

# North Carolina's Medicaid Managed Care Quality Strategy

Status: **DRAFT**  
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## Submit Feedback by April 13, 2018

The North Carolina Department of Health and Human Services welcomes feedback on the proposed Medicaid Managed Care Quality Strategy. Please send written input by April 13, 2018 to:

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**Drop-off:** Department of Health and Human Services, Dorothea Dix Campus, Adams Building, 101 Blaire Drive, Raleigh NC

***Note: This Quality Strategy is drafted as if the Medicaid managed care program is already operational and that pending related legislation has already passed. We note, when relevant, where there are components requiring pending legislative authority. The document reflects high-level Quality Strategy interventions and initiatives; in several areas additional details are available but are purposefully not included. Finally, federal rules dictate several elements of the Quality Strategy and certain sections and the details in those sections are included solely to follow those guidelines.***

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## I. Introduction and Overview

### (A) History of Medicaid Managed Care in North Carolina

North Carolina's Medicaid and NC Health Choice programs provide health coverage to approximately two million North Carolinians, including coverage for over one in two births and two in five children.<sup>1</sup> Nearly 60 percent of the State's Medicaid beneficiaries are under the age of 21, and nearly 58 percent are female.<sup>2</sup>

Today, North Carolina has separate payment and delivery systems for physical health services and behavioral health and intellectual/developmental disabilities (I/DD) services. Physical health services are delivered through fee for service and managed through DHHS' Primary Care Case Management (PCCM) program, while behavioral health and I/DD services are delivered by local management entity-managed care organizations (LME-MCOs), further described below. Starting in 2019, the Department of Health and Human Services (DHHS) will be mandated under NC Session Law 2015-245 to transition most beneficiaries into fully capitated managed care plans, called Prepaid Health Plans (PHPs).

North Carolina has a strong record of investment in innovative programs, managing cost growth, boasts high rates of beneficiary participation in primary care medical homes, and enjoys strong provider participation with over 65,000 enrolled providers. In implementing managed care, North Carolina is building upon its successes to achieve even more – innovating and evolving to improve the health of North Carolinians.

This Quality Strategy aims to guide North Carolina's managed care implementation efforts by establishing clear Aims, Goals, and Objectives to drive improvements in care delivery and outcomes, and the metrics by which progress will be measured. The Quality Strategy sets a clear direction for priority interventions, and details the standards and mechanisms for holding managed care entities accountable for desired outcomes. The Quality Strategy is a roadmap through which DHHS will use managed care infrastructure to facilitate improvements in health and health care through programmatic innovations, whole-person care, provider supports, and steps to address health-related unmet resource needs.

#### *Development of Managed Behavioral HealthCare through the LME-MCOs*

In 2005, the North Carolina Department of Health and Human Services (DHHS) implemented a concurrent 1915(b)/(c)<sup>3</sup> Medicaid waiver to establish managed behavioral health and I/DD care through LME-MCOs. The LME-MCO concept was initially designed as a pilot project to serve Medicaid beneficiaries with mental health, developmental disabilities and substance abuse needs in a limited

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<sup>1</sup> Kaiser Family Foundation. Medicaid State Fact Sheets. North Carolina. <http://files.kff.org/attachment/fact-sheet-medicaid-state-NC>

<sup>2</sup> Medicaid and NC Health Choice Annual Report for State Fiscal Year 2016. Available at: <https://files.nc.gov/ncdma/documents/files/Medicaid-Annual-Report-State-Fiscal-Year-2016.pdf>

<sup>3</sup> The waiver that allowed DHHS to restructure the management responsibilities for the delivery of services to individuals with mental illness, intellectual and other developmental disabilities, and substance use disorders through managed care arrangements with local management entity managed care organizations (LME-MCOs).

catchment area. The pilot LME-MCO also delivered home- and community-based services and supports through the Innovations waiver, a 1915(c) home and community-based services waiver for individuals with intellectual/developmental disabilities. In 2009, DHHS elected to expand the 1915 (b)/(c) Medicaid waiver statewide and initiated a collaborative effort with the North Carolina Division of Medical Assistance (DMA) and the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS). The goal was to restructure the delivery system for Medicaid and state-funded mental health, substance abuse, and intellectual/developmental disabilities services.<sup>4</sup> Currently, DHHS contracts with LME-MCOs to operate Medicaid-funded services through a capitated prepaid inpatient health plan (PIHP) in different regions of the State.

### *Broader Transition to Managed Care*

In September 2015, the NC General Assembly enacted Session Law 2015-245, directing the transition of the State's Medicaid program from a predominately fee-for-service structure to a capitated managed care structure. Since that time, DHHS has worked with the General Assembly and stakeholders to plan the implementation of this directive. DHHS is committed to transitioning North Carolina to Medicaid managed care in a way that advances high-value care, improves population health, engages and supports beneficiaries and providers, and establishes a sustainable program with predictable costs. Specifically, DHHS has identified as high priorities: working with legislators to advance whole-person care so that all plans will include physical health, behavioral health, and substance use services for beneficiaries; addressing unmet health-related resource needs (sometimes called the "social determinants of health"); and enhancing local, community-based care management, as well as other interventions described in more detail throughout this Quality Strategy. At the core of these efforts is the goal of improving the health of North Carolinians through an innovative, whole-person centered, well-coordinated system of care that addresses both medical and non-medical drivers of health.

### **Populations Included in Managed Care**

Starting in July 2019, most Medicaid and NC Health Choice populations will be mandatorily enrolled in managed care. If a carve in of behavioral health services is approved by the NC General Assembly, these populations will be enrolled in PHPs to receive integrated physical health, behavioral health, and pharmacy services at the launch of the managed care program.<sup>5</sup>

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<sup>4</sup> The statewide expansion was authorized by the General Assembly in 2011 in Session Law 2011-264, available at <http://www.ncleg.net/EnactedLegislation/SessionLaws/HTML/2011-2012/SL2011-264.html>

<sup>5</sup> North Carolina has separate payment and delivery systems for physical health services and behavioral health and intellectual/developmental disabilities (I/DD) services. Physical health services are managed through DHHS's Primary Care Case Management (PCCM) program, while behavioral health and I/DD services are delivered by LME-MCOs. Medicaid beneficiaries who are not dually enrolled in Medicare and reside in nursing homes for less than 90 days will be included in managed care from the onset of PHP operations in 2019. Moving forward, DHHS will work with the General Assembly to include behavioral health and I/DD services in the broader Medicaid managed care program and create integrated managed care products for all enrollees.

### Populations Not Initially Included in Managed Care Enrollment

There are limited exceptions to mandatory enrollment for certain populations who may be better served outside of managed care. These populations are either *exempt* (meaning they may choose, but are not required, to enroll in Medicaid managed care) or *excluded* (meaning they must remain enrolled in fee-for-service and may not enroll in managed care). In addition, certain populations will be delayed in their enrollment, allowing for additional time to conduct thoughtful planning and a smooth transition to managed care. Excluded, exempt and delayed populations are described in Figure 1 below.

Figure 1. Populations Exempt, Excluded and Delayed from Managed Care

Exempt Populations	
<ul style="list-style-type: none"> <li>Members of federally recognized tribes<sup>6</sup></li> </ul>	
Excluded Populations <sup>7</sup>	
<ul style="list-style-type: none"> <li>Program of All-Inclusive Care for the Elderly (PACE) beneficiaries</li> <li>Medically needy beneficiaries (also known as “Spend Down”) except for those enrolled in the Innovations, Community Alternatives for Children (CAP/C), Community Alternatives for Disabled Adults (CAP/DA) and Traumatic Brain Injury (TBI) waivers<sup>8</sup></li> <li>Beneficiaries only eligible for emergency services</li> <li>Presumptively eligible beneficiaries, during the period of presumptive eligibility</li> <li>Health Insurance Premium Payment (HIPP) beneficiaries, except for those enrolled in the Innovations, CAP/C, CAP/DA and TBI waivers</li> <li>Family planning beneficiaries</li> <li>Prison inmates</li> </ul>	
Delayed Populations <sup>9</sup>	
Special Populations	Expected Phase-In Timeline (no earlier than):
<ul style="list-style-type: none"> <li>Certain Medicaid and NC Health Choice beneficiaries with an SMI, SED, SUD or I/DD diagnosis and those enrolled in the TBI waiver<sup>10</sup></li> </ul>	<ul style="list-style-type: none"> <li>2 years after managed care implementation</li> </ul>

<sup>6</sup> North Carolina consulted with its only federally-recognized tribe – the Eastern Band of Cherokee Indians (EBCI) – and concluded that tribal members will benefit from having the choice between Medicaid fee-for-service or enrollment in a PHP. DHHS is in discussions with the EBCI Tribe on pathways to becoming the first Native American managed care entity in the country and is exploring options for Tribal enrollees who elect to participate in PHPs. DHHS will work with the General Assembly on the changes necessary to allow the EBCI to offer a managed care plan/tribal option. Current estimates indicate there are approximately 4,000 EBCI members enrolled in Medicaid.

<sup>7</sup> NC Session Law 2015-245 as amended by Session Law 2016-121 excludes all populations listed in this column, with the exception of family planning beneficiaries, individuals receiving refugee medical assistance and prison inmates. In addition, DHHS is seeking authority to exclude family planning beneficiaries prison inmates and individuals receiving refugee medical assistance, as well as include medically needy and HIPP beneficiaries enrolled in the Innovations, CAP/C, CAP/DA and TBI waivers. In addition, beneficiaries who are dually eligible members for Medicare and Medicaid are excluded; but are not included in this list. The State is contemplating phasing these members in to managed care, pending statutory amendments, as noted in Figure 2.

<sup>8</sup> The State submitted an application for its TBI waiver to CMS on Feb. 29, 2016. The waiver request is undergoing CMS review and, if approved, will apply to qualifying individuals enrolled in the Alliance Behavioral Health LME-MCO (Cumberland, Durham, Johnston and Wake counties).

<sup>9</sup> The delayed mandatory enrollment plan is contingent on approval by the General Assembly.

<sup>10</sup> Pending additional legislative authority, the State may permit individuals who are dually eligible for Medicare and Medicaid and have an SMI, SED, SUD or I/DD to enroll in a limited BH I/DD Tailored Plan wrap product for their Medicaid-covered BH and I/DD services at BH I/DD Tailored Plan launch.

<ul style="list-style-type: none"> <li>• Foster Children</li> </ul>	<ul style="list-style-type: none"> <li>• 2 years after managed care implementation</li> </ul>
<ul style="list-style-type: none"> <li>• Medicaid-only beneficiaries receiving long-stay nursing home services</li> </ul>	<ul style="list-style-type: none"> <li>• No sooner than 5 years after managed care implementation</li> </ul>
<ul style="list-style-type: none"> <li>• Medicaid-only CAP/C and CAP/DA waiver beneficiaries<sup>11</sup></li> </ul>	<ul style="list-style-type: none"> <li>• No sooner than 5 years after managed care implementation</li> </ul>
<ul style="list-style-type: none"> <li>• Individuals who are dually-eligible for Medicare and Medicaid</li> </ul>	<ul style="list-style-type: none"> <li>• No sooner than 5 years after managed care implementation</li> </ul>

Additional information on this transition is available in *North Carolina’s Proposed Program Design for Medicaid Managed Care and North Carolina’s Amended Waiver Application*.<sup>12</sup>

### **Linking Quality Strategies for Special Populations During the Transition**

This Quality Strategy focuses on measuring quality performance and outcomes in the early years of managed care, affecting the populations that will transition to managed care immediately (outlined above); it will expand to capture additional populations as they are brought into managed care over time. During the transition, North Carolina will continue to operate existing plans and waiver programs for certain special populations, including LME-MCOs, which will provide behavioral health services to individuals with qualifying behavioral health diagnoses (as noted below). During this time of transition, the quality measures and requirements for each of these special programs will remain in place, and all State Medicaid programs will be focused on the unifying Aims outlined in the section that follows.

Information on the LME-MCO Quality Strategy<sup>13</sup> is appended to this document and quality requirements associated with the CAP/C and CAP/DA waivers are available online:

- [CAP/C Waiver](#)
- [CAP/DA Waiver](#)

## **(B) Quality Strategy Aims, Goals, Objectives, and Measures**

North Carolina’s Quality Strategy is built around the desire to build an innovative, whole-person, well-coordinated system of care, which addresses both medical and non-medical drivers of health and promotes health equity. This vision is distilled into three central Aims:

- (1) Better Care Delivery**
- (2) Healthier People, Healthier Communities**
- (3) Smarter Spending**

<sup>11</sup> If an individual is a CAP/C or CAP/DA waiver beneficiary and also a Health Insurance Premium Payment (HIPP) beneficiary, he or she will be excluded from mandatory managed care.

<sup>12</sup> North Carolina’s Proposed Program Design for Medicaid Managed Care, August 2017. Available Online at: [https://files.nc.gov/ncdhhs/MedicaidManagedCare\\_ProposedProgramDesign\\_FINAL\\_20170808.pdf](https://files.nc.gov/ncdhhs/MedicaidManagedCare_ProposedProgramDesign_FINAL_20170808.pdf)

<sup>13</sup> The LME-MCO Quality strategy will be appended to this document upon final submission to CMS.



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, as is shown in Figure 3 below, 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 in the state. These Aims and Goals were designed to align closely with [CMS’s Quality Strategy](#), adapted to address local priorities, challenges, and opportunities for North Carolina’s Medicaid program.

Figure 3. North Carolina’s Quality Strategy Aims, Goals and Objectives

Aims	Goals	Objectives
<b>Aim 1: Better Care Delivery.</b> <i>Make health care more person-centered, coordinated and accessible.</i>	<b>Goal 1: Ensure appropriate access to care</b>	Objective 1.1: Ensure timely access to care
		Objective 1.2: Maintain Medicaid provider engagement
	<b>Goal 2: Drive patient-centered, whole person care</b>	Objective 2.1: Promote patient engagement in care
		Objective 2.2: Link patients to appropriate care management and care coordination services
		Objective 2.3: Address behavioral and physical health comorbidities
	<b>Aim 2: Healthier People, Healthier Communities.</b> <i>Improve the health of North Carolinians through prevention, better treatment of chronic conditions, and better behavioral health care, working collaboratively with community partners.</i>	<b>Goal 3: Promote wellness and prevention</b>
Objective 3.2: Promote women’s health		
Objective 3.3: Maximize long term services and supports (LTSS) populations’ quality of life		
<b>Goal 4: Improve chronic condition management</b>		Objective 4.1: Improve behavioral health care
		Objective 4.2: Improve diabetes management
		Objective 4.3: Improve asthma management
		Objective 4.4: Improve hypertension management
<b>Goal 5: Work with communities to improve population health</b>		Objective 5.1: Address unmet resource needs
		Objective 5.2: Address the opioid crisis
		Objective 5.3: Address tobacco use
		Objective 5.4: Reduce health disparities
		Objective 5.5: Address obesity
<b>Aim 3: Smarter Spending</b> <i>Pay for value rather than volume, incentivize innovation and ensure appropriate care.</i>	<b>Goal 6: Pay for value</b>	Objective 6.1: Ensure high-value, appropriate care

## Development of the Quality Strategy Aims, Goals, and Objectives

These Goals and Objectives reflect significant community and stakeholder input as well as thoughtful consideration of the quality issues that are most important in North Carolina. DHHS contracted with the North Carolina Institute of Medicine (NCIOM) Task Force on Health Care Analytics (or, the “NCIOM Task Force”) to convene stakeholders across the state to issue recommendations on the specific quality metrics North Carolina Medicaid should focus on during and throughout the transition to managed care. The NCIOM Task Force brought together a statewide group of providers, beneficiaries, quality experts, and managed care plan representatives who recommended a set of Medicaid quality measures to be used to drive improvement in the health of Medicaid beneficiaries.<sup>14</sup> This Quality Strategy and its Objectives recognize that significant process, and are aligned closely with the measures the NCIOM Task Force put forth.

DHHS additionally considered the quality areas of greatest importance to the North Carolina Medicaid population, and where current data indicated an opportunity for targeted improvement. The Objectives set forth are similarly aligned to ensuring beneficiary access to services, particularly in the context of the State’s transition to managed care. For example:

- Objective 1.2 (maintain Medicaid provider engagement) under **Goal 1** (ensure appropriate access to care) recognizes the need to maintain North Carolina’s historically high rate of provider participation in Medicaid to fully meet beneficiaries’ needs, including convenient access to the appropriate range of providers in a timely manner.
- Objectives related to **Goal 2** (drive patient-centered, whole-person care) seek to ensure that beneficiaries are engaged in their health care and are satisfied with their PHP, in addition to ensuring that they are linked to an Advanced Medical Home (AMH) provider, described further in Section II(C).
- The objectives aligned to **Goal 3** (promote wellness and prevention) reflect a continued emphasis on improving the health of children and women – populations that represent, respectively, 60 percent and 58 percent of Medicaid beneficiaries in the State as of 2016.<sup>15</sup>
- Objectives related to **Goal 4** (improve chronic condition management) focus on conditions that heavily impact the North Carolina Medicaid population, including asthma, diabetes, behavioral health, and hypertension. While other chronic conditions were additionally considered for inclusion, DHHS sought to focus on select, targeted priorities that allow for demonstrable progress, reinforced by the NCIOM Task Force’s recommendations and of relevance to existing and newly covered populations in managed care.
- Multiple tie to **Goal 5** (work with communities to improve population health); these Objectives emphasize areas where community engagement will be critical to advancing a high-quality health system, such as meeting unmet resource needs and combating the opioid epidemic. These Objectives recognize and build upon the progress that has been made at a local level throughout the State.

