were mandated to connect to NC HealthConnex starting January 1st, 2023.

So, this year more information about NC HealthConnex and how to connect can be found in the appendix of this slide deck if you are not connected and want to look into that information. But on the next few slides, what I'm going to discuss is just how leveraging the H E will reduce administrative burden and improved processes align with federal interoperability and quality objectives and support the North Carolina Department of Health and Human Services goals and priorities. So this slide is about the first objective we want to touch on, which is reducing administrative burden and improving processes. So on the left you'll see some of the specific challenges that we're currently facing in a little more detail. And then on the right what you'll see is what a future leveraging the HIE would look like. So, as we've already discussed, current processes are really associated with a high level of administrative burden, but utilizing the HIE would reduce this burden by eliminating the requirement to report duplicative information to multiple entities.

And the HIE could really just serve as the single source of truth for information. Second, the HIE allows for real-time access to patient information at the point of service, which allows healthcare professionals and care managers to provide whole person care by seeing the entire picture of a patient's health and breaking down existing information silos. Testimonials from those connected to NC HealthConnex have underscored improvements in continuity of care, reduction in the duplication of testing, such as blood tests and radiology tests, cost savings and the vitality of seeing patient's treatment histories. Third is real-time access to patient health information, which means real-time near real-time care management and quality measurement data. And for the latter, rather than relying on administrative data which summarizes care for the previous calendar year, permission to entities with the HIE would have access to near real-time indicators on performance and have a chance to make an impact again in near real

time using the HIE as a vehicle would also reduce the variability that we're seeing in the standard plans. Interim care gap reports, giving providers a chance to see that closer to near real-time information on their patient panels. And then finally relying on the HIE alone will not standardize the data, but through this movement we hope to reduce operational complexity and improve the quality and completeness of data which would allow for more accurate, timely data that can be pulled in from multiple sources with minimal human interaction.

So, the second piece here is that this vision also aligns with CMS's push for digital quality measures or DQM. The CMS has drafted a definition for digital quality measures, which you can see on the left-hand side of the slide here. It's quality measures organized as self-contained measure specifications and code packages that use one or more sources of health information that is captured and can be transmitted electronically via interoperable systems. That last part really being the key here is the interoperable system. The CMS has set a goal of advancing quality measurements by transitioning all quality measures that are used in CMS reporting programs to DQM in the future. Because they do not require manual coding, they inherently reduce administrative burden. DQM also use standardized data definitions, not only improving accuracy but also allowing for more comparable results across systems. And perhaps most importantly, as we've sort of mentioned a couple times now, DQM would also provide patient specific insights at the point of care summarizing a vast amount of clinical data that currently resides in disparate digital sources. So some data sources that are commonly used in the production of DQM can be seen in the visualization on the right.

And then finally, this movement aligns with DHHS's three priority areas of workforce behavioral health and child and family wellbeing. As we've already discussed, utilizing the capabilities of the H I E would reduce provider's administrative burden and reduce operational complexity for behavioral health and child and family wellbeing. The data that would come in through the HIE would support care managers and practices in identifying, addressing, and sharing information on these issues. And across these three priority areas and beyond improved measurement and data exchange will really allow us to identify intervention points to address disparities in pursuit of health equity. So, this would provide demographics specific information in near real time that providers and practices could use to inform care and close those care gaps.

So, NC HealthConnex has been operating in North Carolina under its current form for many years and is a public-private partnership with SAS. The focus has been recently on increasing provider and health system connections and stabilizing a system of data sharing with over 60,000 providers having contributed records and more than 11 million unique patient records within the HIE right now, NC Medicaid is really optimistic that NC HealthConnex can help us transform our data landscape and increase interoperability, giving us the tools we need to better monitor the health and wellness of our beneficiaries. So how do we get there? So currently we are working with a multitude of partners to better understand the current data quality landscape. So, this includes doing internal exploratory analysis of NC HealthConnex data working with NCQA as they take NC HealthConnex through their data aggregator validation programs and working with our external quality review organization to convene stakeholder work groups that will propose and test solutions. This exploration will ultimately inform future phases of our work, which may include designing incentives for high quality documentation, implementing technology updates, providing pool gap reporting for providers, and overall just operationalizing digital quality measurements. And so with that I'm happy to take any questions in the chat, but I'll be turning it over to Liz from Carolina Complete Health to talk about cap.

