



Promoting Better Care, Quality, and Value through North Carolina's Medicaid Managed Care Transformation

Amanda Van Vleet, MPH
Senior Program Analyst
Quality & Population Health
North Carolina Medicaid

Texas Pediatric DSRIP Learning Collaborative and Stakeholder Forum

June 5, 2019

Agenda

- **Overview of NC's 1115 Waiver**
- **Improving Quality and Population Health through NC Medicaid Managed Care**
- **Deep Dive: Healthy Opportunities**
- **Helpful Links and Resources**
- **Q&A / Discussion**

Overview of NC's 1115 Waiver



North Carolina's Vision for Medicaid Managed Care

“To improve the health of North Carolinians through an innovative, whole-person centered, and well-coordinated system of care that addresses both the medical and non-medical drivers of health.”

Context for Medicaid Transformation

- In 2015, the **NC General Assembly enacted Session Law 2015-245**, directing the transition of Medicaid and NC Health Choice from predominantly fee-for-service to managed care.
- North Carolina Department of Health and Human Services (DHHS) has worked to design a program that:
 - Delivers **whole-person care** through coordinated physical health, behavioral health, intellectual/developmental disability and pharmacy products and care models
 - Addresses the **full set of factors** that impact health, uniting communities and health care systems
 - Performs **localized care management** at the site of care, in the home or community
 - Maintains broad **provider participation** by mitigating provider administrative burden

1115 Waiver Approval is Key Milestone

Receiving waiver approval is a key milestone in the effort to pursue North Carolina's broader Medicaid transformation goals.

DHHS received approval in October 2018 from the Centers for Medicare & Medicaid Services (CMS) for North Carolina's 1115 demonstration waiver that:

- 1. Provides the Department with the authority to implement Medicaid managed care**
- 2. Allows the Department to incorporate innovative features that require federal waiver authority into its new managed care delivery system**

Authority to Implement Medicaid Managed Care

Previously, NC operated a FFS system for physical health and managed care for behavioral health, leading to administrative barriers and non-integrated care.

Under NC's 1115 waiver, physical, behavioral and pharmacy benefits will now be integrated into both Standard Plans and Tailored Plans.

The majority of Medicaid and NC Health Choice (CHIP) beneficiaries will receive Medicaid via managed care through Prepaid Health Plans (PHPs).

NC Medicaid providers will contract with and be reimbursed by PHPs rather than the State directly.

PHPs will receive a capitated payment; providers will primarily be paid fee-for-service at beginning, with evolving path to alternative payment models.

Two types of PHPs:

- Commercial plans
- Provider-led entities

Two types of products:

- Standard Plans for most beneficiaries; scheduled to launch in 2019–2020
- Tailored Plans for high-need populations; estimated to launch in 2021

Note: Certain populations will continue in fee-for-service (FFS) programs on an ongoing basis.

Key Provisions of the 1115 Waiver

- 1** • Behavioral Health Integration and Tailored Plans
- 2** • Opioid Strategy
- 3** • Healthy Opportunities Pilots

1 Behavioral Health Integration and Tailored Plans

Most Medicaid members (those with standard to moderate health care needs) will have Standard plans.

Tailored plans will provide:

- Integrated physical, behavioral and pharmacy benefits to people with a serious mental illness, serious emotional disturbance, severe substance use disorder, intellectual/developmental disability or a traumatic brain injury
- A specific, more intensive set of behavioral health benefits not available in Standard Plans*
- Care management through a specialized behavioral health home model designed to meet beneficiaries' complex needs

IMPACT: Supports the Department's goal to provide managed care beneficiaries seamless access to coordinated care and benefits through one managed care plan and to ensure those with serious behavioral health conditions get the care they need.

* Individuals eligible for Tailored Plans may elect to enroll in either Standard Plans or Tailored Plans, but will only have access to more intensive behavioral health benefits in the Tailored Plans

BH I/DD Tailored Plan Benefits

BH I/DD Tailored Plans will cover additional services targeted toward individuals with significant behavioral health, I/DD, and TBI needs.

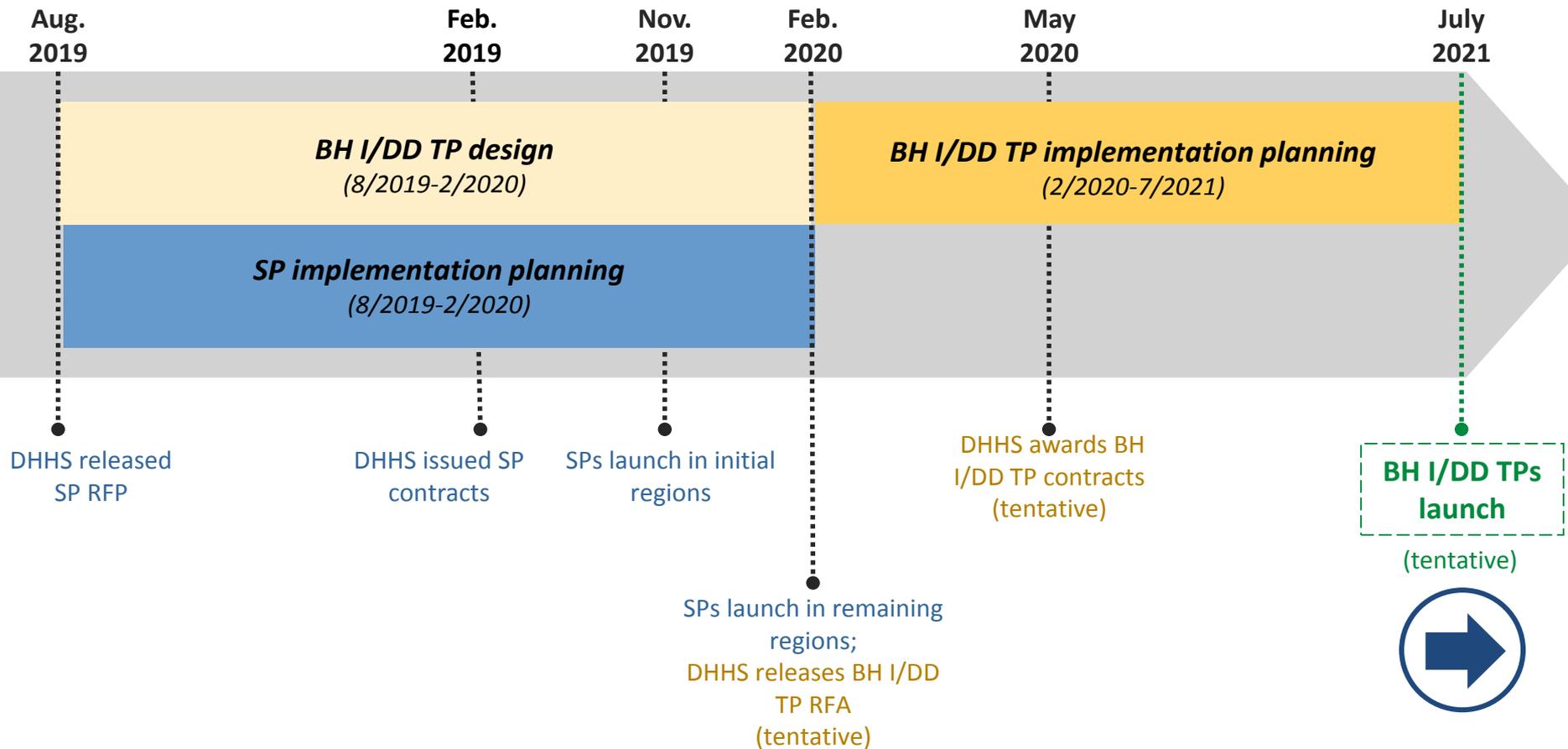
Behavioral Health, I/DD, and TBI Services Covered by <u>Both</u> Standard Plans and BH I/DD Tailored Plans	Behavioral Health, I/DD and TBI Services Covered <u>Exclusively</u> by BH I/DD Tailored Plans (or LME-MCOs Prior To Launch)
<i>Enhanced behavioral health services are italicized</i>	
<p>State Plan Behavioral Health and I/DD Services</p> <ul style="list-style-type: none"> • Inpatient behavioral health services • Outpatient behavioral health emergency room services • Outpatient behavioral health services provided by direct-enrolled providers • <i>Partial hospitalization</i> • <i>Mobile crisis management</i> • <i>Facility-based crisis services for children and adolescents</i> • <i>Professional treatment services in facility-based crisis program</i> • Peer supports* • <i>Outpatient opioid treatment</i> • <i>Ambulatory detoxification</i> • <i>Substance abuse comprehensive outpatient treatment program (SACOT)</i> • <i>Substance abuse intensive outpatient program (SAIOP)**</i> • <i>Clinically managed residential withdrawal (aka social setting detox)*</i> • <i>Research-based intensive behavioral health treatment</i> • <i>Diagnostic assessment</i> • Early and periodic screening, diagnostic and treatment (EPSDT) services • <i>Non-hospital medical detoxification</i> • <i>Medically supervised or ADATC detoxification crisis stabilization</i> 	<p>State Plan Behavioral Health and I/DD Services</p> <ul style="list-style-type: none"> • Residential treatment facility services for children and adolescents • <i>Child and adolescent day treatment services</i> • <i>Intensive in-home services</i> • <i>Multi-systemic therapy services</i> • <i>Psychiatric residential treatment facilities</i> • <i>Assertive community treatment</i> • <i>Community support team</i> • <i>Psychosocial rehabilitation</i> • <i>Substance abuse non-medical community residential treatment</i> • <i>Substance abuse medically monitored residential treatment</i> • <i>Clinically managed low-intensity residential treatment services*</i> • <i>Clinically managed population-specific high-intensity residential programs*</i> • Intermediate care facilities for individuals with intellectual disabilities (ICF/IID) <p>Waiver Services</p> <ul style="list-style-type: none"> • Innovations waiver services • TBI waiver services • 1915(b)(3) services (excluding peer supports if moved to State Plan) <p>State-Funded BH and I/DD Services</p> <p>State-Funded TBI Services</p>

*DHHS plans to submit a State Plan Amendment to add this service to the State Plan.

**DHHS plans to seek legislative approval to add SAIOP to the Standard Plan benefit package.

Tailored Plan Design and Launch Timeline

Until early 2020, DHHS will be conducting intensive planning for both Standard Plans (SPs) and TPs. After SPs launch, DHHS will continue implementation planning for TPs.



2 Opioid Strategy

As part of North Carolina's comprehensive strategy to address the opioid crisis, the Department will:

- **Increase access to inpatient and residential substance use disorder treatment by beginning to reimburse for substance use disorder services provided in institutions of mental disease (IMD), and**
- **Expand the substance use disorder service array to ensure the Department provides access to the full continuum of services**

IMPACT: Strengthens the Department's approach to improving care quality and outcomes for patients with substance use disorders, including decreasing use of long-term use of opioids and increasing use of medication-assisted treatment and other opioid treatment services.

3 Healthy Opportunities Pilots

- **North Carolina will implement within Medicaid managed care a groundbreaking pilot program in two to four geographic areas of North Carolina to improve health and reduce health care costs.**
- **Working with managed care plans, these pilots will identify cost-effective, evidence-based, non-medical strategies focused on addressing Medicaid enrollees' needs in four priority areas that drive health outcomes and costs: housing, food, transportation, and interpersonal violence/toxic stress.**
- **DHHS will increasingly link pilot payments to improvements in health outcomes and efficiency.**
- **DHHS will use a rigorous rapid-cycle assessment strategy to evaluate pilot performance and tailor service offerings to those with demonstrated efficacy.**

IMPACT: Up to 80 percent of a person's health is determined through social and environmental factors and the behaviors that are influenced by them. The Healthy Opportunities pilots leverage federal funding to ensure the most efficient and effective managed care program and to strengthen work already underway in communities to improve population health.

