

## Models of Care that Drive Improvements in Infant Well-Child Visits

Recorded September 22, 2021

### Alyssa Bosold:

Next slide, please. Before we begin, I want to cover a few housekeeping items. All participants logged into this webinar have been muted for the best sound quality possible. We welcome audience questions throughout today's webinar through the Q and A window located at the bottom-right corner of your screen. To send a question or comment related to the webinar, please highlight "All Panelists," and click send in the "Ask" drop-down list. We will address as many questions as possible during today's webinar. If you have any technical issues, please also use the Q and A window. Please select host in the "Ask" drop-down window, and describe your technical issue.

Next slide. I also want to let everyone know that this webinar is being recorded. The recording, slides and transcript from the webinar will be posted on the Medicaid.gov Infant Well-Child Visit landing page. The link is on the slide here, and we also shared it with you through the chats. On the next slide, we will review our webinar agenda. So first, Kristen Zycherman at CMS will provide you all with some welcoming remarks and an overview of our objectives. Following Kristen's remarks, we have three state presentations today. The first is from Lisa Bui of the Oregon Health Authority. She will describe their cross-sectional initiatives for infant and child health. And then we'll hear from Tom Curtis, who will describe how Michigan's state Medicaid agency and its managed care organizations are actively partnering on several well-child efforts and how the state uses disaggregated data to advance health equity. We'll then hear from Jaimica Wilkins, who will present on North Carolina's initiative to support children during the COVID-19 pandemic and the lessons learned that will be carried into their new managed care delivery system. So now, I will turn it over to Kristen for the welcoming remarks.

### Kristen Zycherman:

Hello, everyone. My name is Kristen Zycherman. I'm the lead for the Maternal and Infant Health Initiative at CMS. I'm pleased to welcome all of you for the third webinar in our Infant Well-Child Learning Collaborative series. This learning collaborative is one of our quality improvement initiatives at the Center for Medicaid and CHIP Services within CMS. The goal of our quality improvement work is to support Medicaid and CHIP agencies and their partners, such as other state agencies, health plans, providers and advocates to drive measurable improvement in quality of care and health outcomes for Medicaid and CHIP beneficiaries. Next slide, please. The purpose of today's webinar is to offer considerations for strategies to improve the use and quality of infant well-child care by developing models of care, leveraging partnerships and addressing disparities. We hope that the experiences from North Carolina, Oregon and Michigan will provide tangible steps that other states can adapt for your unique delivery systems. And with that, I'll turn it over to Lisa. Thank you.

### Lisa Bui:

Hello. I'm Lisa Bui, Quality Improvement Director for the Oregon Health Authority. I will give a little bit of background on Oregon first. Oregon is a Medicaid expansion state. We have approximately 1.2 million Medicaid members, with about 40 percent of those representing children, members under the age of 18. There are 16 coordinated care organizations, known as CCOs, who administer Oregon's health plan, which covers the continuum of care across physical health, behavioral health and oral health. Of note, we also have nine federally recognized tribes in the Urban Indian Health Program, in which Oregon regularly partners with.

Next slide. Why we do this work, you know, children. Ensuring the growth, health and well-being for children of Oregon requires all of us to put our thinking caps on. How we do our work, what work we do, who we work with all need to be examined. This will lead to the development of strategies that will realize positive outcomes in the short-and-long-term.

Next slide. I'm going to address a couple of our cross initiatives as well as some specifics within those cross initiatives, but each one of these could be its own presentation. For any of these cross initiatives to work, we have several partners that we work with across Oregon. Oregon leans on these multiple organizations to collaborate across the state. These organizations support an array of services. The services are beyond health. They include education and social determinants of health including housing, WIC programs, Head Start, just to name a few. Now, a little bit about each partner. CCOs, structures include a community advisory council known as a CAC in which most of the CAC membership has to be members, some members themselves, so about 51 percent, I believe. CCOs, along with their CACs, help determine the needs of the community and serve as the coordinating organization for health in their region. A map of Oregon CCOs is provided in the appendix of this slide deck.

For community organizations, we are lucky to have a couple who advocate and support statewide efforts across for child health. These two specific partnerships are the Oregon Pediatric Improvement Partnership, known as OPIP, and the Child Health Institute, CHI. You will hear about each one of these partnerships with OHA in the coming slides, and each one of those partners are hyperlinked to their websites as well. Then there's OHA as the Health Authority, which, in Oregon, includes the Oregon Medicaid program and includes state public health, behavioral health, policy, diversity and equity, inclusion, our state hospital and our tribal programs, again, that connect with the nine federal tribes.

And then our regional partners, out actually across the communities of Oregon, we have a few key partners to call out. We have our local public health authorities. Many are structured around our county line, but then others are grouped together. We have our early learning hubs, and in some regions, we have regional health councils.

Next slide. I'll cover, in the talk here, a few of these policy levers. For policy, we're going to touch on Trauma Informed Care requirements, and then I'll speak in a little bit more depth of Universally offered Home Visiting initiative. And then, for measurement, I'm going to touch on our Kindergarten readiness measures, as well as our CMS child core and what we call Oregon's "home-grown" measures. And then for quality improvement, I'll highlight our Oregon Integrated Care for Kids model, also known as InCK.