Liz Senn:

Thank you, Jess. Good afternoon. My name is Liz Senn and I am a quality improvement coordinator at Carolina Complete Health. Today I'll be presenting the Medicaid member CAP survey, what it is, how it works, and why it's important. The purpose of the CAP survey is to measure our members experiences with the different aspects of our plan. And first of all, let me define that acronym CAP stands for Consumer Assessment of healthcare Providers and Systems. It was developed as a collaboration amongst CMS, ARQ, and NCQA to improve the safety and quality of healthcare in America. Every year a random sample of patients are surveyed about their experiences with their healthcare providers and their Medicaid plan. It's an important component of ensuring that our patients are not just with their health outcomes, but also with the experience they've had with their healthcare plan. The CAP survey lets patients rate aspects of care delivery that matter most to them. And the results represent two populations, adult respondents, and then children, child respondents. And it's really important to know that as a provider you are the most critical component of that experience.

So, the uses and importance of the CAP survey, why is this important? How is it used? CAPS evaluates patients' perceptions as well as the overall satisfaction to improve patient experience. CAPS allows health plans to get that candid anonymous feedback. The information from the survey data is reported, survey scores contribute to accreditation and we take that survey feedback and turn that data into actionable initiatives to improve our overall quality. So how it works, the timeline typically CAPS surveys follow the standard NCQA timeline. North Carolina is currently off that timeline, but we will get on that NCQA calendar in 2024. And the steps involved are your pre-notification letter, the mailed survey, telephone collection, you get your initial caps results and then your final caps results. It's good to note there is a blackout period during this process late February through June. Health plans cannot ask members any caps related question that might influence their survey responses. The good news is that physicians may discuss caps with patients during this period. So there's always an opportunity for education. We now have a new web option for the survey. It is provided to the member via a mail letter and it has instructions on how to go online and take the survey. Also want to note that North Carolina has retired the telephone modality. And again, we're moving to that web option.

So, questions on the CAP survey, you can see those listed below. They kind of pinpoint the patient journey through their healthcare experience and what their experience was in those journeys, such as how quickly could they get a doctor's appointment, did they get the doctors that they needed for their condition? How did they like their specialist, how was their overall care coordination and especially rating of overall healthcare and the rating of health plan. The CAP survey consists of composite and rating measures. Composites are essentially the bucket of an overall topic and the rating measures that apply to that topic are included in the composite bucket. You can see that our composites are getting needed care, quick access to care, physician communication, customer service. And then some of the ratings included are rating of all healthcare, rating of personal doctor, rating of specialists and rating of health plan scoring works with the composite measures for answers, always, usually, sometimes never. And then for our ratings we use a scale of zero to 10 and we're measuring respondent's assessment of health plan and their overall quality of care during a specific time.

The Medicaid cap survey supplemental questions allow plans to dive deeper into certain topics they're especially interested in. So the CAPS core survey plus supplemental questions equal the plans customized caps survey. So some supplemental questions may include behavioral health, maybe something specific to telehealth or other initiatives that a plan or the state is pushing for. And this just

gives you a visual example of what the survey looks like. So to conclude the CAP survey, everyone owns it. Everyone has an opportunity to make a difference and positively influence our member and patients experience along their healthcare journey with us. So you can take every opportunity to improve patient care and health outcomes and look for those chances to introduce CAPS language into conversations with patients and members. And we definitely want to encourage every patient to complete the CAP survey because we know that our happy patients are healthy patients. Thank you. And now I'm going to pass it on to Hannah Fletcher.

Hannah Fletcher:

Good afternoon everyone. My name is Hannah Fletcher and I'm the survey team lead for program evaluation with North Carolina Medicaid. Today I will be discussing the provider experience survey. I'll provide you with an overview of the survey activity in general and then I'll go into our most recent year's survey results and share some of those insights. So, for the implementation of this survey, NC Medicaid partnered with the SHEP Center for Health Services Research at UNC Chapel Hill. The survey is administered among organizations that provide primary care and or OBGYN services to Medicaid patients within the state. And this survey activity is part of a larger multi-year evaluation effort of North Carolina Medicaid Managed Care transformation. This survey provides a snapshot of organizational experiences, contracting and satisfaction with prepaid health plans or PhDs and in the transition to Medicaid Managed Care. And these findings will serve as a leading indicator for quality improvement for the PHPs.