Beneficiary Eligibility for Managed Care

The majority of Medicaid beneficiaries will transition to standard plans beginning in November 2019. Other populations will have delayed enrollment or will be exempt or excluded from managed care (remaining in FFS program):

Excluded from Medicaid Managed Care:

- Partial dual eligibles
- Qualified aliens subject to the five-year bar
- Undocumented aliens
- Medically needy
- Presumptively eligible, during the period of presumptive eligibility
- Health Insurance Premium Payment (NC HIPP) program
- Family planning
- Inmates of prisons
- Community Alternatives Program for Children (CAP/C)**
- Community Alternatives Program for Disabled Adults (CAP/DA)**
- Program of All-Inclusive Care for the Elderly (PACE)

Delayed

- Children in Foster Care
- Behavioral Health Intellectual/Developmental Disability/Traumatic Brain Injury - Tailored Plan launch

Temporarily excluded for up to 5 years:

- Beneficiaries with long-term nursing facility stays
- Dual eligibles

Exempt from Medicaid Managed Care:

- Members of federally recognized tribes, including members of the Eastern Band of Cherokee Indians

PHPs for NC Medicaid Managed Care

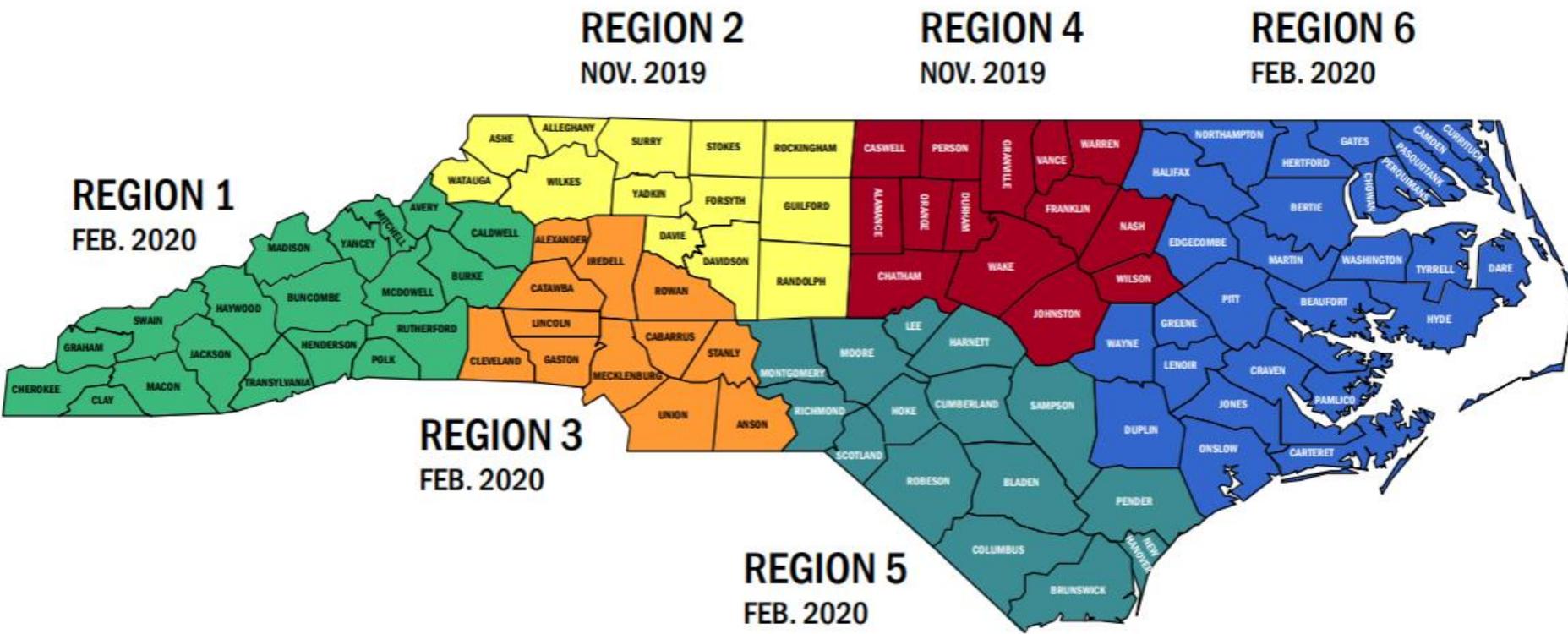
Four Statewide PHP Commercial Contracts

- AmeriHealth Caritas North Carolina, Inc.
- Blue Cross and Blue Shield of North Carolina, Inc.
- UnitedHealthcare of North Carolina, Inc.
- WellCare of North Carolina, Inc.

One Regional Provider-Led Entity

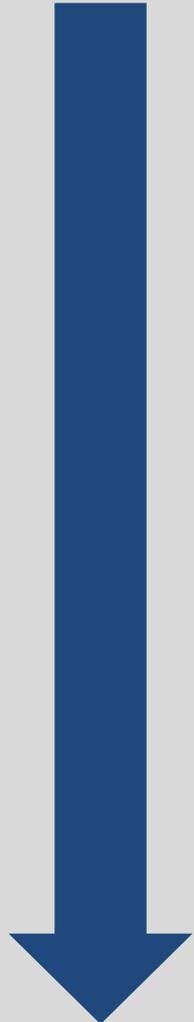
- Carolina Complete Health, Inc. (Regions 3 and 5)

NC Medicaid Managed Care Regions and Roll Out Dates



Rollout Phase 1: Nov. 2019 – Regions 2 and 4
 Rollout Phase 2: Feb. 2020 – Regions 1, 3, 5 and 6

Medicaid Transformation Timeline



Timeline	Milestone
October 2018	1115 waiver approved
February 2019	5 Pre-paid Health Plan (PHPs) contracts awarded
July 2019	Open enrollment begins for members in Phase 1
Summer 2019	PHPs contract with providers and meet network adequacy
November 2019	Managed care Standard Plans launch in Phase 1 regions; Phase 2 open enrollment
February 2020	Managed care Standard Plans launch in Phase 2 regions
July 2021 (est.)	Tailored Plan Launch

Improving Quality and Population Health through NC Medicaid Managed Care: Standard Plans

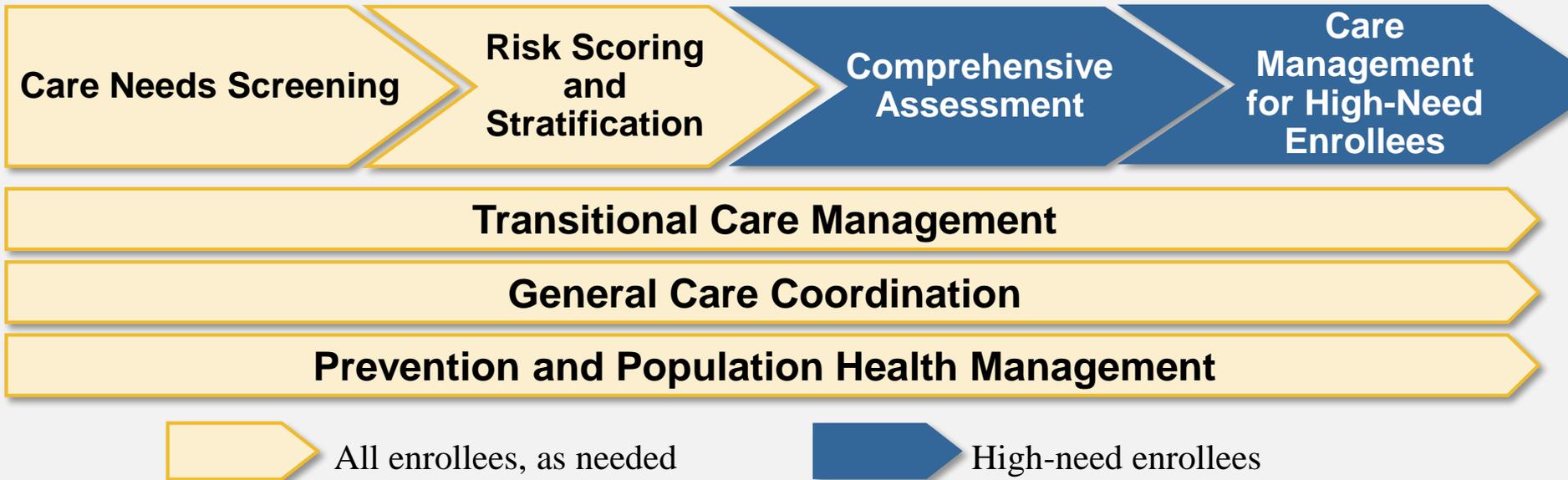
Care Management Approach

Guiding principles of care management approach under NC Medicaid managed care

- ❑ Medicaid enrollees will have access to **appropriate care management**
- ❑ Care management should involve **multidisciplinary care teams**
- ❑ **Local care management** is the preferred approach
- ❑ Care managers will have access to **timely and complete enrollee-level information**
- ❑ Enrollees will have access to **programs and services that address unmet health-related resource needs**
- ❑ Care management will align with **statewide priorities for achieving quality outcomes and value**
- ❑ Care management will be conducted by **PHPs, tier 3 AMHs, and Local Health Departments**

Care Management Approach

The State has developed a process to ensure that high-need individuals and those transitioning out of the hospital will receive appropriate, local care management



- **Processes must also be in place to identify priority populations, including:**
 - Children and adults with special health care needs*
 - Individuals in need of long term services and supports (LTSS)
 - Enrollees with rising risk
 - Individuals with high unmet resource needs (high social risk)

**Including behavioral health, substance use, increased risk for chronic conditions, and foster care populations

Advanced Medical Homes (AMH)

The AMH program provides a pathway for practices to have a larger role in managing the health outcomes and cost for their patient populations.

Goals of AMH Program

- Preserve broad access to primary care services for Medicaid enrollees
- Strengthen the role of primary care in care management, care coordination, and quality improvement
- Allow practices to implement a unified approach to serving Medicaid beneficiaries, minimizing administrative burden
- Practices may rely on in-house care management capacity or contract with a Clinically Integrated Network (CIN) or other partner of their choice.
- Data flow and analytics capabilities

Overview of the AMH Program

Tiers 1 and 2

- PHP retains primary responsibility for care management
- Practice requirements are the same as for Carolina ACCESS
- **Providers will need to coordinate across multiple plans:** practices will need to interface with multiple PHPs, which will retain primary care management responsibility; PHPs may employ different approaches to care management

AMH Payments

(paid by PHP to practice)

- **PMPM Medical Home Fees**
 - Same as Carolina ACCESS
- **Minimum FFS payment floor**

Tier 3

- PHP delegates primary responsibility for delivering care management to the practice level
- Practice requirements: meet all Tier 1 and 2 requirements plus take on additional Tier 3 care management responsibilities
- **Single, consistent care management platform:** Practices will have the option to provide care management in-house or through a CIN/other partner across all Tier 3 PHP contracts

AMH Payments

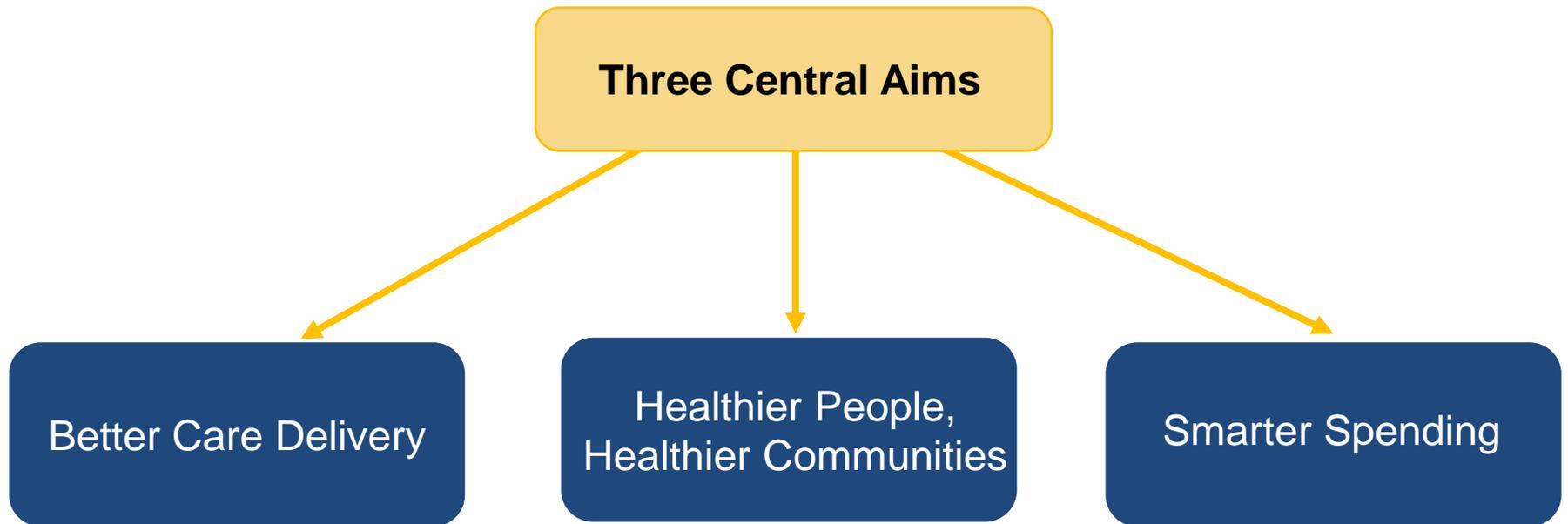
(paid by PHP to practice)