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<sup>14</sup> Available at: <http://nciom.org/metrics-to-drive-improvements-in-health-a-report-of-the-task-force-on-health-care-analytics/>

<sup>15</sup> Medicaid and NC Health Choice Annual Report for State Fiscal Year 2016. Available at: <https://files.nc.gov/ncdma/documents/files/Medicaid-Annual-Report-State-Fiscal-Year-2016.pdf>

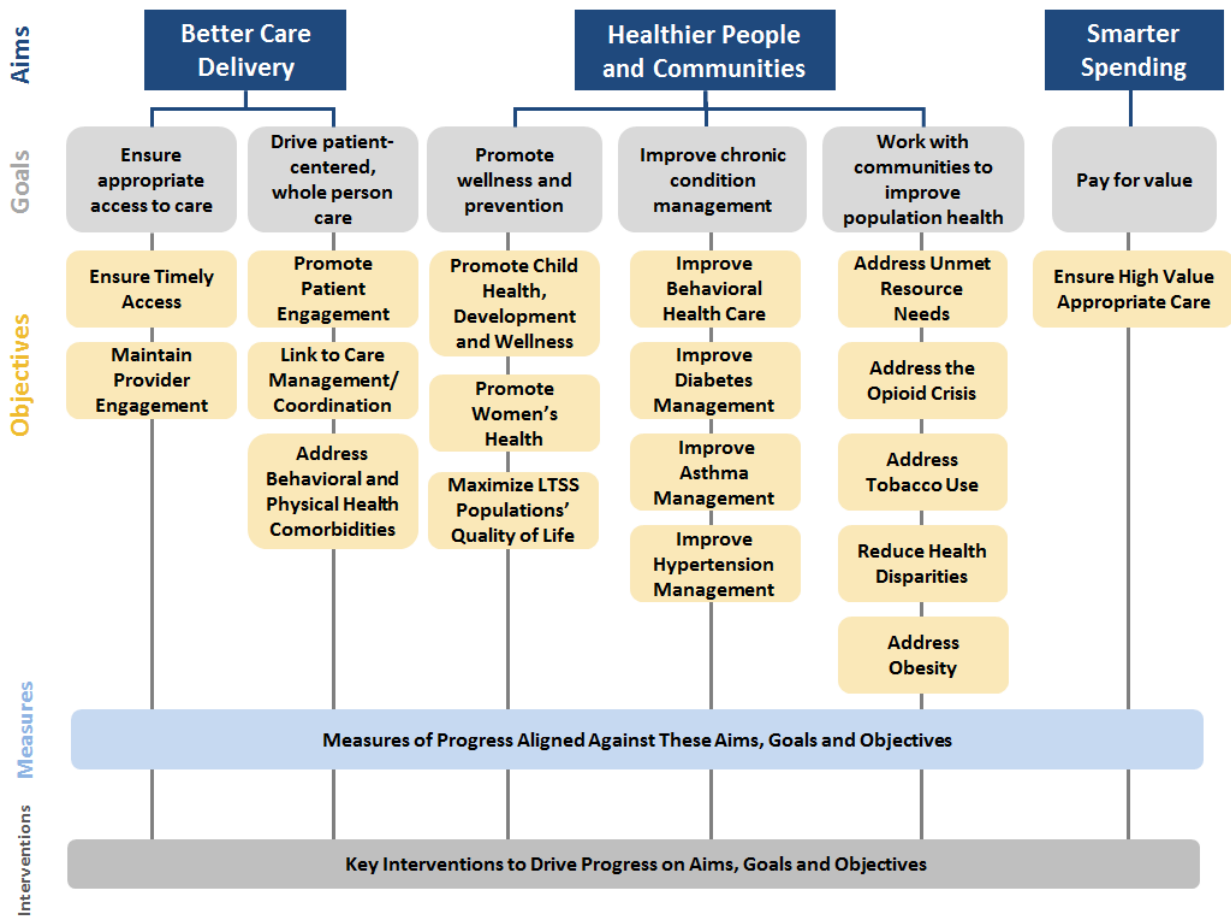
- **Behavioral health** is elevated in multiple places throughout these Objectives, in recognition of the complexity of delivering high-quality care for populations with behavioral health needs, and the prevalence and cost of coexisting behavioral and physical health disorders.
- Similarly, the Quality Strategy highlights a key Objective related to **populations with LTSS needs**; however, most quality Objectives and measures in this Quality Strategy apply to populations with LTSS needs enrolled in PHPs.

Each of the 18 Objectives are tied to a series of focused interventions (described in detail in Section II(C)) used to drive improvements within, and in many cases across, the Goals and Objectives set forth in this Quality Strategy. To assess the impact of these interventions and continue to identify opportunities for improving the quality of care delivered under Medicaid managed care, and in compliance with the requirements set forth in 42 CFR 438.340(b)(2), these interventions are tied to a set of metrics by which progress is assessed.

As baseline data related to PHP performance becomes available, DHHS intends to further refine these Objectives to target specific improvement goals, including additional metrics that address disparities in health. As described in Section III(B), PHPs are required to maintain systems that collect, analyze, integrate, and report encounter data in a timely, accurate, and complete way. This data is used for several purposes, and will be key to the quality of North Carolina's Medicaid managed care program, as directly related to quality performance and otherwise. The External Quality Review Organization (EQRO), further discussed in Section IV(A) and Appendix B of this Quality Strategy, will play a critical role in ensuring the validity of PHPs' reported encounter data, as well as in the validation and calculation of quality measures. DHHS is committed to using these reports to assess opportunities for continued improvement, and how priorities may evolve over time and as additional populations are enrolled in managed care.

Together, this framework represents a comprehensive plan for delivering high quality, accessible, timely care to Medicaid managed care beneficiaries (Figure 4).

Figure 4. Overview of the Quality Strategy Framework



**Overview of Quality Measures**

North Carolina has developed standard performance measures, as required by 42 CFR 438.330(c), that PHPs are required to measure and report to DHHS, as outlined below. Consistent with DHHS’s desire to benchmark its progress against other states’ performance and assess key priorities to drive continuous quality improvement efforts, nearly all of these measures are nationally-recognized. For select areas of priority, PHPs are required to report certain administrative and program-specific measures critical to DHHS’s ability to comprehensively assess performance against the Goals and Objectives set forth in this Quality Strategy.

DHHS requires PHPs to report in a timely, complete, and accurate manner:

- A select set of CMS Adult and Child Core measures, including – at minimum – those outlined in Appendix A of this Quality Strategy and those historically reported to CMS;<sup>16,17</sup>
- All HEDIS measures required for accreditation, regardless of whether the PHP has achieved accreditation to date (PHPs are required to achieve accreditation by Year 3 of operations, as further discussed in Section II(C)(8));
- A select set of additional measures aligned to the Aims, Goals, and Objectives of the Quality Strategy, as identified in Appendix A; and

Additionally, and as is further described in Section IV(A), the EQRO provides DHHS with the results of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey which asks beneficiaries to report on their experiences accessing care.<sup>18</sup>

DHHS uses these patient-reported measures as part of its evaluation of PHP performance and to consider areas that may require additional focus and prioritization as North Carolina’s program and its beneficiaries’ needs evolve. As other special plans and programs are included in managed care, DHHS will assess the incorporation of special population-targeted quality measures. DHHS will continue reporting a subset of the Adult and Child Core measures to CMS, with the goal of increasing the number of Adult and Child Core measures it reports over time.

In addition to quality measures set forth in this Quality Strategy, DHHS requires that PHPs report across several additional areas, including access (as noted in Section II) and compliance with state standards (as noted in Section IV). DHHS will review these reports for quality assurance and improvement purposes, as is further discussed within Section III and IV of this Quality Strategy.

#### *“Priority” Performance Measures*

In addition to DHHS’s continuous quality improvement efforts that evaluate the universe of quality measures outlined above, a focused subset of 33 measures outlined in Appendix A are closely aligned to the Aims, Goals, and Objectives of this Quality Strategy and will be used to monitor and assess individual and collective PHP progress. This prioritized measure list provides PHPs and other stakeholders with an understanding of the key areas of focus aligned with this Quality Strategy and where DHHS has identified the greatest areas of opportunity and need. This focused set of measures will evolve over time as part of the State’s continuous quality improvement process, and as additional and/or alternate areas of opportunity are identified for prioritization. These measures will serve as the basis for the following efforts:

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<sup>16</sup> 2015 annual state reporting for adults is available at: <https://data.medicaid.gov/Quality/2015-Adult-Health-Care-Quality-Measures/hzfi-hf43>; 2015 annual state reporting for children is available at: <https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/child-core-set/index.html>

<sup>17</sup> For more information on the Child and Adult Core Set, see: <https://www.medicaid.gov/federal-policy-guidance/downloads/cib111417.pdf>

<sup>18</sup> For more information on the CAHPS Health Plan Survey, see: <https://www.qualityforum.org/QPS/MeasureDetails.aspx?standardID=903&print=0&entityTypeID=1>

- The development of an annual disparity report that assesses select measures by select strata including age, race, ethnicity, sex, primary language, and disability status<sup>19</sup> broken out, where possible, by key population groups (e.g., LTSS) and geography; and
- The ongoing publication of PHPs' quality performance on the DHHS website.

#### *Behavioral Health Measures — Focusing on Integration in Standard Plans*

As described above, the State has selected multiple Objectives focused specifically on behavioral health, each of which is tied to select quality measures described in Appendix A. These Objectives and the related measures were selected based on alignment with current State reporting on behavioral health measures (both through LME-MCOs and CMS Adult and Child Core measures) and to reflect emerging best practices from leaders on behavioral health measurement, including the National Quality Forum, the Institute for Healthcare Improvement, the Agency for Healthcare Research and Quality (AHRQ), and the Substance Abuse and Mental Health Services Administration (SAMHSA), among others.

#### *LTSS Measures — Focusing on Quality of Life, Rebalancing, and Community Integration*

As described above, the State has set forth an Objective focused specifically on LTSS populations, which is tied to select quality measures described in Appendix A. The LTSS Objective and related measures were selected because they are priorities expressed by these beneficiaries, are comparable across all PHP-covered HCBS and short-stay nursing home beneficiaries, comply with the requirements set forth in 42 CFR 438.340(b)(1) related to quality of life, rebalancing, and community integration activities for individuals receiving LTSS, and reflect best practices identified by the National Quality Forum.<sup>20</sup> Note that some of these metrics will rely on standardized assessments to be conducted by PHPs.

## **(C) Development and Review Of The Quality Strategy**

### **Initial Quality Strategy**

A critical element of transitioning North Carolina's Medicaid program from a fee-for-service to managed care structure has been extensive stakeholder involvement and feedback, including the publication of *North Carolina's Proposed Program Design for Medicaid Managed Care*, for which a 30-day public comment period was issued in August 2017.<sup>21</sup> This program design document laid the groundwork for how DHHS will drive quality, value, care improvement, beneficiary protections, and PHP accountability in a new managed care environment. DHHS also released a Request for Information (RFI) to solicit feedback from potential PHPs and other interested stakeholders on options and considerations related

<sup>19</sup> Disability status, as set forth by 42 CFR 438.340(b)(6), means whether the individual qualified for Medicaid on the basis of a disability.

<sup>20</sup> Quality in Home and Community-Based Services to Support Community Living: Addressing Gaps in Performance Measurement, National Quality Forum, September 2016. Available online at: [http://www.qualityforum.org/Publications/2016/09/Quality\\_in\\_Home\\_and\\_Community-Based\\_Services\\_to\\_Support\\_Community\\_Living\\_Addressing\\_Gaps\\_in\\_Performance\\_Measurement.aspx](http://www.qualityforum.org/Publications/2016/09/Quality_in_Home_and_Community-Based_Services_to_Support_Community_Living_Addressing_Gaps_in_Performance_Measurement.aspx)

<sup>21</sup> North Carolina's Proposed Program Design for Medicaid Managed Care. August 2017. Available Online at: [https://files.nc.gov/ncdhhs/MedicaidManagedCare\\_ProposedProgramDesign\\_FINAL\\_20170808.pdf](https://files.nc.gov/ncdhhs/MedicaidManagedCare_ProposedProgramDesign_FINAL_20170808.pdf)

to PHP design and implementation, including several interventions (e.g., value-based payment) addressed by the Quality Strategy.<sup>22</sup>

As outlined in Section I(B), quality priorities and interventions were derived from review of performance against existing quality measures and outcomes in North Carolina, and built upon the work of the North Carolina Institute of Medicine (NCIOM) Task Force on Health Care Analytics. In addition to the stakeholder engagement activities critical to Medicaid transformation, including work on this Quality Strategy, the following steps were taken to receive input on the Quality Strategy itself, consistent with the standards set forth in 42 CFR 438.340(c):

- Input was obtained from the Medical Care Advisory Committee; and
- The Eastern Band of Cherokee Indians (EBCI) Tribe was consulted in accordance with the State's Tribal consultation policy.

Further, and prior to finalizing this initial Quality Strategy, DHHS will make the Quality Strategy available for a public comment period, used to obtain input from interested stakeholders. At the completion of this comment period, consistent with the requirements set forth in 42 CFR 438.340(c-d), DHHS will incorporate edits to the Quality Strategy as appropriate and submit the document to CMS for feedback prior to adopting it as final. DHHS will make the final Quality Strategy available on its website.

#### **Updates to the Quality Strategy**

DHHS will review and update the Quality Strategy as needed or upon a significant change, and no less than once every three years.<sup>23</sup> The process for reviewing the Quality Strategy will include an evaluation of its effectiveness in the previous three years (or, if updated sooner, since the Quality Strategy's implementation), the results of which will be made publicly available on the DHHS website. For purposes of updating and reviewing the Quality Strategy, "significant change" is defined as:

- A pervasive pattern of quality deficiencies identified through analysis of the quality performance data submitted by the PHPs that results in a change to the Goals or Objectives of the Quality Strategy;
- Overarching changes to quality standards resulting from regulatory authorities or legislation at the State or federal level; or
- A change in membership demographics or the provider network of 50 percent or greater within one year.

Changes to formatting, dates, or other similar edits are defined as "insignificant," as well as regulatory/legislative changes that do not change the intent or content of the requirements contained within. Changes to the details included in the Appendices of the Quality Strategy will also be considered insignificant, but appendices will be regularly updated as needed in the version of the Quality Strategy posted online.

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<sup>22</sup> For additional information on the November 2017 RFIs, see: <https://www.ncdhhs.gov/news/press-releases/dhhs-releases-request-information-medicare-managed-care-program>

<sup>23</sup> This Quality Strategy will start at the launch of managed care, currently planned for July 1, 2019, with an update on or before June 30, 2022 or upon significant change.

Updates to the Quality Strategy will be a part of North Carolina’s continuous quality improvement process and, as required by 42 CFR 438.340(c)(2)(iii), will consider the recommendations provided by the External Quality Review Organization (EQRO) for: (1) improving the quality of health care services furnished by each PHP; and (2) how DHHS can target Goals and Objectives in the Quality Strategy to better support improvement in the quality, timeliness, and access to health care services furnished to Medicaid beneficiaries. Additional information regarding the EQRO’s quality functions can be found in Section IV(A) and Appendix B of this Quality Strategy.

## II. Improvements and Interventions

### (A) PHP Quality Assessment and Performance Improvement Programs

DHHS requires that PHPs, in compliance with 42 CFR 438.330 and additional DHHS requirements, establish and implement an ongoing comprehensive Quality Assessment and Performance Improvement program (QAPI) that must be reviewed and approved by DHHS and include:

- Completion of DHHS-specified performance improvement projects (further described under *Performance Improvement Projects* below);
- Collection and submission of all designated quality performance measurement data (outlined in Section I(B));
- Mechanisms to detect both underutilization and overutilization of services;
- Mechanisms to assess the quality and appropriateness of care for beneficiaries with special health care needs (defined in Section III(A));
- Mechanisms to assess and address health disparities, including findings from the EQRO-developed annual disparity report (further discussed in Section IV(A));
- Mechanisms to assess the quality and appropriateness of care provided to beneficiaries needing long-term services and supports, including assessment of care between settings and a comparison of services and supports received with those set forth in the beneficiary’s treatment/service plan; and
- Participation in efforts by the State to prevent, detect, and remediate critical incidents.

So that DHHS may monitor and ensure the accuracy of PHP reporting, and assess performance against those measures on a PHP-specific and program-wide basis as described in Section IV(A), PHPs must:

- Provide all quality data outlined in Section I(B) on, at minimum, an annual basis to DHHS and the DHHS-specified EQRO;
- Provide to DHHS all accreditation reports; and
- Provide all information required by the EQRO, in compliance with the protocols set forth by CMS for the EQRO activities outlined in Appendix B.<sup>24</sup>

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<sup>24</sup> CMS protocols for EQR-related activities are available at: <https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html>



In addition to the assessments DHHS and the EQRO will conduct to oversee PHPs' performance against the quality Aims, Objectives, and measures further described in Section I(B), PHPs are also required to develop a process to evaluate the impact and effectiveness of their own QAPIs. A description of this PHP process must be submitted to and approved by DHHS with submission of the QAPI itself and be closely aligned to this Quality Strategy.

Further, PHPs are required to participate in ongoing cross-PHP meetings with DHHS and PHP Quality Directors designed to exchange and build upon PHP-identified best practices, discuss arising issues, and plan for upcoming projects. PHPs are also required to participate in an annual Quality Improvement Collaborative. The Quality Management Committee (further described in Section I(C)) serves as a key DHHS interface with PHPs, and is driven by the data collected throughout the assessment processes further described in Section IV(A).

### **Performance Improvement Projects (PIPs)**

In compliance with 42 CFR 438.330(d), and as part of each QAPI, PHPs are required to conduct PIPs that: are designed to achieve significant improvement, sustained over time, in health outcomes and enrollee satisfaction; include measurement of performance using objective quality indicators; include implementation of interventions to achieve improvement in the access to and quality of care; include evaluation of the effectiveness of the interventions based on the performance measures included in Appendix A; and include planning and initiation of activities for increasing or sustaining improvement.

Specifically, PHPs are required to conduct at least three (3) PIPs annually, which must be approved by DHHS, and include:<sup>25</sup>

- Two (2) clinical PIPs, for which PHPs may select a topic of choice from the following four topic areas:
  1. Pregnancy intendedness;
  2. Tobacco cessation;
  3. Diabetes; or
  4. Behavioral health integration.
- One (1) non-clinical PIP, which must be aligned to the Aims, Goals, Objectives, and interventions outlined within this Quality Strategy.

In addition to the PIPs required above, for all overall CMS 416 rates<sup>26</sup> below 75 percent, each PHP must submit an additional PIP on EPSDT screening and community outreach plans.

PHPs will be required to report the status and results of each PIP conducted no less than once annually; these results will, as noted in this Section and Section IV(A), be validated by the External Quality Review Organization and reviewed by DHHS.

