Medicaid Managed Care
Proposed Concept Paper

Provider Health Plan Quality Performance and Accountability

North Carolina Department of
Health and Human Services

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Contents

This document is part of a series of concept papers that the Department of Health and Human Services scheduled for release from late 2017 through early 2018 to provide additional details to stakeholders regarding the transition of North Carolina Medicaid and NC Health Choice programs to a predominantly managed care model. This technical paper is written primarily for providers and health plans that will participate directly in Medicaid managed care, but anyone may respond and provide feedback to the Department, including beneficiaries, advocates or other interested parties. Some topics mentioned in this document may be covered in more detail in other concept papers in the series. For more information on the Department's proposal, stakeholders are encouraged to review the Amended North Carolina Section 1115 Demonstration Waiver Application and previously released concept papers available at ncdhhs.gov/nc-medicaid-transformation.

Input is welcome and appreciated. Send comments to Medicaid.Transformation@dhhs.nc.gov.

I. Introduction

The North Carolina Department of Health and Human Services (the Department) is dedicated to designing a comprehensive Medicaid managed care program that optimizes health and well-being for all North Carolinians. Central to these efforts is a commitment to the delivery of high-quality health care through the development of a data-driven, outcomes-based, continuous quality improvement process that focuses on rigorous measurement against relevant targets, and appropriately rewards PHPs and providers for advancing quality goals.

Quality Overview

As North Carolina transitions to a managed care structure for its Medicaid and NC Health Choice programs,[1] the Department seeks to advance high-value care, improve population health, engage and support providers, and establish a sustainable program with predictable costs. The Department's goal is to improve the health of North Carolinians through an innovative, whole-person centered and well-coordinated system of care, which addresses both medical and non-medical drivers of health.

While the mechanics of reimbursement for health care are changing, the goal of North Carolina Medicaid remains that of improving beneficiaries' health and well-being by delivering the right care, in the right place, at the right time. In designing this transition, the Department is committed to leveraging engagement through the managed care program with prepaid health plans (PHPs) and their contracted providers to improve the quality of health care beneficiaries receive. North Carolina identified targeted quality indicators that will serve as a "north star" for the Department, contracted plans and providers; performance against these indicators will be crucial to assess the success of its new payment approach.

In July 2019, most Medicaid beneficiaries will begin transitioning to PHPs—integrated managed care products providing physical and behavioral health services, long-term services and supports (LTSS), pharmacy and addressing health-related resource needs.[2] Working with the General Assembly, the Department has proposed to create distinct types of PHPs, which will be customized to the populations they serve:

- **Standard plans** will launch in the first year of managed care and will serve the vast majority of Medicaid beneficiaries.
- **Behavioral health and intellectual and developmental disability tailored plans (BH I/DD TPs)** will launch in the third year of managed care and focus on the specialized needs of individuals with behavioral health disorders such as severe persistent mental illness, severe emotional disturbance or substance use disorder, intellectual and developmental disabilities, and traumatic brain injury (TBI).[3,4]

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[1] For purposes of this concept paper, the term "Medicaid" refers to North Carolina Medicaid and NC Health Choice programs, unless specifically described otherwise.

[2] Subject to appropriate legislative authority from the North Carolina General Assembly.

[3] North Carolina is seeking legislative approval to incorporate behavioral health benefits into standard plans and to create BH I/DD TPs.

[4] As of March 9, 2018, the proposed target population for initial enrollment in BH I/DD TPs includes individuals with a qualifying I/DD diagnosis, including those enrolled in or on the waiting list for the Innovations waiver; individuals enrolled in the TBI waiver who are on the waiting list for the TBI waiver or have used a state-funded TBI service; individuals enrolled in the Transition to Community Living Initiative; individuals with a serious mental illness or serious emotional disturbance diagnosis who have used a Medicaid-covered enhanced behavioral health service or a state-funded behavioral health service within the past year; and individuals with a qualifying substance use

Over a five-year period, the majority of North Carolina Medicaid beneficiaries will phase into managed care, with the largest portion enrolling in Year 1 (July 2019–June 2020). Appendix B displays the populations that will phase into managed care by year of implementation.

North Carolina begins the Medicaid managed care transition with a history of commitment to measuring quality and improving health outcomes. As North Carolina transitions to managed care, the Department will work with PHPs and providers to develop a data-driven, outcomes-based, continuous quality improvement process that will build on this history and focus on rigorous outcome measurement against relevant targets and benchmarks, promote equity through reduction or elimination of health disparities, and appropriately reward PHPs and, in turn, providers for advancing quality goals and health outcomes.

Consistent with the Department's commitment to transparency throughout the managed care planning, design and implementation process, the Department is releasing this concept paper to provide information about how PHPs will be held accountable for achieving high quality outcomes. This paper aims to articulate the specific strategies – or "levers" – that the Department will deploy to ensure PHPs are focused on achieving quality, and align PHPs and providers to advance quality at the practice level. Accompanying this paper is a draft of "North Carolina's Medicaid Managed Care Quality Strategy," which provides an overview of the Department's Quality Framework and specific quality priorities, and further details how the Department will set standards for access, plan structure and operations to ensure the quality priorities are addressed. **This concept paper and the draft Quality Strategy focus exclusively on the quality accountability structure for standard plans.** Unique Quality Measures and considerations for BH I/DD TPs will be addressed in subsequent amendments to the Quality Strategy.

The Department welcomes feedback on this concept paper as it continues to refine the approach to ensuring PHPs are held accountable for advancing quality in the Medicaid program.

Vision for Advancing Quality through PHPs

As noted in the draft Quality Strategy, the Department seeks to develop a data-driven, outcomes-based continuous quality improvement process that rewards PHPs for advancing quality outcomes in targeted areas that support three central Aims: 1) Better Care Delivery; 2) Healthier People, Healthier Communities; and 3) Smarter Spending. Goals and Objectives are tied to each of these Aims, along with a series of interventions, including advanced medical homes (AMHs) and a social determinants of health strategy, outlined in more detail in previous papers and specifically designed to improve quality outcomes in North Carolina.

This concept paper describes the specific levers and mechanisms that will be used to hold PHPs and providers accountable for improving quality outcomes in a standard plan. The Department is committed to rewarding PHPs that accurately report and demonstrate meaningful improvement against specified quality targets. Working with PHPs, the Department will collect a robust set of quality data, which will paint a clear picture of service delivery and clinical care at a statewide and, eventually, a regional level, and across demographic measures, such

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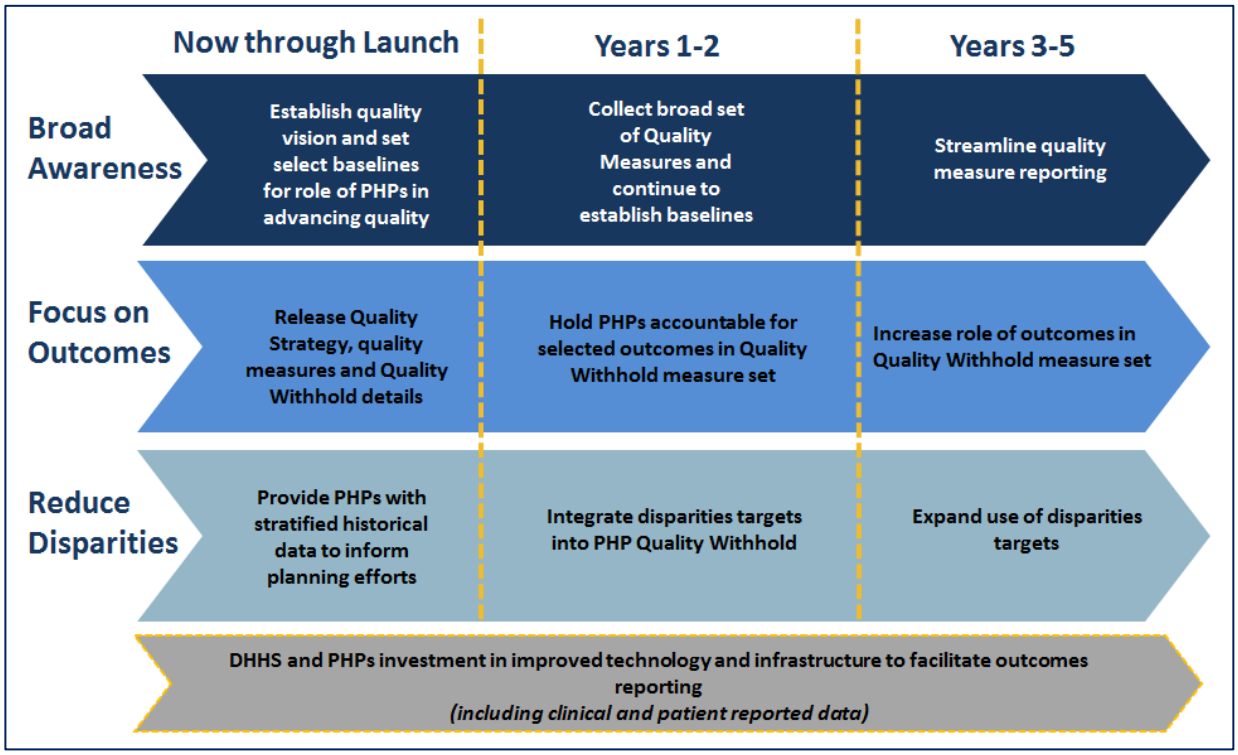
disorder diagnosis who have used a Medicaid-covered enhanced behavioral health service or state-funded behavioral health service within the past year. Other individuals with a TBI, serious mental illness, serious emotional disturbance or substance use disorder may also be eligible to enroll in a BH I/DD TP. For additional details on BH I/DD TPs, please see the BH I/DD TP concept paper.

