Centers for Medicare & Medicaid Services
Medicaid & CHIP
Maternal & Infant Health
Quality Improvement

Infant Well-Child Visit Learning Collaborative

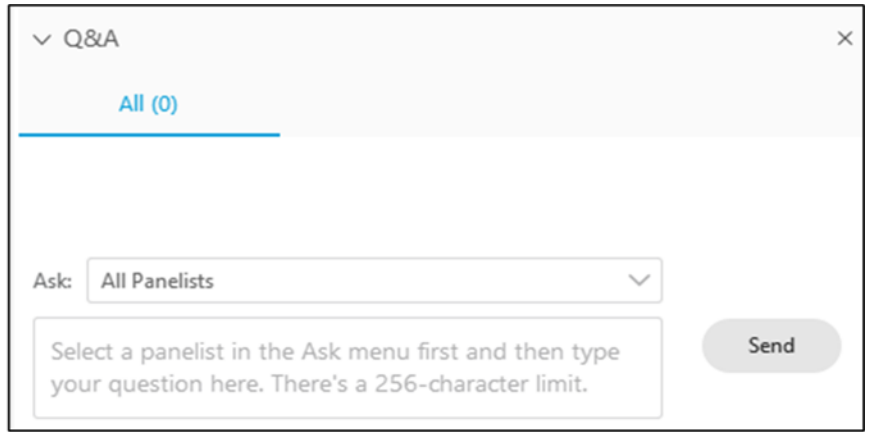
Webinar 3: Models of Care that Drive Improvement in Infant Well-Child Visits

September 22, 2021

Jodi Anthony and Alyssa Bosold, Mathematica
Kristen Zycherman, Center for Medicare and Medicaid Services
Lisa Bui, Oregon Health Authority
Tom Curtis, Michigan Department of Health and Human Services
Jaimica Wilkins, North Carolina Department of Health and Human Services

How to Submit a Question

- **Use the Q&A function to submit questions or comments.**
  - To submit a question or comment, click the Q&A window and select “All Panelists” in the “Ask” menu
  - Type your question in the text box and click “Send”
  - Only the presentation team will be able to see your questions and comments
- **For technical questions, select “Host” in the “Ask” menu**



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Webinar Slides and Recordings

The slides and recording from today and all Infant Well-Child Visit Learning Collaborative webinars, are available at:

https://www.medicaid.gov/medicaid/quality-of-care/improvement-initiatives/well-child-care/index.html

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Agenda

Topic	Speaker(s)
Housekeeping and Agenda	Alyssa Bosold, Mathematica
Welcome and Objectives	Kristen Zycherman, CMS
Cross Sectional Initiatives for Infant and Child health	Lisa Bui, Quality Improvement Director, Oregon Health Authority
Michigan Medicaid Managed Care: Looking at Well-Child Visits	Tom Curtis, MPA, Departmental Specialist, Office of Health Policy and Innovation, Michigan Department of Health and Human Services
Keeping Kids Well: North Carolina Medicaid Initiative to Improve Routine Childhood Vaccines during the Pandemic	Jaimica Wilkins, MBA, CPHQ, ICP, Deputy Director of Quality and Population Health, Division of Health Benefits, NC Department of Health and Human Services
Questions and Discussion	Jodi Anthony, Mathematica
Announcements and Next Steps	Alyssa Bosold, Mathematica

Welcome

Kristen Zycherman, CMS

Objectives

- Consider collaborative partnerships to increase the use and quality of well-child visits
- Learn about models of care that state Medicaid agencies support and monitor
- Understand the adoption of these models in varying service delivery settings
- Identify methods for improving health equity

Cross Sectional Initiatives for Infant and Child Health

Lisa Bui
Quality Improvement Director
Oregon Health Authority

September 22, 2021


THINKER
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IDEAOMETER

Partnerships Needed

Policy Levers

Policy	• Trauma Informed Care requirements • Universally offered Home Visiting (UoHV) initiative
Measurement	• Kindergarten readiness measures • CMS child core • Oregon “home grown” child measures
Quality Improvement	• Oregon Integrated Care for Kids Model (InCK) • Performance Improvement Projects

Trauma Informed Care

Requirements in CCO contracts:

- Intensive Care Coordination requirements
- Delivery System Network reporting
- Community Health Improvement Plans (CHIP)
- Health Equity Plan
- Behavioral Health – provider requirements
    - "Training requirements: Contractor shall ensure Contractor's employees, Subcontractors, and Providers are trained in integration, and Foundations of Trauma Informed Care (https://traumainformedoregon.org/tic-intro-training-modules/) and provide regular, periodic oversight and technical assistance on these topics to Providers."

Universally offered Home Visiting Initiative: Family Connects Oregon

What is it?

An initiative to strengthen families by offering a voluntary home visit by a nurse shortly after the birth of every child.

Why?

The birth of a child is a big change for any family, and most families welcome and need support of some kind, whether that is an answer to a question about breastfeeding or getting connected to a local community resource.

SB 526 and Policy Option Package (POP) 401 were passed in the 2019 Legislative Session, establishing the Universally offered Home Visiting (UoHV) initiative and providing funding for OHA's budget.

Family Connects Oregon

- **Create and strengthen community level systems of care** for families of newborns
- **Offer support** to all new parents in Oregon (regardless of risk and insurance status)
- **Increase access** to community services and supports
- **Promote collaboration and coordination** across Oregon's early childhood and home visiting systems
- **Improve health outcomes** for families across the life-course

Family Connects Oregon

FOR ALL

Helping all families regardless of income or background

THREE WEEKS

Visits are scheduled around 3 weeks after a baby's birth

NO COST TO RECIPIENTS

As an eligible recipient, you will not be charged

REGISTERED NURSE

All visits are made by highly trained nurses

Common Referral Examples by Matrix Factor

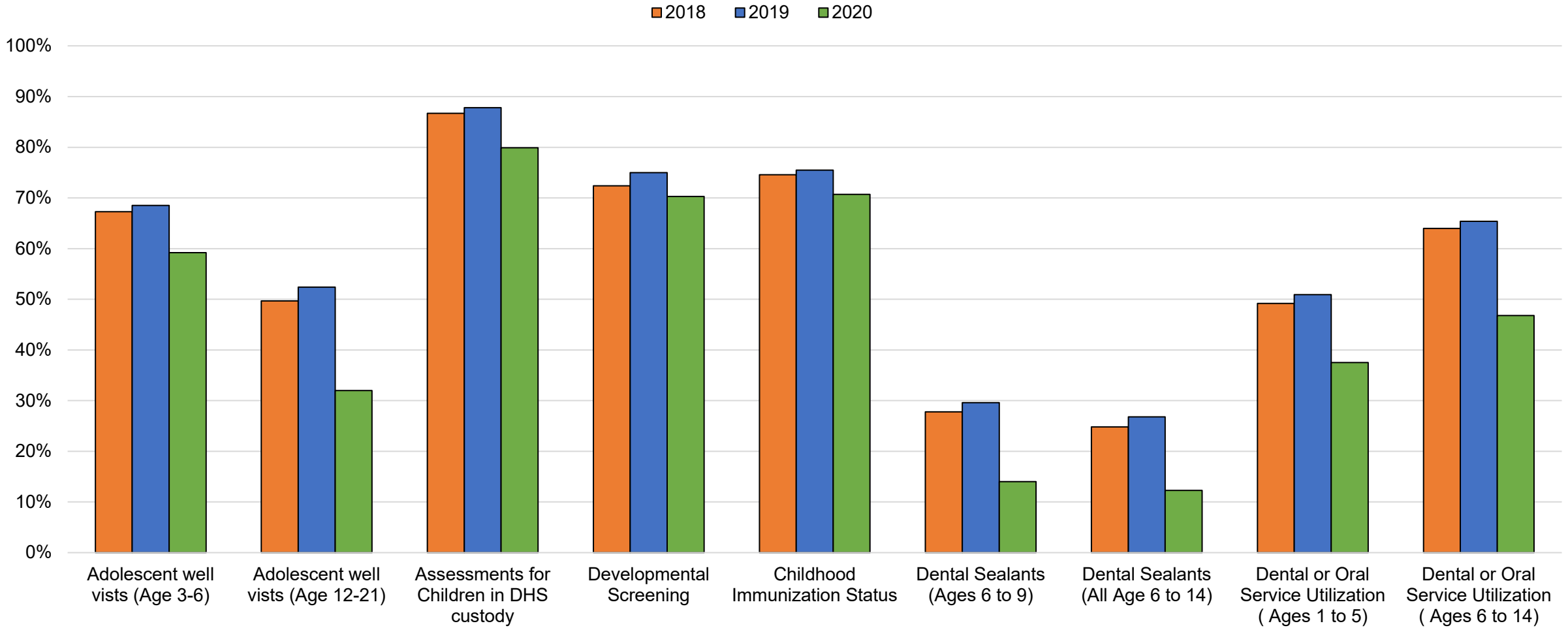
Matrix Domain	Matrix Factor	Referral Example
Support for Health Care	1. Maternal Health 2. Infant Health 3. Health Care Plans	OB/Primary Care Provider Pediatrician Health plan enrollment
Support for Infant Care	4. Child Care Plans 5. Parent-Child Relationship 6. Management of Infant Crying	Child Care Referral Agency Early Head Start, Healthy Families PURPLE Crying education
Support for a Safe Home	7. Household Safety/Material Supports 8. Family and Community Safety 9. History with Parenting Difficulties	Housing Authority Social Worker, DV Shelter Parent Child Interaction Therapy
Support for Parent(s)	10. Parent Well-Being 11. Substance Use in Household 12. Parent Emotional Support	Mental Health Services Substance Use Counseling Parent Support Groups

UoHV Initiative Early Adopter Cohort Communities

CY2021

2022 Incentive Measures for Infant and Child Health

Measure	NQF#	Measure Description
Childhood Immunization Status (Combo 3)	0038	% of children that turned 2 years old during the measurement year and had the Dtap, IPV, MMR, HiB, HepB, VZV, and PCV vaccines by their second birthday.
Immunizations for Adolescents (Combo 2)	1407	% of adolescents that turned 13 years old during the measurement year and had the meningococcal, Tdap, and HPV vaccines by their 13th birthday.
Prenatal & Postpartum Care - Postpartum Care	1517	% of deliveries of live births between October 8 of the year prior to the measurement year and October 7 of the measurement year that had a postpartum visit on or between 7 and 8 days after delivery.
Health Aspects of Kindergarten Readiness: CCO System Level Social-Emotional Health	n/a	This measure promotes improvements to social-emotional health service capacity and access for children birth to age 5. Two parts: (1) CCO attestation to system-level activities (Years 1-3) and, (2) Quantitative child-level social-emotional health reach metric data, assessing reach of social-emotional health assessments and services for children ages 1 to 5 (Year 4).
Preventive Dental or Oral Health Services, ages 1-5 (kindergarten readiness) and 6-14	n/a	Percentage of enrolled children ages 1-5 (kindergarten readiness) and 6-14 who received a preventive dental or oral health service during the measurement year
Mental and Physical Health and Oral Health Assessment Within 60 Days for Children in DHS Custody	n/a	Percentage of children ages 0-17 who received a physical health assessment, children ages 1-17 who received a dental health assessment, and children ages 4-17 who received a mental health assessment within 60 days of the state notifying CCOs that the children were placed into custody with the Department of Human Services (foster care).



Performance on Child Measures

Quality Improvement:
Oregon Integrated Care for Kids Model (InCK)

Oregon's InCK model builds on CCO 2.0 goals, regional partnerships and existing infrastructure.

- **Improve health outcomes** of children and youth age 0-21
- **Reduce out of home placements** (e.g., foster care, juvenile justice, residential behavior health)
- **Reduce costs** associated with unnecessary emergency department visits and inpatient stays

Oregon Integrated Care for Kids (InCK)

Oregon Pediatric Improvement Partnership is lead organization.