- **PMPM Medical Home Fees**
 - Same as Carolina ACCESS
- **Minimum FFS payment floors**
- **PMPM Care Management Fees**
 - Negotiated between PHP and practice
- **Performance Incentive Payments**
 - Negotiated between PHP and practice
 - Based on AMH measure set

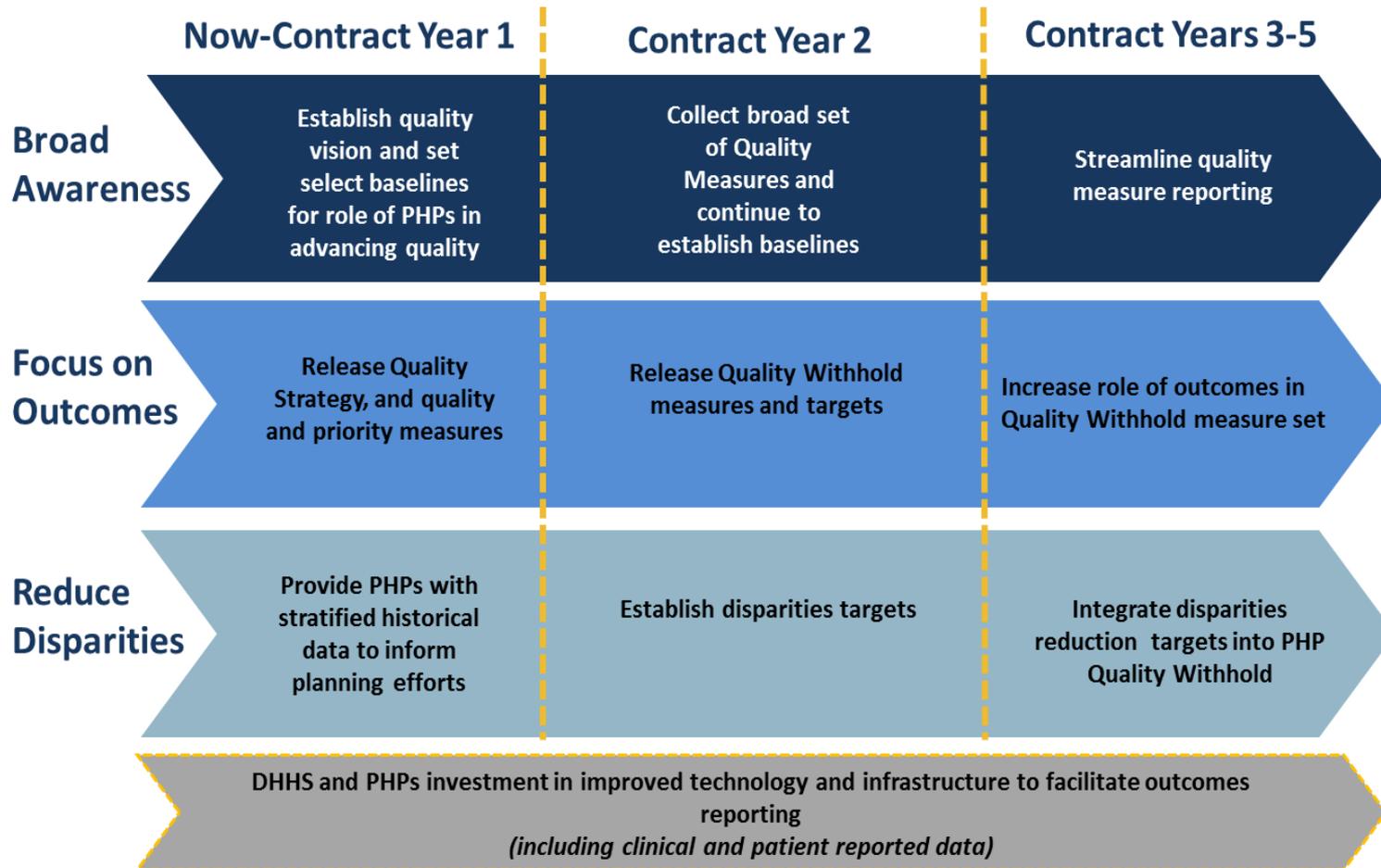
Tier 4: To launch at a later date

North Carolina's Quality Strategy

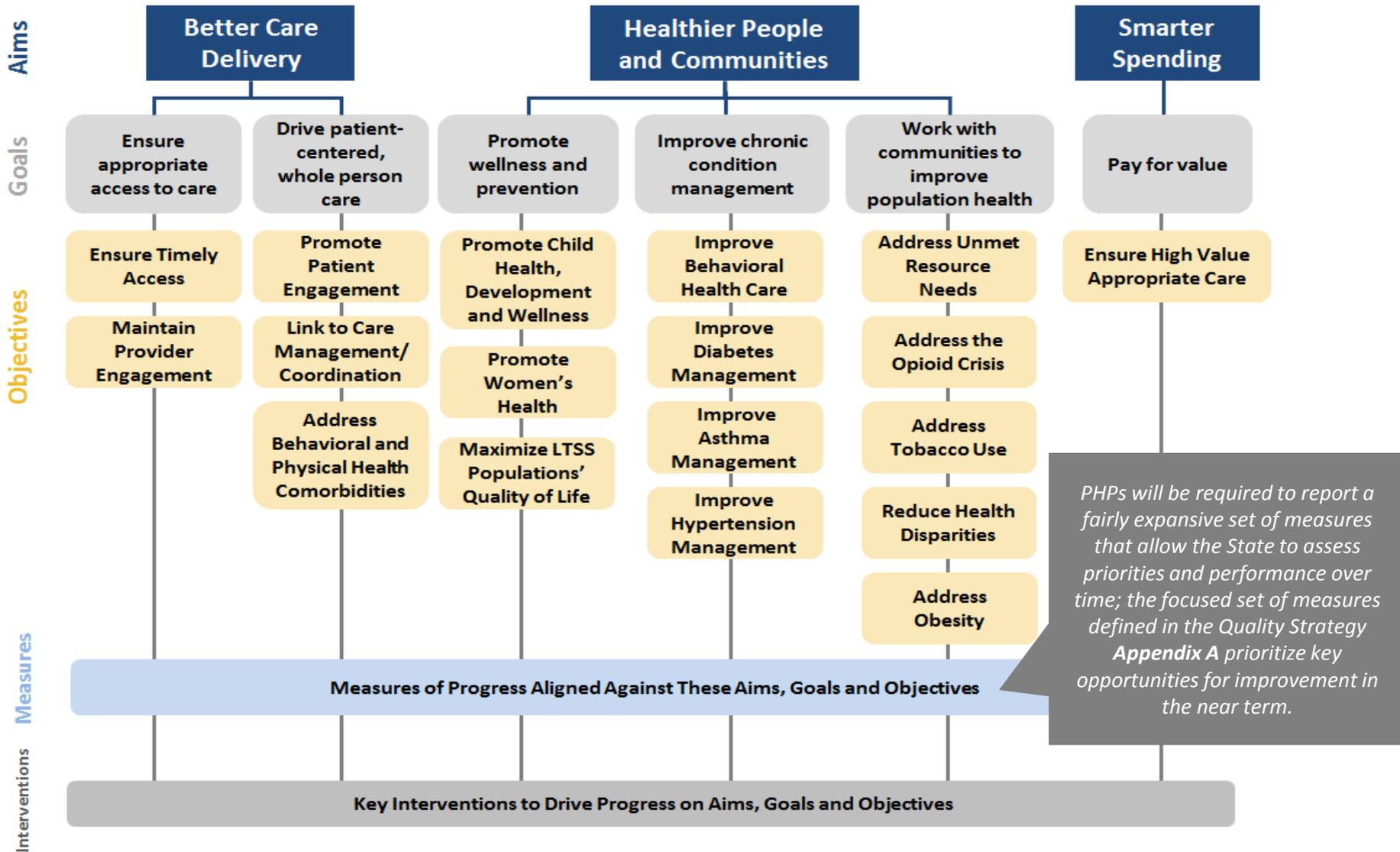
North Carolina's Quality Strategy is built around the desire to build an innovative, whole-person, well-coordinated system of care, which addresses both medical and non-medical drivers of health and promotes health equity.



The Quality Vision Over Time



Overview of the Quality Framework



Interventions and Objectives

Figure 5. Linking Interventions to Objectives

Intervention	1.1: Timely access to care	1.2: Provider Engagement	2.1: Patient engagement	2.2: Care mgmt. & coordination	2.3: Coordinated physical & BH care	3.1: Child health, development, & wellness	3.2: Women's health	3.3: LTSS quality of life	4.1: Behavioral health care	4.2: Diabetes management	4.3: Asthma management	4.4: Hypertension management	5.1: Unmet resource needs	5.2: Opioid crisis	5.3: Tobacco use	5.4: Reduce health disparities	5.5: Obesity	6.1: High value care
(1) Opioid Strategy		◆			◆				◆				◆	◆				◆
(2) Social Determinants of Health Strategy	◆		◆	◆	◆	◆	◆		◆	◆	◆	◆	◆	◆	◆	◆	◆	◆
(3) Advanced Medical Homes (AMHs)	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆				◆	◆
(4) Care Management for High-Risk Pregnancy	◆	◆	◆	◆	◆	◆	◆											◆
(5) Care Management for At-Risk Children			◆			◆							◆			◆		◆
(6) Behavioral Health Integration	◆	◆		◆	◆		◆		◆				◆					
(7) Provider Supports		◆		◆	◆								◆					◆
(8) Workforce	◆	◆														◆		
(9) Telemedicine	◆	◆	◆													◆		◆
(10) Value-Based Payment (VBP)	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆		◆
(11) Centers for Disease Control and Prevention (CDC) 6 18 Initiative							◆			◆					◆			◆
(12) Accreditation	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆		◆	◆	◆	◆	◆
(13) Disparities Reporting & Tracking	◆												◆			◆		

Primary Levers for Quality Performance

1 Quality Measure Reporting

2 Quality Baseline, Benchmarking, and Performance Target Development

3 Disparities Reporting and Tracking

4 Quality Assessment and Performance Improvement Programs (QAPIs)

- PHPs must develop a QAPI aligned to NC DHHS goals, and annually approved by NC DHHS
- Key components include internal-to-PHP processes for monitoring and correcting performance, conducting performance improvement projects, and addressing disparities in care