as race and ethnicity. The Department will require PHPs to quickly establish working relationships with providers and other community stakeholders to support plan-level financial accountability for Quality Measures, including selected clinical outcomes in Year 1. Later years will build on these relationships to attain increasingly ambitious quality performance targets focused on priority outcomes specified by the Department (figure 1.1). The Department will also collect and report on select public health measures to link PHP quality improvement efforts to larger state public health initiatives and goals.

The Department will support this vision through investments in quality performance initiatives and advancement of required infrastructure. In turn, the Department expects PHPs to invest in establishing the infrastructure required to measure quality performance, embed continuous quality improvement efforts to improve outcomes, and possess the capabilities to execute successful strategies to reduce and eliminate health disparities.

Figure 1.1: The Quality Vision Over Time



Over time, PHPs should plan for an increasing proportion of provider contracts to be in advanced payment models that may require alternative approaches to contracting, data sharing, and provider and beneficiary engagement. These contracts will drive accountability, over time, for outcomes not just at a state-benchmarking level, but at a regional level and extending across populations.

Levers for Quality Improvement

The Department will use a variety of tools to ensure PHPs move towards plan-level accountability for health outcomes, and will offer resources to support PHPs and providers in their quality improvement efforts. Most directly, the Department will set goals for PHP quality improvement efforts through the establishment of **quality measure sets**, which PHPs will be required to report, and calculation of baselines, targets and benchmarks for

these measures. These requirements are likely to be a major focus of PHP efforts, and (through the **quality withhold program**, described in greater detail in Section II) will give PHPs direct financial accountability for a subset of overall quality performance improvement and reduction or elimination of disparities.

Additional levers include the following:

- The Department has established requirements for PHP deployment of V**alue-based Payments (VBP),** and **Provider Incentive Programs** as tools to incentivize quality improvement among contracting providers.
- The Department expects PHPs will work with their contracting providers to improve quality through PHP **Performance Incentive Projects**, for which the Department will provide broad guidelines. PHPs will submit an annual **Quality Assessment and Performance Improvement (QAPI) plan,** delineating their plans for Performance Incentive Projects and other quality improvement efforts.
- The Department expects PHPs will engage with external entities to improve quality, including an **Accrediting** body that will assess quality improvement efforts and offer additional guidance and an **External Quality Review Organization (EQRO)** that will validate quality performance and provide feedback to PHPs, including a separate report on health disparities.
- The Department expects PHPs, contracting providers, enrollees and other community stakeholders to share feedback on quality improvement and offer suggestions that can lead to better processes and outcomes.

Most of these levers are described in greater detail in this paper. Additional details on the EQRO and Accreditation are provided in the accompanying Quality Strategy.

II. Quality Measurement and Withholds

To ensure that all North Carolina Medicaid managed care beneficiaries receive high-quality care, PHPs will be expected to report, and be held accountable for performance against, measures aligned to a range of specific Goals and Objectives used to drive quality improvement and operational excellence. The Department's use of specific quality levers to advance toward these Goals and Objectives will evolve, as PHPs' and providers' infrastructure and experience increase, with greater rewards for excellence and more significant penalties for poor performance. The Department recognizes that PHPs will need to invest substantial resources to meet quality reporting requirements, and believes this investment is essential to ensuring the provision of high-quality care. The Department intends to invest in improved technology and infrastructure to support PHP reporting and will streamline reporting requirements when feasible, based on the results of reporting in early years.

Quality Measure Reporting

PHPs must report a set of 64 quality and administrative measures ("**Quality Measures**") that are meant to provide the Department with a complete picture of the PHPs' processes and performance. These measures include a

select set of adult and child core measures,[5] measures required for accreditation, and a select set of additional measures, including administrative measures aligned with key Department interventions. A draft of these quality measures is shown in Appendix A.

A subset of these 64 measures that most closely aligned to the Quality Strategy are designated as "Priority Measures." Priority measures serve as a basis for several specific initiatives under the Quality Strategy, including Provider Incentive Programs (Section III), PHP performance improvement projects (Section IV), and for the quality withhold program (discussed next). These measures may change from year to year as the Department considers PHP performance on the larger measure set. The Department will report publicly on all Priority Measures and may, at its discretion, also report against all Quality Measures.

To provide a clear picture of health disparities and a foundation for additional granularity for measure reporting and targets, PHPs will be required to report against a set of stratification criteria that may include, but are not limited to, race and ethnicity, region (rural vs. urban), eligibility category, and age and gender where appropriate and feasible for many of the Quality Measures. The specific measures that will require stratified reporting include, but are not limited to, all Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures, and all Withhold Measures.

QUALITY STRATEGY

In addition to this paper, the Department has released a Quality Strategy for assessing and improving the quality of health care and services delivered by PHPs. North Carolina's Quality Strategy is built around the desire to build an innovative, whole-person, well-coordinated system of care that addresses both medical and non-medical drivers of health and promotes health equity. This vision is distilled into three central aims:

1) Better care delivery

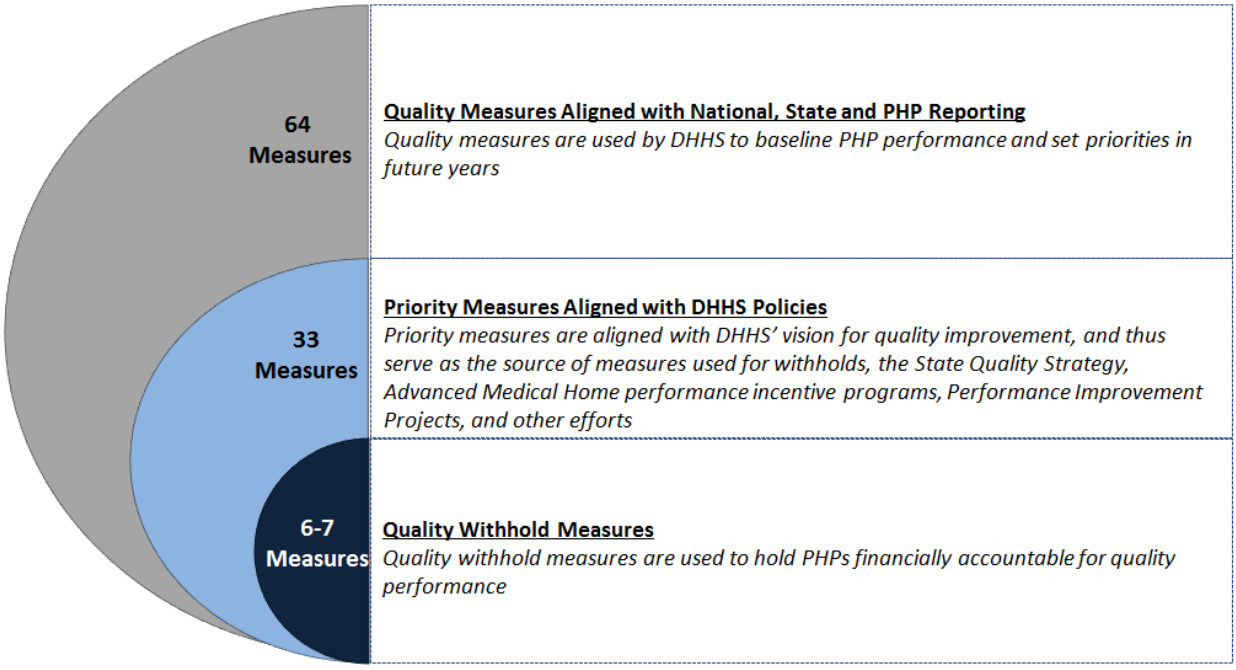
2) Healthier people, healthier communities