Resources:

Summary

Visual

Goals:

- Early identification of children and youth
- Integrated care coordination and case management
- Health information exchange
- Development and implementation of alternative payment models (APMs)

Target Population

All Medicaid and CHIP beneficiaries from **birth to age 21** in Crook, Deschutes, Jefferson, Marion and Polk Counties

Resources

- Lisa Bui, OHA Quality Improvement Director, lisa.t.bui@dhsoha.state.or.us
- Web resources:
  - 2021 CCO Contract Example
  - Home Visiting (UoHV) Initiative: Family Connect Oregon
  - Oregon's CCO Metrics
  - Oregon Integrated Care for Kids (InCK)
    - OHA
    - Oregon Pediatric Improvement Partnership (OPIP)
  - Performance Improvement Projects

Oregon Health Authority

Michigan Medicaid Managed Care:

Looking at Well-Child

Tom Curtis, Manager

Quality Improvement and Program Development

MDHHS
Michigan Department of Health & Human Services

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Overview

- 2.3 million people on Medicaid Statewide (1.8 million are in Managed Care)
- 600,000 in Managed Care are part of Medicaid expansion
- 10 Medicaid Health Plans
- Region 1 has only one MHP; Region 10 has 8 MHPs
- Majority of Medicaid beneficiaries are children, parents of young children, and pregnant moms
- All plans have identical contract requirements

MICHIGAN'S PROSPERITY REGIONS

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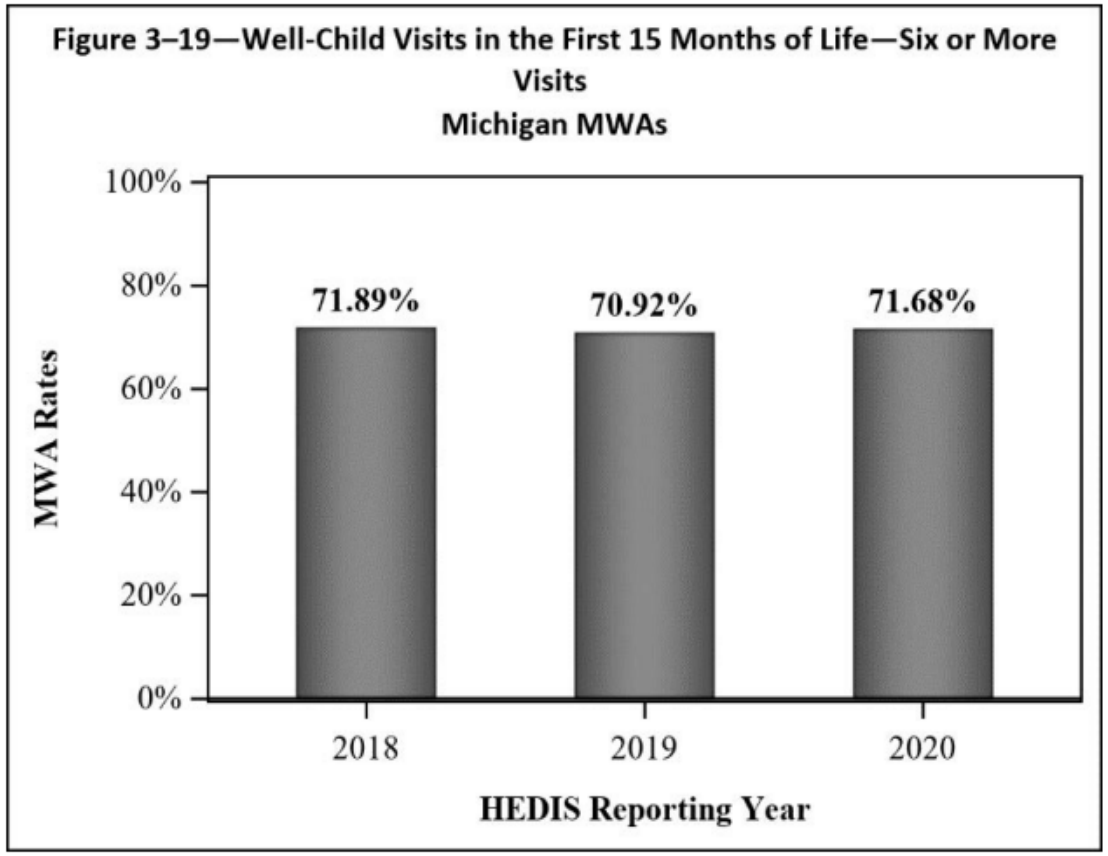
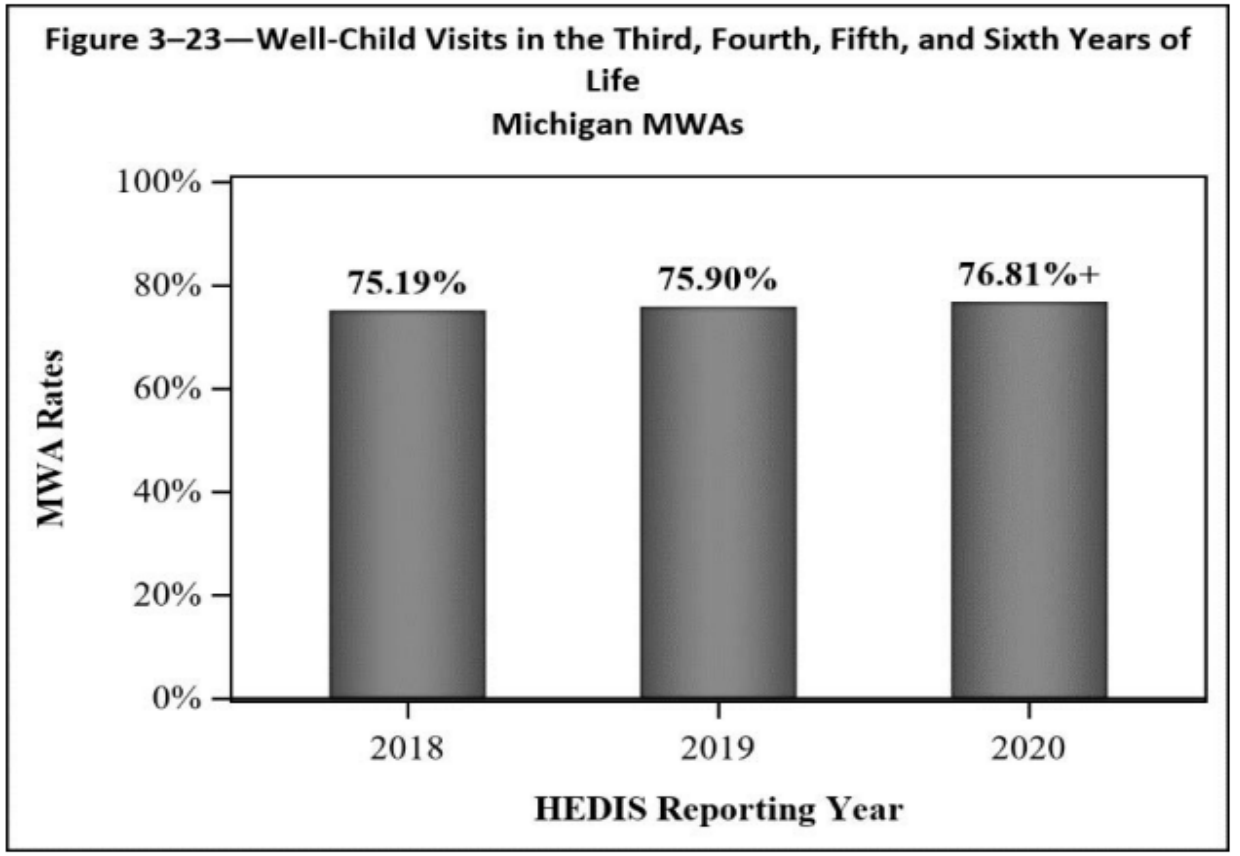
Program Characteristics

- Medicaid health plan representatives as leaders in the Statewide perinatal quality collaborative
- Medicaid support of the Maternal Infant Health Program, an evidence-based home visiting program
- Use of integrated care delivery locations, such as Local Health Departments, which combine preventive care and family supports
- Medicaid support for the Michigan 2020-2023 maternal infant health and equity improvement plan

Overall Performance on Well-Child Visits

Both rates consistently above National 50th Percentile.

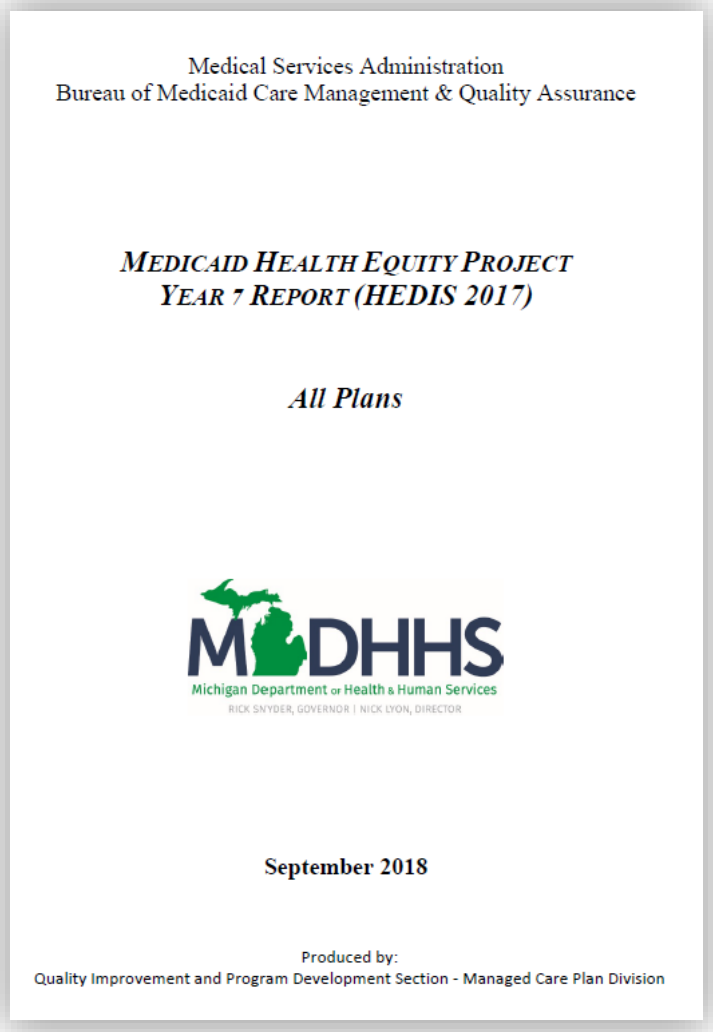




Rates with one cross (+) indicate a significant improvement in performance from the previous year.