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<sup>25</sup> CMS has not specified standard, nationally required PIPs to date.

<sup>26</sup> Form CMS-416 is a required annual Early And Periodic Screening, Diagnostic, and Treatment (EPSDT) screening and participation performance report for state Medicaid agencies to assess the effectiveness of EPSDT services.

## (B) DHHS Quality Management Structure

The State's Quality Management approach is designed to measure and monitor PHP performance against PHP requirements through Quality Assurance, Quality Improvement and Innovation activities for all enrollees, including those with Special Health Care Needs.<sup>27</sup> The State plans to utilize its Quality Management Department and a Quality Management (QM) subcommittee to effectively monitor and review PHP performance across these quality efforts to support key decision-making and ongoing assessment of PHP performance against the Aims, Goals and Objectives previously noted. The QM Committee will be developed to include PHPs, providers, and other stakeholders, such as beneficiaries. The QM Committee is charged with providing input to DHHS on the following elements of its Quality Strategy and its ongoing execution:

- Review and provide feedback on PHPs' proposed Quality Assessment and Performance Improvement Program plans, (further discussed in Section II(A))
- Provide feedback on updates to and revisions of the written Quality Strategy, including accounting for the recommendations put forth by the EQRO
- Provide feedback on the development of and changes to key NC DHHS programs designed to assess PHP performance, reward quality improvement, and ensure PHP accountability, including the PHP withholds program (further discussed in Section IV(A))
- Provide input on updates to the quality measure set PHPs are required to report to DHHS and the measures on the priority measure set, based on statewide priorities, clinical advancements, and/or opportunities to expand the number of CMS Adult and Child Core measures reported

This Committee structure is designed to closely interact with the DHHS management team and staff involved in the development of the interventions described throughout this Quality Strategy and that are contingent upon stakeholder engagement for implementation and ongoing review.

## (C) Interventions

North Carolina has developed a series of interventions aligned closely to this Quality Strategy and designed to build an innovative, whole person centered, well-coordinated system of care, that addresses both medical and non-medical drivers of health. These interventions drive progress towards

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<sup>27</sup> Adults and children with special health care needs are defined as follows:

- Children with Special Health Care Needs are defined as those who have or are at increased risk of having a serious or chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that usually expected for the child's age. This includes, but is not limited to, children or infants: in foster care; requiring care in the Neonatal Intensive Care Units; with neonatal abstinence syndrome; in high stress social environments/toxic stress; receiving Early Intervention; with an SED, I/DD or SUD diagnosis; and/or receiving 1915(b)(3), Innovations or TBI Waiver Services.
- Adults with Special Health Care Needs are defined as those who have or are at increased risk of having a chronic illness and/or a physical, developmental, behavioral or emotional condition and who also require health and related services of a type or amount beyond that usually expected for individuals of similar age. This includes, but is not limited to individuals: with HIV/AIDS; an SMI, SED, I/DD or SUD diagnosis (including opioid addiction), chronic pain; or receiving 1915(b)(3), Innovations or TBI Waiver services.

the Quality Strategy Aims, Goals and Objectives described in Section I(B). Further, progress against these Aims, Goals, and Objectives – and the role of interventions in achieving those Goals – will be assessed using the measures defined in Appendix A of this document along with utilization measures defined within and related to individual interventions. Figure 5 provides an overview of these interventions and how they intersect to advance the objectives set forth within this Strategy.

Figure 5. Linking Interventions to Objectives

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

Each intervention is described in brief, below. In addition, many of these interventions are described in further detail in *North Carolina's Proposed Program Design for Medicaid Managed Care*,<sup>28</sup> and are described in a series of Concept Papers related to North Carolina's Medicaid Transformation.<sup>29</sup>

## **(1) Opioid Strategy**

Like many states, North Carolina is facing an opioid crisis that has worsened over the last decade.<sup>30</sup> The Quality Strategy, in recognition of this crisis, includes a specific Objective (Objective 5.2) related to addressing the opioid crisis, and other Objectives tied to behavioral health, which are impacted by the crisis as well. Building on the NC Opioid Action Plan to reduce opioid addiction and overdose deaths from 2017-2021,<sup>31</sup> North Carolina's Medicaid opioid strategy includes reviewing clinical policies related to prevention of opioid misuse and effective chronic pain treatment to ensure alignment with evidence-based best practices and, effective August 2017, requiring prior approval for certain prescriptions or supply sizes. DHHS recently strengthened its beneficiary lock-in program,<sup>32</sup> and is working to specify policies that PHPs are required to implement, including beneficiary lock-in programs, Strengthen Opioid Misuse Prevention (STOP) Act provisions,<sup>33</sup> increasing access to non-opioid and non-pharmacologic pain management modalities, and specialized education, training, and other best practices for chronic pain management and opiate prescribing.

As is further described in Section III(A) of this Strategy, PHPs are required to report on access to Pain Management specialists as part of the State's network adequacy requirements. Finally, DHHS is seeking a waiver of the Institutions for Mental Diseases (IMD) exclusion to improve access to residential treatment for substance use disorders, and is considering several other interventions which could further advance efforts in line with this quality Objective.

## **(2) Social Determinants of Health Strategy**

Central to the State's effort to improve access, quality, and timeliness of care is a commitment to address unmet health-related resource needs or the social determinants of health—"the structural determinants and conditions in which people are born, grow, live, work and age."<sup>34</sup> Stakeholder

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<sup>28</sup> North Carolina's Proposed Program Design for Medicaid Managed Care. August 2017. Available Online at: [https://files.nc.gov/ncdhhs/MedicaidManagedCare\\_ProposedProgramDesign\\_FINAL\\_20170808.pdf](https://files.nc.gov/ncdhhs/MedicaidManagedCare_ProposedProgramDesign_FINAL_20170808.pdf)

<sup>29</sup> Concept Papers related to North Carolina's Medicaid transformation are available online at: <https://www.ncdhhs.gov/nc-medicaid-transformation>

<sup>30</sup> North Carolina's Opioid Action Plan, 2017-2020

<sup>31</sup> Ibid.

<sup>32</sup> The program restricts beneficiaries who meet at least one of the following criteria to a single prescriber and pharmacy: beneficiaries with six claims of opiates, benzodiazepines and certain anxiolytics; beneficiaries receiving prescriptions for these drugs from more than three prescribers in two consecutive months; or referral from a provider, DMA or CCNC. NCHC enrollees are not subject to lock-in provisions

<sup>33</sup> NC Session Law 2017-74

<sup>34</sup> Michael Marmot et al., "Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health," *The Lancet* 372, no. 9650 (Nov. 8, 2008):1661–1669.

feedback has consistently cited food insecurity, housing instability, and transportation challenges as critical barriers to health, among other risks important to underlying health status, such as interpersonal violence and trauma. These and other social determinants disproportionately impact Medicaid beneficiaries, increase the risk of patients developing chronic conditions, and drive cost; further, these social factors are tied to 70 percent of health outcomes.<sup>35,36</sup>

To effectively address these challenges, DHHS is embedding strategies to address social determinants into its Medicaid program in several ways, including but not limited to:<sup>37</sup>

- A standardized screening instrument related to food insecurity, housing instability, transportation needs, and interpersonal violence, which PHPs will be expected to use to screen Medicaid beneficiaries as they enroll in the plan. PHPs' screening rates constitute a quality measure noted in Sections I(B) and Appendix A<sup>38</sup>
- Ensuring PHPs provide assistance securing health-related services and resource navigation to beneficiaries identified with unmet health-related resource needs
- Supporting evidence-based, regional public-private pilots that provide enrollees with information, services and benefits to address unmet health-related resource needs and measurably improve health and lower costs. PHPs will be required to participate in and collaborate with pilot entities.
- Expanding efforts to map social determinants of health indicators to identify high disparity areas to help guide community planning and resource investment
- Supporting the development of a statewide resource database accessible both online and through a call center

Additionally, PHPs are responsible for reporting on unmet resource needs amongst beneficiaries and efforts to address identified unmet needs. In subsequent years, additional measures will be developed that assess rates of successful resource linkage and, eventually, improvements tied to addressing unmet resource needs.

### **(3) Advanced Medical Homes (AMHs)**

A key strategy in the transition to managed care is to build on the successes of North Carolina's Primary Care Case Management (PCCM) program through the development of a new Advanced Medical Home (AMH) model. The AMH model is designed to strengthen the ability of primary care practices to offer

<sup>35</sup> Linkins KW, Brya JJ, Chandler DW. Frequent users of health services initiative: final evaluation report. 2008 Institute of Medicine. 2015. Capturing Social and Behavioral Domains and Measures in Electronic Health Records: Phase 2. Washington, DC: National Academies Press.

<sup>36</sup> McGinnis JM, Williams-Russo P, Knickman JR. The case for more active policy attention to health promotion. *Health Aff (Millwood)* 2002;21:78–93 Galea S, Tracy M, Hoggatt KJ, Dimaggio C, Karpati A. Estimated deaths attributable to social factors in the United States. *Am J Public Health*. 2011;101:1456–65.

<sup>37</sup> Certain social determinants of health initiatives are pending waiver authority; for more information, see: <https://www.ncdhhs.gov/news/press-releases/dhhs-submits-amendment-medicaid-waiver-application>

<sup>38</sup> Over time, other measures related to this screening may be added – such as the percent of enrollees screened who are high risk and are referred for unmet social needs and/or the percentage of enrollees screened who are high risk and have at least one social determinants of health-related goal in their care plan.

access to care for managed care beneficiaries (including extended office hours and non-visit based forms of access), enhance comprehensiveness of primary care and care management at the local level, and ensure strong preventive care. AMHs provide comprehensive primary and preventive care services to managed care beneficiaries, including patient-centered access, team-based care, population health management, care coordination across medical and social settings, and care management for high risk populations.

AMH certification is initially based on the Carolina Access program with placement into three “Tiers” based on practices’ ability to take on care management functions at the practice or local level. Over time, standards associated with select Tiers may evolve to encompass other advanced primary care functions, such as integration of behavioral health services. PHPs are required to contract with AMHs, and will be required to make incentive payments linked to quality measures and outcomes that are aligned to this Quality Strategy.

For most Medicaid populations, care management – whether episodic or chronic – will directly involve the AMH care team. The number of beneficiaries assigned to AMH practices is a key PHP performance measure, as is highlighted in Appendix A of this Strategy. The PHP plays a crucial role in monitoring care management activities, and takes direct responsibility for managing the care of any beneficiary not enrolled in an AMH, for whom the AMH is not able to meet his/her needs, or for where a local care manager is not available. PHPs are additionally required to take on care management functions that augment what AMHs can provide directly, and are incented to achieve certain DHHS-determined thresholds for the provision of care management at the local level.

#### **(4) Care Management for High-Risk Pregnancy**

North Carolina is known for its approach to high-risk pregnancy management, its high participation rate of perinatal providers in the Medicaid program, and its success in reducing maternal and child health disparities. The care management for high-risk pregnancy initiative builds on the State’s current approach and seeks to improve maternal health and birth outcomes via alignment of practice requirements, incentives, quality reporting, and care management activities for perinatal providers and across PHPs. At the practice level, the initiative consists of financial incentives tied to use of a uniform screening tool and postpartum follow up,<sup>39</sup> standard process expectations (e.g., no elective delivery prior to 39 weeks), quality measures, quality improvement activities, and provider engagement activities.<sup>40</sup> PHPs are required to follow the parameters of the program when contracting with and reimbursing perinatal providers.

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<sup>39</sup> At the start of managed care, PHPs are required to pay practices 50 dollars for every risk screening tool completed at initial visit and 150 dollars for every postpartum visit. Additionally, PHPs must provide an increased rate for vaginal deliveries.

<sup>40</sup> For additional information, see: <https://www.communitycarenc.org/media/files/pmh-data-overview.pdf>

A hallmark of the initiative is the provision of locally-based care/case management services. Pregnant women at high risk of poor maternal and/or infant outcomes may be referred into the program by maternity or other providers, or identified through PHP claims analysis. While retaining oversight and accountability for outcomes, PHPs are required to contract with Local Health Departments or other local care management entities to provide care/case management services to pregnant women at the practice or within the community during the first two years of managed care.

PHP performance is linked to the Quality Strategy through the quality measures noted in Section I(B) and Appendix A of this Strategy, which target specific maternal health outcomes. PHPs are also required to report performance for select process and quality improvement measures (e.g., the percentage of pregnant women screened for high-risk case management services).

## **(5) Care Management for At-Risk Children**

North Carolina has long been committed to addressing risk factors in children who have been exposed to toxic stress in early childhood, are in foster care, or otherwise have complex social or health needs. The Care Coordination for Children (CC4C) program serves children from birth to age five who meet specific risk criteria, providing them with a comprehensive health assessment and dedicated case management to coordinate roles and responsibilities for care. Consistent with the goals of this Quality Strategy, the program aims to improve health outcomes and reduce costs for enrolled children.

In managed care, PHPs are responsible for care management for high-risk young children and are required to preserve the strengths of the current model, which integrates social supports and provides local care/case management services. While retaining oversight and accountability for outcomes, PHPs are required to contract with Local Health Departments or other local care management entities for the provision of care/case management services during the first two years of managed care. As a key component of the broader social determinants of health strategy (described under *Social Determinants of Health Strategy* in this Section of the Quality Strategy), PHPs are expected to screen for, and provide assistance securing health-related services and resource navigation to all beneficiaries, including at-risk children.

PHPs are additionally required to meet quality measures that promote child health, wellness and prevention and are encouraged to develop broader models of care for addressing at-risk children.

## **(6) Behavioral Health Integration**

North Carolina has historically had separate payment and delivery systems for physical health and behavioral health services. At the launch of managed care, and pending legislative authority, Medicaid beneficiaries with lower intensity behavioral health and intellectual and developmental disability (I/DD) needs will, for the first time, receive integrated coverage for behavioral health and physical health services. This integration is a critical component of North Carolina's ability to deliver whole-person, well-coordinated care and is supported by the quality performance measures outlined in

Appendix A of this Quality Strategy and tied to Objective 2.2 to address physical and behavioral health comorbidities.

Further, PHPs are required to meet several requirements related to behavioral health needs. PHPs must identify individuals with significant behavioral health needs as a priority population for care management. PHPs are additionally required to comply with network adequacy standards specific to behavioral health providers, a core component of ensuring appropriate access to care, as outlined in Section II(A) of this Quality Strategy.

## **(7) Provider Supports**

Providers are critical partners in ensuring that the Goals and Objectives of the Quality Strategy are achieved and that interventions are successfully deployed. To build upon North Carolina's existing infrastructure to support clinical improvement, DHHS is providing, directly and through PHPs, additional resources tailored to advance state interventions and ensure providers' ability to achieve the goals outlined in this Quality Strategy. The supports are offered to assist providers in clinical transformation and care improvement efforts at a regional and practice level.

Support is available for AMH practices and other providers, as applicable, with the ongoing advancement of DHHS-led interventions, through two primary functions:

- **Stakeholder Forums.** Stakeholders, including but not limited to clinicians, are convened to address challenges, share best practices, and discuss implementation of quality improvement activities aligned with the Quality Strategy.
- **Technical Assistance.** Practice-level technical assistance is available to support providers with the transition to AMH and other population health improvement initiatives.

PHPs are required to actively participate in stakeholder forums and play a critical role in providing practice-level data to inform technical assistance activities. Additionally, PHPs are responsible for training providers on PHP-specific policies and programs, and must develop an overall training plan that will be reviewed by DHHS and include training on special populations.

## **(8) Workforce**

Addressing Medicaid workforce shortages in rural and underserved communities is a critical element of the State's Medicaid transformation efforts, and is core to meeting the access to care goals outlined in this Quality Strategy.



DHHS plans to commission a rigorous evaluation designed to identify gaps in the Medicaid workforce and launch an Innovation Workforce Fund to address shortages identified in the study.<sup>41</sup> The Fund is designed to provide an integrated suite of incentive programs, including loan repayment and recruitment bonuses to attract critical provider types to rural and underserved areas. The Fund complements existing state loan repayment programs and focuses on addressing shortages specific to the Medicaid population.

DHHS also plans to make Medicaid GME payments to community-based residency programs for provider types critical to population health improvement, including primary care, OB/GYN, general surgery, and community psychiatry. These additional investments in community-based residencies—combined with financial incentives to remain after residency training as part of the Innovation Workforce Fund—will further increase the pipeline of Medicaid providers in underserved areas.

## **(9) Telemedicine**

As the Medicaid program transitions to managed care, telemedicine will play a crucial role in increasing beneficiary access to care, improving outcomes, and decreasing costs. DHHS encourages PHPs to support the use of telemedicine as a tool for ensuring access to needed services. PHPs are permitted to develop their own policies related to telemedicine and telepsychiatry and may cover services and modalities over and above those covered under the State’s fee-for-service telemedicine policy. Additionally, when a PHP enrollee requires a medically necessary service that may not be available within the PHP network, the PHP may provide access to the service via telemedicine. Accordingly, PHPs are permitted in targeted circumstances to leverage telemedicine in their Request for Exception to DHHS’ network adequacy standards.<sup>42</sup>

DHHS also supports the establishment of an independent, statewide telemedicine alliance to increase provider awareness, education and training on telemedicine opportunities and best practices.<sup>43</sup> The Alliance will develop coordinated telemedicine policy priorities, provide a forum to convene stakeholders to share best practices, provide technical assistance and education to providers, and administer the Telemedicine Innovation Fund. The Telemedicine Innovation Fund supports provider-PHP collaborations that pilot evidence-based telemedicine initiatives aligned with the State’s quality strategy goals, such as chronic disease management, wellness promotion and high-value care. Pilots will primarily fund provider training, compensation for staff time to integrate telemedicine into practice workflows, and additional one-time costs not eligible for PHP reimbursement.

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<sup>41</sup> The workforce evaluation and Innovation Workforce Fund initiatives are pending waiver authority; for more information, see: <https://www.ncdhhs.gov/news/press-releases/dhhs-submits-amendment-medicaid-waiver-application>

<sup>42</sup> PHPs are permitted to leverage telemedicine in their Request for Exceptions to the State’s network adequacy standards. When an enrollee requires a medically necessary service that is not available within DHHS’s network adequacy standards, the PHP may offer the service, if applicable and medically appropriate, through telemedicine, in addition to providing access to an out-of-network provider of the needed service. In these instances, the enrollee must have a choice between an out-of-network provider and telemedicine and cannot be required to receive services through telemedicine.