3) Smarter spending

Included within each of these three aims is a series of goals and objectives, intended to highlight key areas of expected progress and quality focus. Together, these aims, goals and objectives create a framework through which North Carolina defines and drives the overall vision for advancing the quality of care provided to Medicaid beneficiaries. See the draft Quality Strategy for additional detail.

[5] Adult and Child core measures are a standardized set of health Quality Measures for Medicaid enrollees that are identified and published by the Secretary of Health and Human Services as a requirement of the Affordable Care Act (Section 1139B).

Figure 2.1: Quality Measure Reporting Framework



In addition to the measure sets above, the Department will provide a select set of public health population-level measures, such as measures related to infant and maternal mortality, that are intended to inform PHPs about regional trends and link PHP performance improvement efforts with larger public health goals. Additional details for how PHPs will be engaged in public health efforts is in Section IV.

QUALITY MEASUREMENT TERMINOLOGY

- **Baseline:** Historic performance on a measure
- **Benchmark:** Optimal performance on a measure
- **Target:** Performance level required for a PHP to receive some or all quality withhold funds

PHPs will be given historical **baselines**, calculated by the Department, for all measures for which comparable historical data are available at the state level. The Department will also calculate **benchmarks**, representing *optimal performance levels*, for all Priority Measures. For Withhold Measures, the Department will also calculate **targets**, representing *the level PHPs much achieve to receive some or all of their quality withhold* amount. In the first year, all PHPs will be held to a single attainment target, which will be set as a percentile of national performance but informed by historic state-level performance on the measure. In subsequent years, PHPs may receive individualized baselines for gap-to-goal quality measurement. In gap-to-goal measurement, PHPs are scored based on the degree to which they have closed the gap between their historical baseline and a predetermined target by improving their performance. While PHPs will not receive separate targets for different population subgroups for all measures, they may receive additional credit on selected measures for reducing disparities between those groups.

PHPs will be responsible for collecting and reporting on many of the 64 Quality Measures. The EQRO will be tasked with conducting the CAHPS survey and a few measures will be reported at the PHP level by the

Department. All measures except "Controlling High Blood Pressure[6]" rely solely on encounter, survey or administrative data available at the PHP level.

All reported measures will be collected annually and validated by the EQRO. The EQRO will also be responsible for developing public facing reports that assess PHP performance against the Quality Measures and a disparities report which will also report PHPs performance against select, stratified measures.

OVERVIEW OF WITHHOLD PROGRAM

"Withholds" refer to a federally authorized option to withhold a share of a PHP's capitation payment contingent on achieving specific program goals. The Department is implementing withholds related to quality performance and other Department priorities. These withholds are:

- Intended to incent PHP behavior beyond basic program requirements and against specific performance goals;
- Compliant with all federal requirements related to rate-setting and actuarial soundness, including that withholds must be "reasonably achievable"; and
- Budget neutral to the Department. In Year 1, each PHP will be able to earn back its withhold based on its performance against each program element.

Quality Withholds Measures

As noted above and in the Quality Strategy, the Department will utilize a withhold program to reward PHPs for efforts in a range of areas, not only for quality improvement but also operational effectiveness, advancement of initiatives around addressing unmet resource needs, telemedicine and accreditation, and AMH Tier 3 contracting goals. The quality-related component of the withhold program is discussed within this paper; it will account for at least 30% of the total withhold in year 1 and at least 60% in subsequent years.

Withhold measures will be selected annually from the Priority Measures set. PHPs will report stratified withhold measure performance data for a range of population subgroups to ensure equity in performance improvement. The Withhold Measures being considered for Year 1 are included in Figure 2.2 below. The Department expects to narrow this list to a core group of six or seven Withhold Measures for use in the first year of contracting.

Figure 2.2 Proposed Year 1 Quality Withhold Measures

MEASURE
Prenatal and Postpartum Care (Both Rates)
Cervical Cancer Screening
Live Births Weighing Less than 2,500 Grams
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life
Asthma Medication Ratio (Total Rate)
Medical Assistance with Smoking and Tobacco Use Cessation
Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)
Follow-Up After Hospitalization for Mental Illness
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Both Rates)

[6] The Department is further considering if hypertension will stay in the measure given that it requires collection of systolic and diastolic blood pressures.

The Year 1 quality withhold measure set focuses on maternal health, childhood immunizations, and cardiovascular health and related risk factors—areas where the Department intends to further advance measurement in future years. PHPs will be assessed for overall performance on these Quality Measures, as defined by attainment against a national benchmark. Because the Department intends for PHPs to build on North Carolina providers' earlier successes in quality improvement, the Department will expect PHPs to be accountable for selected outcomes and reduction of disparities in these areas in the first year of contracting for the following Year 1 measures:

- **Intermediate outcome and outcome measures**: PHP performance will be assessed using these outcomes
    - Comprehensive Diabetes Care (HbA1c Poor Control)
    - Live Births Weighing Less than 2,500 Grams[7]
- **Promotion of equity**: PHPs will receive partial points for minimizing gaps between selected population subgroup performance
    - Prenatal and Postpartum Care

The Department aims to maintain a small withhold measure set, ensuring that each measure carries sufficient weight to influence PHP behaviors. For example, if 30% of the Year 1 withhold is devoted to quality, a quality withhold set of six measures would mean that each individual measure could account for up to 5% of the total withhold; a meaningful sum. When the quality withhold weight increases to at least 60% in Year 2, the Department may elect to increase the size of the withhold set or may maintain the current size and increase each measure's weight. The Department may also consider weighting measures, by assigning different percentages of the total withhold amount by measure, rather than assigning an equal percentage to each measure.

Year 1 Measurement Scoring Process

As noted previously, in Year 1 PHPs' performance on quality withholds will be measured based on attainment. The attainment target for a measure will generally be set as a percentile of national performance on that measure, but the target will be informed by historic state performance. As one potential example, if the average North Carolina score on a given measure in 2017 was 28%, and that performance corresponded with the 50th percentile of national performance in that year, the target for Year 1 would be set at the 50th percentile of national performance in Year 1.