Medicaid Health Equity Report

- Performance rates by race/ethnicity
- Rates stratified by Health Plan
- Trended over time (2012-2018)
- Two calculations:
  - Pairwise comparison (White subpopulation as reference)
  - Index of Disparity (Each subpopulation rate compared to overall Health Plan rate)
- Year over year, African American subpopulations experience disproportionately lower quality of care than all other comparisons, including the White reference subpopulation


Medical Services Administration
Bureau of Medicaid Care Management & Quality Assurance

MEDICAID HEALTH EQUITY PROJECT
YEAR 7 REPORT (HEDIS 2017)

All Plans

MDHHS
Michigan Department of Health & Human Services
RICK SNYDER, GOVERNOR | NICK LYON, DIRECTOR

September 2018

Produced by:
Quality Improvement and Program Development Section - Managed Care Plan Division

Website: https://www.michigan.gov/mdhhs/0,5885,7-339-71547_4860-489167--,00.html

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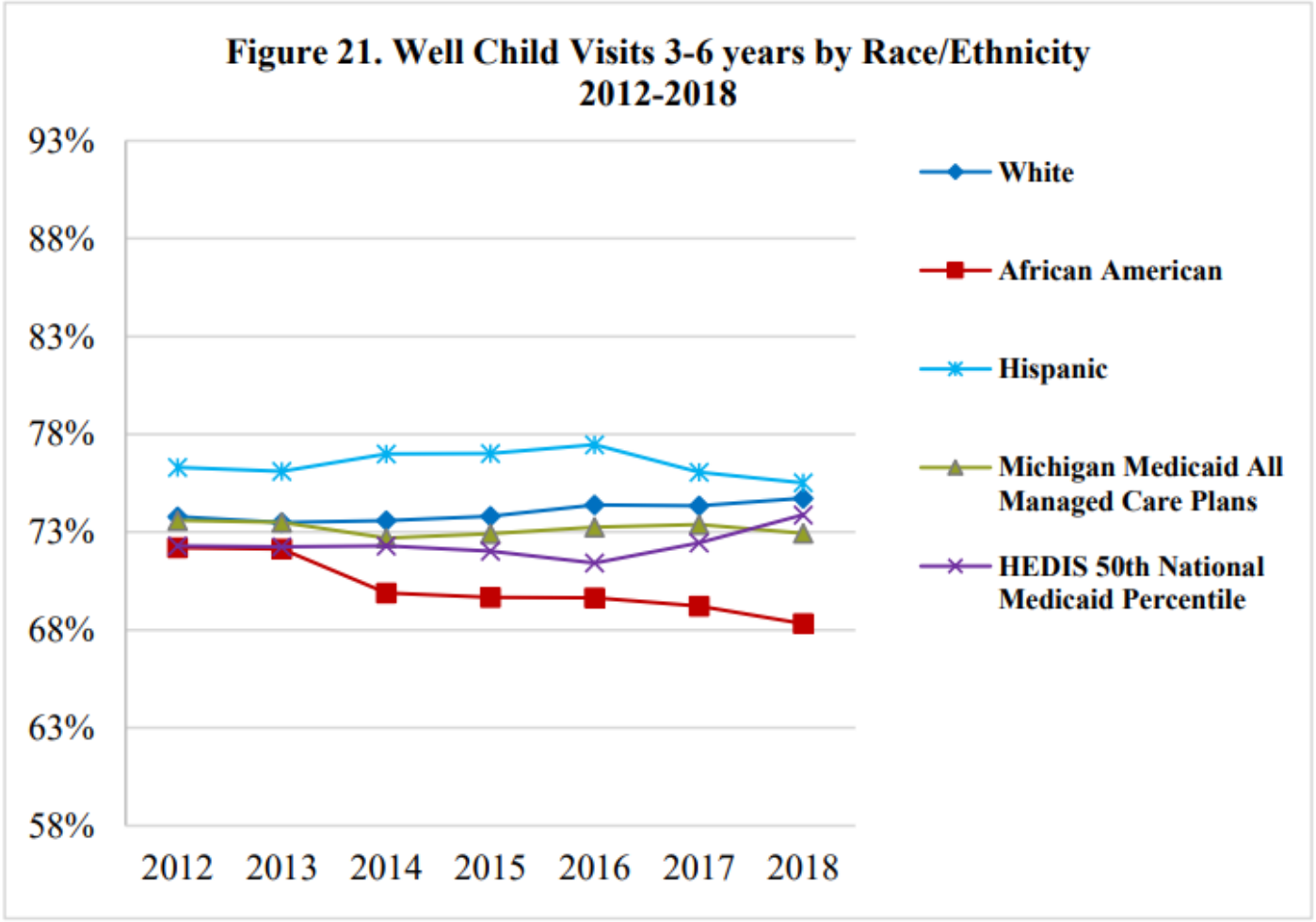
Medicaid Health Equity Report

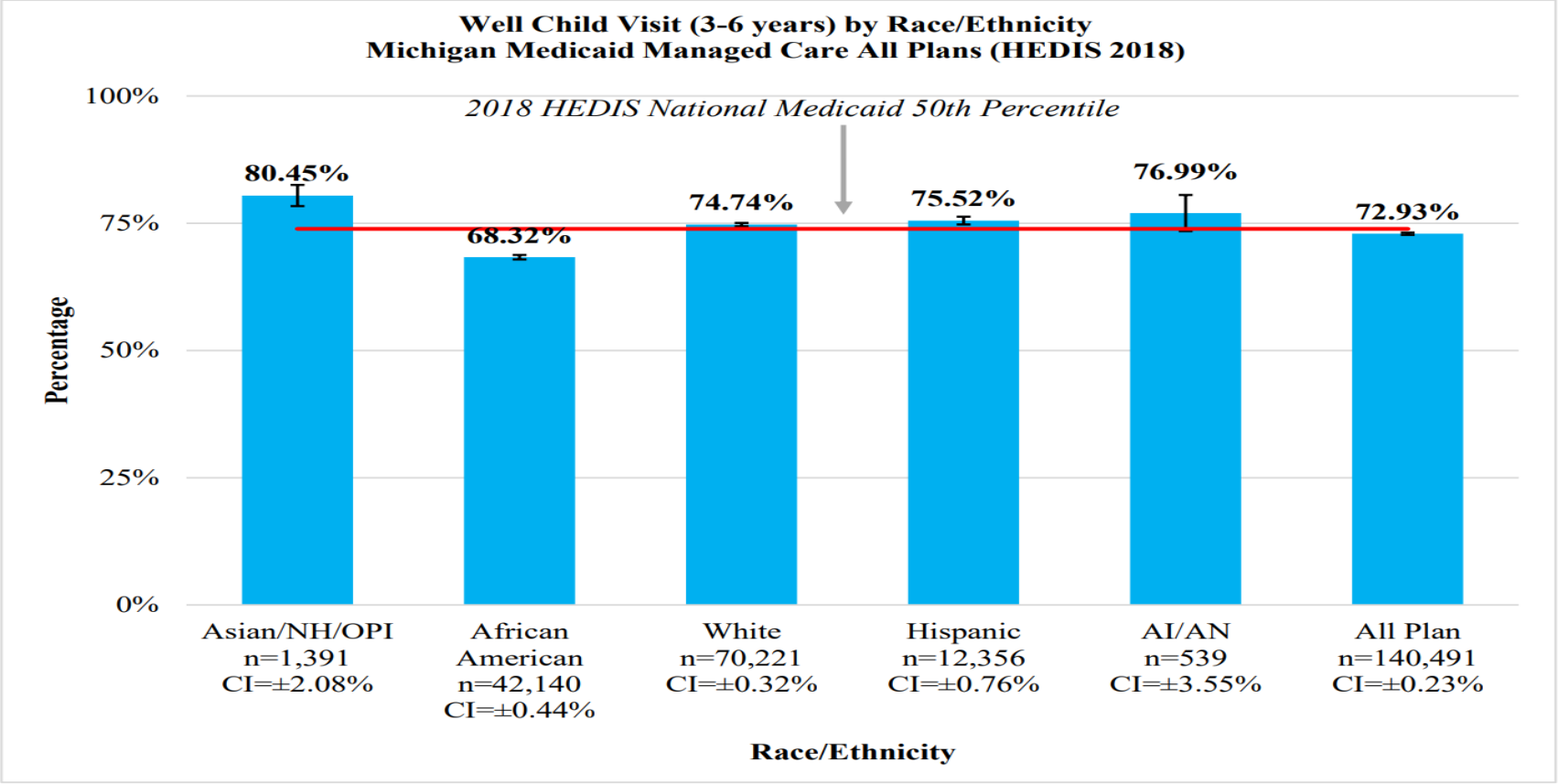


Well-Child Visits

- African American rate decreased from 72% in 2012 to 68% in 2018
- Hispanic rate fluctuated slightly 2012-2018, beginning at 76% and ending at 75%.
- White rate increased between 2012 and 2018 from 74% to 75%

Well-Child Visits Racial Disparities 2018

Figure 8. Well Child Visits (3-6 Years) by Race/Ethnicity



Measure	2018 White Rate	2018 African American Rate	Rate Difference	2018 Hispanic Rate	Rate Difference
Well-Child Visits	74.74%	68.32%	-6.41%	75.52%	+0.78%

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Using Health Equity Measures in Contract and Incentive Programs

Vehicle	Method
Capitation Withhold	• Well-child visits is one measure included • Rewarding achievement of benchmark at Health Plan level as well as statistically significant reduction in racial disparities year over year • Proportion of withhold dedicated to health equity increased over time, ~$15 million in FY 21
Auto Assignment Algorithm	• Developing regional weighted averages • Rewarding achievement of benchmarks with member assignments • Well-child visits not yet included
Contract Compliance	• Deriving HEDIS measure rates using claims and encounters • Validating rates in collaboration with health plans

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The Future of Health Equity Measures in Michigan Medicaid

- Expand use of performance rates derived using claims/encounters stratified by race/ethnicity in incentive and contract compliance programs
- Expand efforts using racial disparity measures defined regionally (rather than by health plan membership) to drive overall population health improvement, with health equity as the focal point of that improvement
- Incorporate racial disparity reduction into physical/behavioral health integration efforts
- Expand use of Community Health Workers and health plan partnership with community-based organizations to address social determinants of health
- Explore use of directed payment programs to address more outcome-based measures of performance targeted at hospitals and providers, transitioning eventually to racial disparities in outcomes

North Carolina Medicaid Initiatives to Improve the Use and Quality of Well-child Care

Jaimica Wilkins, MBA, CPHQ, ICP, CLSSYB
Deputy Director – Quality and Population Health

Division of Health Benefits

September 2021

Non-expansion state

Non-managed care state (until July 1,2021)

2.4M beneficiaries

~50% are under age 18

Purple State Politically

Intervention: Keeping Kids Well Program

Background

On March 10, 2020, the NC Governor declared the COVID19 pandemic state of emergency. The subsequent stay-at-home orders and other community health protections, had a significant impact on the entire healthcare system- including an immediate and measurable decrease in pediatric preventive care.

Under-utilization of well-child visits meant missed opportunities to identify physical, developmental, and behavioral concerns – many of which can be managed or treated.

Missed vaccinations eventually lead to community outbreaks of preventable disease.

NC Medicaid, along with key partners, worked to overcome this.

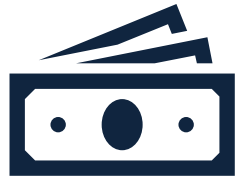
Identified Areas of Focus to Increase Childhood Vaccines

TELEHEALTH

- Modify Medicaid coverage policies to include telehealth coverage

ENHANCED PAYMENTS

- HOSAR - Healthy Opportunities Screening, Assessment and Referrals (January - June 2021)
- AMH Glidepath and Health Equity Payments (April – June 2021)



DISPARITIES

- Address the decrease in pediatric preventive care, especially for African-American and Latinx populations.

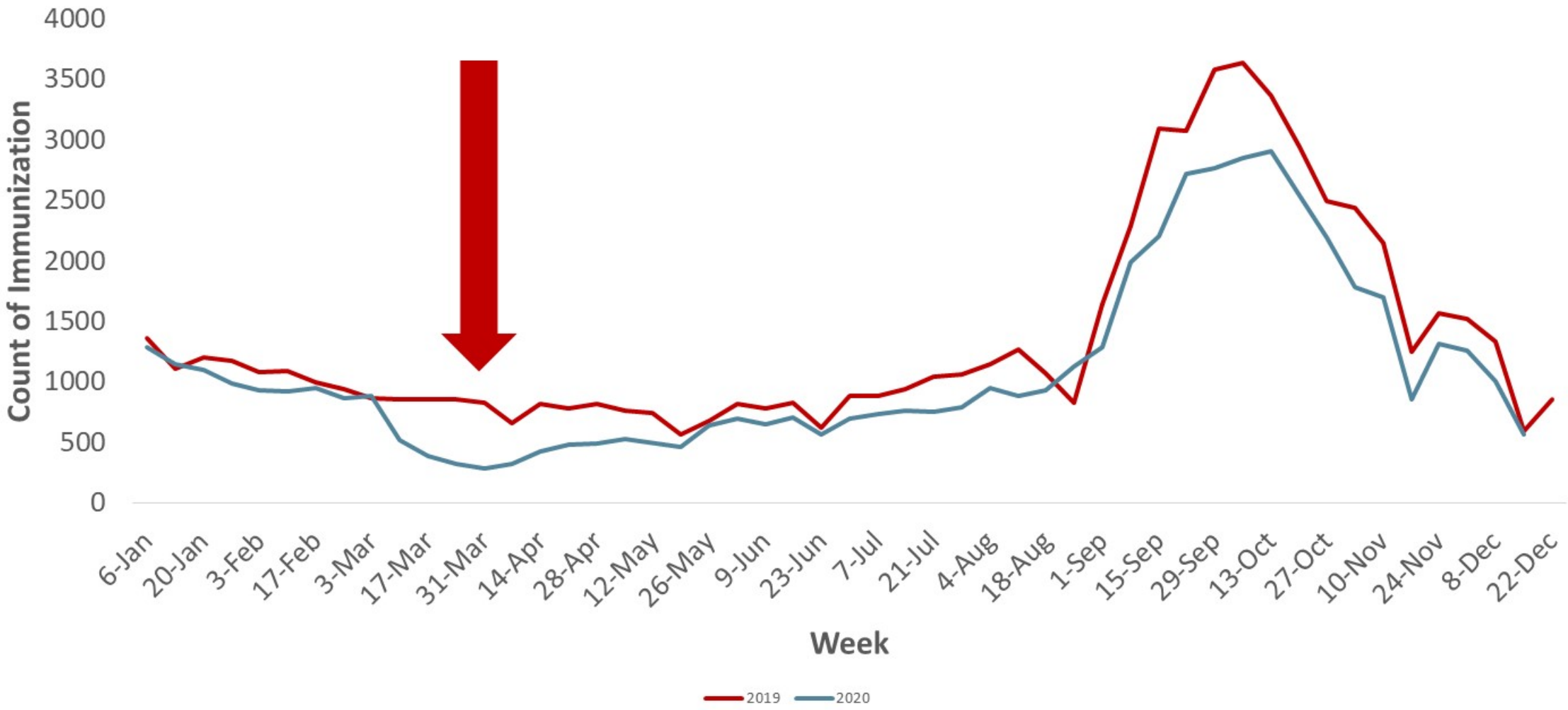
EDUCATION

- Educate parents on required vaccinations with virtual education.
- Educate providers on new coverage policies
- Educate on North Carolina's a meningococcal vaccine for kids 17 years and older.