<sup>43</sup> The statewide telemedicine alliance and pilot initiatives are pending waiver authority; for more information, see: <https://www.ncdhhs.gov/news/press-releases/dhhs-submits-amendment-medicaid-waiver-application>

## **(10) Value-Based Payment (VBP)**

To ensure that payments to providers are increasingly focused on population health outcomes, appropriateness of care, and other measures of value, rather than on a fee-for-service basis, DHHS encourages accelerated adoption of Value-Based Payment (VBP) arrangements between PHPs and providers.

PHPs are required and incentivized to develop and lead innovative strategies to increase the use of VBP arrangements over time – including arrangements that appropriately incentivize providers – and are required to submit their VBP strategies to DHHS and report on their use of VBP contracting arrangements each year. DHHS has defined VBP – for the first two years of PHP operations – as payment arrangements that meet the criteria of the Health Care Payment (HCP) Learning and Action Network (LAN) Advanced Payment Model (APM) Categories 2 through 4.<sup>44,45</sup>

In the early years of Medicaid managed care, DHHS plans to convene stakeholders to develop a longer-term VBP Roadmap. The stakeholder group will be charged with assessing PHPs' advancements to date and opportunities to align VBP arrangements across payers and in accordance with statewide priorities. Providers, payers, policy experts and patient advocates will all play an instrumental role in developing an achievable but ambitious VBP Roadmap with specific goals for value-based payment initiatives in future years.

## **(11) Centers for Disease Control and Prevention (CDC) 6|18 Initiative**

In partnership with the CDC, DHHS's Medicaid program is participating with the Division of Public Health in the 6|18 Initiative, which is based on rigorous evidence for six high-burden health conditions and 18 associated interventions designed to have the greatest health and cost impact. As part of this initiative, DHHS is implementing interventions focused on: (1) reducing tobacco use; (2) preventing unintended pregnancy; and (3) preventing and controlling diabetes. This evidence was used to inform and correlates closely with many elements of this Quality Strategy, including the Objectives focused on these three specific efforts, and on options PHPs have for completion of required Performance Improvement Projects (described in detail in Section II(A)).

## **(12) Accreditation**

As a key component of ensuring that PHPs are held to consistent, current standards for quality, access, and timeliness of care, PHPs are required to attain accreditation from a nationally-recognized accrediting body within the first three years of operations. DHHS will select a single accrediting body to ensure that PHPs are held to a uniform standard, aligned with the State's quality Goals and Objectives.

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<sup>44</sup> For more information on the HCP-LAN APM framework, see: <https://hcp-lan.org/groups/apm-ftp-work-products/>

<sup>45</sup> North Carolina will require PHPs to conduct an annual assessment using the HCP-LAN assessment form, available online at: <https://hcp-lan.org/workproducts/National-Data-Collection-Metrics.pdf>.

Although PHPs are not required to achieve accreditation until the third year of operations, they are incented to meet key accreditation milestones (e.g., PHPs will be permitted to market their accreditation status to beneficiaries), and required to submit the quality, access, and timeliness of care quality measures required for accreditation starting in year 1 of PHP operations.

As noted in Section II(C) of this Quality Strategy, DHHS aims to avoid duplication and inconsistency in quality functions completed across the accrediting body, External Quality Review Organization (EQRO), and DHHS related to plan operations, quality measurement and assessment, and compliance with DHHS standards. DHHS will streamline these activities over time and, where appropriate, exercise the option to use information provided by the accreditation reports to avoid duplication of mandatory activities as permitted by 42 CFR 438.360.

### **(13) Disparity Reporting and Tracking**

The measures in Appendix A will serve as the basis for the Disparities Report. PHPs are directed to report across select measures by select strata, including by age, race, ethnicity, sex, primary language, and disability status, as well as by key population groups (e.g., LTSS) and by geography, where feasible. DHHS monitors these reports to identify disparities, and – based on their results over time – will develop (or require PHPs to develop) targeted interventions and/or other strategies to address identified disparities. In particular, DHHS plans to set targets for improving health disparities; further information about PHPs’ responsibilities related to incorporating disparity assessment and performance improvement in their Quality Assessment and Performance Improvement plans is available in Section II(A); the State’s plan to assess for disparities is further discussed in Section IV(A).

### **(D) Health Information Technology**

North Carolina’s Health Information Technology (HIT) system and initiatives support the overall Quality Strategy. The State’s HIT approach is based on a strategy that spans all stakeholders and takes into consideration current and future plans, policies, processes and technical capabilities. As one of its guiding principles, DHHS is responsible for ensuring its information technology vendors are communicating and coordinating with DHHS and with one another to create a successful and well-integrated system.

Data will play a crucial role in North Carolina’s Medicaid transformation, including its effort to drive a continuous quality improvement process. In support of the overall strategy to improve the quality of care, DHHS is leveraging existing technology tools and considering new capabilities that will help clinicians and care managers access a range of information, including patient-level data, alerts on hospital admissions/discharges, patient assessments, risk stratification, care plans, and social determinants. Additionally, DHHS is working with stakeholders to establish communication between parties involved in encounter data exchange and to plan for other types of information exchange and required reporting.

### III. State Standards for Access, Structure, and Operations

North Carolina’s PHP contracts include robust requirements to ensure that PHPs meet, and in many cases, exceed the standards outlined in 42 CFR Part 438, subpart D and as specified by DHHS. These standards are detailed throughout this Section of the Quality Strategy and include requirements related to beneficiary access to care such as network adequacy, availability of services, access to care during transitions of coverage, assurances of adequate capacity and services, coordination and continuity of care, and coverage and authorization. Further, these requirements relate to the structure and operations that PHPs must have in place in order to ensure the provision of high quality care including provider selection requirements, practice guidelines, information made available to beneficiaries, enrollment and disenrollment processes, confidentiality, appeals and grievance systems, sub-contractual relationships and delegation, and the information technology utilized by PHPs.

DHHS recognizes these PHP requirements as important assurances that member services are adequately and appropriately provided, and further recognizes the importance of monitoring and responding to key indicators of the success of such requirements. As noted throughout this Quality Strategy, and particularly within Section IV(A) and IV(B), DHHS uses the following tools to assess beneficiary and provider perceptions of the effectiveness of these efforts:

- The CAHPS Plan Survey, which assesses beneficiary perception of care; and
- A standard provider survey tool, which measures provider satisfaction.

#### (A) State Access Standards

##### (1) Network Adequacy Standards

PHPs are expected to maintain and monitor a network of appropriate providers that is sufficient to provide adequate access to all services covered under the Medicaid and NC Health Choice programs for all beneficiaries, including those with limited English proficiency or physical or mental disabilities, based on standards developed by the State. To recognize the special needs of accessibility to behavioral health services, the standards include specific measurements for those services. PHPs are expected to also meet standards for appointment wait-times for primary care and specialist care. Per federal regulations at 42 CFR 438.68, PHP networks must meet network adequacy standards that are developed by the State and published online. Network adequacy standards are an important tool for ensuring that beneficiaries have access to providers and care. North Carolina’s network adequacy standards vary by geographic area and include **time and distance standards**, for providers who serve adult and pediatric beneficiary needs, as described in Figures 6 and 7 below, and **appointment wait-time standards**, as described in Figures 8-10.

*Figure 6. Network Adequacy Standards: Time and Distance Standards for Adults and Children*

Provider Type	Urban Standard <sup>46</sup>	Rural Standard <sup>47</sup>
<b>Primary Care (adult and pediatric)</b>	≥ 2 providers within 30 minutes or 10 miles for at least 95% of enrollees	≥ 2 providers within 30 minutes or 30 miles for at least 95% of enrollees
<b>Specialty Care (adult and pediatric) – See below for a list of provider types that are subject to this standard</b>	≥ 2 providers (per specialty type) within 30 minutes or 15 miles for at least 95% of enrollees	≥ 2 providers (per specialty type) within 60 minutes or 60 miles for at least 95% of enrollees
<b>OB/GYN</b>	≥ 2 providers within 30 minutes or 10 miles for at least 95% of enrollees	≥ 2 providers within 30 minutes or 30 miles for at least 95% of enrollees
<b>Hospitals</b>	≥ 2 hospitals within 30 minutes or 15 miles for at least 95% of enrollees	≥ 2 hospitals within 30 minutes or 30 miles for at least 95% of enrollees
<b>Pharmacies</b>	≥ 2 pharmacies within 30 minutes or 15 miles for at least 95% of enrollees	≥ 2 pharmacies within 30 minutes or 30 miles for at least 95% of enrollees
<b>Outpatient Behavioral Health Services<sup>48</sup></b>	≥ 2 providers of each outpatient behavioral health service within 30 minutes or 30 miles of residence for at least 95% of enrollees	≥ 2 providers of each outpatient behavioral health service within 45 minutes or 45 miles of residence for at least 95% of enrollees
<b>Location-Based Services<sup>49</sup></b>	≥ 2 providers of each service within 30 minutes or 30 miles of residence for at least 95% of enrollees	≥ 2 providers of each service within 45 minutes or 45 miles of residence for at least 95% of enrollees
<b>Behavioral Health Crisis Services<sup>50</sup></b>	≥ 1 provider of each crisis service within each PHP region <sup>51</sup>	

<sup>46</sup> For the purposes of the state’s network adequacy standards, “urban” is defined as *non-rural counties*, or counties with average population densities of 250 or more people per square mile. This includes 20 counties that are categorized by the North Carolina Rural Economic Development Center (“the Rural Center”) as “regional cities or suburban counties” or “urban counties.” These 20 counties include 59 percent of the state’s population. See more at [http://www.ncleg.net/documentsites/committees/BCCI-6678/4-6-16/NCRC3%20Rural\\_Center\\_Impacts\\_Report.pdf4-6-16.pdf](http://www.ncleg.net/documentsites/committees/BCCI-6678/4-6-16/NCRC3%20Rural_Center_Impacts_Report.pdf4-6-16.pdf).

<sup>47</sup> For the purposes of the network adequacy standards, “rural” is defined as counties with population densities below 250 people per square mile. Per the Rural Center, there are 80 counties in North Carolina that meet this definition; these counties are home to 41 percent of the state’s population. See more at [http://www.ncleg.net/documentsites/committees/BCCI-6678/4-6-16/NCRC3%20Rural\\_Center\\_Impacts\\_Report.pdf4-6-16.pdf](http://www.ncleg.net/documentsites/committees/BCCI-6678/4-6-16/NCRC3%20Rural_Center_Impacts_Report.pdf4-6-16.pdf).

<sup>48</sup> “Outpatient behavioral health services” includes outpatient behavioral health services provided by direct-enrolled providers (e.g., psychiatry) for adults and children.

<sup>49</sup> “Location-based behavioral health services” includes: psychosocial rehabilitation (for adults); substance abuse comprehensive outpatient services (for adults); substance abuse intensive outpatient programs (for adults and children); opioid treatments (for adults).

<sup>50</sup> A behavioral health crisis is defined as a non-life-threatening situation in which a person experiences an intensive behavioral, emotional, or psychiatric response triggered by a precipitating event. The person may be at risk of harm to self or others, disoriented or out of touch with reality, functionally compromised, or otherwise agitated and unable to be calmed. If this crisis is left untreated, it could result in a behavioral health emergency. For purpose of time and distance standards, “crisis services” does not include mobile crisis services. See the Community/Mobile Services Appointment Wait-time Standards below for a standard for mobile services.

<sup>51</sup> “PHP region” refers to the six regions identified in the N.C. Legislative Report: “Transformation and Reorganization of North Carolina’s Medicaid and NC Health Choice Programs,” March 1, 2016, <https://files.nc.gov/ncdhhs/Medicaid-NCHC-JLOC-Report-2016-03-01.pdf>. (Note that Alamance County is included in Region IV.)

Provider Type	Urban Standard <sup>46</sup>	Rural Standard <sup>47</sup>
<b>Inpatient Behavioral Health Services<sup>52</sup></b>	≥ 1 provider of each inpatient BH service within each PHP region	
<b>Behavioral Health Specialized Services<sup>53</sup></b>	≥ 1 provider of specialized services (partial hospitalization) within 30 minutes or 30 miles for at least 95% of enrollees	≥ 1 provider of specialized services (partial hospitalization) within 60 minutes or 60 miles for at least 95% of enrollees

North Carolina does not cover any State Plan LTSS services that would require beneficiaries to travel to a provider, and therefore time and distance standards do not apply. DHHS requires PHPs to meet the requirements in Figure 7 to ensure access to LTSS services for which providers travel to beneficiaries.

Figure 7. Access Standards for Long Term Services and Supports

Provider Type	Urban Standard	Rural Standard
<b>All State Plan LTSS (except nursing facilities)<sup>54</sup></b>	PHPs must have at least two LTSS provider types, identified by distinct NPI, accepting new patients available to deliver each State Plan LTSS in every county.	PHPs must have at least two providers accepting new patients available to deliver each State Plan LTSS in every county; providers are not required to live in the same county in which they provide services.
<b>Nursing Facilities</b>	PHPs must have at least 1 nursing facility accepting new patients in every county.	PHPs must have at least 1 nursing facility accepting new patients in every county.

**Primary Care Access Standards:** “Primary care” means basic or general health care provided by a medical professional (such as a general practitioner, pediatrician or nurse) with whom a patient has initial contact and by whom the patient may be referred to a specialist.

Figure 8. Access Standards for Primary Care

Visit Type	Definition	Standard
<b>Preventive Care</b>	Care provided to prevent illness or injury; examples include, but are not limited to, routine physical examinations,	Within 30 calendar days

<sup>52</sup> For adults, “inpatient behavioral health services” includes: acute care hospitals with adult inpatient psychiatric beds; other hospitals with adult inpatient psychiatric beds; acute care hospitals with adult inpatient substance use beds; and other hospitals with adult inpatient substance use beds. For children, it includes: acute care hospitals with adolescent/child inpatient psychiatric beds; other hospitals with adolescent/child inpatient psychiatric beds; acute care hospitals with adolescent inpatient substance use beds; other hospitals with adolescent inpatient substance use beds.

<sup>53</sup> “Specialized services” includes partial hospitalization for adults and children.

<sup>54</sup> “State Plan LTSS” is defined as: Nursing facility, Home Health, personal care, hospice, home infusion therapy, private duty nursing, and durable medical equipment.

Visit Type	Definition	Standard
	immunizations, mammograms and pap smears.	
<b>Urgent Care Appointment</b>	Care provided for a non-emergent illness or injury with acute symptoms that require immediate care; examples include, but are not limited to, sprains, flu symptoms, minor cuts and wounds, sudden onset of stomach pain and severe, non-resolving headache.	Within 24 hours
<b>Routine/Check-up Appointment without Symptoms</b>	Non-symptomatic visits for health check.	Within 30 calendar days
<b>After-Hours Access – Emergent and Urgent</b>	Care requested after normal business office hours.	Immediately (available 24 hours a day, 7 days a week, 365 days a year)

**Specialty Care Access Standards:** “Specialty care” means specialized health care provided by physicians whose training focused primarily in a specific field, such as neurology, cardiology, rheumatology, dermatology, oncology, orthopedics and other specialized fields.

Figure 9. Access Standards for Specialty Care

Visit Type	Definition	Standard
<b>Urgent Care appointment</b>	Care provided for a non-emergent illness or injury with acute symptoms that require immediate care; examples include, but are not limited to, sprains, flu symptoms, minor cuts and wounds, sudden onset of stomach pain and severe, non- resolving headache.	Within 24 hours
<b>Routine/Check-up Appointment without Symptoms</b>	Non-symptomatic visits for health check.	Within 30 Calendar days
<b>After-Hours Access – Emergent and Urgent Instructions</b>	Care requested after normal business office hours.	Immediately (available 24 hours a day, 7 days a week, 365 days a year)

**Behavioral Health Care Access Standards:** “Behavioral health care” means health care services provided for treatment and services in the community for behavioral and/or substance use disorders. Standard plans cover certain behavioral health care services for individuals with mild to moderate behavioral health care needs.<sup>55</sup> The access standards that follow apply to the services standard plans cover for the mild to moderate population.

<sup>55</sup> Pending legislative authority.

Figure 10. Access Standards for Behavioral Health Care

Visit Type	Definition	Standard
<b>Community/Mobile Services for Behavioral Health Care</b>	For adults and children, direct and periodic services that are available at all times, 24 hours a day, seven days a week, 365 days a year, and primarily delivered face-to-face with the individual and in locations outside the agency’s facility.	Within 30 minutes
<b>Urgent Care appointment for Behavioral Health Care</b>	Urgent behavioral health services include urgent mental health services and urgent SUD services. Urgent mental health services are those services for conditions in which a person is not actively suicidal or homicidal, denies having a plan, means or intent for suicide or homicide, but expresses feelings of hopelessness, helplessness, or rage; has potential to become actively suicidal or homicidal without immediate intervention; displays a condition which could rapidly deteriorate without immediate intervention; and/or without diversion and intervention, will progress to the need for emergency services/care. Urgent SUD services are those services for conditions in which a person is not imminently at risk of harm to self or others or unable to adequately care for self, but by virtue of the person’s substance use is in need of prompt assistance to avoid further deterioration in the person’s condition which could require emergency assistance.	Within 24 hours
<b>Routine Behavioral Health Care appointment</b>	Routine behavioral health services include Mental health services provided when a person describes signs and symptoms resulting in impaired behavioral, mental, or emotional functioning, which has impacted the person’s ability to participate in daily living or markedly decreased the person’s quality of life; and SUD services provided when a person describes signs and symptoms consequent to substance use resulting in a level of impairment, which can likely be diagnosed as an SUD according to the current version of the Diagnostic and Statistical Manual.	Within 14 calendar days
<b>After-Hours Access through Behavioral Health Practitioners - Emergent and Urgent Instructions</b>	Emergency behavioral health services include emergency mental health services (i.e., services for life-threatening conditions in which a person is suicidal, homicidal, actively psychotic, displaying disorganized thinking or reporting hallucinations, and delusions that may result in harm to self or harm to others, and/or displaying vegetative signs and is unable to care for self; includes crisis intervention) and emergency SUD services (i.e. services for life-threatening conditions in which a person is by virtue of their use of alcohol or other drugs, suicidal, homicidal, actively psychotic, displaying disorganized thinking or reporting hallucinations and delusions which may result in self-harm or harm to others, and/or is unable to adequately care for self without supervision	Immediately (available 24 hours a day, 7 days a week, 365 days a year)



	due to the effects of chronic substance use; and includes crisis intervention).	
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The adult and pediatric providers that are subject to the State’s specialty care standards include:

- Allergy/immunology;
- Anesthesiology;
- Cardiology;
- Dermatology;
- Endocrinology;
- ENT/otolaryngology;
- Gastroenterology;
- General surgery;
- Hematology/oncology;
- Nephrology;
- Neurology;
- Ophthalmology;
- Optometry;
- Orthopedic surgery;
- Pain management (board certified);
- Pulmonology;
- Radiology; and
- Urology.