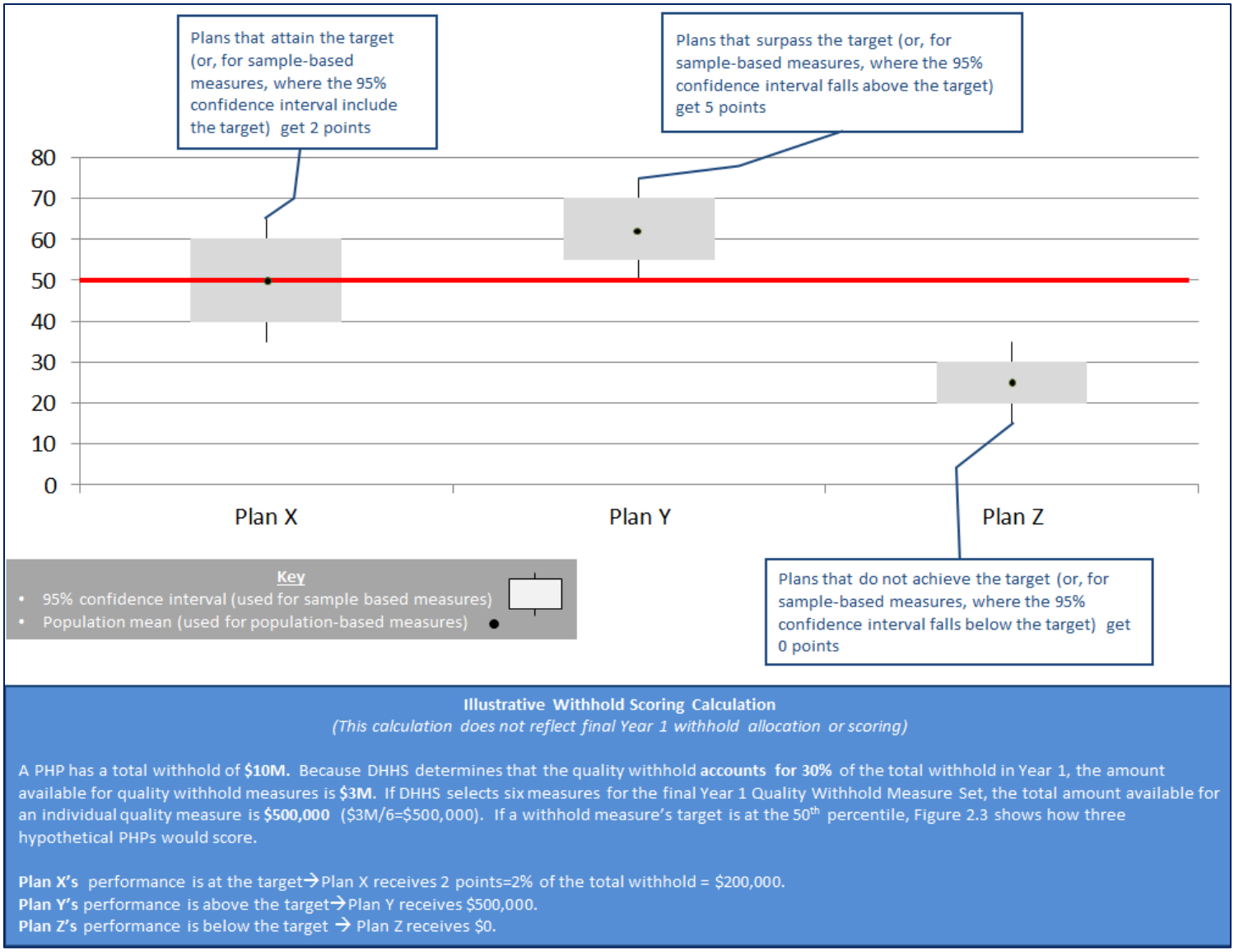
Measures will be scored against their preset targets. For measures where 95% confidence intervals for PHP performance overlap the target, the PHP will receive partial credit toward their quality withhold score. For measures where 95% confidence intervals for PHP performance lie completely above the target, the PHP will receive full credit. For measures where 95% confidence intervals for PHP performance lie completely below the target, the PHP will receive no credit. For measures that are calculated using a full population rather than a sample, population means will be used rather than confidence intervals. When possible, the Department will release targets at least 90 days before the beginning of each performance year.[8] However, when the Department

[7] This measure is currently specified for population-level reporting and will require re-specification for reporting at the PHP level. The Department expects to incorporate PHP feedback into the re-specification process.

[8] The Department will release the Year 1 Withhold Measures and targets in the fall of 2018 to provide PHPs with notice prior to managed care beginning on July 1, 2019.

shifts to an improvement-based measurement process in future years, PHPs may not receive their plan-specific baselines until several months into the performance year, because of the additional time required to receive and analyze end-of-year encounter data.

Figure 2.3 Illustrative Example of a Year 1 Withhold



Illustrative Withhold Scoring Calculation

(This calculation does not reflect final Year 1 withhold allocation or scoring)

A PHP has a total withhold of **$10M.** Because DHHS determines that the quality withhold **accounts for 30%** of the total withhold in Year 1, the amount available for quality withhold measures is **$3M.** If DHHS selects six measures for the final Year 1 Quality Withhold Measure Set, the total amount available for an individual quality measure is **$500,000** ($3M/6=$500,000). If a withhold measure's target is at the 50th percentile, Figure 2.3 shows how three hypothetical PHPs would score.

Plan X's performance is at the target→Plan X receives 2 points=2% of the total withhold = $200,000.
Plan Y's performance is above the target→Plan Y receives $500,000.
Plan Z's performance is below the target → Plan Z receives $0.

Future Uses of Quality Withholds and Overall Quality Results

As previously noted, the withhold measure set will shift toward outcome measures over time, with an increasing focus on not only improving performance under a gap-to-goal assessment approach, but also on eliminating disparities. In later years, Withhold Measures will likely involve more outcomes measures and incorporate clinical data in addition to encounter, survey and administrative data.

In future years, the Department will also implement new uses for PHPs' quality scores that go beyond calculation of quality withholds. For example, the Department will expect PHPs to further incorporate quality scores into internal continuous quality improvement and value-based purchasing efforts, described further below. The Department will also use PHP quality scores in the PHP auto-assignment algorithm, allowing PHPs with higher quality scores to disproportionally be assigned new beneficiaries. If quality performance is unacceptably low over a continued period, the Department may decline to renew or terminate a PHP contract.

III. Quality Measurement in Provider Incentives/Value-based Purchasing

To advance the Department's vision for quality and to ensure that payments to providers are increasingly focused on population health, appropriateness of care and other measures related to value, the Department is encouraging accelerated adoption of VBP arrangements between PHPs and providers, and requiring that PHPs' Provider Incentive Programs be aligned with the Quality Strategy and related measures. Use of VBP and Provider Incentive Programs will ensure that PHPs and providers are recognized and rewarded for quality gains.

Provider Incentive Programs

PHPs will be required to have performance incentive programs designed to fit within categories 2 through 4 of the Health Care Payment Learning and Action Network (HCP-LAN) framework (explained in further detail, below). Specifically, PHPs must contract with AMH Tier 3 providers and may, at their discretion, target additional providers (AMH or otherwise). Provider incentive programs must align with the Quality Strategy, must use a sub-set of the Priority Measures noted within the Quality Strategy and in Appendix A of this document, and must base rewards on practice performance against a specific threshold. The Department will review these Provider Incentive Programs, and the specific incentives that will be tied to such programs, prior to their deployment by PHPs. As noted earlier and in the "North Carolina's Care Management Strategy under Managed Care" concept paper, the Department expects to raise the bar on the types of Provider Incentive Programs that that will count toward VBP targets. For example, in the early years of managed care, a pay-for-performance model through which a provider earns additional upside bonus dollars based on quality measure performance is allowed, but over time, Provider Incentive Programs may shift to alternative payment models with shared savings based on the total cost of care for individual practices or groups of individual practices that can together meet minimum beneficiary attributions. For AMH Tier 4 practices, which formally will be officially recognized in Year 3 of managed care, payments will be based on alternative payment models within broad criteria to be set by the Department, including larger upside shared savings payments including downside risk for total cost of care with capped downside risk (similar to the Medicare Shared Savings Program's "Track 1+").

The Department will also require that PHPs pay Pregnancy Medical Home providers the current levels of PMH incentive payments through the end of the first year of managed care, which are 1) completing a standardized risk-screening tool at initial visit ($50), and 2) conducting a postpartum visit ($150).

In addition to the above incentive programs, PHPs will be allowed and encouraged to develop physician incentive plans that sit outside VBP and PMH requirements, and are aligned with the Quality Strategy. This flexibility is meant to encourage innovation between PHPs and providers. If a PHP chooses to develop an additional physician incentive plan, they will be required to submit that plan for review with the Department before use.