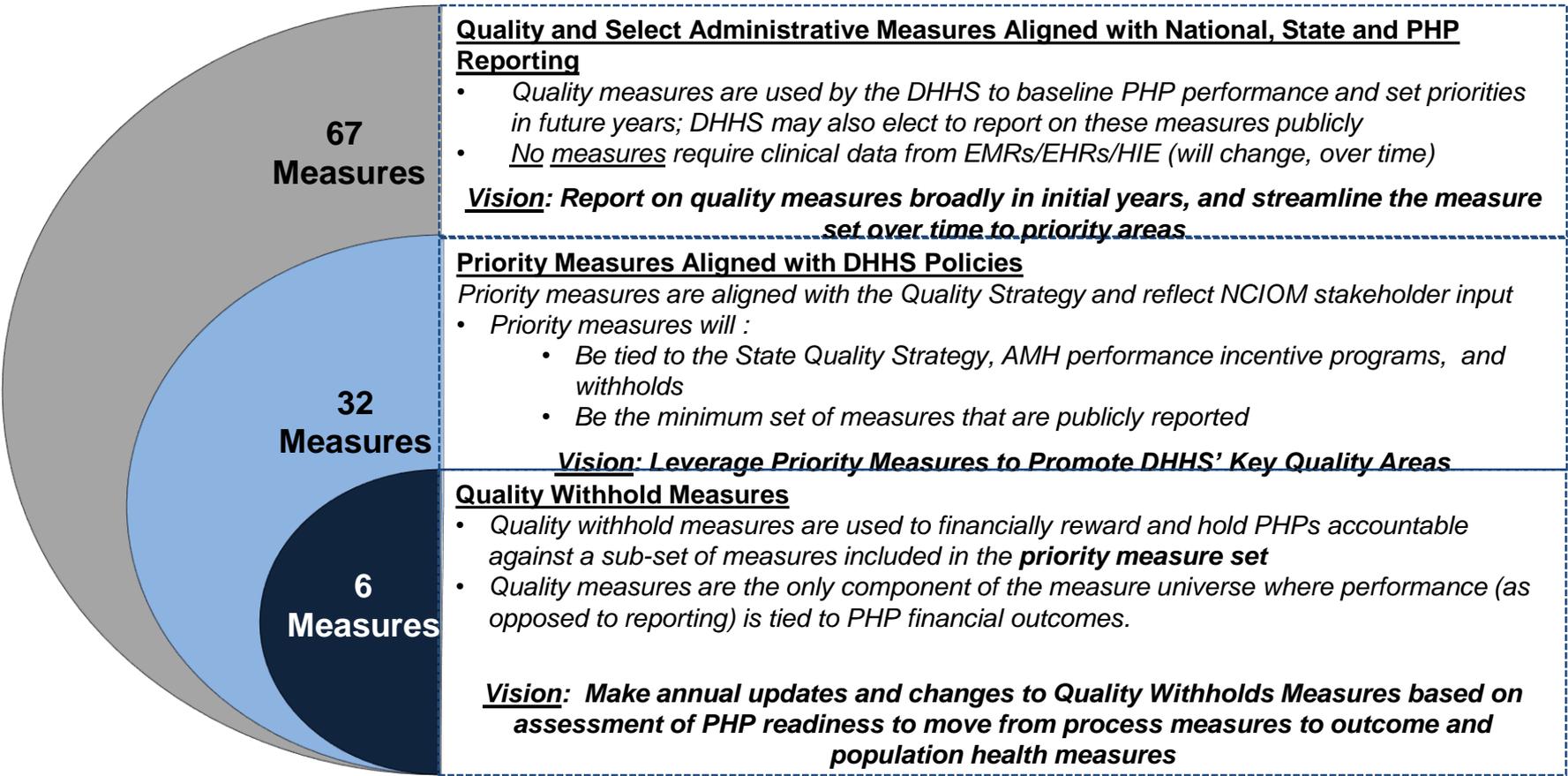
5 Value-Based Payment/Provider Incentives

- PHPs are required to develop a provider incentive program for AMH Tier 3 providers; incentives must be based on AMH quality measure list (a subset of the measures used for Quality reporting)
- PHPs are given flexibility to develop provider incentives – a tool for: (1) meeting NC DHHS-set minimums for payments attributed to alternative payment models; and (2) meeting NC DHHS-set quality targets

6 Cross-Cutting Quality Levers

- Accountability for quality performance is layered into accreditation requirements, member auto-assignment processes, and provider credentialing decisions

Robust Measure Set Allows Broad Data Collection with Focus on DHHS Priorities for Eventual Financial Accountability



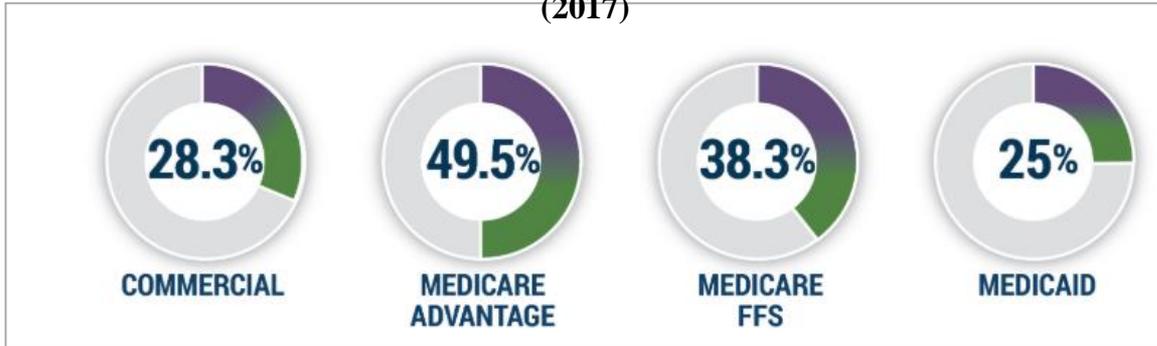
Shift to Value-Based Payment is Well Underway Nationally and in North Carolina

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

National Landscape

- **34%** of U.S. healthcare payments were “value-based” in 2017, up from **23%** in 2015, according to research conducted by the Healthcare Payment Learning and Action Network (HCP-LAN).*
- Value-based arrangements were most common in Medicare but are widespread across payers.

Percentage of Healthcare Payments in Level 3 or 4 Payment Models by Payer (2017)



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

North Carolina

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

“Blue Cross NC and Five Major Health Systems Announce Unprecedented Move to Value-Based Care”
-BCBSNC, 1/2019

“Blue Cross NC, UNC Health Alliance Agreement Lowers Triangle ACA Rates by More Than 21 Percent”
- Business Wire, 8/2018

“Duke Physician-Led Network Exceeds Quality Standards, Saves Medicare Millions”
-Duke Health, 9/2018

NC Provider VBP Landscape: Key Takeaways

Hospital-affiliated systems of all sizes have widespread adoption of VBP, though few have experience with two-sided risk models. Independent practices have limited VBP experience.

Large Systems	Midsize and Small Systems	Independent
<ul style="list-style-type: none">▪ All of the largest systems have Medicare ACO models in place (Atrium, Duke, UNC, WakeMed, Novant, Mission, WFB)<ul style="list-style-type: none">– 3 of 7 have two-sided risk– 3 earned shared savings in 2017▪ 4 of the largest systems also participate in the BCBS Blue Premier Model (UNC, Duke, WakeMed, Novant)<ul style="list-style-type: none">– Does <u>not</u> include Atrium, the largest Medicaid system▪ Large systems are an important piece of the AMH landscape<ul style="list-style-type: none">– At least* 28% of Tier 3 practices (14% of all AMH practices) are affiliated with large systems	<ul style="list-style-type: none">▪ 4 of the 5 midsize and small systems in AMH participate in MSSP (Cape Fear, Cone, Caromont, New Hanover)<ul style="list-style-type: none">– Does <u>not</u> include First Health of the Carolinas– Cone/Triad ACO participates in two-sided risk model– Only Cone/Triad ACO earned shared savings▪ Cone Health participates in BCBS Blue Premier Model▪ These systems are a smaller piece of the AMH landscape<ul style="list-style-type: none">– At least* 5% of Tier 3 practices (3% of all AMH practices) are affiliated with small or mid-sized systems	<ul style="list-style-type: none">▪ Adoption of VBP is limited▪ CCPN is a large player in the AMH landscape (38% of Tier 3 practices) but does not currently participate in any VBP models▪ FQHCs have a Medicare ACO<ul style="list-style-type: none">– Upside-only risk– Did not earn shared savings in 2017▪ KeyHealth IPA partners with WakeMed in a Medicare ACO<ul style="list-style-type: none">– Upside-only risk– Did not earn shared savings in 2017▪ Independent providers are a large piece of the AMH landscape<ul style="list-style-type: none">– At least* 40% of Tier 3 practices (20% of all AMH practices) are independent

NC VBP Strategy

Vision for Medicaid Transformation:

Drive an innovative, whole-person centered, and well-coordinated system of care which addresses both medical and non-medical drivers of health

Improved quality performance

Better health outcomes

Increased efficiency

Provider engagement and support

Rapid progress

VBP Strategy

A payment strategy that supports the vision and goals for transformation and aligns incentives around purchasing "health"

VBP Requirements That Support and Align with Key Initiatives

PHPs' Role in Buying Health

- Align financial incentives and accountability around total cost of care, overall health outcomes, and quality gains
- VBP arrangements must be aligned with DHHS' Quality Strategy and related measures
- Incorporate Opportunities for Health (SDOH) into VBP strategy
- Offer performance incentive payments to tier 3 Advanced Medical Homes (AMHs), Pregnancy Medical Homes (PMHs), and other providers
- Expect DHHS to raise the bar on the types of programs that will count toward VBP targets over time

VBP Guidance to Date



The Department's initial round of guidance speaks to VBP definitions and targets for contract years one and two of Medicaid managed care.

Defines VBP: Any payment arrangement that falls in categories 2 through 4 of the [HCP-LAN](#) APM framework

- **Sets PHP targets:** By the end of contract year 2, the portion of a PHP's medical expenditures governed under VBP arrangements must either increase by twenty (20) percentage points or represent at least fifty percent (50%) of total medical expenditures

- **All payments to all Tier 3 AMHs will count as VBP**, since all Tier 3 contracts are required to include the opportunity to earn Performance-Based Incentive Payments

- **No PHP withholds in contract years 1-2 tied to VBP.** Signaled that the Department may begin withholds in contract year 3 tied to VBP arrangements

- **The Department will release more guidance in summer 2019**, which will define NC's longer-term vision for paying for health and outline DHHS' approach to measuring and incentivizing the use of VBP arrangements in the coming years

Payment categories excluded from target numerator and denominator:

- Directed payments to hospitals associated with UNC and Vidant medical schools
- Additional utilization-based payments to certain providers, as described in the RFP Section D. Providers, Subsection 4. Provider Payments

Future VBP Guidance

Additional VBP guidance will be released summer 2019. The Department plans to solicit stakeholder feedback and iterate its VBP strategy over time.

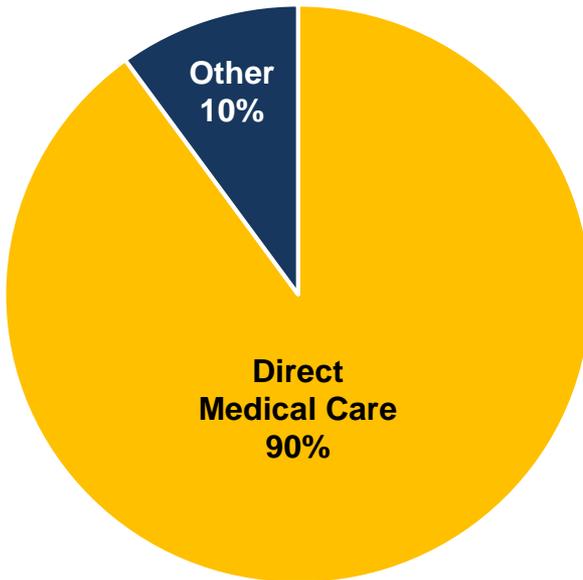
- Defines the Department's longer-term VBP strategy**
- Sets VBP definitions and targets for years 3-5**
- Builds on the AMH model for linking quality and outcomes to total cost of care**
- Applies withholds to PHPs related to VBP targets beginning in year 3**
- The Department's VBP strategy will take into account varying levels of provider size, geography, populations served, and readiness to take on risk, and will use the AMH model as the center of a member's whole-person care**

Healthy Opportunities

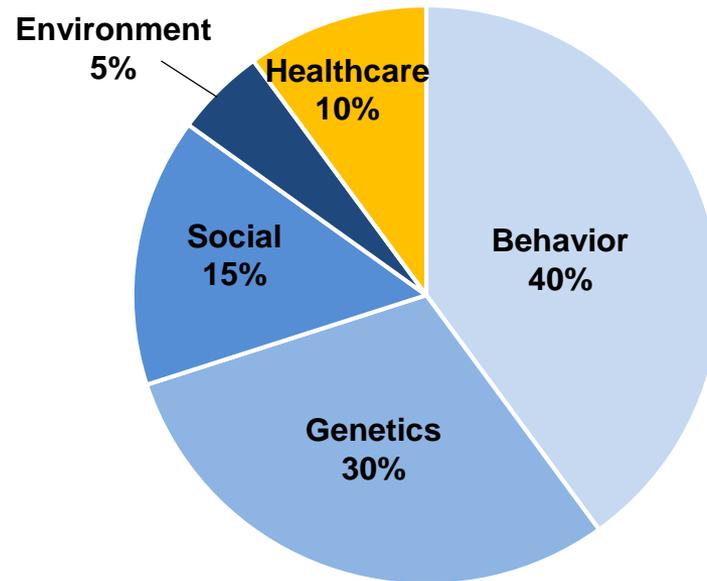
Why Emphasize Non-Medical Drivers of Health?