So, the most recent survey that we have results for is the 2022 survey, and this survey was built on the initial baseline instrument that was developed in the fall of 2022. It was developed in consultation with clinicians, health system and practice leaders and other stakeholders from the Department of Health and Human Services. And this survey was sampled and fielded at the organizational level as most interactions with the prepaid health plans occur at the organizational rather than the individual or clinician level. The primary survey domains this activity covered were practice characteristics, contracting and negotiating with the PHPs experienced with clinical and administrative factors, factors overall perceived effects of PHPs on care delivery and behavioral health in tailored plans.

So, for the survey administration, IQVIA OneKey data was used to identify over 1200 unique organizations that provide primary care and OBGYN services in North Carolina. We used Medicaid provider data to confirm this sample and survey responses were collected between April and July of 2022. Mixed methods were used for the recruitment process and through phone call mailing and email recruitment, it was determined that approximately 62.9% of the organizations in the sample were eligible to receive the survey. So the overall response rate for the provider survey was relatively high with a response rate of 50.2%. The respondents represented diverse organizations, many from large integrated delivery systems all the way to solo practice physicians. However, most respondents, 96% specifically were from these independent practices or independent medical groups. And 66% reported the organization size as small with only one to two physicians at the organization. 98% of the respondents reported their organization provided primary care services, 11% reported providing prenatal and postnatal care and 6% reported providing inpatient obstetrics care. And then in terms of geography, there was a fairly equal spread of non-rural versus rural organizations that responded.

So, we'll take a look at our survey results now from 2022. So first, looking at contracting with the PHPs rates of contracting with each of the five available health plans ranged from about 73% to about 94%. So

that is to say that the vast majority of respondent organizations contract with all five PHPs. Additionally, the respondent organizations contracted with an average of 4.3 plans out of the five total available. However, 85.3% of the provider organizations that had not contracted with all five plans did not anticipate adding any PHP contracts in the coming year. When asked in this survey so organizations were able to rate their contracting experiences with the five separate PHPs on a scale of one to four, with one being poor and four being excellent and the mean overall ratings for the five PHPs ranged from a score of about 2.56 to 2.69 and 89% of provider organizations indicated that they did not anticipate dropping any standard plan PHP contracts in the coming year. And one of the largest reported obstacles in contracting with PHPs was communication difficulties.

So. the organizations were asked a series of questions regarding the perceived effects of health plans on care delivery. And as we can see in this figure, many of the organizations reported no change for all factors that influence care delivery. These factors that influence care delivery included the ability to access care overall provider experience, overall financial health of the medical group or practice overall patient experience, overall quality of healthcare delivery and overall health and wellbeing. Of note, the domain of care delivery that worsened the most when compared to the others was overall provider experience with 37% of responses indicating that things had either worsened or strongly worsened since the implementation of health plans. Likewise, the domain of care delivery that improved the most when compared to the others was overall health and wellbeing with 26% of respondents indicating that things had improved or strongly improved since the implementation of health plans.

There were also survey domains that measured the experience of organizations with the PHPs on a number of clinical and administrative factors. For most clinical factors, the PHPs performed well and these included access for Medicaid patients to medical specialists, behavioral health prescribers, behavioral health therapists, and access to needed drugs. And some opportunities for improvement were identified in these factors were primarily administrative factors which include provider relations overall timeliness to answer questions and or resolve problems, timeliness of claims processing, and then care case management for patients. So to summarize the key findings of this survey, it was found that open-ended comments revealed notable administrative burden in sustaining multiple PHP relationships, which providers say has ultimately harmed patient access to care. Large provider organizations rated their experiences with health plans lower than smaller provider organizations access to behavioral health prescribers and therapists were rated substantially lower than all of other domains. And then lastly, PhDs had opportunities for improvement on provider relations, timeliness to answer questions, resolve problems and process claims, and engaging in care and case management. And just to let everyone know, we did also complete a 2023 provider experience survey and we do not yet have the results for this, but we'll be posting these results publicly to the DHHS website when those are finalized. Thank you all so much for your time today and I'll turn it over to Dr. Lawrence.