Value-based Payments

PHPs are required to develop and lead innovative strategies to increase the use of VBP arrangements over time. Prior to the launch of managed care and annually thereafter, PHPs will be required to submit a VBP plan that will describe their VBP strategies to the Department. PHPs will also be required to report on their use of VBP contracting arrangements each year. The VBP plan will indicate the specific programs and VBP arrangements the PHPs will implement, the specific provider incentives that will be tied to these arrangements, and the outcomes that these programs will target, which must be aligned with the Quality Strategy. Additionally, the plan must address how the PHP will incorporate addressing social determinants of health in its VBP strategy.

For the first two years of PHP operations, the Department defined VBP as payment arrangements that meet the criteria of the HCP-LAN Advanced Payment Model (APM) Categories 2 through 4.[9] Within this framework, the Department requires that by the end of Year 2 of PHP operations, the portion of each PHP's medical expenditures governed under VBP arrangements will either:

- Increase by 20 percentage points, or
- Represent at least 50% of total medical expenditures.

The Department expects to see increasing levels of APMs in Categories 3B (Downside Risk) and 4 (Full-Risk Population-based Payments). In the early years of PHP operations, and once additional information on VBP arrangements in the market is collected, the Department plans to convene stakeholders to develop a longer-term VBP roadmap, and to provide input into how to drive the market toward payment models based on higher LAN Categories. Stakeholders will also weigh in on assessing PHPs' advancements to-date and opportunities to align VBP arrangements across payers and in accordance with statewide priorities.

IV. Tactical Efforts to Advance Quality in Managed Care

In addition to the quality efforts already discussed, the Department will deploy several practical tactics to ensure PHP alignment with the Quality Strategy and to address emerging quality priorities. All items below are discussed in detail in the Quality Strategy, and are summarized here for reference.

[9] For more information on the HCP-LAN APM framework, see: https://hcp-lan.org/groups/apm-fpt-work-products/

PHP Quality Assessment and Performance Improvement Programs

The Department requires PHPs to establish and maintain an ongoing comprehensive QAPI. Each year, PHPs must submit their QAPI, which the Department reviews and approves. QAPIs must include PHP performance improvement projects (described next) and documentation of the PHP's submission of all required quality data; and descriptions of mechanisms to detect and address underutilization and overutilization of services, assess quality and appropriateness of care for beneficiaries with special health care needs and those requiring long-term services supports, remediation of critical incidents, and a process for assessing the PHP's performance, including underperformance on Quality Measures.

PHPs must include in the QAPI how PHPs will assess and address health disparities. As PHPs report against stratified Quality Measures, they will incorporate PHP-specific programs into the QAPI designed to reduce disparities and track how efforts progress, over time. Additionally, to the extent PHPs and the Department work together on targeted public health initiatives (e.g. opioid crisis, infant mortality) that involve select quality interventions, the Department will require that those interventions be embedded in the QAPIs. Additionally, PHPs will be expected to engage as active partners in Healthy NC 2020 and 2030 planning, including thorough review and discussion of PHP-level data and quality performance.

PHP Performance Improvement Projects

To improve performance, PHPs are required to conduct at least three PIPs annually, including two clinical PIPs, from among the topics of pregnancy intendedness, tobacco cessation, diabetes and behavioral health integration, and one non-clinical PIP, which must be aligned to the Aims, Goals, Objectives and interventions outlined within the Quality Strategy. In addition to the required PIPs, PHPs with low rates of Early and Periodic Screening, Diagnostic and Treatment (EPSDT) of below 75% must submit an additional PIP on EPSDT screening and community outreach plans. PIP progress must be assessed using measures drawn from the priority measure set listed in Appendix A.

V. Next Steps

The Department will continue to engage with stakeholders as it refines the Quality Strategy and works with PHPs and providers to measure and advance quality in North Carolina. Providers, PHPs, beneficiaries and advocacy groups will play an important role in this planning process to ensure a strong focus on high quality care from the start of managed care implementation.

The final list of Quality, Priority, and Withhold Measures will be released in fall 2018, along with state baselines, benchmarks and targets. The Department will also continue to develop its infrastructure for managed care and will be releasing detailed guidance on the collection and monitoring of data and specific reporting requirements in advance of the July 1, 2019, start date for managed care implementation.

Appendix A: Quality Performance Measures

#	MEASURE NAME	MEASURE DESCRIPTION	MEASURE STEWARD	PRIORITY MEASURE	WITHHOLD MEASURE
1	**Adherence to Antipsychotic Medications for Individuals with Schizophrenia** **NQF #: 1879**	The percentage of beneficiaries 19–64 years of age during the measurement year with schizophrenia who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period.	NCQA - HEDIS		
2	**Adult Body Mass Index (BMI) Assessment** **NQF #: 0023**	The percentage of beneficiaries 18–74 years of age who had an outpatient visit and whose body mass index (BMI) was documented during the measurement year or the year prior to the measurement year.	NCQA - HEDIS	X	
3	**Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (the total of all ages for each of the 3 rates)** **NQF #: 0024**	The percentage of beneficiaries 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of the following during the measurement year. • BMI percentile documentation* • Counseling for nutrition • Counseling for physical activity **Because BMI norms for youth vary with age and gender, this measure evaluates whether BMI percentile is assessed rather than an absolute BMI value.*	NCQA - HEDIS	X	
4	**Annual Dental Visits (Total Rate)** **NQF #: 1388**	The percentage of beneficiaries 2–20 years of age who had at least one dental visit during the measurement year. This measure applies only if dental care is a covered benefit in the organization's Medicaid contract.	NCQA - HEDIS		
5	**Dental Sealants for 6-9 Year Old Children at Elevated Carries Risk** **NQF #: 2508**	Percentage of beneficiaries ages 6 to 9 at elevated risk of dental caries (i.e., "moderate" or "high" risk) who received a sealant on a permanent first molar tooth within the measurement year.	ADA on behalf of the Dental Quality Alliance		

#	MEASURE NAME	MEASURE DESCRIPTION	MEASURE STEWARD	PRIORITY MEASURE	WITHHOLD MEASURE
6	**Percentage of Eligibles Who Received Preventive Dental Services** **NQF #: 1334**	Percentage of individuals ages 1 to 20 who are enrolled in Medicaid or CHIP Medicaid Expansion programs for at least 90 continuous days, are eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services, and who received at least one preventive dental service during the reporting period.	CMS (collected via CMS-416)	X	
7	**Antidepressant Medication Management (Both Rates)** **NQF #: 0105**	The percentage of beneficiaries 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression and who remained on an antidepressant medication treatment. Two rates are reported. 1. *Effective Acute Phase Treatment.* The percentage of beneficiaries who remained on an antidepressant medication for at least 84 days (12 weeks). 2. *Effective Continuation Phase Treatment.* The percentage of beneficiaries who remained on an antidepressant medication for at least 180 days (6 months).	NCQA - HEDIS		
8	**Appropriate Testing for Children with Pharyngitis** **NQF #: 0002**	The percentage of children 3–18 years of age who were diagnosed with pharyngitis, dispensed an antibiotic and received a group A streptococcus (strep) test for the episode. A higher rate represents better performance (i.e., appropriate testing).	NCQA - HEDIS		
9	**Appropriate Treatment for Children with Upper Respiratory Infection** **NQF #: 0069**	The percentage of children 3 months–18 years of age who were given a diagnosis of upper respiratory infection (URI) and were not dispensed an antibiotic prescription.	NCQA - HEDIS		
10	**Medication Management for People with Asthma (Medication Compliance 75% Rate only)** **NQF #: 1799**	The percentage of beneficiaries 5–64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period. Two rates are reported: 1. The percentage of beneficiaries who remained on an asthma controller medication for at least 50% of their treatment period. 2. The percentage of beneficiaries who remained on an asthma controller medication for at least 75% of their treatment period.	NCQA - HEDIS		