The State will revisit this list of specialty care providers periodically and revise the list based on the utilization and needs of the PHP enrollee population.

*Mandatory Network Providers*

In addition to meeting the State’s network adequacy standards, federal and state statute and regulations require PHPs to contract with certain types of providers. Federal regulations require PHP networks to include in their networks at least one federally qualified health center (FQHC), at least one rural health clinic (RHC), and at least one freestanding birth center (FBC), where available, for the PHP’s contracted service area. North Carolina statute<sup>56</sup> requires PHPs to contract with *all* “essential providers” in their geographical coverage area, unless DHHS approves an alternative arrangement for securing the types of services offered by the essential providers. Essential providers include: FQHCs; RHCs; rural health centers overseen by DHHS; free/charitable clinics; State veterans homes; and local health departments.

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<sup>56</sup> NC S.L. Session Law 2015-245 as amended by Session Law 2016-121.

### *Out of Network Services*

In the event the PHP's provider network is unable to provide necessary covered services to an enrollee, the PHP must adequately and timely cover these services out-of-network for the enrollee for as long as the PHP's provider network is unable to provide them. PHPs are responsible for communicating administrative requirements (e.g., prior authorization requirements, to the degree prior authorization is not prohibited under federal regulation) and coordinating payment with the out-of-network providers and ensuring the cost to the beneficiary is no greater than it would be if the services were furnished within the network. In certain cases where there may be a longer-term need, the PHP and out-of-network provider may be encouraged to engage in single case agreements to ensure both parties understand what is administratively and financially expected and to minimize potential disputes which may disrupt the beneficiary care. Additionally, beneficiaries may switch PHPs under certain conditions during the lock-in period to obtain medically necessary services that are not all available within the PHP's network.

### *Exceptions to Network Adequacy Standards*

PHPs that are unable to meet the network adequacy standards may request an exception for a specific provider type in a specific region. PHPs are required to submit to the State a request for an exception with corresponding information in support of that request. Criteria for State review and acceptance of an exception includes but is not limited to:

- Utilization patterns in the specific service area;
  - The number of Medicaid providers in the relevant provider type/specialty practicing in specific service area;
  - The history of beneficiary complaints regarding access; and
  - Specific geographic considerations;
  - The proposed long-term plan by the PHP to address the access to care gap in its network; and
- The comprehensiveness and appropriateness of the PHP's plan for addressing beneficiary needs, including the PHP's process for making referrals to out-of-network providers, as relevant, and the PHP's use of telemedicine and other telecommunications technology, as appropriate.

Where exception requests are approved, DHHS will monitor beneficiary access to the relevant provider types in the relevant regions on an ongoing basis and annually report the findings to CMS, in line with federal regulations.

### *Telemedicine*

PHPs may use telemedicine as a tool for ensuring access to needed services in accordance with their own telemedicine coverage policies, as approved by the State. When an enrollee requires a medically necessary service that is not available within the State's expected driving distance, the PHP will be expected to ensure that enrollee has access to that service and could utilize either an out-of-network provider or could access the service through telemedicine, if applicable and medically appropriate. The enrollee must have a choice between an out-of network provider and telemedicine and cannot be

forced to receive services through telemedicine. While PHPs may not use telemedicine to meet the State’s network adequacy standards, they may leverage telemedicine in their request for an exception from the State’s network adequacy standards.

## **(2) Availability of Services**

PHPs must contract with enough providers to ensure that all services covered under the contract are available and accessible to beneficiaries in a timely manner, as required under 42 CFR 438.206. To ensure this, under state law, PHPs must include all willing providers in their networks, except when a PHP is unable to negotiate rates or where there are provider quality concerns. As described previously, PHPs must also contract with all “essential providers” in their area unless DHHS approves another arrangement. North Carolina also seeks to ensure the availability of services through, among other things, its network adequacy standards, which include both time and distance standards and appointment wait-time standards (see above). Other requirements on PHP networks and the availability of services covered under the contract include:

- Direct access to a women’s health specialist for covered care necessary to provide women’s routine and preventive health care services (note that this is in addition to the enrollee’s designated source of primary care if that source is not a women’s health specialist);
- Direct access to emergency services, children’s screening services, and Local Health Department services;
- Direct access to behavioral health services, such that PHPs will not require beneficiaries to obtain a referral or prior authorization for at least one mental health assessment and at least one substance dependence assessment from a participating provider in any calendar year;
- Direct access to covered services offered by family planning providers and/or family planning services;
- Direct access to specialists, for beneficiaries with special health care needs (defined under subsection 3, “Coordination and Continuity of Care”), in a manner that is appropriate for the beneficiaries’ health condition and age;
- Access to a second opinion from either a network provider or an out-of-network provider (to be arranged by the PHP), at no cost to the enrollee;
- Access to necessary covered services from an out-of-network provider for as long as the PHP’s network is unable to provide such services;
- Access to covered services 24 hours a day, 7 days a week, when medically necessary; and Access to network providers during hours of operation that are no less than the hours of operation offered to commercial enrollees or, if the provider serves only Medicaid beneficiaries, comparable to Medicaid FFS.

PHPs must also ensure the availability and delivery of services in a culturally and linguistically competent manner to all beneficiaries, including those with limited English proficiency and literacy and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender

identity. PHPs must also ensure that network providers deliver physical access, reasonable accommodations, and accessible equipment for beneficiaries with physical or mental disabilities.

### **(3) Access to Care During Transitions of Coverage**

In compliance with the transition of care policy requirements set forth by 42 CFR 438.62, North Carolina's has established transition of care standards that apply to all beneficiaries, including those in need of long term services and supports (LTSS).

In instances in which a beneficiary transitions into a PHP (either from FFS or another PHP or coverage type):

- When a beneficiary is in ongoing course of treatment or has an ongoing special condition where switching providers may disrupt the enrollee's care, the beneficiary may continue seeing his/her provider (even if they are out-of-network) for up to 90 days.<sup>57</sup>
- New enrollees who are pregnant and in their 2nd or 3rd trimester may continue seeing their provider(s) through their pregnancy and up to 60 days after delivery.

When a provider in good standing<sup>58</sup> leaves a PHP's network:

- PHP enrollees may continue seeing that provider for up to 90 days.
- PHP enrollees who are pregnant and in their 2nd or 3rd trimester may continue seeing the provider through pregnancy and up to 60 days after delivery.

### **(4) Assurances of Adequate Capacity and Services**

In accordance with 42 CFR 438.207, North Carolina maintains a monitoring and oversight system to ensure that PHPs have adequate capacity to provide care to all beneficiaries in their respective service areas. Key components of the State's monitoring and oversight activities include, but are not limited to:

- Requiring PHPs to submit an access plan and regular documentation (including provider network data and report(s) that summarize findings from PHPs' own network data analysis) to demonstrate network adequacy;
- Requiring PHPs to submit updated machine-readable provider directories in a standardized format;
- Contracting with an external quality review organization (EQRO) to review *and* validate PHP data and findings;
- Requiring that PHPs be accredited (by year 3);
- Monitoring beneficiary complaints related to access to care and provider networks;
- Reviewing quality measurement data to show realized access;

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<sup>57</sup> At the time standard plans are launched, an enrollee who is in an ongoing course of treatment for a benefit only offered through LME-MCOs will be required to remain in fee-for-service/LME-MCO coverage to continue receiving that benefit.

<sup>58</sup> "Good standing" means the provider is not terminated due to quality or other reasons, such as fraud, from the PHP's network

- Reviewing Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey findings related to beneficiary experience of availability and access to services and taking action as needed; and
- When necessary, issuing Corrective Action Plans (CAPs) when PHPs are identified as non-compliant with network adequacy standards and access requirements.

As outlined in Appendix B, DHHS will contract with a qualified EQRO to perform an annual external quality review (EQR) of each PHP to, among other things, determine PHP compliance with network adequacy and access requirements, confirm the adequacy of each PHP's network, and validate PHPs' data. The EQRO must include the findings of the annual EQR in a technical report, which will be posted on the State's website. DHHS will monitor beneficiary access to care issues, including using geographic mapping and other techniques.

## **(5) Coordination and Continuity of Care**

### *Care and Coordination of Services*

PHPs have overall responsibility for ensuring that all beneficiaries have an ongoing source of care according to their needs, and communicate this responsibility along with a point of contact at the PHP, as required by 42 CFR 438.208(b). PHPs are responsible for coordinating services between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays. In the event that a beneficiary changes enrollment across PHPs or the fee for service program (for example, once a beneficiary exceeds 90-days in a nursing home), PHPs are required to coordinate with other source(s) of coverage to ensure continuity and non-duplication of services.

PHPs are additionally responsible for assessing risk in their enrolled populations, including risk based on social determinants of health, rising risk, and other risks. As required by 42 CFR 438.208(b)(3), PHPs are required to make best efforts to conduct a universal screening process for newly enrolled beneficiaries within 90 days of enrollment. DHHS requires PHPs to include within their initial screening tools standardized questions relating to highest-priority social determinants of health (housing, food, transportation, and interpersonal violence). PHPs are required to implement a care management strategy that takes the results of these screenings into account as well as markers of high cost based on past claims (including pharmacy). In recognition that care management for those with complex health and/or social needs is most effective when delivered in the community, PHPs are required to meet State requirements to ensure that care management for high-needs beneficiaries is delivered in predominantly community settings at a local level. As required by 42 CFR 438.208(b)(iv), PHPs are required to coordinate their services with those received from community and social support providers.

Primary care practices, including those that operate as AMHs, play a critical role in care management and care coordination for PHP enrollees. Particularly for those with chronic health needs, care management is most effective when delivered locally. PHPs are required to deliver care management

locally to the maximum extent possible (including by AMHs and other local care managers, such as Local Health Departments), while also taking into account the diversity of North Carolina's delivery system.

#### *Additional Services for Beneficiaries with Special Health Care Needs or Who Need LTSS*

For beneficiaries who have special health care needs and beneficiaries who need LTSS, PHPs are required, in compliance with the parameters set forth in 42 CFR 438.208(c), to conduct a comprehensive assessment to identify any ongoing special conditions that require a course of treatment or regular care monitoring.

Adults and children with special health care needs are defined as follows:

- **Children with Special Health Care Needs** are defined as those who have or are at increased risk of having a serious or chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that usually expected for the child's age. This includes, but is not limited to, children or infants: in foster care; requiring care in the Neonatal Intensive Care Units; with neonatal abstinence syndrome; in high stress social environments/toxic stress; receiving Early Intervention; with an SED, I/DD or SUD diagnosis; and/or receiving 1915(b)(3), Innovations or TBI Waiver Services.
- **Adults with Special Health Care Needs** are defined as those who have or are at increased risk of having a chronic illness and/or a physical, developmental, behavioral or emotional condition and who also require health and related services of a type or amount beyond that usually expected for individuals of similar age. This includes, but is not limited to individuals: with HIV/AIDS; an SMI, SED, I/DD or SUD diagnosis (including opioid addiction), chronic pain; or receiving 1915(b)(3), Innovations or TBI Waiver services.

Based on the comprehensive assessment, the State requires PHPs to identify enrollees who require LTSS and to develop a person-centered care plan for such enrollees. The care plan must be developed by a person with expertise in LTSS service coordination and trained in person-centered planning processes. The PHP also must ensure that a beneficiary with special health care needs determined through assessment to require a course of treatment or regular care monitoring has direct access to a specialist as appropriate for the enrollee's condition and identified needs.

PHPs are responsible for identifying individuals with special health care needs and in need of LTSS primarily through the use of a claims data review, predictive modeling, and/or care needs screening. PHPs are required to use this information to ensure the development of an appropriate treatment/service plan as described above.

## (6) Coverage and Authorization of Services

PHPs are required to cover the same services as are required in Medicaid fee-for-service, except for a small number of services carved out of Medicaid managed care by statute.<sup>59</sup> Consistent with the requirements set forth in 42 CFR 438.210, North Carolina has developed an approach to PHP clinical coverage policies and utilization management (UM) that safeguards beneficiary access to services while encouraging PHP innovation.

PHPs are required to use the DHHS definition of medical necessity when making coverage determinations and are prohibited from setting benefit limits that are more stringent than in the State's fee-for-service program. For example, if the fee-for-service program covered 10 visits for a specific service, PHPs could cover 12 visits, but could not limit a beneficiary to a visit amount less than 10.

DHHS requires that PHPs use a common prior authorization request form for all services. PHPs are additionally required to use a standard request process for "in-lieu of services," designed to encourage PHPs to cover services or settings that are not otherwise covered under the State Plan but are a medically appropriate, cost-effective alternative to a service that is covered.

Finally, for a limited number of services, DHHS requires that PHPs follow specific clinical coverage policies developed by the State.

## (B) Structure and Operations Standards

### (1) Provider Selection

PHPs are required to implement written policies and procedures for the selection and retention of network providers. These policies and procedures must meet State and federal requirements, including:

- **"Any willing provider" requirement:** PHPs may not exclude providers from their networks except for failure to meet objective quality standards or refusal to accept network rates.<sup>60</sup>
- **Credentialing and re-credentialing:** PHPs must follow a documented process that is in line with the State's uniform credentialing policy and centralized credentialing verification program for

<sup>59</sup> NC Session Law 2015-245, as amended, excludes dental services; services provided through the Program of All-Inclusive Care for the Elderly; (PACE); services documented in an Individualized Education Program (IEP) and provided or billed by Local Education Agencies; services provided and billed by a Children's Developmental Services Agency (CDSA) that are included on the child's Individualized Family Service Plan; services for Medicaid program applicants during the period of time prior to eligibility determination.; and the fabrication of eyeglasses, including complete eyeglasses, eyeglass lenses, and ophthalmic frames. DHHS also recommends that the fitting and the provider visual aid dispensing fee for eyeglasses be carved out of managed care, which would require a statutory change. Currently, S.L. 2015-245 also carves out Behavioral health services for Medicaid recipients currently covered by the local management entities/managed care organizations (LME/MCOs) for four years after the date capitated contracts begin. DHHS is seeking a statutory change.

<sup>60</sup> NC Session Law 2015-245 as amended by Session Law 2016-121. Note that this state statute also requires PHPs to contract with all providers in their geographical coverage area that are designated by DHHS as "essential providers" (see the "Mandatory Network Providers" section above), unless DHHS approves an alternative arrangement for securing the types of services offered by the essential providers.

making a quality determination to move to contracting or re-contracting with network providers.

- **Enrolled providers:** PHPs may only contract with providers who are enrolled in the Fee-for-Service program
- **Nondiscrimination:** In selecting and contracting with network providers, PHPs must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.
- **Excluded providers:** PHPs may not employ or contract with providers that are excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Social Security Act.

## (2) Practice Guidelines

Consistent with the requirements of 42 CFR 438.236, PHPs are required to develop practice guidelines that:

- Are based on valid and reliable clinical evidence or a consensus of providers in the particular field;
- Consider the needs of beneficiaries;
- Are adopted in consultation with contracting health care professionals; and
- Are reviewed and updated periodically as appropriate.

Additionally, DHHS requires that PHPs meet the following standards:

- The PHP's QI Committee or other designated committee must approve clinical practice guidelines;
- The PHP must adopt guidelines from recognized sources or feedback of board-certified practitioners from appropriate specialties that would use the guidance;
- The PHP must adopt guidelines for at least two medical conditions and at least two behavioral health conditions, with at least one behavioral health guideline that addresses children and adolescents;
- The PHP must update guidelines against clinical evidence at least every two years, or more frequently if the national guidelines change within the two-year period;
- The PHP must annually evaluate the consistency with which health care professionals in UM apply criteria in decision making;
- The PHP must act on opportunities to improve consistency, if applicable;
- The PHP must distribute clinical practice guidelines and revisions to all practitioners who are likely to use them; and
- As requested by DHHS, PHPs must submit to DHHS a copy of any required clinical practice guidelines and make the PHP's Chief Medical Office (or designee) available to discuss the coordination of clinical practice guidelines and clinical coverage policies.



PHPs are required to disseminate the guidelines to all affected providers and, upon request, to enrollees and potential enrollees. PHPs will make decisions related to utilization management, beneficiary education, and coverage of services consistent with these guidelines.

### **(3) Enrollee Information**

To ensure the capacity for Medicaid managed care education and PHP/ Primary Care Provider (PCP) selection support at Medicaid managed care launch, DHHS will procure an enrollment broker to facilitate outreach, education, and consumer assistance to enrollees and potential enrollees.

Furthermore, in accordance with State standards and the federal requirements in 42 CFR 438.10, all informational materials developed by the State, the enrollment broker, the ombudsman program and PHPs will be made available in formats and languages that ensure their accessibility, including that materials are provided at an appropriate reading level.