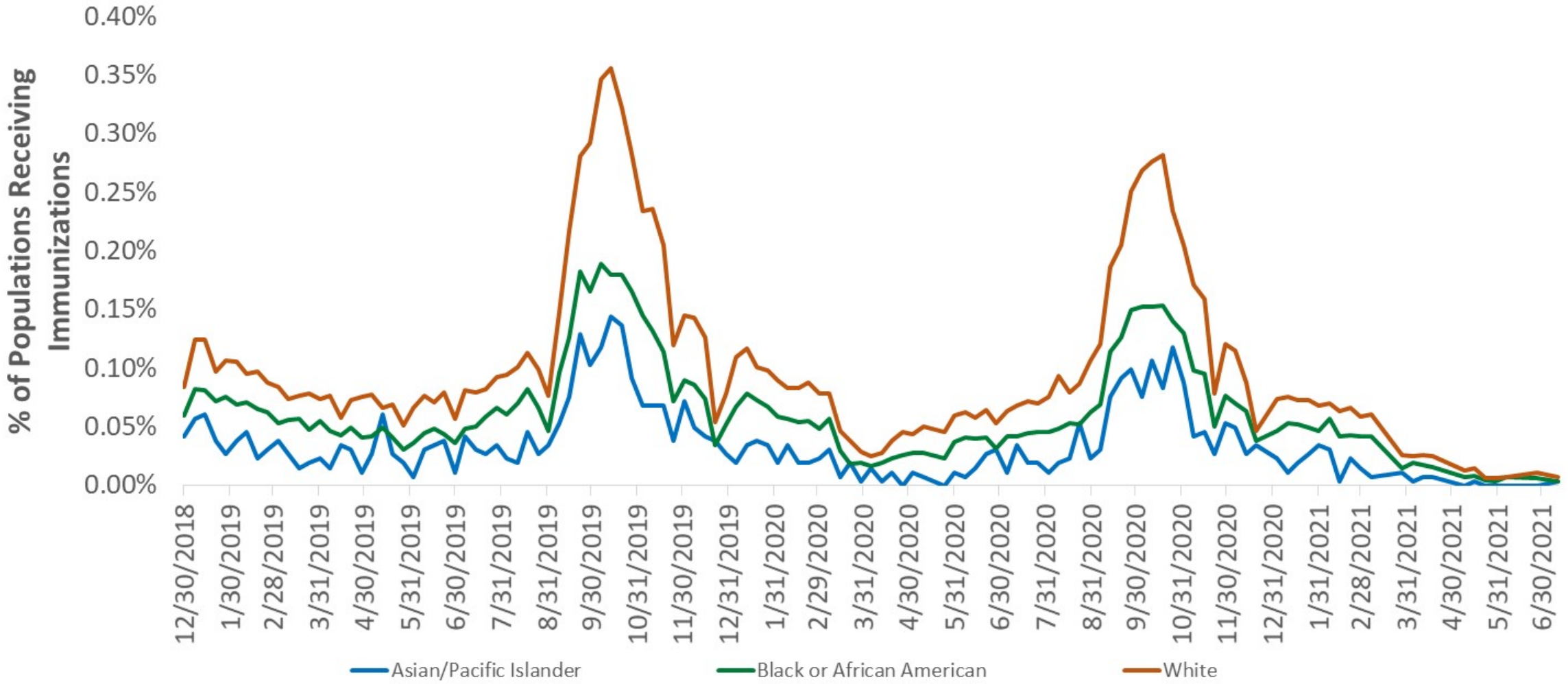
OVERCOME BARRIERS

- Address barriers visiting their pediatrician or family physician.

Childhood Immunizations for 2019 and 2020



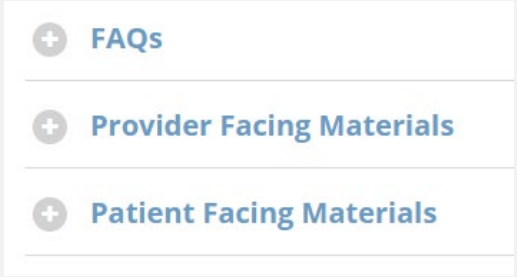
Weekly Proportion of Population Receiving Childhood Immunizations by Race



Keeping Kids Well Program

To help increase well-child visits and immunization rates, Community Care of North Carolina (CCNC) and NC AHEC, under the direction of the Department launched the Keeping Kids Well program.

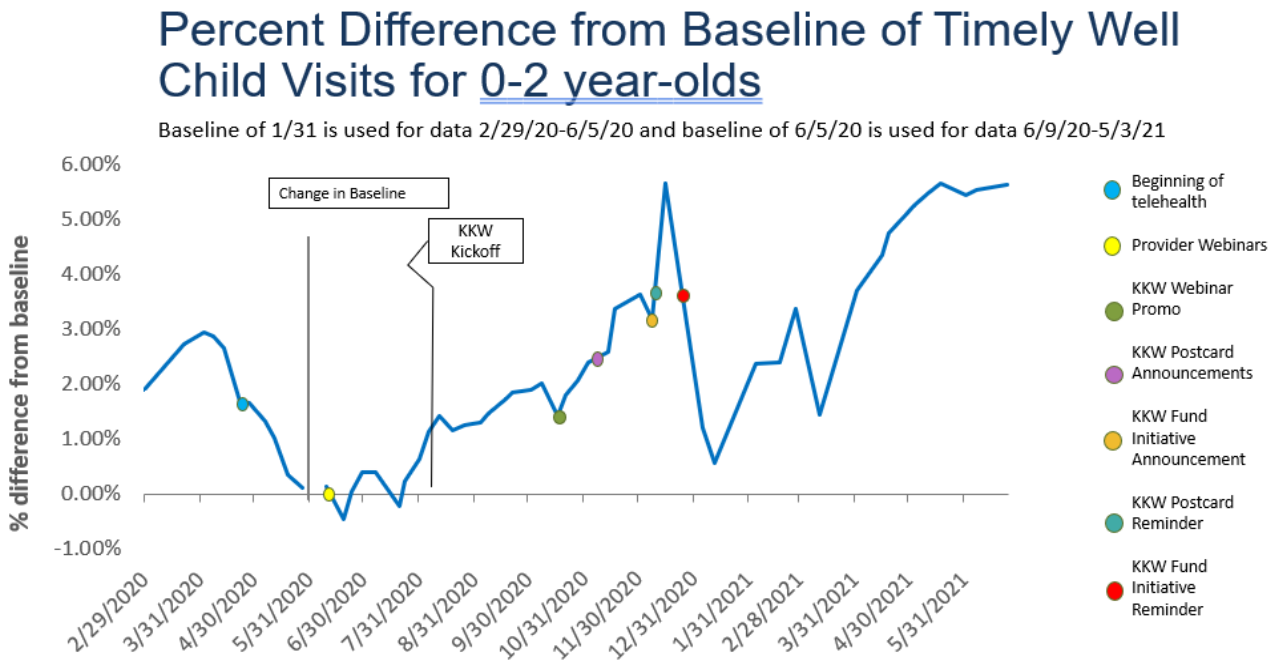
- NC Medicaid data are showing a marked decrease in well-child visits and recommended vaccinations for almost every practice in the state, especially for African-American and Latinx populations.
- CCNC and NC AHEC work with practices experiencing a greater number of care gaps to improve these measures and work to raise awareness of the problem among North Carolina's parents.
- **Patient and provider resources are available at:** communitycarenc.org/keeping-kids-well



Supporting Quality Performance

Keeping Kids Well Program Highlights

- **Launched August 3, 2020**
- **3-pronged approach**
  - Patient Outreach – English/Spanish and Latinx/African American
  - Practice Support – 1:1 Coaching to 300 practices with > 500 care alerts
  - Advisory Group- NCAFP, NC Peds, Reach Out and Read, Office of Rural Health, Division of Public Health, Local Health Departments
- **Partnerships –** Reach Out and Read, Health Systems, Pharmaceutical Companies, Pfizer VAKS Program
- **9 Interventions –** EHR, Internet/Social Media, Staff Engagement, School Systems, News Outlets, Promotion Months, Acute Care Visits, Clinical/Operational Workflow, Group Visits



KKW stabilized the downward trend of immunizations

State Fiscal Year 22 Quality Improvement

- Sunset KKW June 30, 2021
- Kickoff Managed Care (MC) QI projects July 1, 2021
  - 3 QI standard QI projects in FY22
  - Adult PIP - Comprehensive Diabetes Care: HbA1C Poor Control (>9.0%)
  - Child PIP - Childhood Immunization Status- CIS (Combo 10)
  - Maternal Health PIP – Timeliness of Prenatal Care
- Merge Pfizer VAKS efforts into MC QI Projects

Lessons Learned for Keeping Kids Well

Challenges

- Practice resistance
- Ensuring practices received timely, concise and non-duplicative information
- Time Intensive – collaboration of all parties involved
- Not a short-term, “one size fits all” effort