Dr. William Lawrence:

Good afternoon folks. I am William Lawrence from Carolina Complete Health. Appreciate this opportunity to very briefly present to you guys and we'll go to the next slide. The Administrative Simplification work group is actually a collaborative effort amongst all five PHPs, which really looks at ways to minimize some of the administrative burdens, which we've heard mentioned not only in that provider survey but in several of the areas of discussion today. This was convened originally as a work group called upon by the North Carolina Medical Society with the CEOs of the five health plans, recognizing some of the challenges that having multiple agencies serving the Medicaid population might

bring. So, we have had a more than 2-year consistent group that has met to discuss and identify opportunities to look at policies and processes between the five PHPs and align them wherever possible to create a little bit more seamless interaction with the PHPs for our providers.

And you see before you just some of the outcomes from that effort. One of them is actually this form that we're speaking on today because originally the plan was that each PHP would be doing quality forms on a periodic basis with all of our Providers, and we recognize that would be a lot of effort for a provider that was contracted with multiple PHPs. How can we collaborate and bring quality information together and share it in a fashion that's consistent across all? This is an example of that. Another one is our primary care provider change form. We recognize that assignment issues are definitely a ongoing issue with Medicaid members transitioning from one status to another, and so we created a single form that all the plans would honor to identify changes in the primary care provider for members at the practice level.

Just has a couple of the things that we currently are working on, like a member reassignment guide, tip sheet for behavioral health crisis and continuing to work on some things around provider training. But in addition, we are also proactively starting to look at expansion as it approaches and identifying ways that we may be able to work to ease that burden as we try to ensure that new members under expansion are able to receive timely and comprehensive care. We're working with our hospital association to identify additional issues that affect our inpatient care and we welcome feedback from the field on additional topics that may be of interest. With that, given the time, I will turn it over to Chris Weathington.

Chris Weathington:

Thank you, Dr. Lawrence. Well we hope this information has been helpful to you so far and I'm just going to go through the Q and A box and see if there's opportunity for us to address further questions. I see that we've already answered a number of questions and I encourage participants to go in the Q and A box and scroll through the questions and answers. I think you may find those answers informative or helpful. There's a question here about what is the member reassignment guide, what will it cover? Dr. Lawrence, can you help us with that one,

Dr. William Lawrence:

So, I think that is basically giving, it will be a venue to give more consistent guidance about how we go through the process of member reassignment when a change is occurring or a change is requested by a member. Also, when we identify situations where a provider has members in their panel that aren't actually their members and having a consistent process to be able to update the plans about those findings and to help get those stress.

Chris Weathington:

Thank you. I know this is a big need and appreciate the efforts on simplifying and standardizing the administrative requirements. There is a comment here. Thank you for simplifying and standardizing. This is a continuous need. There was a suggestion for North Carolina Medicaid, can you report on these two providers on a regular basis? This is the first time seen and need to hear more about this, at least quarterly would help inspire provider confidence. So thank you very much for that feedback and we'll take that back with NC Medicaid team. There was another comment. We're experiencing significant

issues finding specialists to refer to for ophthalmology, rheumatology, urology, neurology, endocrinology, all theologies I guess, which makes it harder to improve their quality of care. It's gotten worse since Medicaid, Managed, Care began. And Covid, what are we doing to address this? And I know that's a concern by the health plans and Medicaid to make sure you have an adequate provider network to refer to and there are provider network adequacy requirements in place to help ensure that folks have people to go to. But does anyone here across the health plans or Medicaid want to comment on this particular question or is anyone able to address?

Sam Thompson:

Sorry Chris. We certainly understand the issue, but it's a problem that's bigger than the quality team network adequacy is. We are all dealing with it and we certainly want to make it better, but it's something we would need to take back and talk to partners within the organization about our response.

Chris Weathington:

Okay, thank you Sam. I appreciate that Dr. Lawrence. I think you like you want to comment as well.