Recognizing the importance of beneficiaries receiving consistent and accurate information about how to effectively use the managed care program, PHPs will develop and the State will approve an enrollee handbook which will include the following information:

- Benefits provided by the PHP, including the amount, duration and scope of those benefits, and guidance on how and where to access benefits, including transportation, family planning services and supplies from out-of-network providers;
- Procedures for obtaining benefits, including any requirements for service authorizations and/or referrals for specialty care and for other benefits not furnished by the beneficiary's primary care provider;
- The extent to which, and how, after-hours and emergency coverage are provided;
- Any restrictions on the beneficiary's freedom of choice among network providers;
- Cost sharing, if any is imposed under the cost sharing State Plan amendment (SPA);
- Beneficiary rights and responsibilities;
- The process of selecting and changing the beneficiary's primary care provider;
- Grievance, appeal, and State fair hearing procedures and timeframes;
- How to exercise an advance directive, as set forth in federal requirements;
- The toll-free telephone number for member services, medical management, and any other unit providing services directly to beneficiaries and how to access auxiliary aids and services, including additional information in alternative formats or languages; and
- Information on how to report suspected fraud or abuse.

PHPs are permitted to provide this information by mail, email (only if beneficiary has expressed consent for email) in addition to posting online.

Information provided will promote the delivery of service in a culturally competent manner to all beneficiaries, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities and regardless of gender, sexual orientation or gender identity.

### *Provider Directories*

PHPs must compile in a format specified by DHHS and make available to enrollees and potential enrollees the following information about all its network providers. This information, comprising the PHP provider directory, must be made available in electronic form, and upon request, in paper form.<sup>61</sup>

- Provider names (first, middle, last)
- Group affiliation(s) (i.e., organization or facility name(s), if applicable)
- Street address(es) of service location(s)
- County(ies) of service location(s)
- Telephone number(s) at each location
- Website URL(s)
- Provider specialty
- Whether provider is accepting new beneficiaries
- Provider's linguistic capabilities, i.e., languages (including American Sign Language) offered by provider or a skilled medical interpreter at provider's office
- Whether provider has completed cultural competency training
- Office accessibility (i.e., whether location has accommodations for people with physical disabilities, including in offices, exam room(s) and equipment)
- Telephone number that beneficiaries can call to confirm the information in the directory

Per 42 CFR 438.10, information included in a paper provider directory must be updated at least monthly and electronic provider directories must be updated no later than 30 calendar days after the PHP receives updated provider information. Provider directories must be posted on the PHP's website, in a machine-readable file and format, as specified by the State.

## **(4) Enrollment and Disenrollment**

In designing the managed care enrollment and disenrollment policies, North Carolina recognizes the importance of ensuring Medicaid and NC Health Choice applicants and their families experience a simple, streamlined eligibility and enrollment process that ensures a timely and accurate determination of Medicaid eligibility and user-friendly PHP and PCP selection process. In the future, DHHS envisions beneficiaries applying for health coverage, receiving an eligibility determination, and selecting a PHP based on their preferred PCP with the help of educational resources in one sitting. The State and the enrollment broker will be responsible for effectuating enrollment and disenrollment requirements consistent with those set forth in 42 CFR 438.54 and 438.56.

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<sup>61</sup> Per federal regulations, PHPs must make their provider directories available in the prevalent non-English languages in their particular service areas and in alternative formats upon request of the potential enrollee or enrollee at no cost. Auxiliary aids and services must also be made available upon request of the potential enrollee or enrollee at no cost.

## *Enrollment*

County Departments of Social Services (DSS) offices will continue to conduct Medicaid eligibility determinations and will assess whether beneficiaries are mandatorily required to enroll in a PHP. The DSS offices will then share that information with the enrollment broker who will be tasked with supporting beneficiaries with PHP and PCP selection.

As part of the transition to Medicaid managed care and prior to the launch in July 2019, DHHS will establish a 60 day PHP choice period for current Medicaid beneficiaries. Beneficiaries will be sent notices from DHHS about their PHP options, the time period they have to select a PHP, and contact information for in-person, by telephone and online consumer enrollment broker support for selecting a PHP and PCP.

Upon Medicaid managed care launch, new Medicaid applicants will be given an opportunity to select a PHP as part of the Medicaid application process. Individuals who do not select a PHP at application will be auto-assigned by DHHS into a PHP based on an algorithm that takes into account available information including whether they are a member of a special population (e.g., member of a federally recognized tribe or in foster care), his or her geographic location, provider-beneficiary relationship, PHP assignments for other family members and equitable PHP distribution with enrollment ceilings and floors for each PHP to be used as guidelines. The beneficiary will be sent a notice informing them of the PHP auto-assignment and given 90 days to change their PHPs for any reason.

North Carolina has a long history of serving beneficiaries through the medical home model and recognizes how important it is to preserve beneficiary-provider relationships in the transition to managed care. DHHS is committed to creating a one-stop-shop experience that allows beneficiaries to select a PHP and PCP during the application process, whether the individual applies online, over the phone, through the mail or in-person. Applicants will be encouraged and given tools (such as a provider search tool) to help them base their PHP selection on their provider relationships and select their PCP at the time they select their PHP. Applicants who do not select a PCP will be auto-assigned to one by their PHP.

Certain special populations have enrollment processes tailored to their unique needs or circumstances:

- **Tribal Members.** Because all members of a federally recognized tribe are exempt from managed care, the State will ensure that tribal members are educated about their option to either enroll in fee-for-service or in managed care and the implications of their selection. Upon the establishment of a Tribal PHP Option, individuals will be auto-assigned into that PHP with the option to change.
- **Children in Foster Care.** To ensure that children in foster care enroll in a Statewide specialized foster care PHP that is designed to best meet this unique population's needs, children in foster care will be passively enrolled in the specialized PHP, with the option to change their PHP at any time during the coverage year for any reason.

### *Switching Plans/Disenrollment*

All managed care beneficiaries – whether they select or are assigned to a PHP – have a 90-day period following the PHP effective coverage date to switch PHPs “without cause.” After the completion of the 90-day period, most beneficiaries must remain enrolled in their PHP for the remainder of their eligibility period unless they can demonstrate a “with cause” reason for switching.<sup>62</sup> Certain special populations may switch PHPs “without cause” at any time, including children in foster care, , members of a federally recognized tribe and beneficiaries receiving LTSS in institutional and community-based settings. All beneficiaries will have the option to switch plans annually at the time of eligibility redetermination.

In rare cases, PHPs will be permitted to request to DHHS beneficiary disenrollment only if the enrollee’s behavior seriously hinders the PHP’s ability to care for the beneficiary or other members and the PHP has documented efforts to resolve the enrollee’s issues. Consistent with 42 CFR 438.56, PHPs will be prohibited from requesting beneficiary disenrollment because of an adverse change in the enrollee’s health status, enrollee’s utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from the enrollee’s special needs.

### **(5) Confidentiality**

To ensure compliance with 42 CFR 438.224, PHP contracts will require that the PHP ensure that it, its network providers and subcontractors comply with the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations (collectively, “HIPAA”) and The Health Information Technology for Economic and Clinical Health Act of 2009 and its implementing regulations (collectively, “HITECH”) and all applicable federal and state privacy laws that are more restrictive. Accordingly, beneficiaries must be notified of any inappropriate disclosures as required by law.

### **(6) Grievance and Appeals Systems**

DHHS is committed to ensuring that beneficiaries are able to address their problems quickly and with minimal burden, and requires PHPs to meet the standards set forth in 42 CFR 438.228. North Carolina is committed to honoring and supporting the right of beneficiaries to pursue a formal appeal of an adverse benefit determination through their PHP, or upon exhaustion of the PHP appeal process, through timely access to a State fair hearing. (42 CFR §§ 438. 228, 438.400, 438.402) Additionally, beneficiaries will also be able to appeal enrollment and disenrollment determinations by the enrollment broker under a similar process.

Beneficiaries also will be provided the opportunity to file a grievance with their PHP to express their dissatisfaction with any issue that does not relate to an adverse benefit determination (e.g., concerns

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<sup>62</sup> In addition to the reasons specified in 42 CFR 438.56(d)(2)(i-iv), the State considers the following as cause for disenrollment: the enrollee’s complex medical conditions would be better served under a different PHP; a family member becomes newly eligible and is enrolled in a different PHP; poor performance of PHP, upon launch of evaluations of PHP performance; a PHP was sanctioned which resulted in a suspension of all new enrollment.

regarding quality of care or behavior of a provider or PHP employee). DHHS will require PHPs to report on their appeal and grievance processes and outcomes, and monitor PHP performance to ensure compliance with related requirements and address any issues that may arise.

### *Beneficiary Grievances*

Beneficiaries may file a grievance with a PHP at any time, either orally or in writing. PHPs are required to acknowledge receipt of each grievance in writing within five calendar days and must resolve the grievance within 30 calendar days from the date the PHP receives the grievance. In instances in which the grievance relates to the denial of an expedited appeal request, PHPs are required to resolve the grievance and provide notice to all affected parties within five calendar days from the date the PHP receives the grievance, and include within the notice DHHS-specified content. These standards comply with Federal requirements for beneficiary grievances. (42 CFR §§ 438.402 and 438.406)

### *Beneficiary Appeals*

Federal law sets forth the specific standards for beneficiary rights for appeals which all PHPs are expected to follow. (42 CFR §§ 438.402; 438.406; 438.408; and 438.420.) Specifically, in North Carolina beneficiaries in Medicaid managed care must first seek to resolve appeals with their PHP and will have 60 days from the date of the notice of an adverse benefit determination to file a request for an appeal with the PHP. PHPs are required to send written acknowledgement of the request within five calendar days for a standard appeal and within 24 hours for an expedited appeal request. To ensure access to services, beneficiaries may request that their benefits be continued or reinstated while the appeal is pending.

PHPs must provide written notice of resolution as expeditiously as the appellant's health condition requires and within 30 calendar days of receipt of a standard appeal request. For an expedited appeal request, PHPs must provide written notice of resolution, and make "reasonable effort" to provide oral notice within 72 hours of receipt of an appeal.

If the PHP upholds the adverse benefit determination, the beneficiary may request a State fair hearing through the Office of Administrative Hearings; the request must be made no later than 120 calendar days from the date of the notice. Beneficiaries will have the right to request a continuation of benefits while the appeal is pending.

### *Ombudsman Program*

North Carolina is committed to providing beneficiaries with support and active preparation related to the appeals, grievance and State fair hearing process, as well as to facilitating real-time issue resolution. DHHS will seek funding to support the establishment of an ombudsman program external to the Department focused on providing advocacy, assistance and education to beneficiaries while navigating the Medicaid managed care system and the appeals, grievance and fair hearing process. The ombudsman program also will serve an oversight function, monitoring trends in PHP

performance or beneficiary concerns, and proactively providing feedback to DHHS regarding any issues that arise.

In order to ensure PHP compliance with the appeals and grievances requirements set forth by DHHS, PHPs are required to report:

- Each notice of adverse benefit determination, including DHHS-specified data points related to the determination;
- DHHS-specified information related to the outcome of the appeal;
- The number of expedited appeal requests and number of expedited appeal denial requests;
- The number and reason for any extensions of appeal resolution timeframes;
- The number of administrative denials of benefits and “inability to process” denials;
- DHHS-specified data elements related to the reasoning for grievances, timing of receipt and review / review meetings, and the date of grievance resolution.

### **(7) Sub-Contractual Relationships and Delegation**

All PHP sub-contractual relationships and delegations of services or functions on behalf of the PHP under the PHP contracts are required to comply with 42 CFR 438.230. PHPs will remain accountable for all contract terms which are performed by subcontractors and delegation. PHPs will be required to complete pre-delegation assessments or reviews prior to the effective delegation date to assess readiness. As part of the readiness review, DHHS confirms that PHPs have the necessary policies, procedures, and documents to evidence such compliance and periodically audit PHPs’ compliance with this requirement during the term of the contract.

### **(8) PHP Health Information Technology**

As required under 42 CFR 438.242, North Carolina requires each PHP to maintain health information systems that collect, analyze, integrate, and report encounter data and other types of information to support utilization, grievances and appeals, and disenrollment for reasons other than loss of Medicaid eligibility. PHPs will also be expected to support effective and efficient care management and coordination through their health information technology systems working in concert with Medicaid providers and other entities. State law mandates that by June 1, 2018, most Medicaid providers, including hospitals, physicians, physician assistants, and nurse practitioners who provide Medicaid services and who have an electronic health record system must be connected to the designated statewide health information exchange, HealthConnex. All other Medicaid providers must connect by June 1, 2019.

## **IV. Assessment**

There are several mechanisms DHHS uses to monitor and enforce PHP compliance with the standards set forth throughout this Quality Strategy, and to assess the quality and appropriateness of care

provided to Medicaid managed care beneficiaries. The following sections provide an overview of the key mechanisms utilized by DHHS to enforce these standards and identify ongoing opportunities for improvement.

## **(A) Assessment of Quality and Appropriateness of Care**

Section II(A) describes the quality assessment and performance improvement programs (QAPIs) PHPs are required to implement to comply with federal and DHHS standards. DHHS uses those PHP required reports and data elements, as well as those developed by DHHS and the EQRO, to assess and, when needed, correct the quality of care provided by PHPs. Further, this information is used to drive continuous quality improvement activities including those related to monitoring performance against and updating this Quality Strategy.

To monitor and ensure the accuracy of PHP reporting and performance against quality measures on a PHP-specific and program-wide basis, DHHS:

- Requires, reviews and approves each PHP's QAPI, including how the PHP will assess and improve upon its own performance against its QAPI on an annual basis;
- Sets parameters for the performance improvement projects (PIPs) described in Section II(B), including changes to such programs based on DHHS-identified quality priorities and opportunities for targeted improvement;
- Conducts monthly and as otherwise needed PHP Quality Director meetings, to engage with PHPs and address issues as they arise;
- Reviews all accreditation and EQRO compliance reports to determine areas of deficiency including and, as needed, sets forth and monitors PHP corrective actions plans;
- Works closely with EQRO to develop the requirements for and understand opportunities for improvement as a result of the disparity report discussed within this section of the Strategy;
- Publishes the quality data described in Section I(A), in order to promote transparency regarding PHP and program performance and engage stakeholders on opportunities for improvement;
- Designs and administers the quality withhold program, further discussed below; and
- Utilizes the EQRO quality performance reports, outlined in Figure 10 below to drive improvement and performance against the Quality Strategy.

Further, upon PHPs' completion of accreditation requirements (as discussed in Section II(C)(8)), DHHS will determine which activities, if any, will be deemed met by accreditation. To ensure that information can be accurately and readily compared across PHPs and within the program broadly, EQRO activities will not be deemed met by accreditation until all PHPs are required to have met consistent accreditation standards. Any requirements deemed by completion of accreditation requirements will be implemented in compliance with the standards set forth in 42 CFR 438.360 related to the non-duplication of mandatory activities with accreditation review.

Figure 9. EQRO Functions Related to Quality Assessment and Performance Improvement<sup>63</sup>

EQRO Activities
<ul style="list-style-type: none"> <li>• Validate PHPs’ performance improvement projects outlined in Section II(A) of this Quality Strategy</li> <li>• Validate all PHP-submitted quality performance measures outlined in Section I(B), and aggregate measures for collective review by DHHS</li> <li>• Calculate performance measures in addition to those reported by PHPs and validated by the EQRO, as requested by DHHS</li> <li>• Conduct the CAHPS Plan Survey</li> <li>• Validate the encounter data reported by PHPs</li> <li>• Produce an annual technical report that summarizes findings on access and quality of care, including:               <ol style="list-style-type: none"> <li>1. A description of the manner in which the data from all activities conducted were aggregated and analyzed, and conclusions were drawn as to the quality of care provided by each PHP;</li> <li>2. An assessment of each PHP’s strengths and weaknesses for the quality of care provided;</li> <li>3. Recommendations for improving the quality of health care services provided by each PHP;</li> <li>4. Comparative information about all PHPs; and</li> <li>5. Starting in year 2 of PHP operations, an assessment of the degree to which each PHP has effectively addressed the recommendations for quality improvement made by the EQRO during the previous year’s external quality review.</li> </ol> </li> <li>• Produce an annual disparity report, assessing PHP and program-wide performance against select measures indicated in Appendix A based on select strata including age, race, ethnicity, sex, primary language, disability status, and a breakdown of measures for key population groups (e.g., LTSS).</li> <li>• Provide technical assistance, as directed by DHHS, to PHPs as related to conducting PIPs, quality reporting, and accreditation preparedness.</li> </ul>

### **Disparity Report**

In compliance with the requirements set forth in 42 CFR 438.340 (b)(6) and as discussed in Section I(B), PHPs must report select measures outlined in Appendix A based on select strata including age, race, ethnicity, sex, primary language, and disability status, *where feasible*.<sup>64,65</sup> This information is provided to PHPs upon beneficiary enrollment, and is used by DHHS to better understand disparities of care within and across PHPs, and by the EQRO to develop an annual disparity report that identifies trends in variation in health services and outcomes based on the factors noted above, in addition to geography. This report is intended to support the State’s development of a plan of action for measuring and evaluating efforts to remediate disparities in the Medicaid program. DHHS will take into consideration the results of this report, to be made publicly available on the DHHS website, and develop focused interventions where practicable. As appropriate, these interventions will include:

- Development of disparity-specific quality measure improvement targets, on a program-wide and/or PHP-specific basis;

<sup>63</sup> Figure 10 contains only those EQRO activities related to the quality improvement activities described within this section of the Quality Strategy. For a full list of the activities conducted by the EQRO and discussed throughout this document, see Appendix E.

<sup>64</sup> Consistent with the requirements set forth in 42 CFR 438.340(b)(6), “disability status” means whether the individual qualified for Medicaid on the basis of a disability.

<sup>65</sup> This demographic information is collected via the Medicaid application and transmitted to PHPs at the time of enrollment.



- Adjustment to, or the introduction of new, program-wide interventions and/or policies catered to the needs of those identified populations;
- Development of modified, or additional, PHP performance improvement project (PIP) requirements; and/or
- Additional requirements for PHP quality assessment and performance improvement programs (QAPIs), further described in Section II(A) of this Quality Strategy.

DHHS will use the disparity report, along with other reports such as those from accrediting bodies and generated within DHHS, in its annual review of each PHP’s proposed QAPI to ensure that each PHP is actively assessing – and responding to – opportunities to improve health disparities in collaboration with DHHS-developed, cross-PHP interventions. DHHS is committed to developing measure targets that not only address overall continuous quality improvement, but target opportunities to improve health disparities.