Wins

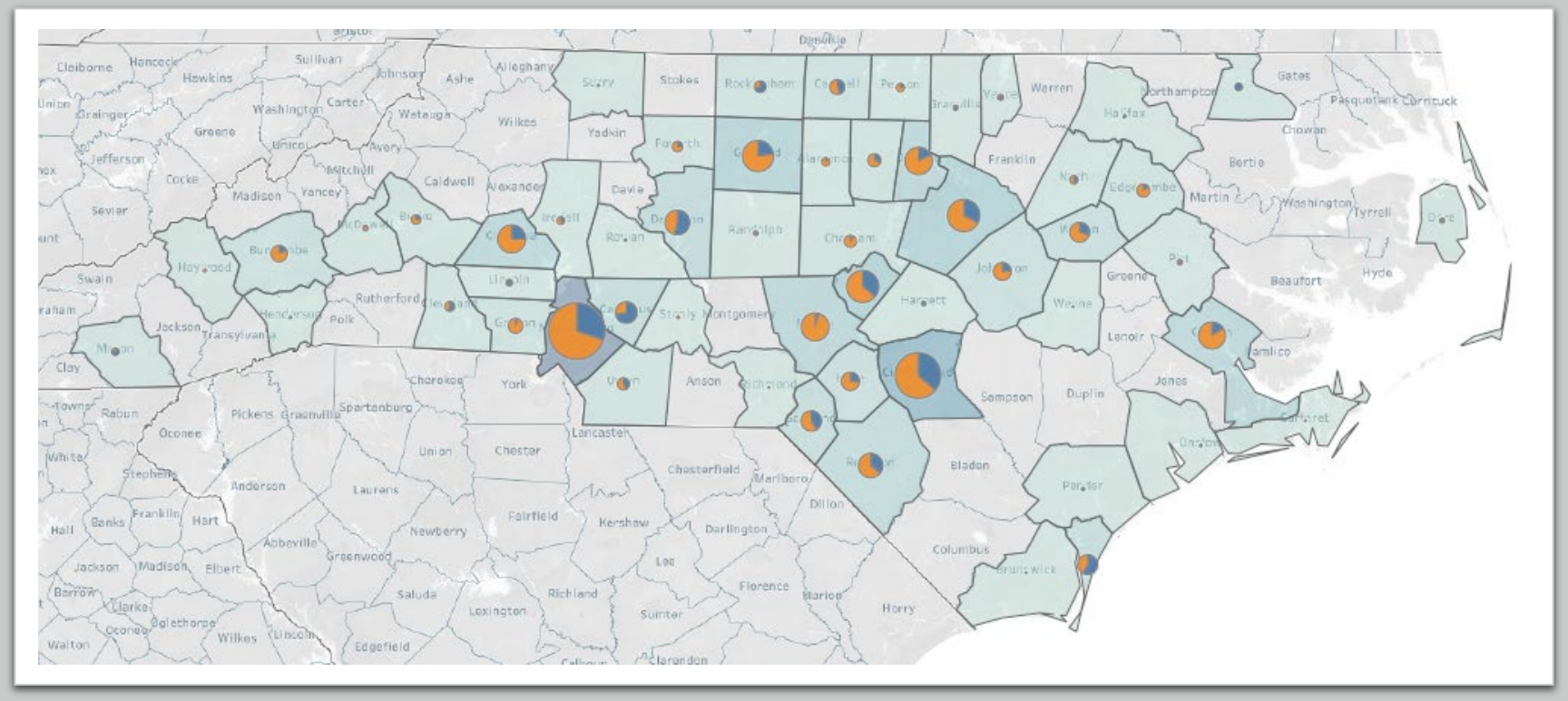
- Flattened the curve of outstanding immunizations
- Established effective outreach and performance metrics that are achievable and meaningful
- 57,000+ Postcards delivered to 198 offices
- Practices, coaches, and practice relations representatives learned from each other
- Practices, coaches, and PRRs learned from each other
- Helped lead into AMH tier support work

Provider-based incentives to promote primary care access and address disparities

Healthy Opportunities Screening and Referral

- Reimbursement: Carolina Access II providers reimbursed for positive Healthy Opportunities screenings (January – June 2021)
- Positive Screening: At least one unmet need identified using the North Carolina Department of Health and Human Services (DHHS) standard screening questions or an equivalent instrument covering beneficiary needs related to DHHS's 4 priority domains (food, housing/utilities, transportation and interpersonal safety)
- Coding: Z codes indicating a patient's identified resource need(s) when submitting claims for Healthy Opportunities screenings. G9919 billing code With Place of Service Indicator (school, homeless shelter, FQHC, Urgent Care, etc)

Healthy Opportunities Screening and Referral



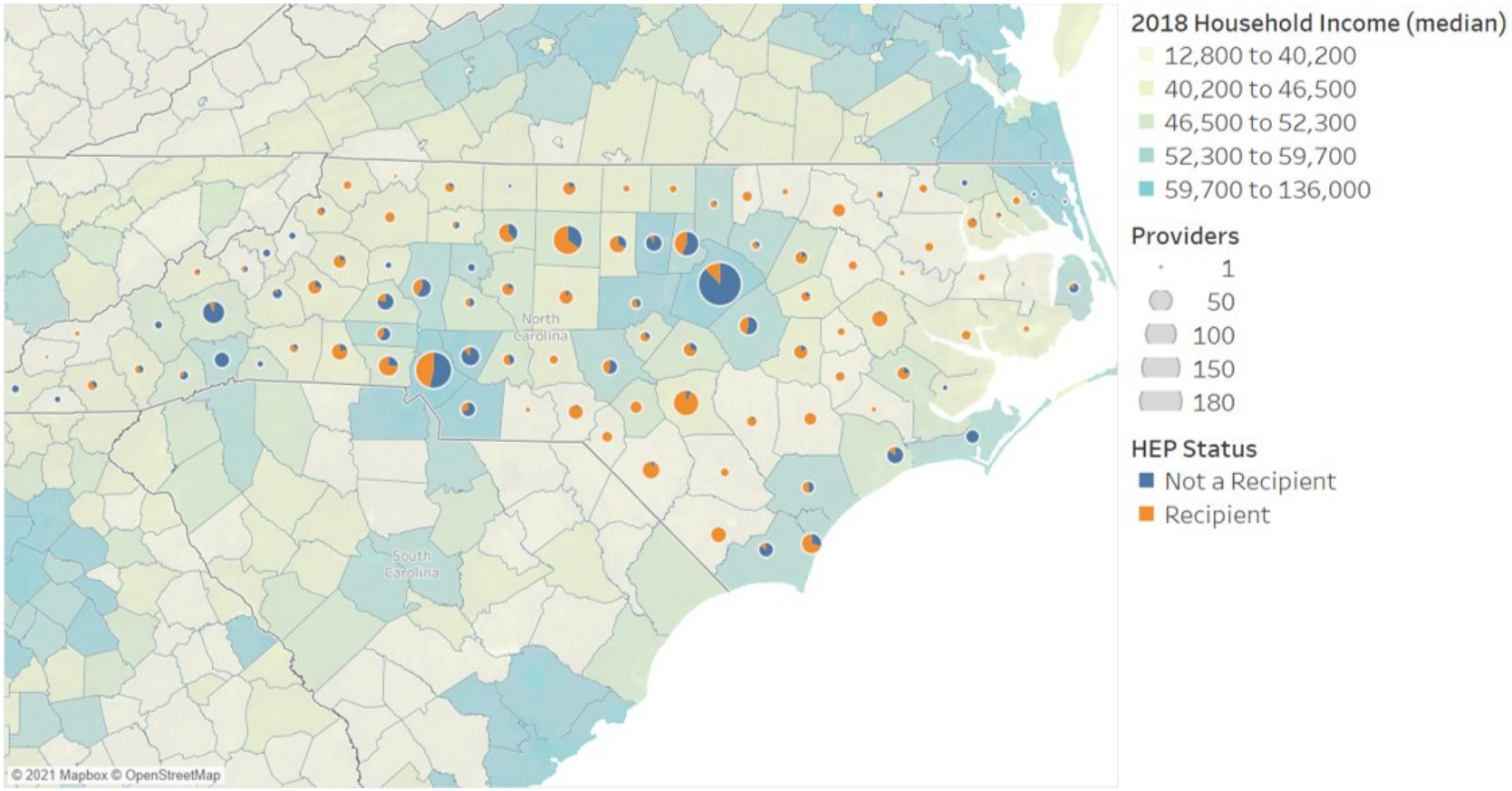
https://medicaid.ncdhhs.gov/blog/2021/02/01/temporary-clinical-policy-modifications-payment-healthy-opportunities-screening-and

What We Learned

- 6400 Claims January-June
- Top Needs Identified:
  - Access to Food
  - Covering the Cost of Heat, Electricity and Water
  - Transportation to Medical Care

Health Equity Payments (HEP)

Tier 3 Practice Count by County by HEP Status



- Available: April – June 2021
- Eligible providers: Carolina Access I and II providers serving beneficiaries from high needs areas.
- Increased PMPM based on practice's mix of beneficiaries (measured by poverty rate at beneficiary's census tract).
- $53.9 Million distributed April-June across 1804 primary care practices
- Payments for Health Equity Incentive Poverty Tier 1 (poverty scores 17% - 21%) received $9PMPM
- Payments for Health Equity Incentive Poverty Tier 2 (poverty scores > 21%) received $18 PMPM

https://medicaid.ncdhhs.gov/blog/2021/03/19/health-equity-payment-initiative

Health equity and reducing disparities in managed care

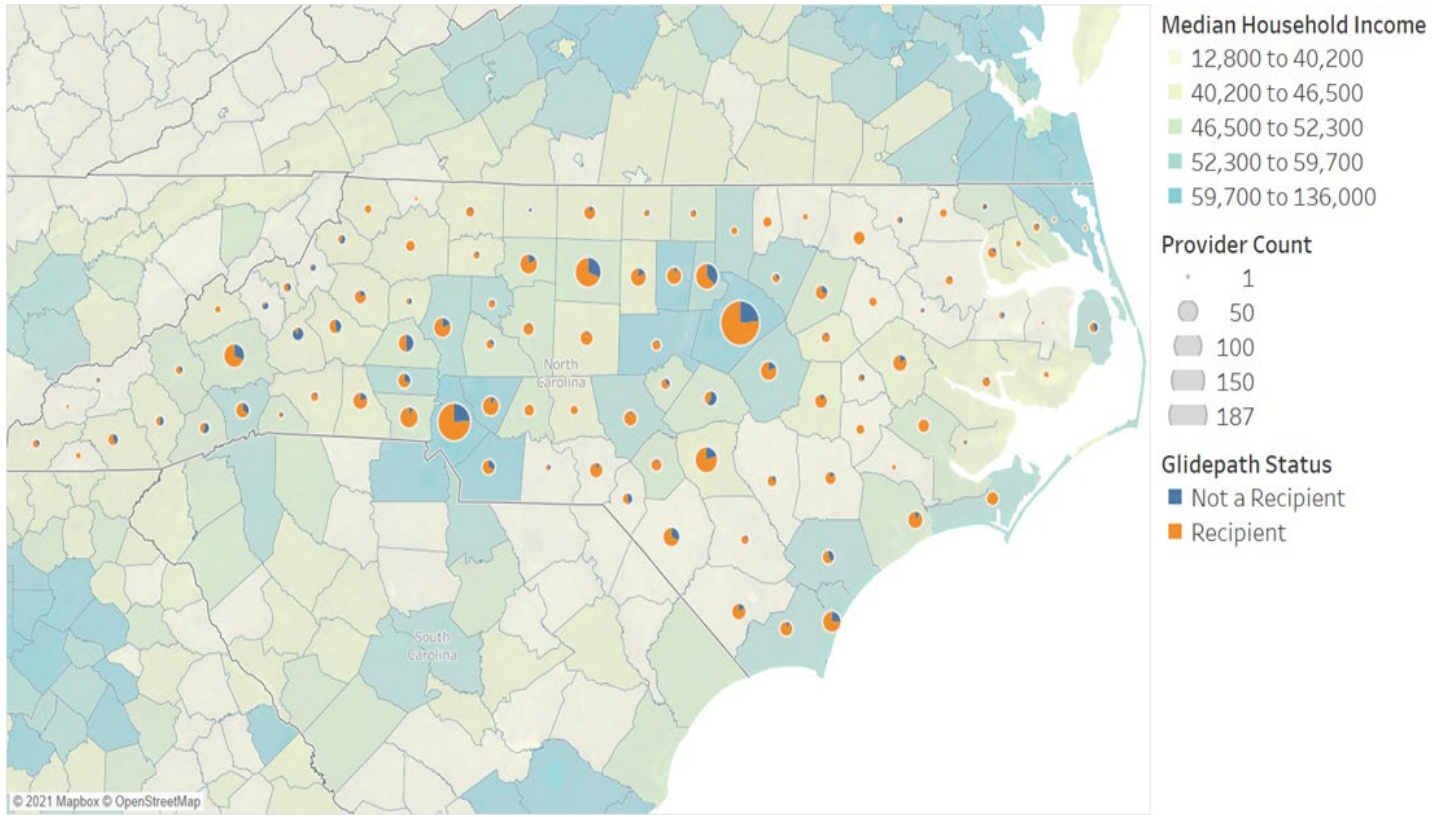
AMH Counts by County by Glidepath Status

NC Medicaid offered time-limited payments to Advanced Medical Home (AMH) Tier 3s who demonstrated successful readiness for AMH Tier 3 responsibilities.