Mismatch: We are Currently Buying Healthcare, not “Health”

Healthcare Spending



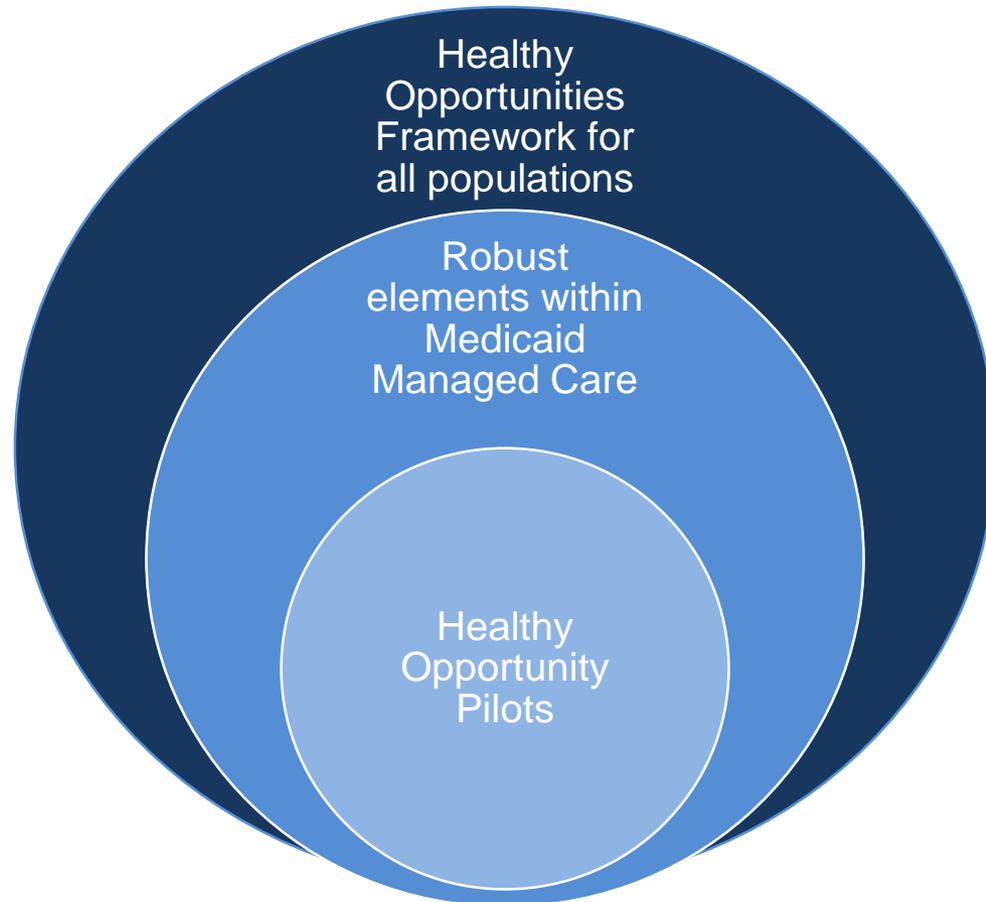
Drivers of Health



The greatest opportunity to improve health lies in addressing a person's unmet essential needs.

Opportunities for Health

All North Carolinians deserve the opportunity for health. As such, we need to address the medical and non-medical drivers of health.



Statewide infrastructure and elements

Hot Spot Map

- Interactive GIS map of social determinants of health indicators at neighborhood level statewide

Screening Questions

- Statewide standardized screening questions

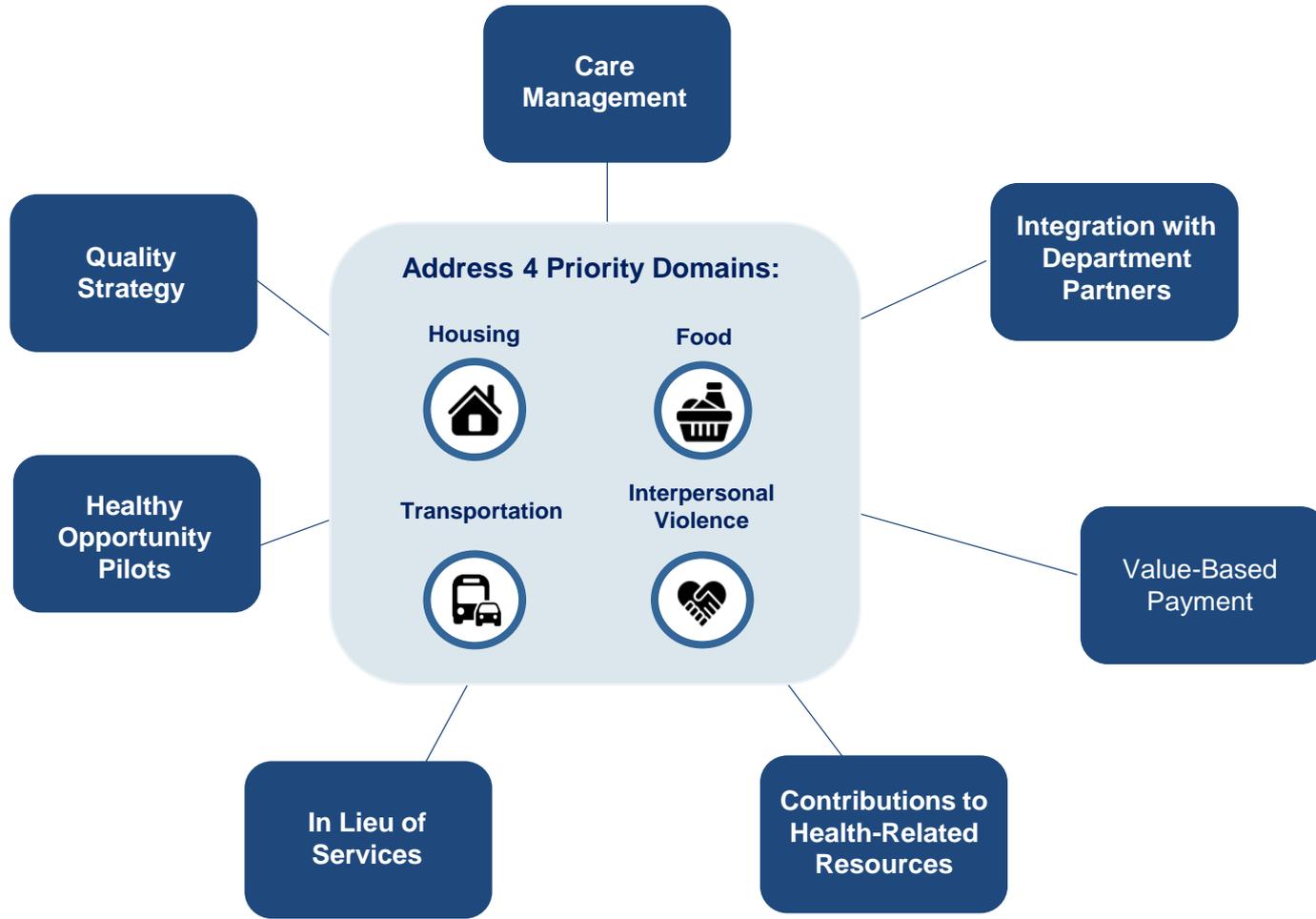
NCCARE360

- Statewide coordinated network with a robust data repository and referral platform with close the loop functionality and outcome reporting

Workforce Development

- E.g., Community Health Workers core competencies, curriculum, and training

Robust Elements in Medicaid Managed Care



Investing in Healthy Opportunities Through Care Management

PHPs will ensure that non-medical drivers of health are integrated into care management.

Care Management

- PHP will establish care management competencies, workforce, and procedures that enable the care team to comprehensively address unmet health-related needs, including:
 - Screening for and addressing these needs through trauma-informed care, navigation support, and other strategies
 - Using North Carolina-developed tools, including: standardized Care Needs Screening questions, NCCARE360, “Hot Spot” Map
 - Engaging appropriate staff on the care team, including community health workers, medical and behavioral health specialists, pharmacists, peer specialists, navigators, etc.

PHPs will use DHHS' standardized care needs screening tool as part of the initial care needs screening.

Care Management: Screening Tool

Goals

- Routine identification of unmet health-related resource needs
- Statewide, standardized collection of data for all populations

Development

- Drew from validated tools (e.g. PRAPARE, Hunger Vital Sign, Pregnancy Medical Home) and informed by currently used tools
- Simple & streamlined to be accessible to broadest audience/settings
- Technical Advisory Group
- Released April 2018 for Public Comment
- Field testing in 18 clinical sites

Implementation

- Recommended to be used across settings and populations

Health Screening		
We believe everyone should have the opportunity for health. Some things like not having enough food or reliable transportation or a safe place to live can make it hard to be healthy. Please answer the following questions to help us better understand you and your current situation. We may not be able to find resources for all of your needs, but we will try and help as much as we can.		
Food	Yes	No
1. Within the past 12 months, did you worry that your food would run out before you got money to buy more?		
2. Within the past 12 months, did the food you bought just not last and you didn't have money to get more?		
Housing/ Utilities	Yes	No
3. Within the past 12 months, have you ever stayed: outside, in a car, in a tent, in an overnight shelter, or temporarily in someone else's home (i.e. couch-surfing)?		
4. Are you worried about losing your housing?		
5. Within the past 12 months, have you been unable to get utilities (heat, electricity) when it was really needed?		
Transportation	Yes	No
6. Within the past 12 months, has a lack of transportation kept you from medical appointments or from doing things needed for daily living?		
Interpersonal Safety	Yes	No
7. Do you feel physically and emotionally unsafe where you currently live?		
8. Within the past 12 months, have you been hit, slapped, kicked or otherwise physically hurt by anyone?		
9. Within the past 12 months, have you been humiliated or emotionally abused by anyone?		
Optional: Immediate Need	Yes	No
10. Are any of your needs urgent? For example, you don't have food for tonight, you don't have a place to sleep tonight, you are afraid you will get hurt if you go home today.		
11. Would you like help with any of the needs that you have identified?		

Investing in Healthy Opportunities Through Care Management

PHPs will use NCCARE360 to identify community-based resources and connect high-need members to these resources.

Care Management: NCCARE360

NCCARE360 (NC Resource Platform) is a telephonic, online, and interfaced IT platform, providing:

- A robust statewide resource database of community-based organizations and social service agencies
- A referral platform for payers, care managers, clinicians, community health workers, social service agencies, community members, and others to refer and connect members directly to community resources and track the connections and outcomes through “closed-loop referral” capacity

PHPs will, at minimum:

- Use NCCARE360 for its community-based organization and social service agency database/directory to identify local, community-based resources and refer members to these resources
- Track closed-loop referrals once the functionality is ready for use (currently rolling out the platform regionally)

PHPs may use existing platforms for this capability until NCCARE360 is certified as fully functional and ready for statewide PHP adoption



Investing in Healthy Opportunities Through Care Management

Care Management: NCCARE360

Configurable Screening

- Will include statewide screening tool
- Can add additional screening questions/ tools as needed

Electronic Referral Management

- Seamless referral workflow sends the right data to the right provider(s) to address specific needs

Assessment/Care Plan Management

- Custom care plans for each service are attached to referrals

Bi-Directional Communication/Alerts

- Automated notifications keep all organizations up to date, while care team members can securely communicate with each other