**PHP Withhold Program**

PHPs are required to meet several performance and reporting thresholds to remain in compliance with DHHS contract provisions; failure to achieve these minimum performance thresholds may result in sanctions (as further described in Section IV(C)). Additionally, there are a number of priority areas where DHHS is encouraging PHPs to perform beyond compliance thresholds through a uniquely designed withhold program, in which a portion of each PHP’s capitation rate is withheld and paid when the PHP meets reasonably achievable performance targets.

In accordance with the requirements set forth in 42 CFR 438.6 and DHHS’s goal to advance the withhold program to focus on key performance improvement areas over time, the withhold payment opportunities outlined in Figure 10 below are included in the first year of the PHP withhold program. PHPs will have the opportunity to earn “partial credit” for performance in measures within each performance area, which will be weighted according to importance and feasibility. Each year, DHHS will assess PHPs’ performance across withhold payment areas to modify the program to continually advance its goals, focus on new targets that foster continuous quality improvement, and assess opportunities to tie the withhold program to evolving priorities. For example, DHHS aims to dissolve more infrastructure-related measures after the first year of PHP operations, and to increase the withhold program’s focus on quality measure performance and outcomes over time.

*Figure 10. PHP Withhold Program Year 1 Measurement Areas*

Year 1 Measurement Area	Overview
<b>Enhanced Operational Performance</b>	Dedicated measures related to critical initiatives, such as reporting of accurate encounter data and establishment of select program priorities/interventions
<b>Quality Measure Performance</b>	PHP performance aligned to set targets on a subset of required measures in Appendix A

Year 1 Measurement Area	Overview
<b>Provision of “Local” Care Management</b>	Thresholds related to PHPs contracting with Tier 3 AMH practices that are equipped to provide care management locally
<b>Accreditation</b>	Early achievement of health plan accreditation milestones, designed to ensure early operational effectiveness
<b>Social Determinants of Health</b>	Performance standards related to addressing beneficiaries’ unmet social needs, such as completing care needs screenings and referring identified beneficiaries with unmet resource needs to social services
<b>Telemedicine</b>	Standards for engaging in/implementing telemedicine programs designed to expand access to care and/or test an approach to chronic disease management and prevention

### **(B) Monitoring and Compliance of PHP Access, Structure, and Operations**

PHPs are contractually required to collect and submit timely encounter, quality, and performance data to DHHS. PHPs are also required to submit reports on a range of other metrics, as discussed throughout this Quality Strategy, including demonstration of network adequacy, value-based contracting arrangements and volume, nature, and outcomes of grievances and appeals. These reports are essential to DHHS’s ability to evaluate the program and hold PHPs accountable. In addition to DHHS’s monitoring, the North Carolina Department of Insurance (DOI) licenses PHPs and ensures that they meet solvency standards through processes similar to those used for existing commercial managed care plans.

DHHS requires approval of and performs monitoring against PHPs’ compliance with access, structure and operations through a variety of concurrent mechanisms, including those housed within the State and those conducted through external quality review (as outlined in Appendix B). DHHS ensures PHPs’ compliance with the standards set forth in this Quality Strategy and required by PHP contracts by:

- Reviewing PHP’s governing policies and procedures during readiness and EQR reviews, and as necessary to ensure compliance with the PHP contract.
- Requiring the reports set forth throughout this Strategy and within PHP contracts. DHHS reviews each report to ensure continued compliance with the relevant contractual requirement and tracks and trends any potential non-compliance to engage the PHP in corrective action prior to the PHP being noncompliant. For example, and as is discussed in Section III(B)(6), DHHS requires PHPs to submit monthly report on beneficiary grievances and appeals to ensure timeliness of those required processes.
- Auditing PHPs at any time, for any reason, if there is a suspicion of non-compliance or deficiency. In such instances, DHHS may require the PHP to submit a Corrective Action Plan (CAP) or take other corrective action, including imposing liquidated damages and/or intermediate sanctions.

- Reviewing, as determined by DHHS, PHPs' Compliance Plans, and any other policy and procedure governing how PHPs monitor compliance and quality of services provided by their networks, at any time.<sup>66</sup>
- Annually review the PHPs' required Fraud Prevention Plan and require the PHP to make any modifications, and the State may also require a PHP to perform specific and/or targeted monitoring or auditing activities in addition to those outlined in the PHP's Fraud Prevention Plan. PHPs will also submit an annual Fraud Prevention Report outlining the outcome and scope of the activities set forth in its Fraud Prevention Plan, including, at a minimum, the items listed in Appendix C.

Based on the EQRO's review of PHPs' compliance with contractual requirements and/or any deficiencies identified with requirements that results in a Notice of Deficiency (NOD) issued by DHHS to the PHP, the PHP, at a minimum, is required to submit a Corrective Action Plan (CAP). The CAP must address each deficiency specifically and provide a timeline by which corrective action will be completed. Follow-up reviews may be conducted as appropriate to assess the PHP's progress in implementing and/or validation of its implementation of the CAP. This issuance of an NOD will not preclude the State from imposing intermediate sanctions, for instance, in the event that potential member harm, or fraud or abuse, or substantial non-compliance with contractual requirements is identified.

### **Provider Screening**

DHHS also serves as the gatekeeper to the Medicaid program by screening providers for enrollment in the Medicaid program. This is based on each provider's assignment into risk categories, collecting and evaluating the provider's ownership and control disclosure forms, and performing monthly screenings of all Medicaid enrolled providers against:

- The Social Security Administration's Death Master File;
- The National Plan and Provider Enumeration System (NPPES);
- The List of Excluded Individuals/Entities (LEIE);
- The System for Award Management (SAM); and
- The DHHS Excluded Provider List (collectively, the "Exclusion Lists").

Additionally, all providers are subject to criminal background checks by DHHS. Providers must be enrolled in North Carolina Medicaid and have gone through North Carolina's centralized credentialing program to participate in the PHP program.

PHPs are also required to perform precontracting and monthly screenings of all network providers against the Exclusion Lists. PHP and DHHS shall report to one another if they identify any provider as appearing on the Exclusion Lists in order to ensure that no payments are paid to a provider appearing such Exclusion Lists.

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<sup>66</sup> PHPs are required to have in effect a Compliance Plan which complies with 42 CFR 438.608.

## **Program Integrity**

DHHS oversees required PHP program integrity activities through frequent communication and receipt of detailed reports of each PHP's compliance and program integrity activities. DHHS conducts operational audits and data reviews of PHPs and providers and, through these activities, as appropriate, will share any information between PHPs regarding potential fraud, waste or abuse by providers or beneficiaries. DHHS will require certain monitoring and auditing activities; PHPs will describe the specifics of those activities in their Fraud Prevention Plan. DHHS will review credible allegations of fraud, while each PHP's Special Investigations Unit (SIU) is legally and contractually required to promptly refer those matters to DHHS. Should DHHS determine that fraud allegations appear credible, as required under federal regulation, DHHS will refer the matter to the North Carolina Department of Justice Medicaid Investigations Division ("MID") or other law enforcement agencies for review. MID will evaluate the matter and determine whether it or the PHP should continue the investigation.

As noted in Appendix C, DHHS performs a full review of the PHP's compliance program and program integrity activities at least every three years through its EQR process. On an annual basis, DHHS performs tracer audits of each PHP to ensure that the PHP is following its NC DHHS-approved processes and Fraud Prevention Plan in carrying out its program integrity obligations.

While providing oversight and compliance auditing of the PHP fraud, waste and abuse efforts, the DHHS Program Integrity unit will continue to provide mandated fraud, waste and abuse investigations and auditing for the fee-for-service services not transitioned to Medicaid managed care.

## **(C) Use of Sanctions**

The State may impose any or all sanctions, including requiring a PHP to take remedial action, imposing intermediate sanctions and/or assessing liquidated damages, due to non-compliance with contract requirements or applicable federal or state law which includes, but is not limited to, a finding by DHHS that a PHP acts or fails to act as follows:

- Fails substantially to provide medically necessary services that the PHP is required to provide, under law or under the Contract with the State, to an enrollee covered under the Contract;
- Imposes on enrollees premiums or charges that are in excess of the premiums or charges permitted under the Medicaid program;
- Acts to discriminate among enrollees on the basis of their health status or need for health care services. This includes termination of enrollment or refusal to re-enroll a beneficiary, except as permitted under the Medicaid program, or any practice that would reasonably be expected to discourage enrollment by beneficiaries whose medical condition or history indicates probable need for substantial future medical services;
- Misrepresents or falsifies information that it furnishes to CMS or to DHHS;
- Fails to comply with the requirements for physician incentive plans, as set forth (for Medicare) in 42 C.F.R. §§ 422.208 and 422.210.

- Distributes directly, or indirectly through any agent or independent contractor, marketing materials that have not been approved by the Department or that contain false or materially misleading information; or
- Violates any of the other applicable requirements of Sections 1903(m), 1905(t), or 1932 of the Social Security Act and any implementing regulations.

Upon the discovery of non-compliance or a deficiency, DHHS will assign the non-compliance or deficiency into one of four risk levels. The risk level assignment and the imposition of specific sanctions against a PHP will be commensurate with the non-compliance or deficiency, taking into consideration some or all of the following factors:

- The nature, severity, and duration of the violation;
- The type of harm suffered due to the violation (e.g., impact on the quality of care, access to care, or program integrity);
- Whether the violation (or one that is substantially similar) has previously occurred;
- The timeliness in which the PHP self-reports a violation;
- The PHP's history of compliance;
- The good faith exercised by the PHP in attempting to stay in compliance (including self-reporting by the PHP); or
- Any other factor that DHHS deems relevant based on the nature of the violation.

## V. Conclusion and Opportunities

### Opportunities for Improvement In Data Collection and Measurement

Continuous assessment of progress against this Quality Strategy is not without challenges. As North Carolina Medicaid continues its transition from a predominantly fee-for-service model with PCCM model to a system of managed care, new roles and responsibilities will continue to create new processes and potential challenges for data collection. Currently, DHHS's Medicaid data infrastructure leverages a combination of fee-for-service claims and encounter data from LME-MCOs, and a significant amount of the analysis and reporting of data to providers is managed through DHHS's contract with its PCCM vendor. To manage utilization and improve outcomes through Medicaid managed care, DHHS must collect and process encounter data from PHPs and integrate these data from plans with fee-for-service claims for carved-out populations and services.

To address potential challenges with the State's collection of encounter data, PHPs will be held accountable for submitting timely and accurate encounter data on a regular basis. PHP contracts provide guidance specifying the format, frequency, quality review, and other standards for encounter data submission, and specify incentives and financial penalties for plans to submit timely and accurate encounter data. DHHS has systems to track the current portfolio of statewide quality measures, as described in Section I(B) and in Appendix A. As additional measures may be identified, including metrics that require the collection of data beyond that which is captured in claims and encounter data or described in this Quality Strategy, DHHS will continue to work with stakeholders to enhance existing capabilities and/or develop new data collection processes and systems to accommodate these needs.

To enhance PHPs' and Medicaid providers' ability to improve the effectiveness and efficiency of care, DHHS will explore opportunities to reduce the costs and complexity of data collection by: (1) creating consistent approaches to data collection and reporting, and (2) aggregating the collection of data from multiple sources into single, statewide systems.

### **Opportunities for Advancing the Quality of Care**

In addition to implementation and assessment of the components of North Carolina's Quality Strategy, DHHS looks forward to several opportunities to expand and build upon DHHS interventions to transform and drive quality improvements within its Medicaid managed care program. Key elements of this transformation and opportunities as DHHS looks to the future include:

- Further refinement of the Quality Objectives outlined within this Quality Strategy, based on the identification of opportunities for improvement based on PHP and program-wide performance results in Year 1, and in order to mitigate health disparities;
- The continued integration of social determinants of health and addressing unmet resource needs in treatment planning, provision of services and improvements in overall health outcomes;
- Development of the State's Value Based Payment Roadmap, designed to build upon PHP advancements in the first two years of managed care; and
- Building upon the integration of behavioral health and physical health services, a key element of driving whole-person centered care forward.

Further, described throughout this Quality Strategy are requirements, standards, and protocols built to ensure the State, PHPs, the EQRO, and other key entities and stakeholders remain engaged in ongoing, active quality improvement efforts. For example: PHPs are required to report several DHHS-defined quality measures, including those in Appendix A; these measures will be assessed and validated by the EQRO, and DHHS will work together with the EQRO, PHPs and other key experts and stakeholders to continually review progress on these measures, identify opportunities for improvement, and maintain the Quality Strategy as a living documentation of these efforts.

This Quality Strategy aligns the many Medicaid improvement efforts taking place in North Carolina – particularly the State's transition to managed care and the interventions described in Section II(C) – with the State's goal to build an innovative, whole-person, well-coordinated system of care, addressing both medical and non-medical drivers of health. The Quality Strategy recognizes the importance of continuous quality improvement, and NC DHHS anticipates that, over time, modified Goals, Objectives, and Measures will be set forth in order to drive continued improvement against the greatest areas of opportunity and need. Further, this Quality Strategy – through several interventions and mechanisms described within – recognizes the importance of continued provider engagement and the value in building upon program successes. The Aims, Goals, Objectives and measures detailed in this Quality Strategy provide the framework for assessing progress in quality improvement during its transition to

managed care and in the context of the populations that will be included in that transition in the near-term, and will continue to evolve as part of the continuous quality improvement process.

Engagement and feedback are critical to the success of this Quality Strategy, to DHHS's quality efforts moving forward, and to Medicaid's transformation efforts broadly. DHHS welcomes and encourages stakeholder comments on this initial Quality Strategy prior to its finalization, and on an ongoing basis as it is updated and the State conducts a continuous quality improvement process. DHHS will continue to engage the Medical Care Advisory Committee (MCAC) and with beneficiaries, providers, plans, elected officials, local agencies, communities, and other stakeholders throughout the health care and social services systems to shape, implement and monitor Medicaid program changes – including on changes that relate to quality, the transition to managed care, and several other related topics.

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## Appendices

### Appendix A: Priority Quality Performance Measures<sup>67</sup>

PHPs are required to annually submit to DHHS quality measures aligned to accreditation requirements, a subset of CMS Adult and Child Core measure sets, measures aligned to specific State interventions and programs, and measures identified by DHHS as priority measures, as is further outlined in Section I(B).

This Appendix does **not** depict the full universe of quality measures that PHPs are required to report or may be required to report in the future; rather, it is intended to outline select, priority quality measures that will be used to assess disparities in care and to identify the subset of quality measures that will be publicly reported on NC DHHS’s website annually. Over time and as the continuous quality improvement process evolves, DHHS will refine the measures required from PHPs, based on PHP performance over time, the evolution of national clinical standards, and North Carolina-specific opportunities for improvement.

Measure Name	Measure Description <i>(for clinical and CAHPS survey measures)</i>	Data Source	Measure Steward <i>(if applicable)</i>
<b>Objective 1.1: Ensure Timely Access to Care</b>			
Getting Care Quickly  NQF #: 0006	The survey asks enrollees 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. <ul style="list-style-type: none"> <li>• 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)</li> <li>• Q6: Respondent got non-urgent appointment as soon as needed (or, for the Child Version: Child got non-urgent appointment as soon as needed)</li> </ul>	EQRO: CAHPS Health Plan Survey 5.0H, Adult Version and CAHPS Health Plan Survey 5.0H, Child Version	AHRQ
Getting Needed Care  NQF #: 0006	The survey asks enrollees 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.	EQRO: CAHPS Health Plan Survey 5.0H, Adult Version and CAHPS	AHRQ

<sup>67</sup>This list of Priority Quality Performance measures are in draft form and will be finalized by DHHS.



Measure Name	Measure Description (for clinical and CAHPS survey measures)	Data Source	Measure Steward (if applicable)
	<ul style="list-style-type: none"> <li>• 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)</li> <li>• 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)</li> </ul>	Health Plan Survey 5.0H, Child Version	
<b>Objective 1.2: Maintain Medicaid Provider Engagement</b>			
Overall Provider Satisfaction with PHP	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	EQRO: Standardized Provider Survey <sup>68</sup>	
<b>Objective 2.1: Promote Patient Engagement in Care</b>			
Rating of All Health Care <b>NQF #:0006</b>	The survey asks enrollees for several ratings on a scale of 0 to 10, with 0 being the worst and 10 being the best. <ul style="list-style-type: none"> <li>• Q8: Rating of all health care (or, for the Child Version: Q8: Rating of all health care)</li> </ul>	EQRO: CAHPS Health Plan Survey 5.0H, Adult Version and CAHPS Health Plan Survey 5.0H, Child Version	-AHRQ
Rating of Personal Doctor <b>NQF #:0006</b>	The survey asks enrollees for several ratings on a scale of 0 to 10, with 0 being the worst and 10 being the best. <ul style="list-style-type: none"> <li>• Q16: Rating of personal doctor (or, for the Child Version: Q19: Rating of Personal Doctor)</li> </ul>	EQRO: CAHPS Health Plan Survey 5.0H, Adult Version and CAHPS Health Plan Survey 5.0H, Child Version	-AHRQ
<b>Objective 2.2: Link Patients to Appropriate Care Management and Care Coordination Services</b>			
Number of Medicaid Beneficiaries Attributed to AMH, Tier 3 <sup>69</sup>	The number of beneficiaries attributed to an AMH Tier 3 practice	DHHS: Administrative Data	-
Customer Service <b>NQF #:0006</b>	The survey asks enrollees 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. <ul style="list-style-type: none"> <li>• Q22: Customer service gave necessary information/help (or, for the Child Version: Q25: Customer service gave necessary information/help)</li> </ul>	EQRO: CAHPS Health Plan Survey 5.0H, Adult Version	AHRQ

<sup>68</sup> DHHS will develop and/or specify a standardized survey tool to be used by PHPs in collecting data for this measure.