AMH Glidepath Eligibility

This Program offered $8.51 PMPM to Advanced Medical Homes to support the preparation for Managed Care Launch in April – June 2021 if the AMH:

- Attested with DHHS as a Tier 3 Advanced Medical Home
- Active AMH Practices (NPI + Location) must have attested as an AMH Tier 3 within NC Tracks Provider Portal
- Completed Contracting with at least two (2) PHPs at the AMH Tier 3 level
- Successful Data Exchange



NC DHHS conducted validation prior to initiating payment for each month.

https://files.nc.gov/ncdma/documents/Transformation/NCMT-PopHealth-Glidepath-FINAL-1-20-21.pdf

Continuous Quality Improvement: Benchmarking and Attention to Addressing Health Equity

The Department is committed to developing targets for all plan-reported quality measures that promote overall continuous quality improvement and health equity.

Contract Year 1 and 2:

The Department's **benchmark for each plan-reported quality measure* will be a 5% relative improvement over the prior year's North Carolina Medicaid statewide performance for that measure.**

Plans will each be **compared against their respective program's historical performance** (i.e., Medicaid Managed Care plan-level targets will be a 5% relative increase from the previous year's product-line-wide rate).

Measures will be risk-adjusted where appropriate based on the specifications of each measure.

Contract Year 3 and Beyond:

The Department will **hold Standard Plans and BH I/DD Tailored Plans financially accountable for ensuring that improvements in quality narrow or eliminate health disparities.**

The Department **may adjust the benchmarking methodology** based on information gathered in the first two years.

The Department will **continue to promote accurate data collection.**

See the Appendix Slides for Further Detail

*For measures of contraceptive care, the Department will not apply an external performance benchmark, reflecting the preference-sensitive nature of contraceptive care. The Department will monitor measure results to assess where contraceptive access may be insufficient.

Questions

Jodi Anthony, Mathematica

How to Submit a Question

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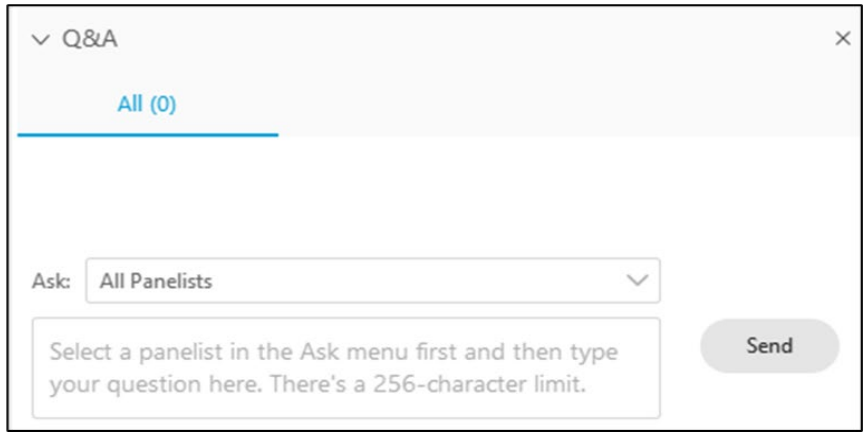

Announcements and Next Steps

Alyssa Bosold, Mathematica

Medicaid.gov Well-Child Care Landing Page

Visit the Medicaid.gov Well-Child Care landing page for information about the Infant Well-Child Visit Learning Collaborative's upcoming webinars and affinity group.

https://www.medicaid.gov/medicaid/quality-of-care/improvement-initiatives/well-child-care/index.html

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Well-Child Care Landing Page Contents

- **Recording and transcript of this webinar**
- **Registration for upcoming webinars**
  - September 27, 3:00-4:00 PM ET
    - Affinity Group Information Session
- **Infant Well-Child Visit Affinity Group Fact Sheet**
- **Infant Well-Child Visit Affinity Group EOI Form**
  - EOI forms are due September 30 at 8:00 PM ET

https://www.medicaid.gov/medicaid/quality-of-care/improvement-initiatives/well-child-care/index.html

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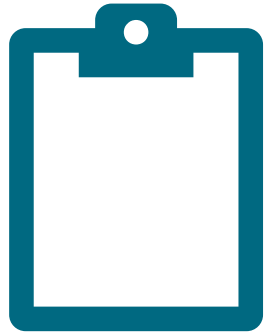
Thank you for participating!

- Please complete the evaluation as you exit the webinar
- If you have any questions, or we didn't have time to get to your question, please email MACQualityImprovement@mathematica-mpr.com



Appendix

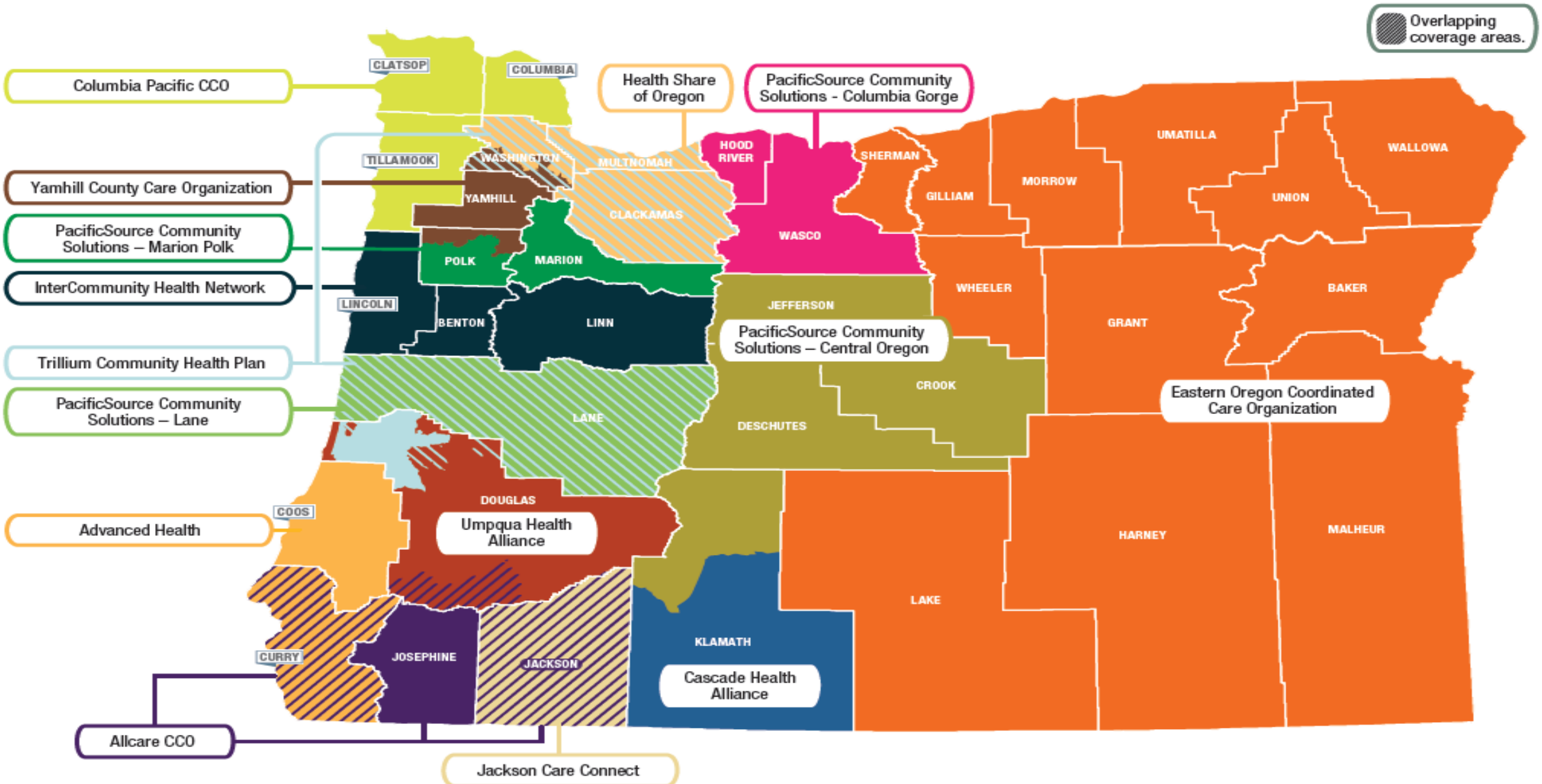
Cross Sectional Initiatives for Infant and Child Health

Lisa Bui
Quality Improvement Director
Oregon Health Authority

September 22, 2021

Coordinated Care Organization 2.0 Service Areas

Oregon Health Authority



Appendix: North Carolina Medicaid Initiatives to Improve the Use and Quality of Well-child Care

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Division of Health Benefits

September 2021

Centers for Medicare & Medicaid Services
Medicaid & CHIP
Maternal & Infant Health
Quality Improvement

Childhood Immunization Status- CIS (Combo 10)

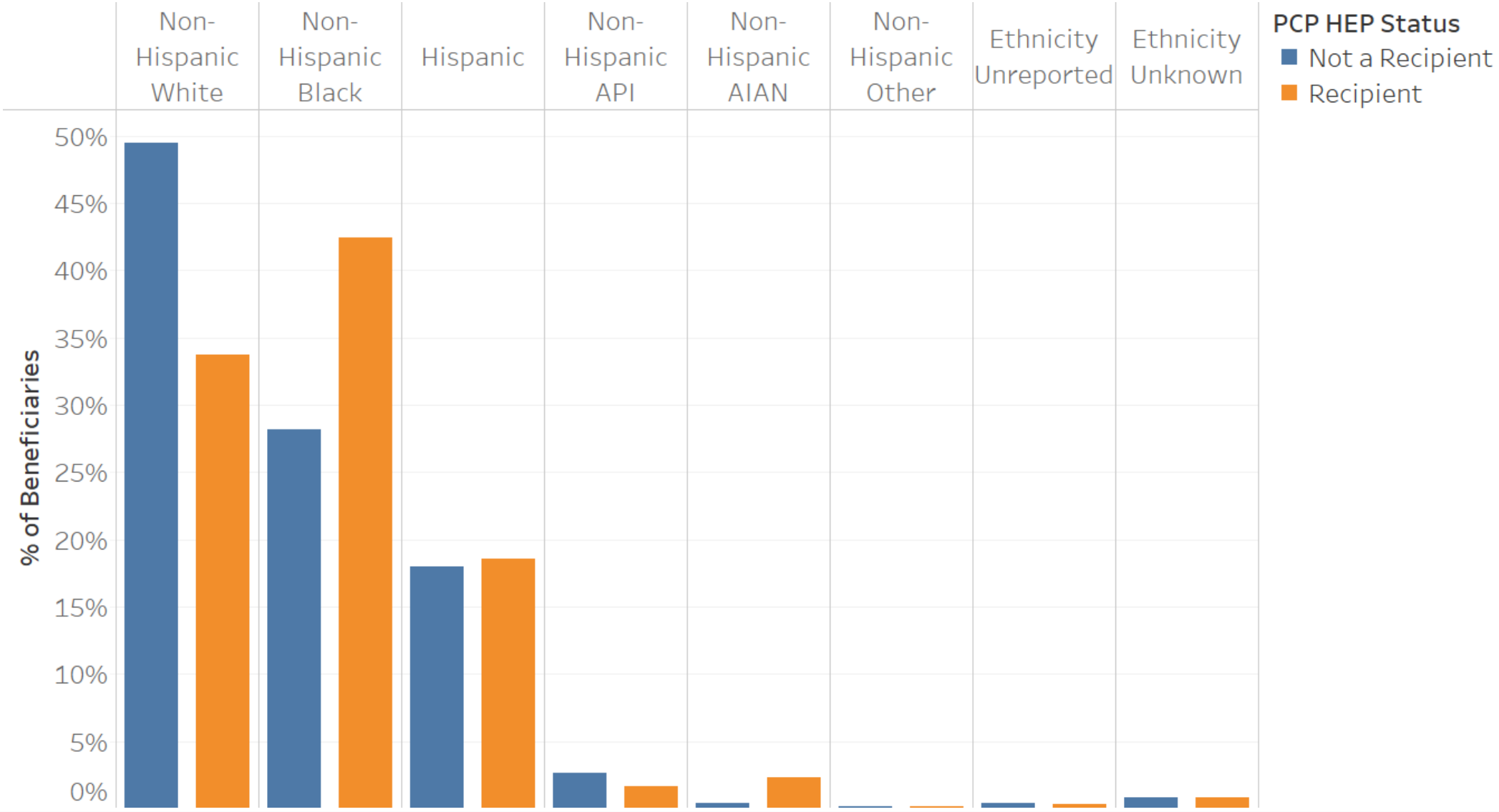
Description:

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.