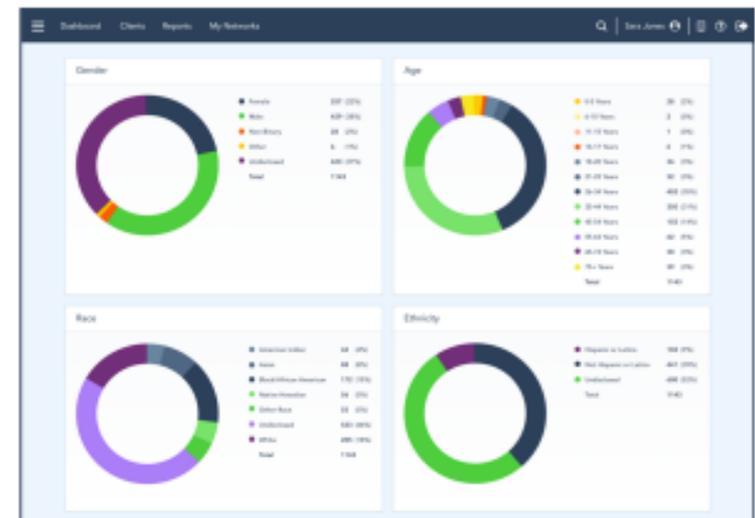
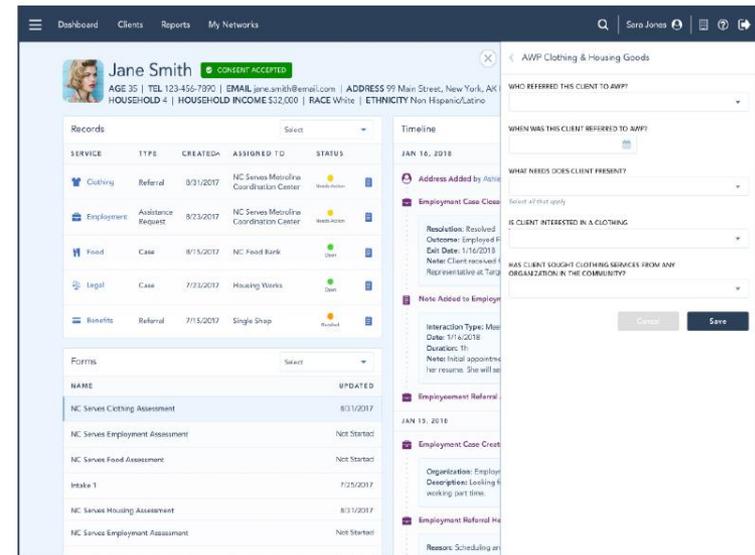
Real-time reporting of outcomes, impact, performance, & efficiency

- You get to know exactly what services were delivered, and the entire history for every intervention by your external partners

Configurable and structured reporting

- Granular and detailed outcomes for every type of service

- Integrates with other platforms such as EHRs (ex. EPIC), 211 platforms, VA resources, and other community tools (ex. Salesforce) to ensure seamless workflows



Investing in Healthy Opportunities Through Care Management

PHPs are encouraged to use the NC “Hot Spot” Map to strategically guide contributions to health-related resources in the regions and communities it serves.

Care Management: “Hot Spot” Map

- The NC “Hot Spot” Map uses geographic information system (GIS) technology to map resource needs and other indicators across the state
- Statewide map now live: <http://www.schs.state.nc.us/data/hsa/>
- GIS/ESRI Story mapping of 14 social determinant of health indicators with a summary statistic
- Displays geographical health & economic disparities

Social and Neighborhood	Economic	Housing and Transportation
% < HS Diploma	Household Income	% Living in Rental Housing
% Households with Limited English	% Poverty	% Paying >30% of Income on Rent
% Single Parent Households	Concentrated Poverty	% Crowded Household
Low Access to Healthy Foods	% Unemployed	% Households without a Vehicle
Food Deserts	% Uninsured	

Investing in Healthy Opportunities Through Care Management

Care Management: "Hot Spot" Map

North Carolina Social Determinants of Health by Regions

- About
- Region 1
- Region 2
- Region 3
- Region 4
- Region 5
- Region 6
- Region 7
- Region 8
- Region 9
- Region 10

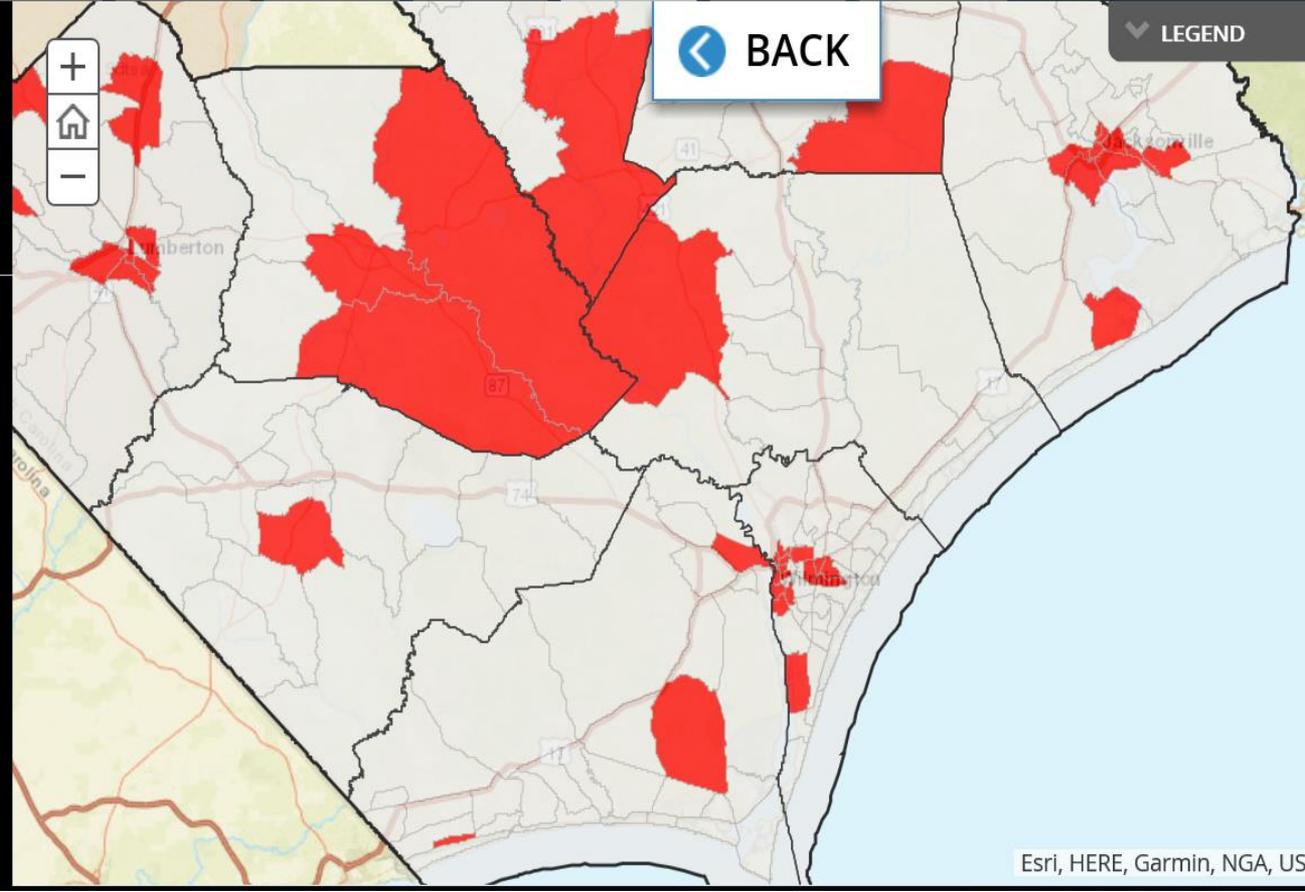
A story on health inf...  

NC Social Determinants of Health - Local Health Departments Region 8

- [Percent of Households Speaking Limited English](#)
- [Percent Single Parent Households](#)
- [Low Access to Healthy Foods](#)
- [Food Deserts](#) ←
- [Turn All Layers Off](#)

Education

An estimated 88,175 (14.8%) adult



Esri, HERE, Garmin, NGA, US

Investing in Healthy Opportunities Through Care Management

PHPs will engage appropriate staff on the care team to meet the needs of members, including medical and behavioral health specialists, pharmacists and pharmacy technicians, peer specialists, navigators, and community health workers.

Care Management: Workforce

- Develop, train and strengthen workforce needed to support healthy opportunity initiatives/Trauma Informed Care
- Community health workers, case managers, etc.
- Released report on Community Health Workers, May 2018: *Community Health Workers in North Carolina: Creating an Infrastructure for Sustainability*



**COMMUNITY HEALTH WORKERS
IN NORTH CAROLINA:**
CREATING AN INFRASTRUCTURE
FOR SUSTAINABILITY

Final Report and Stakeholder Recommendations of the
North Carolina Community Health Worker Initiative

May 2018

PHPs will incorporate non-medical drivers of health into their Quality Strategies.

Quality Strategy

- PHPs will focus on health outcomes and not only health care process measures
- PHPs will report on rates of completed screenings for unmet health-related resource needs
- PHPs are encouraged to identify opportunities to contribute to health-related resources in the Quality Assurance and Performance Improvement (QAPI) plan



Investing in Healthy Opportunities Through VBP

PHPs will incorporate addressing opportunities for health into their value-based payment (VBP) strategies.

Value-Based Payment Strategy

PHPs will submit a written plan (“VBP Strategy”) to the Department that indicates how it will incorporate addressing opportunities for health into its value-based payment strategy to align financial incentives and accountability around total cost of care and overall health outcomes

			
CATEGORY 1 FEE FOR SERVICE - NO LINK TO QUALITY & VALUE	CATEGORY 2 FEE FOR SERVICE - LINK TO QUALITY & VALUE	CATEGORY 3 APMS BUILT ON FEE-FOR-SERVICE ARCHITECTURE	CATEGORY 4 POPULATION - BASED PAYMENT
	A Foundational Payments for Infrastructure & Operations (e.g., care coordination fees and payments for HIT investments)	A APMs with Shared Savings (e.g., shared savings with upside risk only)	A Condition-Specific Population-Based Payment (e.g., per member per month payments, payments for specialty services, such as oncology or mental health)
	B Pay for Reporting (e.g., bonuses for reporting data or penalties for not reporting data)	B APMs with Shared Savings and Downside Risk (e.g., episode-based payments for procedures and comprehensive payments with upside and downside risk)	B Comprehensive Population-Based Payment (e.g., global budgets or full/percent of premium payments)
	C Pay-for-Performance (e.g., bonuses for quality performance)		C Integrated Finance & Delivery Systems (e.g., global budgets or full/percent of premium payments in integrated systems)
		3N Risk Based Payments NOT Linked to Quality	4N Capitated Payments NOT Linked to Quality

Investing in Healthy Opportunities Through Pilots

What are the Healthy Opportunities Pilots?

The federal government authorized up to \$650 million in state and federal Medicaid funding to test evidence-based, non-medical interventions designed to improve health outcomes and reduce healthcare costs for a subset of Medicaid enrollees.

Pilot funds will be used to:

- Cover the cost of federally-approved Pilot services
 - DHHS is developing a fee schedule to reimburse entities that deliver these non-clinical services*
- Support capacity building to establish “Lead Pilot Entities” and strengthen the ability of human service organizations to deliver Pilot services
 - DHHS will procure Lead Pilot Entities with deep roots in their community that can facilitate collaboration across the healthcare and human service providers through building partnerships.*

NC’s priority “Healthy Opportunities” domains

Housing



Food



Transportation



Interpersonal
Violence



Who Qualifies for Pilot Services?

To qualify for pilot services, Medicaid managed care enrollees must have:



At least one Needs-Based Criteria:

Physical/behavioral health condition criteria vary by population:

- Adults (e.g., 2 or more chronic conditions)
- Pregnant Women (e.g., multifetal gestation)
- Children, ages 0-3 (e.g., Neonatal intensive care unit graduate)
- Children 0-21 (e.g., Experiencing three or more categories of adverse childhood experiences)



At least one Social Risk Factor:

- Homeless and/or housing insecure
- Food insecure
- Transportation insecure
- At risk of, witnessing or experiencing interpersonal violence

What Services Can Enrollees Receive Through the Pilots?

North Carolina's 1115 waiver specifies services that can be covered by the Pilot.