#	MEASURE NAME	MEASURE DESCRIPTION	MEASURE STEWARD	PRIORITY MEASURE	WITHHOLD MEASURE
11	**Asthma Medication Ratio (Total Rate)** **NQF #: 1800**	The percentage of beneficiaries 5–64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.	NCQA - HEDIS	X	X
12	**Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis** **NQF #: 0058**	The percentage of adults 18–64 years of age with a diagnosis of acute bronchitis who were not dispensed an antibiotic prescription.	NCQA - HEDIS		
13	**Breast Cancer Screening** **NQF #: 2372**	The percentage of women 50–74 years of age who had a mammogram to screen for breast cancer.	NCQA - HEDIS		
14	**Cervical Cancer Screening** **NQF #: 0032**	The percentage of women 21–64 years of age who were screened for cervical cancer using either of the following criteria: • Women 21–64 years of age who had cervical cytology performed every 3 years • Women 30–64 years of age who had cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years	NCQA - HEDIS	X	X
15	**Childhood Immunization Status (Combination 10)** **NQF #: 0038**	The percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and nine separate combination rates.	NCQA - HEDIS	X	
16	**Chlamydia Screening in Women (Total Rate)** **NQF #: 0033**	The percentage of women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.	NCQA - HEDIS		

#	MEASURE NAME	MEASURE DESCRIPTION	MEASURE STEWARD	PRIORITY MEASURE	WITHHOLD MEASURE
17	**Comprehensive Diabetes Care (BP Control [<140/90], HbA1c Control [<8.0%], Eye Exam)** **NQF #: 0061; 0575; 0055**	The percentage of beneficiaries 18–75 years of age with diabetes (type 1 and type 2) who had each of the following: • Hemoglobin A1c (HbA1c) testing. • HbA1c poor control (>9.0%). • HbA1c control (<8.0%). • HbA1c control (<7.0%) for a selected population* • Eye exam (retinal) performed. • Medical attention for nephropathy. • BP control (<140/90 mm Hg). * Additional exclusion criteria are required for this indicator that will result in a different eligible population from all other indicators. This indicator is only reported for the commercial and Medicaid product lines.	NCQA - HEDIS		
18	**Comprehensive Diabetes Care: HbA1c poor control (>9.0%).**[10] **NQF #: 0059**	The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) whose most recent HbA1c level during the measurement year was greater than 9.0% (poor control) or was missing a result, or if an HbA1c test was not done during the measurement year.	NCQA - HEDIS	X	X
19	**Statin Therapy for Patients with Diabetes (Both Rates)** **NQF #: 0547**	The percentage of beneficiaries 40–75 years of age during the measurement year with diabetes who do not have clinical atherosclerotic cardiovascular disease (ASCVD) who met the following criteria. Two rates are reported: 1. *Received Statin Therapy*. Beneficiaries who were dispensed at least one statin medication of any intensity during the measurement year. 2. *Statin Adherence 80%*. Beneficiaries who remained on a statin medication of any intensity for at least 80% of the treatment period.	NCQA - HEDIS		

[10] Both this measure and the Comprehensive Diabetes Care measure are included because the Department believes HbA1c: poor control (>9.0%) is more feasible for inclusion in the Quality Withhold program in the first year. In future years, HbA1c: poor control (>9.0%) may be removed.

#	MEASURE NAME	MEASURE DESCRIPTION	MEASURE STEWARD	PRIORITY MEASURE	WITHHOLD MEASURE
20	**Comprehensive Diabetes Care (CDC)** **NQF #: 0731**	The focus is on the percentage of beneficiaries 18-75 years of age with a diagnosis of Diabetes (Type 1 and Type 2) who had each of the following during the measurement year, as identified by claim/encounter or automated laboratory data. Hemoglobin A1c (HbA1c) testing in the current measurement year, HbA1c poor control (>9.0%), HbA1c control, Eye exam (retinal) performed, Medical attention for Nephropathy, B/P control (<140/90 mm Hg.)	NCQA - HEDIS		
22	**Controlling High Blood Pressure** **NQF #:0018**	The percentage of beneficiaries 18–85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled during the measurement year based on the following criteria: • Beneficiaries 18–59 years of age whose BP was <140/90 mm Hg • Beneficiaries 60–85 years of age with a diagnosis of diabetes whose BP was <140/90 mm Hg • Beneficiaries 60–85 years of age without a diagnosis of diabetes whose BP was <150/90 mm Hg *Note: Use the Hybrid Method for this measure. A single rate is reported and is the sum of all three groups.*	NCQA - HEDIS	X	
23	**Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications** **NQF #: 1932**	The percentage of beneficiaries 18–64 years of age with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.	NCQA - HEDIS		

#	MEASURE NAME	MEASURE DESCRIPTION	MEASURE STEWARD	PRIORITY MEASURE	WITHHOLD MEASURE
24	**Statin Therapy for Patients with Cardiovascular Disease (Both Rates)** **NQF #: 0543—adherence**	The percentage of males 21–75 years of age and females 40–75 years of age during the measurement year, who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and met the following criteria. The following rates are reported: 1. *Received Statin Therapy*. Beneficiaries who were dispensed at least one high-intensity or moderate-intensity statin medication during the measurement year. 2. *Statin Adherence 80%*. Beneficiaries who remained on a high-intensity or moderate-intensity statin medication for at least 80% of the treatment period.	NCQA - HEDIS		
25	**Annual Monitoring for Patients on Persistent Medications** **NQF #: 2371**	This measure assesses the percentage of patients 18 years of age and older who received a least 180 treatment days of ambulatory medication therapy for a select therapeutic agent during the measurement year and at least one therapeutic monitoring event for the therapeutic agent in the measurement year. Report the following three rates and a total rate: 1. Annual Monitoring for patients on angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB): At least one serum potassium and a serum creatinine therapeutic monitoring test in the measurement year. 2. Annual monitoring for patients on digoxin: At least one serum potassium, one serum creatinine and a serum digoxin therapeutic monitoring test in the measurement year. 3. Annual monitoring for patients on diuretics: At least one serum potassium and a serum creatinine therapeutic monitoring test in the measurement year. Total rate. (the sum of the three numerators divided by the sum of the three denominators)	NCQA-HEDIS		
26	**Flu Vaccinations for Adults Ages 18-64** **NQF #: 0039**	The percentage of beneficiaries 18–64 years of age who received a flu vaccination between July 1 of the measurement year and the date when the CAHPS 5.0H Adult Survey was completed.	AHRQ (CAHPS Health Plan Survey 5.0H, Adult Version)		

#	MEASURE NAME	MEASURE DESCRIPTION	MEASURE STEWARD	PRIORITY MEASURE	WITHHOLD MEASURE
27	**Follow-Up After Hospitalization for Mental Illness** **NQF #: 0576**	The percentage of discharges for beneficiaries 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had a follow-up visit with a mental health practitioner. Two rates are reported: 1. The percentage of discharges for which the beneficiary received follow-up within 30 days after discharge. 2. The percentage of discharges for which the beneficiary received follow-up within 7 days after discharge.	NCQA - HEDIS	X	X
28	**Follow-Up for Children Prescribed ADHD Medication (Both Rates)** **NQF #: 0108**	The percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed. Two rates are reported. 1. *Initiation Phase*. The percentage of beneficiaries 6–12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who had one follow-up visit with practitioner with prescribing authority during the 30-day Initiation Phase. 2. *Continuation and Maintenance (C&M) Phase*. The percentage of beneficiaries 6–12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.	NCQA - HEDIS		

#	MEASURE NAME	MEASURE DESCRIPTION	MEASURE STEWARD	PRIORITY MEASURE	WITHHOLD MEASURE
29	**Frequency of Prenatal Care (≥81 percent of expected visits only)** **NQF #: 1391**	The percentage of Medicaid deliveries on or between November 6 of the year prior to the measurement year and November 5 of the measurement year that had the following number of expected prenatal visits: • <21 percent of expected visits • 21 percent–40 percent of expected visits • 41 percent–60 percent of expected visits • 61 percent–80 percent of expected visits • ≥81 percent of expected visits *Note: this measure uses the same denominator as the Prenatal and Postpartum Care measure.* *Note: this measure has the same structure as measures in the Effectiveness of Care domain. The organization must follow the Guidelines for Effectiveness of Care Measures when calculating this measure.*	NCQA - HEDIS		
30	**Prenatal and Postpartum Care (Both Rates)** **NQF #: 1517**	The percentage of deliveries of live births on or between November 6 of the year prior to the measurement year and November 5 of the measurement year. For these women, the measure assesses the following facets of prenatal and postpartum care. • *Timeliness of Prenatal Care*. The percentage of deliveries that received a prenatal care visit as a beneficiary of the organization in the first trimester, on the enrollment start date or within 42 days of enrollment in the organization. • *Postpartum Care*. The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.	NCQA - HEDIS	X	X