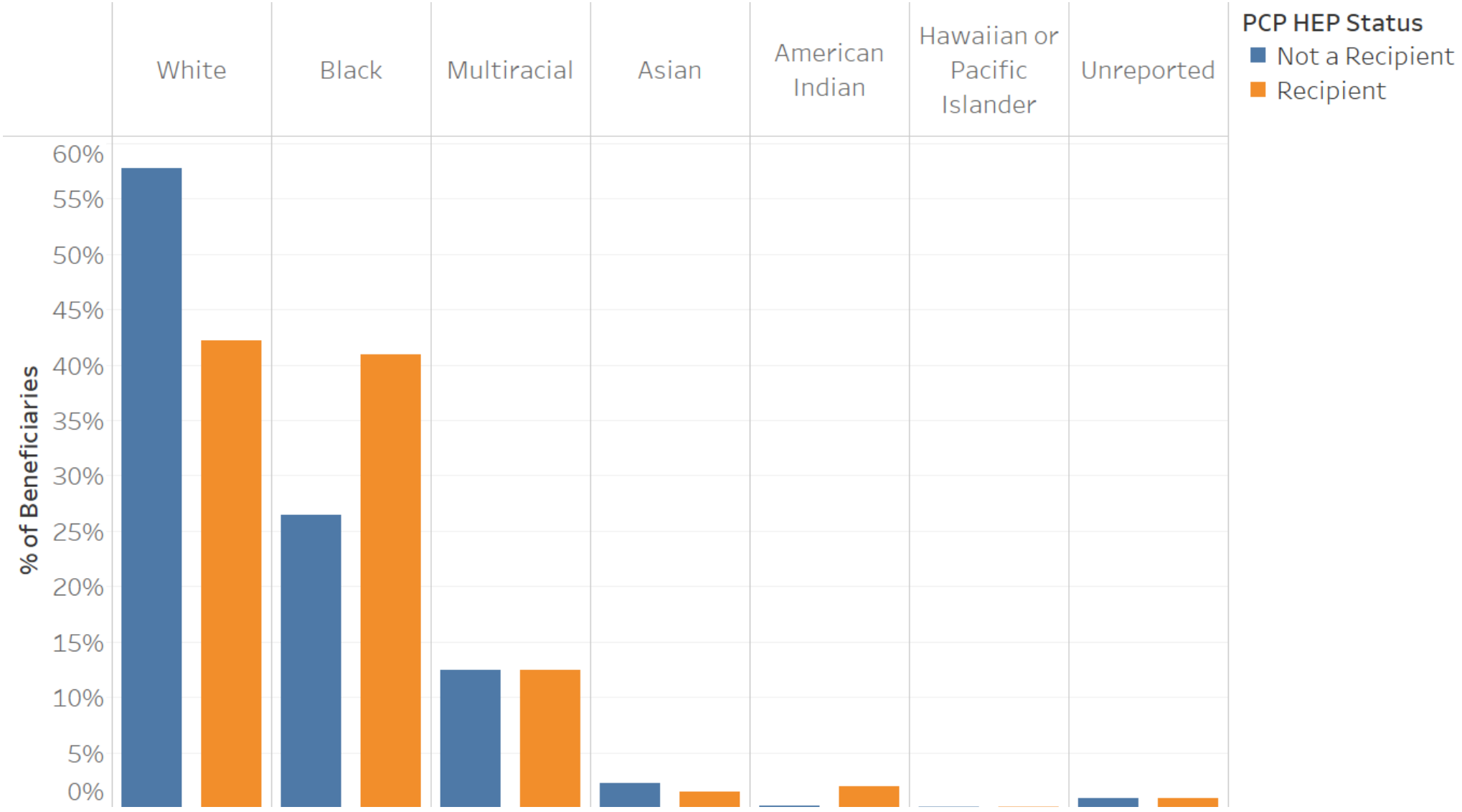
Exclusions:

- Exclude children who had a contraindication for a specific vaccine from the denominator for all antigen rates and the combination rates. The denominator for all rates must be the same.
- Exclude contraindicated children only if administrative data do not indicate that the contraindicated immunization was rendered in its entirety.
  - Denominator The eligible population.
  - Numerators For MMR, hepatitis B, VZV and hepatitis A, count any of the following:
    - Evidence of the antigen or combination vaccine, or
    - Documented history of the illness, or
    - A seropositive test result for each antigen.

HEP Ethnicity of Beneficiaries at Tier 3 AMHs



HEP Race of Beneficiaries at Tier 3 AMHs



Stratified Reporting Requirements

Standard Plans and Behavioral Health I/DD Tailored Plans are expected to report measure results that are stratified, where applicable, using the stratified reporting details indicated in each measure's technical specification.

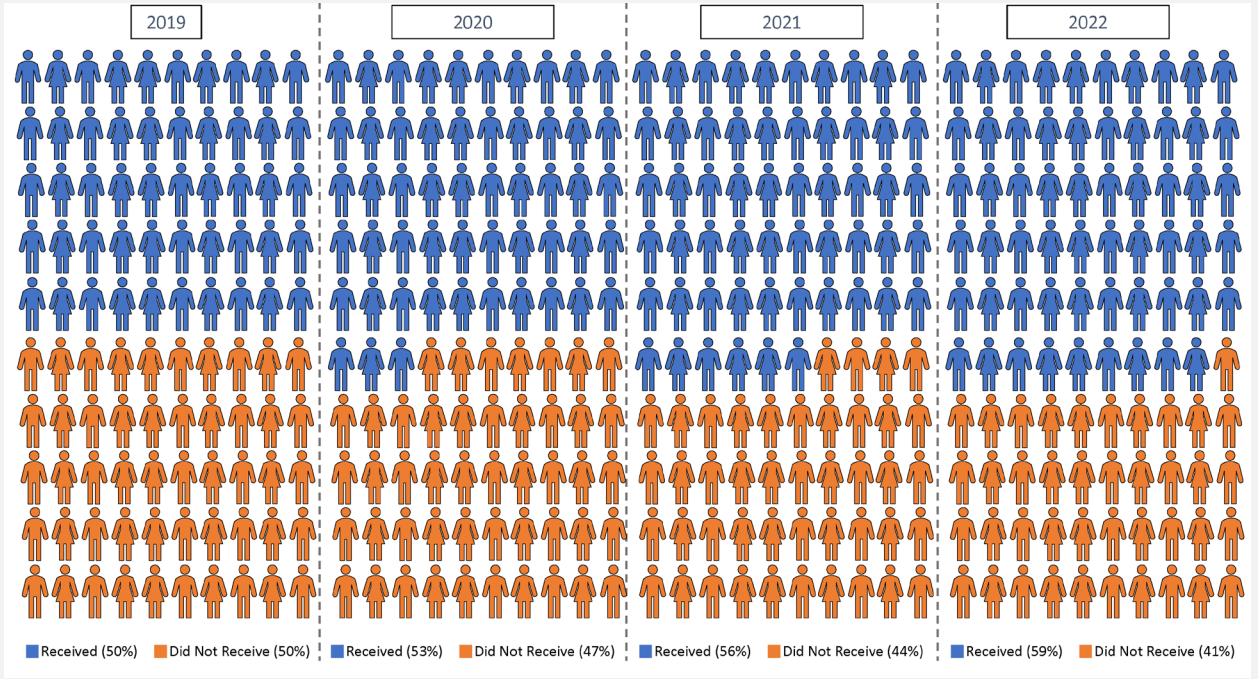
Stratified Reporting Elements

Stratification Element	Strata	Source
Age	For pediatric measures: 0–1, 2–3, 4–6, 7–10, 11–14, 15–18, 19–20, 21 For maternal health: <19, 19–20, 21, 22–24, 25–34, 35+ For adult/full pop. measures: 0–18, 19–20, 21, 22–44, 45–64, 65+	DHHS enrollment data
Race/Ethnicity	Hispanic, Non-Hispanic Black, Non-Hispanic White, American Indian/Alaska Native, Asian/Pacific Islander, Other	DHHS enrollment data (self-reported where possible)
Gender	Male, Female, Third Gender (Other)	DHHS enrollment data (self-reported where possible)
Primary Language	English, Spanish, Other	DHHS enrollment data (self-reported where possible)
LTSS Needs Status	ABD, Non-ABD	Managed care plan screening
Disability Status	Disability, No Disability	DHHS enrollment data
Geography	Rural, Urban	DHHS enrollment data
Service Region	Standard Plans: 1–6 BH I/DD Tailored Plans: 1–7	DHHS enrollment data

Contract Years 1-2: Incremental Quality Measure Targets

Health plans will be compared against their program's historical performance and are expected to show at least a 5% relative improvement over the prior year's North Carolina Medicaid statewide performance for that measure.

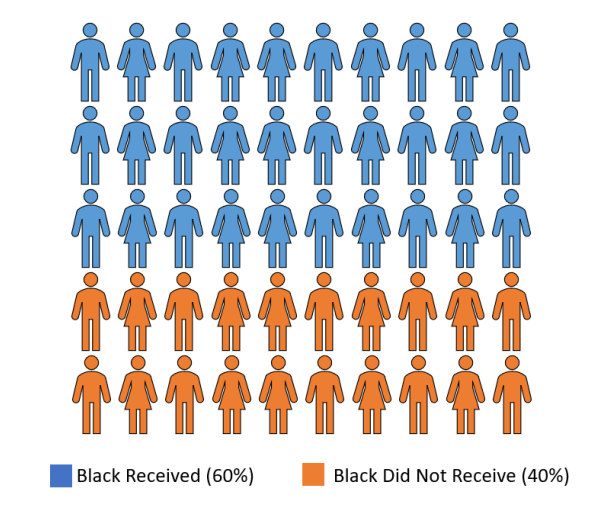
Example: Each year the proportion of eligible women in health plan A that receive a Chlamydia screening increases by 5%. Each blue icon represents 10 women who received their screening. Health plan A's performance goes from 50% (500/1000) in 2019 to 59% (590/1000) in 2022, meaning that health plan A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

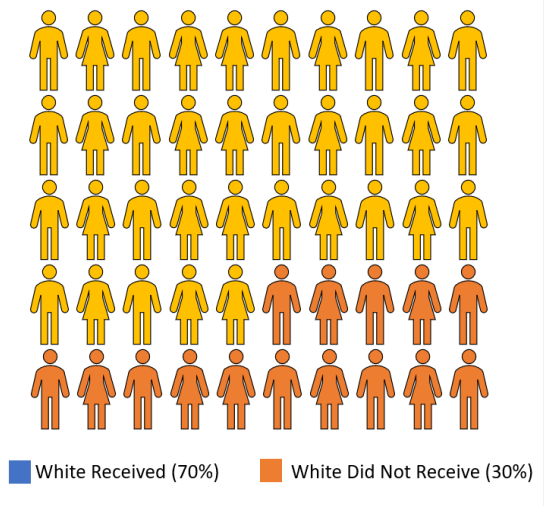


Disparity Definition and Identification

The Department will identify selected quality measures with significant disparities, defined as a greater than 10% relative gap in performance between a group of interest and a reference group.*

Example: 60% (300/500) of Black patients in health plan B receive the flu vaccine, while 70% (350/500) of white patients in health plan B receive the flu vaccine. (Each icon represents 10 patients.) This 50-patient difference equates to a 14% disparity, so the measure of influenza vaccination demonstrates a significant disparity.





* This disparity definition was developed by AHRQ as outlined in the 2019 National Healthcare Quality and Disparities Report, available here: https://www.ahrq.gov/research/findings/nhqrdr/nhqdr19/index.html

Incremental Disparity Targets

The Department expects a 10% relative improvement in the performance for the group of interest for at least two years and until the gap between a group of interest and the overall population is less than a relative 10%.