Housing

- Tenancy support and sustaining services
- Housing quality and safety improvements
- One-time securing house payments (e.g., first month's rent and security deposit)



Food

- Linkages to community-based food services (e.g., SNAP/WIC application support)
- Nutrition and cooking coaching/counseling
- Healthy food boxes
- Medically tailored meal delivery



Transportation

- Linkages to existing public transit
- Payment for transit to support access to pilot services, including:
 - Public transit
 - Taxis, in areas with limited public transit infrastructure



Interpersonal Violence (IPV)

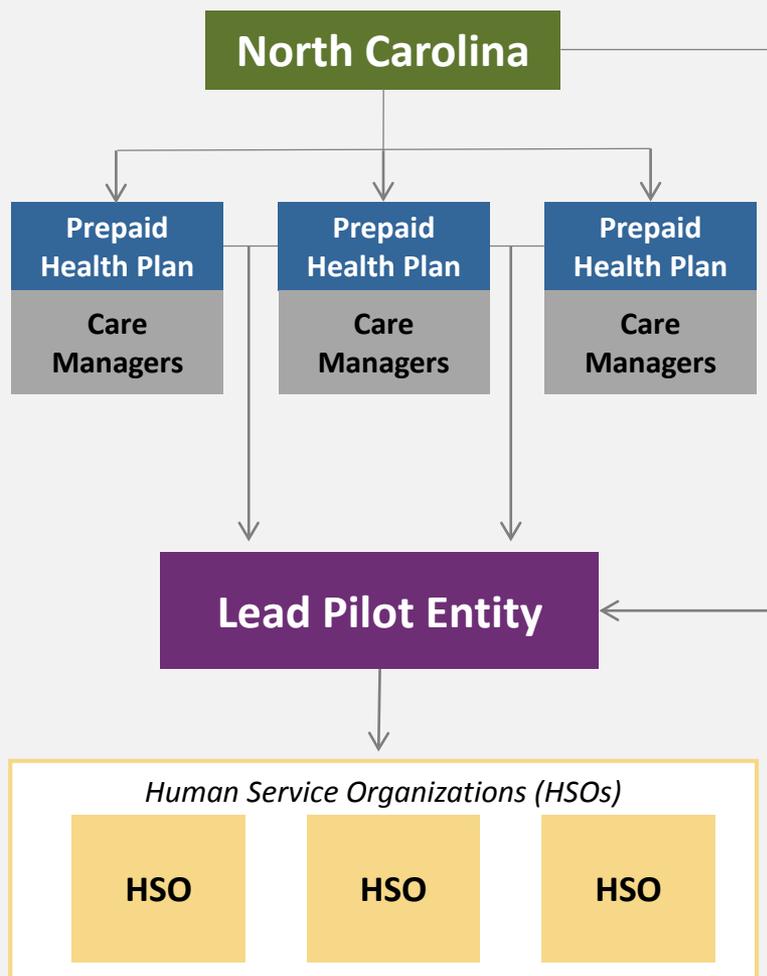
- Linkages to legal services for IPV related issues
- Evidence-based parenting support programs
- Evidence-based home visiting services

**See appendix for full list of approved pilot services.*

Investing in Healthy Opportunities Through Pilots

What Entities Are Involved in the Pilots?

Sample Regional Pilot



Pilot Overview

- The Healthy Opportunities Pilots will test the impact of providing selected evidence-based interventions to Medicaid enrollees.
- Over the next five years, the pilots will provide up to \$650 million in Medicaid funding for pilot services in two to four areas of the state that are related to housing, food, transportation and interpersonal safety and directly impact the health outcomes and healthcare costs of enrollees.
- Pilots will allow for the establishment and evaluation of a systematic approach to integrating and financing evidence-based, non-medical services into the delivery of healthcare.

Deeper Dive: Key Entities' Roles in the Pilots

PHPs

- Contract with any LPE operating within the PHP's region and participate in pilots operating in its region
- Manage a Pilot budget
- Approve which enrollees qualify for Pilot services and which services they qualify to receive
- Ensure the provision of integrated care management to Pilot enrollees

Care Managers

- Frontline service providers predominantly located at Tier 3 AMHs and LHDs interacting with beneficiaries
- Assess beneficiary need for Pilot services and manage coordination of pilot services, in addition to managing physical and behavioral health needs
- Track enrollee progress over time

Lead Pilot Entities

- Serve as the essential connection between PHPs and HSOs.
- Two to four LPEs will be competitively procured by DHHS in 2019
- Develop, manage, pay and oversee a network of HSOs
- Provide support and technical assistance for HSO network
- Convene Pilot entities to share best practices

Human Service Organizations

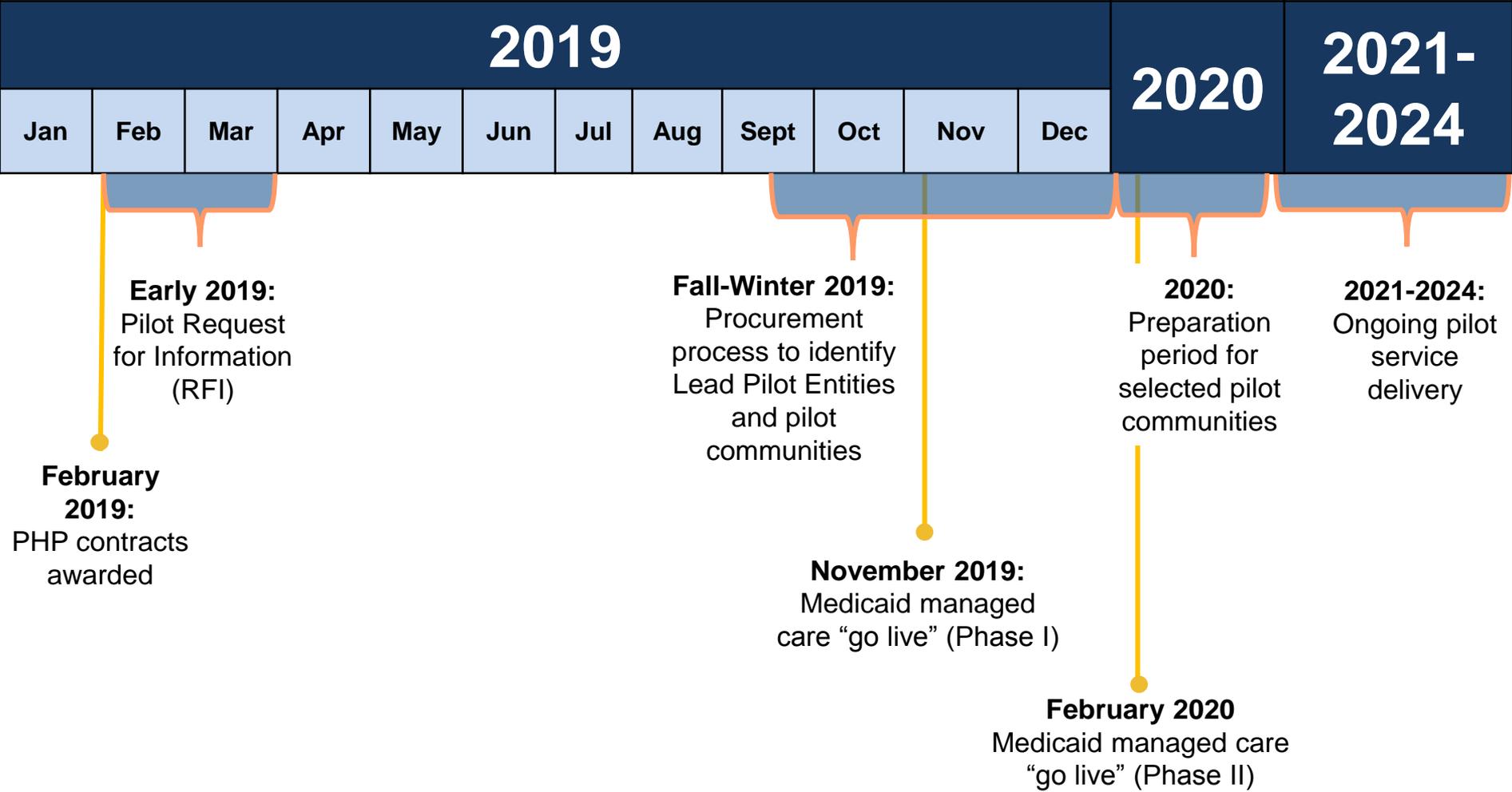
- Frontline social service providers that contract with the LPE to deliver authorized, cost-effective, evidence based Pilot services to Pilot enrollees
- Participate in the healthcare delivery system, including submitting invoices and receiving reimbursement for services delivered

Evaluation - Rapid Cycle/Summative

- Evaluation core component of design; Learnings from pilot are fundamental purpose
- Rapid cycle assessments
 - Evaluation throughout pilots to learn in real time and make adjustments
 - Evolving metrics - Operational readiness, service delivery, resource needs met, self-reported quality of life, health outcomes, utilization, cost
- Summative evaluation
 - Health, utilization, and cost savings overall and by sub-groups
 - Determine cost-neutrality and cost-effectiveness of interventions by sub-group
 - Implementation science
 - Learn how to scale interventions that worked into Medicaid statewide

Investing in Healthy Opportunities Through Pilots

Major Milestones for Medicaid Transformation and Healthy Opportunities Pilots



In Lieu of Services

- PHPs are encouraged to use In Lieu of Services to finance services that improve health through connecting members with resources, social services, and other supports upon receipt of the Departmental approval.

Housing



Food



Transportation



Interpersonal
Violence



Contributions to Health-Related Resources

PHPs are encouraged to make contributions to health-related resources that help to address members' and communities' unmet health-related needs.

Contributions to Health-Related Resources

- PHPs are encouraged to voluntarily contribute to health-related resources targeted towards high-impact initiatives that improve health outcomes and cost-effective delivery of care within the regions and communities they serve
- PHPs that voluntarily contribute to health-related resources **may count the contributions towards the numerator of their Medical Loss Ratio (MLR)**
- A PHP that voluntarily contributes at least one-tenth percent (0.1%) of its annual capitation revenue in a region to health-related resources may be awarded a **preference in auto-assignment** to promote enrollment in each region in which the PHP contributes

Integration with Department Partners

PHPs will work with county agencies, public health, mental health, and education programs, and county- and community-based organizations to connect members to health-related resources.

Integration with Department Partners

- Have a strong understanding of North Carolina's local communities and engage with county agencies (e.g. **local health departments, local Department of Social Services, Area Agencies on Aging, Local Education Agencies, housing authorities, county commissioners**, etc.) and county- and community-based organizations (e.g. **faith-based organizations, food pantries**) to understand the unique resource needs of each community and integrate the model of care with the local community. Establish ongoing partnerships with these entities to improve the health of members.
- Make appropriate use of State health agencies, State vocational rehabilitation agencies, and Title V grantees (**Maternal and Child Health/Crippled Children's Services**) for referrals. Make use of other public health, mental health, education programs and related programs, such as **Head Start, Title XX (Social Services)** programs, and the Special Supplemental Food Program for Women, Infants and Children (**WIC**), to ensure an effective child health program.
- Partner with other agencies and organizations to work toward the aims of the Department's public health goals and Quality Strategy. Take a population-based approach to improving the overall health of Medicaid members and work collaboratively with community partners on targeted public health initiatives (e.g. **opioid crisis, infant mortality**).
- Actively participate and support the Department's public health initiatives and coordinate with all existing public health and human services programs, including reporting, education, and care management activities. That includes coordination with the following: Women, Infants, and Children (**WIC**) Program; **Newborn screening programs; Hearing Screening Program; Vaccines for Children (VFC) Program** and **NC Immunization Registry; NCDPH Early Intervention Program**

For More Information



NC Medicaid Transformation:

<https://www.ncdhhs.gov/assistance/medicaid-transformation>

NC Medicaid Quality Improvement and Value:

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

Healthy Opportunities:

<https://www.ncdhhs.gov/about/department-initiatives/healthy-opportunities>

Contact: amanda.vanvleet@dhhs.nc.gov

Questions/Discussion

Appendices

Primary Care Provider Selection and Auto-Assignment

Under managed care, enrollees may choose their primary care provider (PCP) or they will be auto-assigned.

PCP Selection

- The enrollment broker (Maximus) will provide beneficiaries with information and assistance in selecting their PCP at the time of PHP enrollment.
- Subsequent changes to PCP assignment are managed by the beneficiary's PHP. Enrollees can change their PCP **without cause** within 30 days of notification of assignment, and up to one additional time every 12 months; enrollees may change their PCP **with cause** at any time.

PCP Auto-Assignment

- Enrollees that do not select a PCP during the plan selection period will be assigned a PCP by the PHP in which they enroll.
- All enrollees will have a 30-day "grace period" after notification of their PCP assignment to change their PCP without cause.
- PCP auto-assignment will consider:
 - Enrollee claims history
 - Family member PCP assignment
 - Geography
 - Special medical needs
 - Language/cultural preference

Provider Enrollment and Credentialing

Credentialing is a critical part of the federally regulated screening and enrollment process. A centralized approach will reduce administrative burden on providers and maximize efficiency among plans.