<sup>69</sup>Administrative and financial measures designed by DHHS. Technical specifications currently under development

Measure Name	Measure Description (for clinical and CAHPS survey measures)	Data Source	Measure Steward (if applicable)
	<ul style="list-style-type: none"> <li>Q23: Customer service was courteous and respectful (or, for the Child Version: Q26: Customer service was courteous and respectful)</li> </ul>		
Parents' Experiences with Coordination of Their Child's Care  <b>NQF #: 0009</b>	<ul style="list-style-type: none"> <li>CC7: Respondent got the help needed, from doctors or other health providers in contacting child's school or daycare</li> <li>CC18: Someone from child's health plan, doctor's office, or clinic helped coordinate child's care among different providers or services</li> </ul>	EQRO: CAHPS Health Plan Survey 5.0H, Child Version	AHRQ
<b>Objective 2.3: Address Behavioral and Physical Health Comorbidities</b>			
Percent of Beneficiaries with MH/DD/SU Visit with PCP Visit in Same Measurement Year <sup>70</sup>	The percentage of enrollees with MH/DD/SU needs with at least one visit with their attributed AMH PCP within the same measurement period	PHPs: Claims Data	-
<b>Objective 3.1: Promote Child Health, Development, and Wellness</b>			
Childhood Immunization Status (Combination 10)  <b>NQF #: 0038</b>	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.	PHPs: Claims Data	NCQA
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life  <b>NQF #: 1516</b>	The percentage of children 3-6 years of age who had one or more well-child visits with a PCP during the measurement year.	PHPs: Claims Data	NCQA
Immunizations for Adolescents (Combination 2)  <b>NQF #: 1407</b>	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	PHPs: Claims Data	NCQA

<sup>70</sup> Administrative, financial, or process measure designed by DHHS; Technical specifications currently under development

Measure Name	Measure Description (for clinical and CAHPS survey measures)	Data Source	Measure Steward (if applicable)
	birthday. The measure calculates a rate for each vaccine and two combination rates.		
Percent of Eligibles Who Received Preventive Dental Services  <b>NQF #: 1334</b>	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.	PHPs: Claims Data	CMS (collected via the CMS-416 form)
<b>Objective 3.2: Promote Women's Health</b>			
Cervical Cancer Screening  <b>NQF #: 0032</b>	The percentage of women 21–64 years of age who were screened for cervical cancer using either of the following criteria: <ul style="list-style-type: none"> <li>• Women 21–64 years of age who had cervical cytology performed every 3 years</li> <li>• Women 30–64 years of age who had cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years</li> </ul>	PHPs: Claims Data	NCQA
Prenatal and Postpartum Care (Both Rates)  <b>NQF #: 1517</b>	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. <ul style="list-style-type: none"> <li>• Timeliness of Prenatal Care. The percentage of deliveries that received a prenatal care visit as a member of the organization in the first trimester, on the enrollment start date or within 42 days of enrollment in the organization.</li> <li>• Postpartum Care. The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.</li> </ul>	PHPs: Claims Data	NCQA
Live Births Weighing Less Than 2,500 Grams  <b>NQF #: 1382</b>	The percentage of births with birthweight <2,500 grams	TBD: State Vital Records	CDC
Contraceptive Care: Postpartum  <b>NQF #: 2904</b>	Among women ages 15 through 44 who had a live birth, the percentage that is provided: <ol style="list-style-type: none"> <li>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.</li> </ol>	PHPs: Claims Data	US Office of Population Affairs

Measure Name	Measure Description (for clinical and CAHPS survey measures)	Data Source	Measure Steward (if applicable)
	2) A long-acting reversible method of contraception (LARC) within 3 and 60 days of delivery.		
Contraceptive Care: Most & Moderately Effective Methods  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.	PHPs: Claims Data	US Office of Population Affairs
Pregnancy risk screening form <sup>71</sup>	The percentage of Non-Emergency deliveries with a completed standardized pregnancy risk screening within the measurement period	PHPs: Standardized Screening Tool <sup>72</sup>	-
<b>Objective 3.3: Maximize LTSS Populations' Quality of Life<sup>73,74</sup></b>			
Percent of LTSS population with a health risk assessment completed within 90 days of enrollment <sup>75</sup>	The percentage of enrollees with LTSS needs with a completed health risk assessment within 90 days of enrollment during the measurement period	PHPs: Standardized Screening Tool	
Participants in the Demonstration who remained stable or improved in ADL function between previous and most recent assessment <sup>76</sup>	The number of enrollees 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	PHPs: Standardized Screening Tool	

<sup>71</sup>Administrative, financial, or process measure designed by DHHS; Technical specifications currently under development

<sup>72</sup> DHHS will develop and/or specify a standardized survey tool to be used by PHPs in collecting data for this measure.

<sup>73</sup> For additional information regarding the measures included for Objective 3.3, reference the National Quality Forum, "Quality in Home and Community-Based Services to Support Community Living: Addressing Gaps in Performance Measurement," September 2016. Available at:

[http://www.qualityforum.org/Publications/2016/09/Quality\\_in\\_Home\\_and\\_Community-Based\\_Services\\_to\\_Support\\_Community\\_Living\\_Addressing\\_Gaps\\_in\\_Performance\\_Measurement.aspx](http://www.qualityforum.org/Publications/2016/09/Quality_in_Home_and_Community-Based_Services_to_Support_Community_Living_Addressing_Gaps_in_Performance_Measurement.aspx)

<sup>74</sup> DHHS will develop and/or specify a standardized survey tool to be used by PHPs in collecting data for this measure.

<sup>75</sup> Administrative, financial, or process measure designed by DHHS; Technical specifications currently under development

<sup>76</sup> Administrative, financial, or process measure designed by DHHS; Technical specifications currently under development

Measure Name	Measure Description (for clinical and CAHPS survey measures)	Data Source	Measure Steward (if applicable)
<b>Objective 4.1: Improve Behavioral Health Care</b>			
Follow-up After Hospitalization for Mental Illness  NQF #: 0576	The percentage of discharges for members 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 member received follow-up within 30 days after discharge. 2. The percentage of discharges for which the member received follow-up within 7 days after discharge.	PHPs: Claims Data	NCQA
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Both Rates)  NQF #: 0004	"The percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) abuse or dependence who received the following. • Initiation of AOD Treatment. The percentage of members 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 members who initiated treatment and who had two or more additional AOD services or MAT within 34 days of the initiation visit."	PHPs: Claims Data	NCQA
<b>Objective 4.2: Improve Diabetes Management</b>			
Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)  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.	PHPs: Claims Data	NCQA
<b>Objective 4.3: Improve Asthma Management</b>			
Asthma Medication Ratio (Total Rate)  NQF #: 1800	The percentage of members 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.	PHPs: Claims Data	NCQA
<b>Objective 4.4: Improve Hypertension Management</b>			

Measure Name	Measure Description (for clinical and CAHPS survey measures)	Data Source	Measure Steward (if applicable)
Controlling High Blood Pressure  NQF #:0018	The percentage of members 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: <ul style="list-style-type: none"> <li>• Members 18–59 years of age whose BP was &lt;140/90 mm Hg</li> <li>• Members 60–85 years of age with a diagnosis of diabetes whose BP was &lt;140/90 mm Hg</li> <li>• Members 60–85 years of age without a diagnosis of diabetes whose BP was &lt;150/90 mm Hg</li> </ul> <i>Note: A single rate is reported and is the sum of all three groups.</i>	PHPs: Claims Data	NCQA
<b>Objective 5.1: Address Unmet Resource Needs</b>			
Rate of Screening for Unmet Social Needs <sup>77</sup>	The percentage of enrollees screened for unmet social needs form the health risk screening by the PHP within measurement period.	PHPs: Standardized Screening Tool <sup>78</sup>	-
<b>Objective 5.2: Address the Opioid Crisis</b>			
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.	PHPs: Claims Data	PQA
<b>Objective 5.3: Address Tobacco Use</b>			

<sup>77</sup> Administrative, financial, or process measure designed by DHHS; Technical specifications currently under development

<sup>78</sup> DHHS will develop and/or specify a standardized survey tool to be used by PHPs in collecting data for this measure.

Measure Name	Measure Description (for clinical and CAHPS survey measures)	Data Source	Measure Steward (if applicable)
<p>Medical Assistance with Smoking and Tobacco Use Cessation</p> <p><b>NQF #: 0027</b></p>	<p>The following components of this measure assess different facets of providing medical assistance with smoking and tobacco use cessation:</p> <ul style="list-style-type: none"> <li>• Advising Smokers and Tobacco Users to Quit. A rolling average represents the percentage of members 18 years of age and older who were current smokers or tobacco users and who received advice to quit during the measurement year.</li> <li>• Discussing Cessation Medications. A rolling average represents the percentage of members 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.</li> <li>• Discussing Cessation Strategies. A rolling average represents the percentage of members 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.</li> </ul>	<p>EQRO: CAHPS Health Plan Survey 5.0H, Adult Version</p>	<p>AHRQ</p>
<b>Objective 5.4: Reduce Health Disparities</b>			
<i>Select measures in this Appendix are to be reported by select strata, including age, race, ethnicity, sex, primary language, and disability status and broken out, where possible, by key populations groups (e.g., LTSS) and geography</i>			
<b>Objective 5.5: Address Obesity</b>			
<p>Adult Body Mass Index (BMI) Assessment</p> <p><b>NQF #: 0023</b></p>	<p>The percentage of members 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.</p>	<p>PHPs: Claims Data</p>	<p>NCQA</p>
<p>Weight Assessment and Counseling for Nutrition and Physical Activity for children/Adolescents (the total of all ages for each of the three rates)</p> <p><b>NQF #: 0024</b></p>	<p>The percentage of members 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.</p> <ul style="list-style-type: none"> <li>• BMI percentile documentation*</li> <li>• Counseling for nutrition</li> <li>• Counseling for physical activity</li> </ul> <p>*Because BMI norms for youth vary with age and gender, this measure evaluates whether BMI percentile is assessed rather than an absolute BMI value.</p>	<p>PHPs: Claims Data</p>	<p>NCQA</p>
<b>Objective 6.1: Ensure High Value and Appropriate Care</b>			

Measure Name	Measure Description (for clinical and CAHPS survey measures)	Data Source	Measure Steward (if applicable)
Inpatient Utilization- General Hospital/Acute Care (IPU) <b>NQF #: 1598</b>	This measure summarizes utilization of acute inpatient care and services in the following categories: total inpatient, maternity, surgery, medicine.		NCQA
VBP Penetration Rate <sup>79</sup>	The portion of medical expenses that are in VBP arrangements as defined by the HCP-LAN Framework, Categories 2-4	DHHS: PHP VBP Assessment Results	-

## Appendix B: External Quality Review Organization (EQRO) Activities

As noted throughout this Quality Strategy, the External Quality Review Organization plays a critical role in reporting against PHPs' performance in several areas required by (meaning federal regulations require that these activities are completed by the EQRO), and optional (meaning that the State has elected to use the EQRO for these activities) under 42 CFR 438.352 and 438.364. A collective overview of these functions discussed throughout the Quality Strategy is included below.

Mandatory EQRO Activities
<ul style="list-style-type: none"> <li>• Validation of performance improvement projects (PIPs) conducted by each PHP</li> <li>• Validation of each PHP's reported performance measures</li> <li>• Review of each PHP's compliance with the standards set forth in 42 CFR 438 Subpart D</li> <li>• Validation of PHP network adequacy<sup>80</sup></li> <li>• Annual technical report that summarizes findings on access and quality of care, including the requirements set forth in 42 CFR 438.364.</li> </ul>
Optional Activities
<ul style="list-style-type: none"> <li>• Validation of encounter data reported by each PHP</li> <li>• Administration of the CAHPS Plan Survey</li> <li>• Calculation of performance measures in addition to those reported by PHPs, at the direction of DHHS or as required for completion of the technical and/or disparity report</li> <li>• Completion of studies on quality that focus on an aspect of clinical or nonclinical services at a point in time (e.g., specific assessment of the interventions described within this Quality Strategy), at the direction of DHHS</li> </ul>
Additional Activities

<sup>79</sup> Administrative, financial, or process measure designed by DHHS; Technical specifications currently under development

<sup>80</sup> Validation of network adequacy is required by 42 CFR 438.358(b)(iv), pending release of EQRO protocols related to this requirement. In the interim, DHHS utilizes the EQRO for this function as an additional activity. Additional information can be found in this June 2016 CMCS informational bullet: <https://www.medicaid.gov/federal-policy-guidance/downloads/cib061016.pdf>



- Review, in conjunction with the requirements set forth in 42 CFR 438 Subpart D, of the requirements set forth by DHHS in PHP contracts
- Technical assistance to PHPs as related to conducting PIPs, quality reporting, and accreditation preparedness, as directed by DHHS
- Annual disparity report, assessing PHP and program-wide performance against select measures indicated in Appendix A based on select strata including age, race, ethnicity, sex, primary language, and a breakdown of measures for key population groups (e.g., LTSS)
- Tracer audits of each PHP for program integrity

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## Appendix C: Minimum Required Elements of PHPs' Annual Fraud Prevention Plans and Reports

PHP Fraud Prevention Plan Minimum Requirements
<ul style="list-style-type: none"> <li>The name of the Compliance Officer</li> </ul>
<ul style="list-style-type: none"> <li>Description of the SIU, the roles within the SIU, and staffing by title</li> </ul>
<ul style="list-style-type: none"> <li>Description of the SIU staff qualifications</li> </ul>
<ul style="list-style-type: none"> <li>PHP's internal controls and policies and procedures that are designed to prevent, detect, and report known or suspected fraud and abuse activities</li> </ul>
<ul style="list-style-type: none"> <li>The process and procedures to ensure that all suspected fraud and abuse reported in compliance with the Contract</li> </ul>
<ul style="list-style-type: none"> <li>The process and procedure to ensure that all network provider terminations related to suspected or confirmed fraud and abuse, as well as PHP staff termination for engaging in prohibited marketing conduct are reported to NC DHHS as required by the Contract</li> </ul>
<ul style="list-style-type: none"> <li>Employee and contractor education on federal and state laws, as well as PHP practices for detection, identification, reporting and prevention of fraud, waste and abuse to ensure that the PHP's officers, directors, employees, contractors, network providers, and beneficiaries know and understand these obligations</li> </ul>
<ul style="list-style-type: none"> <li>A description of the PHP's specific controls to detect and prevent potential fraud and abuse, including, without limitation:               <ul style="list-style-type: none"> <li>A list of automated pre-payment claims edits</li> <li>A list of automated post-payment claims edits</li> <li>A list of desk audits on post-processing review of claims planned</li> <li>A list of reports on network provider profiling used to aid program and payment integrity review</li> <li>The methods PHP will use to identify high-risk claims and PHP's definition of "high-risk claims"</li> <li>Visit verification procedures and practices, including sample sizes and targeted provider types or locations</li> <li>A list of surveillance and/or utilization management protocols used to safeguard against unnecessary or inappropriate use of Medicaid services</li> <li>Policies and procedures used by the PHP designed to prevent, detect, and report known or suspected fraud and abuse activities</li> <li>A list of references in provider and enrollee material regarding fraud and abuse referrals (e.g. on member EOB)</li> <li>Work plans for conducting both announced and unannounced site visits and field audits of network providers determined to be at high risk to ensure services are rendered and billed correctly</li> <li>The process by which the SIU shall monitor PHP's marketing representative activities to ensure that the PHP does not engage in inappropriate activities, such provision of inducements</li> </ul> </li> </ul>
<ul style="list-style-type: none"> <li>Assurance that the identities of individuals reporting violations of by the PHP are protected and that there is no retaliation against such persons</li> </ul>
<ul style="list-style-type: none"> <li>Describe criminal background exclusion screening process for its owners, agents, employees, network providers, and subcontractors</li> </ul>
Annual PHP Fraud Prevention Report Minimum Requirements
<ul style="list-style-type: none"> <li>The name of the PHP</li> </ul>
<ul style="list-style-type: none"> <li>The name of the person and department responsible for submitting the Fraud Prevention Report</li> </ul>
<ul style="list-style-type: none"> <li>The date the report was prepared</li> </ul>
<ul style="list-style-type: none"> <li>The date the report is submitted</li> </ul>

<ul style="list-style-type: none"> <li>• Name of persons who have SIU responsibilities, as well as the name of the Compliance Officer</li> </ul>
<ul style="list-style-type: none"> <li>• A list of activities planned but not performed under the approved Fraud Prevention Plan and the reason(s) for non-performance.</li> </ul>
<ul style="list-style-type: none"> <li>• The results of the activities performed pursuant to the approved Fraud Prevention Plan and any additional similar activities performed which were not included in the Fraud Prevention Plan, including trainings provided</li> </ul>
<ul style="list-style-type: none"> <li>• A summary spreadsheet of each audit, on-site review or other activity containing the following: <ul style="list-style-type: none"> <li>○ Insert the PHP case number, if any</li> <li>○ Insert the NPI(s) of the providers subject to the review or activity and name(s) of the providers.</li> <li>○ Insert the dates when the audit, review or activity commenced and when it was completed.</li> <li>○ Insert the activity type: Audit, Self-Audit, Investigation, and Review. "Audit" is defined as a PHP performing provider monitoring or audit of a group of Providers; "Self-Audit" is defined as a provider conducting its own QA and identifying/self-disclosing billing anomalies, discrepancies, or overpayments; An "Investigation" is defined as a case initiated by a lead, referral, complaint and/or FAMS data analytics reports; a "Review" is defined as any other activity that lead to the information, such as grievance or appeal.</li> <li>○ Insert a brief statement about the concern, allegation or complaint</li> <li>○ Insert findings or requests associated with the allegation or complaint.</li> <li>○ Refrain from using 'substantiated' or 'unsubstantiated' as the only finding statement.</li> <li>○ Identify the payback amount/overpayment amount, if any.</li> <li>○ Identify if an appeal was provided and the results, including overpayment amount, if any.</li> <li>○ Identify the amount recouped by the PHP, if any</li> <li>○ Identify the remaining amount owed to PHP, if any</li> <li>○ Insert the date received the allegation or complaint as the Open date</li> <li>○ Insert the date the all action on the case has been exhausted and/or final determinations has been rendered with the exception of referrals sent to PI for the closed date</li> <li>○ Indicate if the matter was referred to PI for potential fraud.</li> <li>○ Include any additional comments related to the case, provider, or additional administrative actions taken. Also, include if the activity was completed outside the SIU.</li> </ul> </li> </ul>
<ul style="list-style-type: none"> <li>• List any providers subject to prepayment review, the length of any such review, and the outcome</li> </ul>
<ul style="list-style-type: none"> <li>• A description of any predictive modeling used</li> </ul>