#	MEASURE NAME	MEASURE DESCRIPTION	MEASURE STEWARD	PRIORITY MEASURE	WITHHOLD MEASURE
31	**Contraceptive Care: Postpartum** **NQF #: 2904**	Among women ages 15 through 44 who had a live birth, the percentage that is provided: 1) A most effective (i.e., sterilization, implants, intrauterine devices or systems (IUD/IUS)) or moderately (i.e., injectables, oral pills, patch, ring, or diaphragm) effective method of contraception within 3 and 60 days of delivery. 2) A long-acting reversible method of contraception (LARC) within 3 and 60 days of delivery. Two time periods are proposed (i.e., within 3 and within 60 days of delivery) because each reflects important clinical recommendations from the U.S. Centers for Disease Control and Prevention (CDC) and the American College of Obstetricians and Gynecologists (ACOG). The 60-day period reflects ACOG recommendations that women should receive contraceptive care at the 6-week postpartum visit. The 3-day period reflects CDC and ACOG recommendations that the immediate postpartum period (i.e., at delivery, while the woman is in the hospital) is a safe time to provide contraception, which may offer greater convenience to the client and avoid missed opportunities to provide contraceptive care.	US Office of Population Affairs	X	
32	**Contraceptive Care: Most & Moderately Effective Method** **NQF #: 2903**	The percentage of women aged 15-44 years at risk of unintended pregnancy that is provided a most effective (i.e., sterilization, implants, intrauterine devices or systems (IUD/IUS)) or moderately effective (i.e., injectables, oral pills, patch, ring, or diaphragm) FDA-approved methods of contraception. The proposed measure is an intermediate outcome measure because it represents a decision that is made at the end of a clinical encounter about the type of contraceptive method a woman will use, and because of the strong association between type of contraceptive method used and risk of unintended pregnancy.	US Office of Population Affairs	X	
33	**Immunizations for Adolescents (Combination 2)** **NQF #: 1407**	The percentage of adolescents 13 years of age who had one dose of meningococcal conjugate vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday. The measure calculates a rate for each vaccine and two combination rates.	NCQA - HEDIS	X	

#	MEASURE NAME	MEASURE DESCRIPTION	MEASURE STEWARD	PRIORITY MEASURE	WITHHOLD MEASURE
34	**Adolescent Well-Care Visit** **NQF #:**	Percentage of adolescents ages 12 to 21 who had at least one comprehensive well-care visit with a primary care practitioner (PCP) or an obstetric/gynecologic (OB/GYN) practitioner during the measurement year.	NCQA - HEDIS		
35	**Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Both Rates)** **NQF #: 0004**	The percentage of adolescent and adult beneficiaries with a new episode of alcohol or other drug (AOD) abuse or dependence who received the following. • *Initiation of AOD Treatment*. The percentage of beneficiaries who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth or medication assisted treatment (MAT) within 14 days of the diagnosis. • *Engagement of AOD Treatment*. The percentage of beneficiaries who initiated treatment and who had two or more additional AOD services or MAT within 34 days of the initiation visit.	NCQA - HEDIS	X	X
36	**Medical Assistance with Smoking and Tobacco Use Cessation** **NQF #: 0027**	The following components of this measure assess different facets of providing medical assistance with smoking and tobacco use cessation: • Advising Smokers and Tobacco Users to Quit. A rolling average represents the percentage of beneficiaries 18 years of age and older who were current smokers or tobacco users and who received advice to quit during the measurement year. • Discussing Cessation Medications. A rolling average represents the percentage of beneficiaries 18 years of age and older who were current smokers or tobacco users and who discussed or were recommended cessation medications during the measurement year. • Discussing Cessation Strategies. A rolling average represents the percentage of beneficiaries 18 years of age and older who were current smokers or tobacco users and who discussed or were provided cessation methods or strategies during the measurement year.	AHRQ (CAHPS Health Plan Survey 5.0H, Adult Version)	X	X

#	MEASURE NAME	MEASURE DESCRIPTION	MEASURE STEWARD	PRIORITY MEASURE	WITHHOLD MEASURE
37	**Pharmacotherapy Management of COPD Exacerbation (Both Rates)** **NQF #: 2856**	The percentage of COPD exacerbations for beneficiaries 40 years of age and older who had an acute inpatient discharge or ED visit on or between January 1–November 30 of the measurement year and who were dispensed appropriate medications. Two rates are reported: 1. Dispensed a systemic corticosteroid (or there was evidence of an active prescription) within 14 days of the event. 2. Dispensed a bronchodilator (or there was evidence of an active prescription) within 30 days of the event.	NCQA - HEDIS		
38	**Visits in the First 15 Months of Life** **NQF #: 1392**	The percentage of children 15 months old who had the recommended number of well-child visits with a PCP during their first 15 months of life.	NCQA - HEDIS		
39	**Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life** **NQF #: 1516**	The percentage of children 3-6 years of age who had one or more well-child visits with a PCP during the measurement year.	NCQA - HEDIS	X	X
40	**Children and Adolescents' Access to Primary Care Practitioners**	Percentage of children and adolescents ages 12 months to 19 years who had a visit with a primary care practitioner (PCP). Four separate percentages are reported: •Children ages 12 to 24 months and 25 months to 6 years who had a visit with a PCP during the measurement year •Children ages 7 to 11 years and adolescents 12 to 19 years who had a visit with a PCP during the measurement year or the year prior to the measurement year	NCQA - HEDIS		
41	**Live Births Weighing Less than 2,500 Grams** **NQF #: 1382**	The percentage of births with birthweight <2,500 grams	CDC	X	X
42	**Use of Opioids at High Dosage in Persons Without Cancer** **NQF #: 2940**	The proportion (XX out of 1,000) of individuals without cancer receiving prescriptions for opioids with a daily dosage greater than 120mg morphine equivalent dose (MED) for 90 consecutive days or longer.	PQA		

#	MEASURE NAME	MEASURE DESCRIPTION	MEASURE STEWARD	PRIORITY MEASURE	WITHHOLD MEASURE
43	**Concurrent use of Prescription Opioids and Benzodiazepines**	This measure examines the percentage of individuals 18 years and older with concurrent use of prescription opioids and benzodiazepines. The denominator includes individuals 18 years and older by the first day of the measurement year with 2 or more prescription claims for opioids filled on 2 or more separate days, for which the sum of the days' supply is 15 or more days during the measurement period. Patients in hospice care and those with a cancer diagnosis are excluded. The numerator includes individuals from the denominator with 2 or more prescription claims for benzodiazepines filled on 2 or more separate days, and concurrent use of opioids and benzodiazepines for 30 or more cumulative days.	PQA	X	
44	**Getting Care Quickly** **NQF #: 0006**	The survey asks beneficiaries how often they got care as soon as needed when sick or injured and got non-urgent appointments as soon as needed and allows the following response options: never; sometimes; usually; or always. • Q4: Respondent got care for illness/injury as soon as needed (or, for the Child Version: Child got care for illness/injury as soon as needed) • Q6: Respondent got non-urgent appointment as soon as needed (or, for the Child Version: Child got non-urgent appointment as soon as needed)	AHRQ (CAHPS Health Plan Survey 5.0H, Adult Version and CAHPS Health Plan Survey 5.0H, Child Version)	X	
45	**Getting Needed Care** **NQF #: 0006**	The survey asks beneficiaries how often it was easy for them to get appointments with specialists and get the care, tests, or treatment they needed through their health plan and allows the following response options: never; sometimes; usually; or always. • Q9: Easy for respondent to get necessary care, tests, or treatment (or, for the Child Version: Easy for child to get necessary care, tests, or treatment) • Q18: Respondent got appointment with specialists as soon as needed (or, for the Child Version: Respondent got child an appointment with specialists as soon as needed)	AHRQ (CAHPS Health Plan Survey 5.0H, Adult Version and CAHPS Health Plan Survey 5.0H, Child Version)	X	