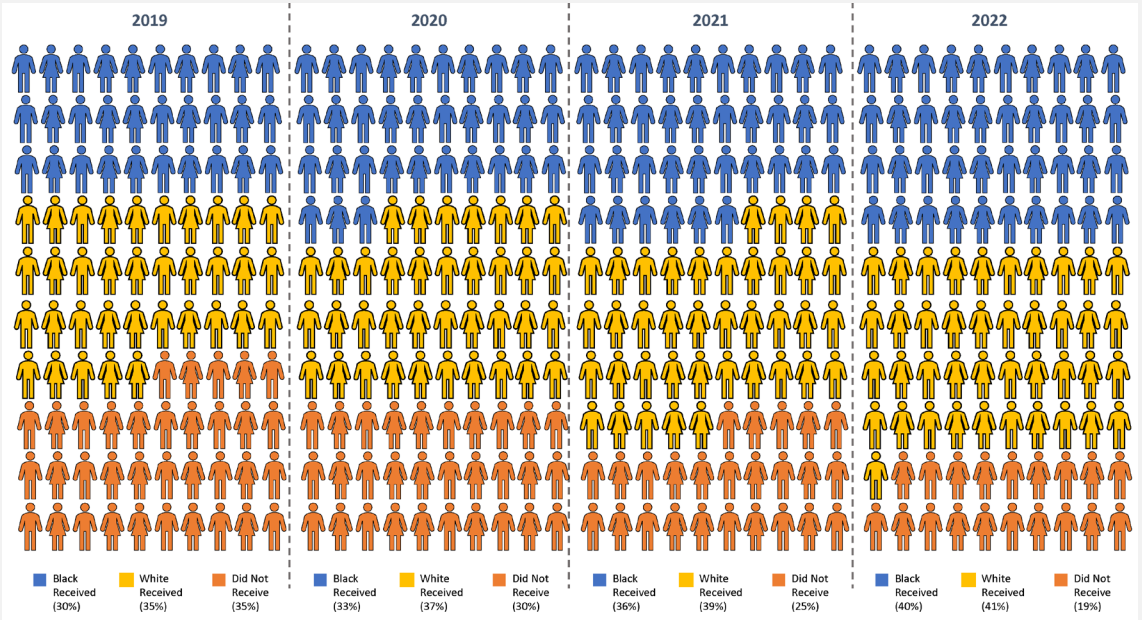
Example: Each year the proportion of Black patients in health plan B that receive the flu vaccine increases by 10%. Each blue icon represents 10 vaccinated patients. Performance within health plan B's Black population goes from 60% (300/500) in 2019 to 80% (400/500) in 2022, meaning that health plan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

! Plans must achieve the disparity target for two years consecutively.

Incremental Disparity Targets: Combining Overall and Disparity Targets

The Department plans to assess whether disparities have narrowed <u>in addition</u> to considering overall performance improvement for each plan's respective enrolled population compared against their Standard Plan or BH I/DD Tailored Plan peers.

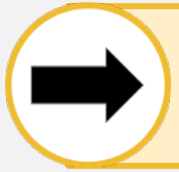
Example: Each year the proportion of Black beneficiaries in health plan B that receive a flu vaccine (blue icons) increases by 10% while the proportion of white beneficiaries that receive a flu vaccine (yellow icons) increases by 5%. Health plan B's performance across their total population increases from 65% (650/1000) in 2019 to 81% (810/1000) in 2022 and the disparity has **also** been reduced, meaning that health plan B meets the combined target and is eligible for any withhold.



Under Development: Quality Withhold Program

Beginning in the third contract year, the Department will hold Standard Plans and Behavioral Health I/DD Tailored Plans financially accountable for their performance on a set of quality withhold measures.

- The withhold measures will be drawn from the set of measures Standard Plans and Behavioral Health I/DD Tailored Plans reported the previous year.
- Initial withhold measures for Behavioral Health I/DD Tailored Plans will be shared prior to Behavioral Health I/DD Tailored Plan launch.
- The Department has identified the following as potential withhold measures for Standard Plans. **This list is subject to change prior to implementation:**
  - Prenatal and Postpartum Care
  - Low Birth Weight
  - Well-child Visits in the First 30 Months of Life
  - Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)
- The withhold measure set will shift toward outcome measures over time, with an increasing focus on improving performance under a gap-to-goal assessment approach as well as eliminating disparities.



In future years, the Department will implement new uses for Standard Plans and Behavioral Health I/DD Tailored Plans quality scores that go beyond calculation of withhold targets. For example, the Department will expect Standard Plans and Behavioral Health I/DD Tailored Plans to further incorporate quality scores into internal ongoing quality improvement and value-based purchasing efforts.

Annual Health Equity Report

Data will be used to develop a plan of action for measuring and evaluating efforts to address health equity in the Medicaid program.

- Standard Plans and BH I/DD Tailored Plans are expected to engage with the Department's designated External Quality Review Organization (EQRO), which will develop an annual health equity report.
- The report will document the Department's progress toward the goal of reducing disparities (e.g. race and ethnicity, geography, disability status) and share Standard Plans' and Behavioral Health I/DD Tailored Plans' stratified quality performance.
- The Department will use this report to guide development of sub-population-specific quality improvement strategies (see **Next Slide**), which will begin with systematic identification of disparities in the Medicaid program and progress through rewarding Standard Plans and BH I/DD Tailored Plans that can generate more equitable improvement in outcomes for their enrolled members.
- In Year 1, the requirement is limited to stratified reporting. This reporting will serve to map out the disparities in North Carolina Medicaid.

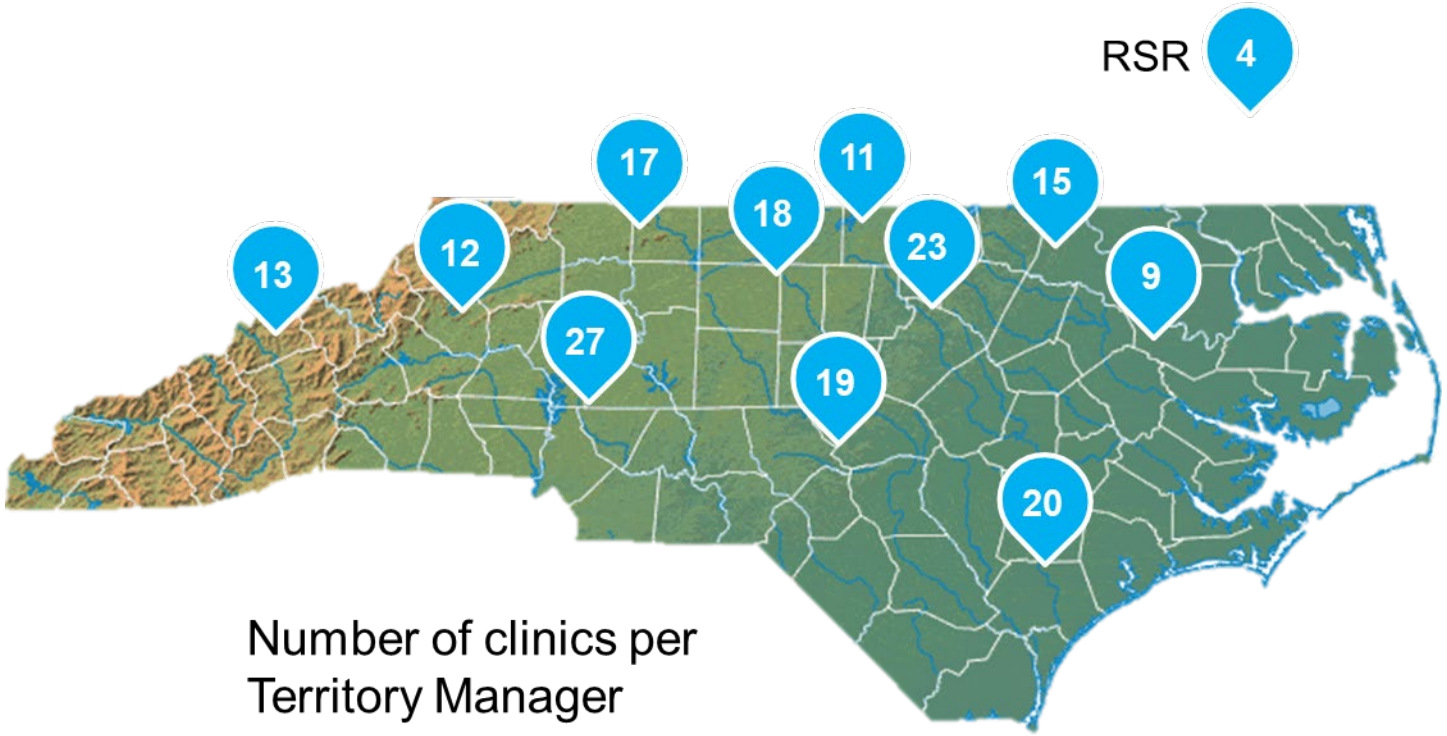
Health Equity Interventions

The Department will take into consideration analysis generated by the health equity report and develop focused interventions, where practical.

- As appropriate, these interventions may include:
  - Development of quality measure improvement targets focused on areas of disparities, on a program-wide and/or plan-specific basis;
  - Adjustment to, or the introduction of new, program-wide interventions and/or policies focused on the needs of populations experiencing disparities in quality outcomes;
  - Development of modified, or additional, plan PIP requirements; and/or
  - Additional requirements to be included in each managed care plans' Quality Assessment and Performance Improvement plan (QAPI).
- The Department will use the health equity analysis and other reports in its annual review of each plan's proposed QAPI to ensure that each plan is actively assessing – and responding to – opportunities to close health disparities in collaboration with Department-developed, cross-plan interventions.

KEEPING KIDS WELL PROGRAM

State level impact



Total Postcards Ordered
Nov 2020-August 2021
Total Offices-198
Total Postcards-57,785

Asheville	2,960
Hickory	3,690
RSR	700
Charlotte	4,860
Durham	3,740
Fayetteville	5,410
Greensboro	4,245
Greenville	1,600
Raleigh	6,390
Rocky Mount	11,650
Wilmington	5,490
Winston Salem	7,050
TOTALS	57,785

Quality Initiatives within the AMH Program

The Department requires Standard Plans to monitor the performance of AMHs in all tiers to ensure delivery of high-quality care.

- All practices will be eligible to earn negotiated Performance Incentive Payments based on the set of measures in the AMH measure set, which were selected for their relevance to primary care and care coordination.
  - Performance Incentive Payments are optional for Tier 1 and 2 AMHs.
  - Standard Plans are required to offer opportunities for such payments to Tier 3 AMHs.
- Standard Plans are not required to use all the AMH measures, but any quality measures they choose must be drawn from this set; plans are not permitted to use measures drawn elsewhere.

AMH Measure Set

NQF#	Measure Name	Steward	Frequency*
Pediatric Measures			
NA	Child and Adolescent Well-Care Visits (WCV)	NCQA	Annually
0038	Childhood Immunization Status (Combo 10) (CIS)	NCQA	Annually
1407	Immunizations for Adolescents (Combo 2) (IMA)	NCQA	Annually
NA	Well-Child Visits in the First 30 Months of Life (W30)	NCQA	Annually
Adult Measures			
0032	Cervical Cancer Screening (CCS)	NCQA	Annually
0033	Chlamydia Screening in Women (CHL)	NCQA	Annually
0018	Controlling High Blood Pressure (CBP)	NCQA	Annually
0059	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	NCQA	Annually
1768	Plan All-Cause Readmissions (PCR) [Observed versus expected ratio]	NCQA	Annually
0418/ 0418e	Screening for Depression and Follow-up Plan (CDF)	CMS	Annually
NA	Total Cost of Care		Annually

*Monthly gap measure reports are also required.

RESOURCES

https://medicaid.ncdhhs.gov/blog/2021/03/19/health-equity-payment-initiative

https://files.nc.gov/ncdma/documents/Transformation/NCMT-PopHealth-Glidepath-FINAL-1-20-21.pdf

https://medicaid.ncdhhs.gov/blog/2021/02/01/temporary-clinical-policy-modifications-payment-healthy-opportunities-screening-and

https://www.communitycarenc.org/keeping-kids-well