Dr. Lawrence:

Yeah, Chris, I was just going to add, as Sam said, specialty care is a challenge, especially when you look at pediatric subspecialists. Just the availability is always a challenge, but I do want to make sure that people recognize for all of the plans that if you have a situation where someone has a specific clinical need for a specialist and you're not seeing that in the network, you should be working with us, you should be working through the case managers for those members to reach out to us to help make sure that we are coordinating care in a fashion that meets that individual's needs. So just because there's not necessarily a specialist in network doesn't mean that we don't have a responsibility to try to ensure that that care can be met, even if that means in some cases having to go out of state. So we do coordinate those types of needs for our members and you should engage your health plan resources to support those needs. So, we have channels in place to make sure that no Medicaid patient is left behind.

That's very helpful. There's kind of an interesting nuanced question. I'm not sure this if anyone on the panel may be able to answer this, but can home care providers create programs and help with some of the testing and care management for clients in these fields?

Chris Weathington:

Kendra, the person who asked this question, if you want to, okay, someone is answering this right now. Would you like to unmute yourself to answer this question? Okay, let me, it looks like we're getting ready to answer that and type the answer into the question back to you. So there a copy of these slides are in the Q and A box as well as in the appendix section. You will see resources for how to get ahold of each of us in the health plans at North Carolina AHEC Practice Support. Just know that you can reach out directly to practice support@ncaheck.net if you need assistance. But the health plans also have folks in the quality team that can help you, and also encourage you to also work with your clinically integrated network, your C I N as well and just know that we're all here to help you and there's no wrong door.

There was a question of does the combo 10 vaccine measure apply only to children two years and younger? Correct. That's true. There were some questions about withhold measures our providers having their payments withheld. No, that applies between Medicaid and the health plans. However,

health plans are offering incentives to providers to ensure that those care gaps are closed as part of that program and that business model. There was a question about behavioral health integration and that is something that we encourage all primary care practices to consider. Where there are resources, we know that it's very difficult to refer out, but there is a new model endorsed by North Carolina Medicaid, the Health Plans, and the CIS as well around the collaborative care model, which is an evidence-based behavioral health model. And if you need assistance with that, we have wonderful resources for recruitment for behavioral healthcare managers, psychiatry consultants that are available in a data registry. So if you are interested in that, just reach out to us at practice support at NC AHEC dot net. We'll be happy to help you. Sam and team, there was a comment about patient panels not being accurate. They recognize that you do have new patients that join that the practice may not have necessarily seen. However, they sometimes are assigned patients who are not age or gender appropriate when they feel like when they reach out to health plans, they're not always getting them removed. And I saw where Carolina Complete Health answered and so did AmeriHealth Caritas. But any suggestions from the panelists around that panel management issue?

Panelist:

Well yeah, I can tell you our perspective on that Chris. And we know it's a very large problem and we're doing everything we can to understand it. And I saw, I think it was CCH who put in one of the first steps, especially as it relates to if you're getting assigned men to OBS or adults to pediatric practices, is go into NC tracks and make sure that your information about who can be assigned to your practice is correct. But we've, this could be a long end commit a bunch of reports to try and help us understand the scope of this. And some of the things we are doing is standing up a CIN registration process because the information about practices and which practices are aligned to which CIS is not necessarily clear for PHPs or the CIS or DHB.

So, we're standing that up in the near term with better communication with the PHPs. And in the longer term we're building something into the new NC track system. We're improving panel data communication between AMHS and CIS so that as the data flow back and forth, they can be seen in the same place by everyone. We know that different groups are looking at it in different places. Right now, one of the very big things that's more low hanging fruit that we need to be communicating better is beneficiaries are assigned at a practice level at a site level.

These reports have indicated that that's not broadly understood that there are some practices, cis and maybe even PHPs that are considering assignment as to an individual provider to Medicaid. That's not the way it works. And that seems to be resulting in substantial confusion. We're going to do our best to communicate to that, to the field and see that systems are changed to address that. Okay. I mean I can keep going Chris, but okay.

Chris Weathington:

Well, we've hit the one o'clock hour and there are still some good questions there. If you stay on for a few minutes, there may be some folks that could type in answers to those questions and get those back out to you. But otherwise, we will follow up after this call. But I want to thank everyone for your time today. We hope this information has been helpful. Again, reach out to us at AHEC Practice Support North Carolina Medicaid, Provider Ombudsman, the North Carolina Medicaid Health Plans, and your CIS for further assistance. We're here to help you and there's no wrong door. But thank you very much for

your time and on behalf of the panelists and myself, we hope the rest of your week goes well. And thank you for all that you do.