#	MEASURE NAME	MEASURE DESCRIPTION	MEASURE STEWARD	PRIORITY MEASURE	WITHHOLD MEASURE
46	**Coordination of Care** **NQF #: 0009**	Parents' Experiences with Coordination of Their Child's Care • CC7: Respondent got the help needed from doctors or other health providers in contacting child's school or daycare • CC18: Someone from child's health plan, doctor's office, or clinic helped coordinate child's care among different providers or services	AHRQ (CAHPS Health Plan Survey 5.0H, Item Set for Children with Chronic Conditions)	X	
47	**Customer Service** **NQF #:0006**	The survey asks beneficiaries how often customer service staff were helpful and treated them with courtesy and respect and allows the following response options: never; sometimes; usually; or always. • Q22: Customer service gave necessary information/help (or, for the Child Version: Q25: Customer service gave necessary information/help) • Q23: Customer service was courteous and respectful (or, for the Child Version: Q26: Customer service was courteous and respectful)	AHRQ (CAHPS Health Plan Survey 5.0H, Adult Version and CAHPS Health Plan Survey 5.0H, Child Version)	X	
48	**Rating of Health Plan** **NQF #:0006**	The survey asks beneficiaries for several ratings on a scale of 0 to 10, with 0 being the worst and 10 being the best. • Q26: Rating of health plan (or, for the Child Version: Q29: Rating of health plan)	AHRQ (CAHPS Health Plan Survey 5.0H, Adult Version and CAHPS Health Plan Survey 5.0H, Child Version)		
49	**Rating of All Health Care** **NQF #:0006**	The survey asks beneficiaries for several ratings on a scale of 0 to 10, with 0 being the worst and 10 being the best. • Q8: Rating of all health care (or, for the Child Version: Q8: Rating of all health care)	AHRQ (CAHPS Health Plan Survey 5.0H, Adult Version and CAHPS Health Plan Survey 5.0H, Child Version)	X	
50	**Rating of Personal Doctor** **NQF #:0006**	The survey asks beneficiaries for several ratings on a scale of 0 to 10, with 0 being the worst and 10 being the best. • Q16: Rating of personal doctor (or, for the Child Version: Q19: Rating of Personal Doctor)	AHRQ (CAHPS Health Plan Survey 5.0H, Adult Version and CAHPS Health Plan Survey 5.0H, Child Version)	X	

#	MEASURE NAME	MEASURE DESCRIPTION	MEASURE STEWARD	PRIORITY MEASURE	WITHHOLD MEASURE
51	**Rating of Specialist Seen Most Often** **NQF #:0006**	The survey asks beneficiaries for several ratings on a scale of 0 to 10, with 0 being the worst and 10 being the best. • Q16: Rating of specialist (or, for the Child Version: Q23: Rating of specialist)	AHRQ (CAHPS Health Plan Survey 5.0H, Adult Version and CAHPS Health Plan Survey 5.0H, Child Version)		
52	**Overall Provider Satisfaction with PHP**[11]	Survey asking providers overall experience and satisfaction with PHP based on rating scale of PHP meeting the community providers' needs and expectations within the measurement period.		X	
53	**Number of Medicaid Beneficiaries Attributed to AMH, Tier 3**[12]	The number of beneficiaries attributed to an AMH		X	
54	**Percent of Beneficiaries with MH/DD/SU Visit with PCP Visit in Same Measurement Year**[13]	The percentage of beneficiaries with MH/DD/SU needs with at least one visit with their attributed AMH PCP within the same measurement period		X	
55	**Pregnancy risk screening form**[14]	The percentage of Non-Emergency deliveries with a completed standardized pregnancy risk screening within the measurement period		X	
56	**Percent of LTSS population with a health risk assessment completed within 90 days of enrollment**[15]	The percentage of beneficiaries with LTSS needs with a completed health risk assessment within 90 days of enrollment during the measurement period		X	

[11] Administrative and financial measures designed by the Department. Technical specifications currently under development.

[12] *Ibid.*

[13] *Ibid.*

[14] *Ibid.*

[15] *Ibid.*

#	MEASURE NAME	MEASURE DESCRIPTION	MEASURE STEWARD	PRIORITY MEASURE	WITHHOLD MEASURE
57	**Participants in the Demonstration who remained stable or improved in ADL function between previous and most recent assessment[16]***	The number of beneficiaries with LTSS who report improved or remained stable for # of 5 classic activities of daily living (ADL) from initial health risk assessment to identified periodic assessment period interval		X	
58	**Rate of Screening for Unmet Social Needs[17]***	The percentage of beneficiaries screened for unmet social needs from the health risk screening by the PHP within measurement period		X	
59	**Use of Imaging Studies for Low Back Pain** **NQF #:0052**	The percentage of beneficiaries with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis.	NCQA - HEDIS		
60	**Total Cost of Care[18]***	Total Medicaid spend per beneficiary per month			
61	**Ambulatory Care (AMB)**	This measure summarizes utilization of ambulatory care in the following categories: outpatient visits, ED visits. Results reported as visits per 1,000 beneficiary months	NCQA - HEDIS		
62	**Inpatient Utilization- General Hospital/Acute Care (IPU)** **NQF #: 1598**	This measure summarizes utilization of acute inpatient care and services in the following categories: total inpatient, maternity, surgery, medicine.	NCQA - HEDIS	X	

[16] Administrative and financial measures designed by the Department. Technical specifications currently under development.

[17] *Ibid.*

[18] *Ibid.*

#	MEASURE NAME	MEASURE DESCRIPTION	MEASURE STEWARD	PRIORITY MEASURE	WITHHOLD MEASURE
63	**Plan All-Cause Readmissions** **NQF #: 1768**	For beneficiaries 18 years of age and older, the number of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. Data are reported in the following categories: 1. Count of Index Hospital Stays (IHS) (denominator) 2. Count of 30-Day Readmissions (numerator) 3. Expected Readmissions Rate	NCQA - HEDIS		
64	**VBP Penetration Rate[19]***	The portion of medical expenses that are in VBP arrangements as defined by the HCP-LAN Framework, Categories 2-4		X	
65	**Select Public Health measures-- TBD BY the Department[20]**	Population Health Indicators as reported by the Division of Public Health, for attributed Medicaid beneficiaries as indicated within the measurement period including Infant Mortality (Medicaid), Health Days, Tobacco Use Rates, Overweight/Obesity Rates.			

[19] *Ibid.*

[20] Administrative and financial measures designed by the Department. Technical specifications currently under development.

Appendix B: Estimated Comprehensive Managed Care Enrollment by Cohort Based on the Department's Proposed Phase in Schedule

POPULATION COHORT WITH PROPOSED TIMING FOR COMPREHENSIVE MANAGED CARE ENROLLMENT	BENEFICIARIES BASED ON SFY 2016 HISTORICAL ENROLLMENT		
	Estimated Average Beneficiaries by Group	Estimated Average Beneficiaries by Cohort	Cohort as Percent of Total Beneficiaries
Year 1: Standard Plan - Aged, Blind, Disabled	140,000	1,525,000	73%
Year 1: Standard Plan - All Other	1,385,000		
Year 3: Tailored Plan - Non-Duals	85,000	135,000	6%
Year 3: Tailored Plan - Duals	27,000		
Year 3: Foster Children	23,000		
Year 5: Non-Dual LTSS	5,000	217,000	10%
Year 5: Full Duals (Non-TP)	212,000		
Excluded: Family Planning	103,000	208,000	10%
Excluded: Medically Needy	23,000		
Excluded: Other	82,000		
Total	**2,085,000**	**2,085,000**	**100%**

Source

Exhibit prepared Feb. 8, 2018, by the Department's Division of Health Benefits based on "Population Profiles," released Nov. 9, 2017, and available on the Medicaid website at ncdhhs.gov/medicaid-transformation.

Notes

- Estimates are based on SFY 2016 historical experience and do not include projected enrollment growth.
- Timing for managed care enrollment is proposed and subject to change.
- Tailored plan population estimates are subject to change based on legislation and data availability.
- "Non-dual LTSS" includes CAP/C, CAP/DA and individuals with a nursing facility stay of 90 days or more.
- "Excluded: Other" is primarily comprised of partial dual eligible beneficiaries.
- See source documentation for calculation methodology, assumptions and limitations.