- Enrollment process similar to today
- Centralized credentialing and recredentialing policies uniformly applied
- Nationally recognized, third-party credentials verification organization (CVO)

Providers must be enrolled as a Medicaid or NC Health Choice provider to be paid for services to a Medicaid beneficiary*

Centralized Credentialing

APPLICATION & VERIFICATION

DHHS Process

Provider applies

PDM/CVO verifies credentials

- Application is single point-of-entry for all credentialing information
- Medicaid Managed Care and Medicaid Fee-for-Service

- PDM/CVO certified by national accrediting organization (e.g., NCQA, URAC)
- Ensures meaningful, rigorous, and fair processes

PROCUREMENT & CONTRACTING

PHP Process

PHP PNPC reviews & approves/denies

PHP and provider negotiate contract

- PHP Provider Network Participation Committee (PNPC)
- Established and maintained by PHP
- Reviews and makes objective quality determinations
- Cannot request more information for quality determinations
- Meets nationally recognized accrediting organization standards

- PHP network development staff secures contracts with providers credentialed and enrolled in Medicaid

Plan Selection and Auto-Assignment

DHHS will conduct extensive outreach to encourage beneficiary plan selection and will auto-assign those that do not choose a plan according to a transparent process.

Plan Selection

DHHS, in partnership with enrollment broker (Maximus), will provide choice counseling, enrollment assistance and education to beneficiaries. Maximus will work with county departments of social services to educate beneficiaries at local level.

Plan Auto-Assignment

The State will auto-assign all beneficiaries who do not select a plan according to the following algorithm:

- 
- Beneficiary's geographic location
 - Beneficiary's membership in a special population (e.g., member of federally recognized tribes or BH I/DD Tailored Plan eligible)
 - PCP/AMH selection upon application and PCP/AMH historic relationship
 - Plan assignments for other family members
 - Previous PHP enrollment during previous 12 months (for those who have "churned" on/off Medicaid managed care)
 - Equitable plan distribution with enrollment subject to:
 - PHP enrollment ceilings and floors, per PHP, to be used as guides
 - Increases in a PHP's base formula based on their contributions to health-related resources
 - Intermediate sanctions or other considerations defined by the Department that result in enrollment suspensions or caps on PHP enrollment

Beneficiaries have 90 days after PHP enrollment to switch PHPs "without cause." After 90 days, beneficiaries may switch PHPs at annual redetermination.*

Standardization

DHHS has worked to mitigate administrative burden for clinicians.

PHPs will be subject to requirements designed to ease clinician administrative burden, including:

- Standardizing and simplifying processes and standards across PHPs wherever appropriate
- Incorporating a centralized, streamlined enrollment and credentialing process
- Ensuring transparent payments for PHPs and fair contracting and payments for clinicians
- Standardizing quality measures across PHPs
- Using standard prior authorization forms
- Establishing a single statewide preferred drug list that all PHPs will be required to use
- Covering the same services as Medicaid Fee-for-Service (except select services carved out of managed care)
- Requiring PHPs to use DHHS' definition of "medical necessity" when making coverage decisions and set FFS benefit limits as a floor in managed care

Network Adequacy

Network adequacy standards help ensure beneficiaries have access to providers and care.

- North Carolina’s network adequacy standards vary by geographic area and include **time and distance standards*** and **appointment wait-time standards**
- PHPs are required to contract with “any willing provider” unless the provider refuses to accept the PHP’s rates or does not meet the PHP’s quality standards
- The PHP’s network must provide adequate access for all beneficiaries, including those with limited English proficiency or physical or mental disabilities

Provider Type	Urban Standard	Rural Standard
Hospitals	≥ 1 hospital within 30 minutes or 15 miles for at least 95% of members	≥ 1 hospital within 30 minutes or 30 miles for at least 95% of members
Primary Care	≥ 2 providers within 30 minutes or 10 miles for at least 95% of members	≥ 2 providers within 30 minutes or 30 miles for at least 95% of members
Specialty Care	≥ 2 providers (per specialty type) within 30 minutes or 15 miles for at least 95% of members	≥ 2 providers (per specialty type) within 60 minutes or 60 miles for at least 95% of members
Inpatient BH	≥ 1 provider of each inpatient behavioral health service within each PHP region	

*Partial list of standards listed in table; complete list can be found in PHP RFP, available at: <https://www.ncdhhs.gov/request-information>

Provider FFS Payment

**PHPs will be required to contract with “any willing qualified provider.”
PHP payment rates to most in-network providers will be subject to rate floors.**

In-Network Payment

- PHPs are required to contract with “any willing qualified provider” unless the provider refuses to accept the PHP’s rates or does not meet the PHP’s objective quality standards.
- Payment to in-network hospitals, physicians, and physician extenders must be no less than 100% of the Medicaid fee-for-service rate, unless the PHP and provider mutually agree to an alternative reimbursement arrangement.
- Special payment provisions apply to certain provider types, such as local health departments, public ambulance providers, and FQHCs; additional details will be provided in future webinars.

Out-of-Network Payment

- PHPs are prohibited from paying out-of-network providers that refused to accept a PHP contract or failed to meet objective quality standards more than 90% of the Medicaid FFS rate. This *excludes* emergency and post-stabilization services, which are to be reimbursed at no more than 100% of the Medicaid FFS rate.
- PHPs must reimburse out-of-network providers 100% of the Medicaid FFS rate if the provider was excluded for reasons other than the above.

Public Reporting of Performance

- *Accreditation Progress and Results*—DHHS will publish PHP progress toward receiving this accreditation, and will report the accreditor’s findings for each PHP during its accreditation process.
- *Annual Quality Measures at Plan Level*—DHHS will share plan-level rates for the quality measures described in Section III, to facilitate comparison among plans. Beneficiaries and the public should have access to a reliable report on how plans are performing on specific elements.
- *Health Equity Report*—DHHS will assess disparities in care and outcomes across the demographics described in section above, and publish a report summarizing areas or 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 PHP(s) with which they have contracted. The Department will publish overall satisfaction rates and other findings from this survey.
- *CAHPS Survey Results*—DHHS, in partnership with a third party, will field the CAHPS Survey to assess patient experience in receiving care. The Department will publish overall ratings of plans, overall ratings of all care received and other findings from this survey.
- *Future*-- DHHS is also considering other methods of sharing PHP performance data, including access reports and plan report cards with aggregate quality data collected from each PHP.

List of Quality Measures - Part 1/4

Measure Name	Priority Measure	AMH Measure	Interim Measure	Gap Measure
Adherence to Antipsychotic Medications for Individuals With Schizophrenia			x	X
Adult Body Mass Index (BMI) Assessment	x			X
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (the total of all ages for each of the 3 rates)	x			
Total BMI Percentile Documentation				
Total Counseling for Nutrition				
Total Counseling for Physical Activity				
Annual Dental Visits (Total Rate)				X
Dental Sealants for 6-9 Year Old Children at Elevated Carries Risk				X
Percentage of Eligibles Who Received Preventive Dental Services	x			X
Antidepressant Medication Management (Both Rates)			X	x
Acute Phase Treatment				
Continuation Phase Treatment				
Appropriate Testing for Children With Pharyngitis			x	
Appropriate Treatment for Children With Upper Respiratory Infection			x	
Medication Management for People With Asthma (Medication Compliance 75% Rate only)			x	
Asthma Medication Ratio (Total Rate)	x	x	x	x
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis			x	
Breast Cancer Screening				x
Cervical Cancer Screening	x	x		x
Childhood Immunization Status (Combination 10)	x	x		x
Chlamydia Screening in Women (Total Rate)				x
Comprehensive Diabetes Care (BP Control [$<140/90$], HbA1c Control [$<8.0\%$], Eye Exam)				x
Hemoglobin A1c (HbA1c) Testing (HA1C)				
Hemoglobin A1c (HbA1c) Poor Control ($>9.0\%$)				
Eye (Retinal) Exam			X (12 month rolling average)	
			x	
Comprehensive Diabetes Care: HbA1c poor control ($>9.0\%$).	x		X (12 month rolling average)	x

List of Quality Measures- Part 2/4

Measure Name	Priority Measure	AMH Measure	Interim Measure	Gap Measure
Statin Therapy for Patients With Diabetes (Both Rates)				x
Received Statin Therapy			X (12 month rolling average)	
Statin Adherence 80%				
Comprehensive Diabetes Care (CDC)			X (12 month rolling average)	
Controlling High Blood Pressure	x	x	x	x
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications				x
Diabetes Care for People with Serious Mental Illness:HbA1c Poor Control (>9.0%)				
Statin Therapy for Patients With Cardiovascular Disease (Both Rates)				x
Received Statin Therapy Total			x	
Statin Adherence 80% Total			X (12 month rolling average)	
Annual Monitoring for Patients on Persistent Medications				x
ACE/ARB				
Digoxin				
Diuretics				
Total Combined Rate				
Flu Vaccinations for Adults Ages 18-64				x
Follow-Up After Hospitalization for Mental Illness	x	x	x	
7- Day Follow-up				
30-Day Follow-up				
Follow-Up for Children Prescribed ADHD Medication (Both Rates)				x
Initiation Phase				
Continuation and Maintenance (C&M) Phase				
Frequency of Prenatal Care (≥81 percent of expected visits only)				
Prenatal and Postpartum Care (Both Rates)	x			
Timeliness of Prenatal Care				
Postpartum Care				x

List of Quality Measures- Part 3/4

Measure Name	Priority Measure	AMH Measure	Interim Measure	Gap Measure
Contraceptive Care: Postpartum	x			
Contraceptive Care: Most & Moderately Effective Methods	x			
Immunizations for Adolescents (Combination 2)	x	x		x
Adolescent Well-Care Visit				x
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Both Rates)	x			
Age 13-17 yrs: Initiation of AOD Treatment				
Age 13-17 yrs: Engagement of AOD Treatment				x
Age 18+ years: Initiation of AOD Treatment				
Age 18+ years: Engagement of AOD Treatment				x
Total Rate: Initiation of AOD Treatment				
Total Rate: Engagement of AOD Treatment				x
Medical Assistance With Smoking and Tobacco Use Cessation	x	x		x
Pharmacotherapy Management of COPD Exacerbation (Both Rates)				x
Systemic Corticosteroid				
Bronchodilator				
Well-Child Visits in the First 15 Months of Life				
0 Visits				
1 Visit				
2 Visits				
3 Visits				
4 Visits				
5 Visits				
6 or More Visits				
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	x	x		x
Use of opioids from multiple providers in persons without cancer				
Continuity of Pharmacotherapy for Opioid Use Disorder				
SUB-3 Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge and SUB-3a Alcohol and Other Drug Use Disorder Treatment at Discharge				

List of Quality Measures- Part 4/4

Measure Name	Priority Measure	AMH Measure	Interim Measure	Gap Measure
Children and Adolescents' Access to Primary Care Practitioners				
12 - 24 months of age				
25 months - 6 years old				
7- 11 years old				
12- 19 years old				
Live Births Weighing Less than 2,500 Grams	x			x
Use of Opioids at High Dosage in Persons Without Cancer				x
Current use of Prescription Opioids and Benzodiazepines	x			
Follow-up After ED Visit for Mental Illness or Alcohol or Other Drug Abuse				
Diabetes Care for People with Serious Mental Illness: HbA1c Poor Control (>9.0%)				
Screening for Pregnancy Risk				
Screening for Opportunities for Health				
Getting Care Quickly	x			
Getting Needed Care	x			
Coordination of Care	x			
Customer Service	x			
Rating of Health Plan				
Rating of All Health Care	x			
Rating of Personal Doctor	x			
Rating of Specialist Seen Most Often				
Overall Provider Satisfaction with PHP	x			
Use of Imaging Studies for Low Back Pain				
Total Cost of Care	x	x		
Ambulatory Care (AMB)				
Inpatient Utilization- General Hospital/Acute Care (IPU)	x			
Plan All-Cause Readmissions	x	x		
Measures of Avoidable Utilization	x	x		
<ul style="list-style-type: none"> • Emergency Department Visits • Hospitalizations • Pediatric Hospitalizations 				