Next slide. For Trauma Informed Care, within the CCO contract, we have several callouts around Trauma Informed Care. Within the contract, there are actual references in each one of these bullet items, and this is not an exhaustive list, but it is in the intensive care coordination requirements, our Delivery System Network reporting, our Community Health Improvement Plans. Those are very similar to the Community Health Assessments that are done in other states with their hospitals and regions. Those are done in collaboration with our CCOs and our local public health, again, very regional approach.

We also have a health equity plan for CCOs in which, again, Trauma Informed Care is called out. And then in Behavioral Health, what you'll notice is, in the Trauma Informed Care callout, many of these reference that they have to have a Trauma Informed network, and then specifically within behavioral health, it calls out for the frequent, regular, periodic oversight of training requirements of their actual members and contractors. So again, having a health system delivery that is informed by Trauma Informed Care.

Next slide. Okay, this one will go into a little bit more detail. It is our Universally offered Home Visiting Initiative that started earlier this year. The Family Connect Oregon, as we call it, is a voluntary home visiting initiative that began through our legislative leadership and passed in 2019 with a vision of home visit by a nurse after each child's birth. Next slide. The goals of Family Connects Oregon is to create and strengthen the community-level systems of care, offer supports to all new parents in Oregon, increase access to those community supports and services, promote collaboration across those services and organizations and then ultimately improve health outcomes for families across the life-course. Next slide.

As a reminder, the Family Connects Oregon services are available for all births in Oregon, regardless of income, background, or insurance coverage. There are no costs to the family for the visit, and the visit is scheduled for around 3 weeks after the birth by a registered nurse. Next slide. What begins with a voluntary home visit shortly after birth can be a complex implementation of the services needed identified from that visit. The potential services a parent, child or family may need cross the multiple partners mentioned earlier in this presentation. Health plans, health care delivery, early learning, local public health authorities, as I mentioned, which include housing and social services and WIC, could all be a partner that receives a referral from any one of these types of needs that are identified from that home visit.

So what you see under Support for Health Care—I'll just call them out—if, in fact, the mother needs a kind of a postpartum visit and just needs to kind of get that connected, then the referral will be made and assist them to get them into their primary care or OB provider. But it can also go to as far as family and community safety supports and a safe home in which that home visit leads to social worker or domestic violence shelter kind of referral. So you can see that even though it's just one home visit, it can lead to a whole host of referrals, and again, it could be multiple referrals for any one of the families.

Next slide. This is a map showing the early adopters. Again, the initiative was passed in our 2019 legislation, and then COVID with 2020, so many of these early adopters began here in 2021. We had eight who have started in 2021, calendar year. We have eight additional who will come on in early '22. Those are all of the darker-shaded colors on this map, and that will be about 16 of 36 counties that we already have slated to implement the Family Connect Oregon program.

Next slide. I'm going to transition from the home visiting to now talk about our measurement strategy. Our Oregon measurement strategy has been kind of established since 2012. We have an incentivized measurement strategy that includes quality pool payout for CCOs on performance. The measures listed on this slide are the 2022 Incentive Measures for Infant and Child Health. Again, this was recently adopted. Of note, you'll notice in this measure set is a couple of what we call those home-grown measures. It's also some of the core measures, as well, the CMS core. The home-grown measures we'll want to call out is right in the middle of the table.

There is one that's just recently adopted, the Health Aspects of Kindergarten Readiness: CCO System Level Social-Emotional Health. This measure was developed with OPIP as the measure steward with the key partnership of the Children's Health Institute and OHA. The measure in its first few years will be attestation and capacity building, with coming years, reach a social-emotional health assessment and service for children ages 1 to 5. Another home-grown metric is the last one, which is the Mental Physical and Oral Health Assessment Within 60 Days for Children with DHS Custody. Again, this partnership is within OHA, the CCOs and our partners over at DHS, Department of Human Services, across the state, otherwise known as those who help coordinate the foster care in Oregon.

Next slide. This slide is just a snapshot of various child measures. These are not a one-for-one from the previous slide. The previous slide showed the 2022 incentive measures that will be assessed going forward for 2022 calendar year. This slide shows the performance across child health measures, including some that are on the incentive pool and then a few that are in the child core. A few callouts on this data is that 2020 COVID obviously had an impact on many of Oregon's measures, performance with access and utilization, to prevention services being impacted. Prior to COVID, what you can see in 2019 is that we were seeing improvement across all of the measures, which was really, really great momentum to lead into 2021 and we hope to get back there.

Next slide. Moving from measurement to quality improvement, I'm going to highlight a key project in Oregon's prevention and early child work. This is the Integrated Care for Kids. It's the InCK model. It's a cooperative agreement that OHA received from the Center for Medicare and Medicaid Innovation, CMMI, at CMS. Oregon is one of eight state partnerships in this endeavor. The overall goal of InCK is to improve health outcomes of children ages zero to 21, reduce out-of-home placements and reduce costs associated with unnecessary inpatient and/or ER visits.

Next slide. One of those partnerships that I mentioned earlier, again, is OPIP. OPIP is the leading organization for the InCK grant. We estimate that the target population for the InCK grant is 88,235 across the five counties, so again, from birth to age 21. The general overview of the three components of the InCK grant here in Oregon is that there is a level one that all children here under 21 in the target population area, those five counties that I mentioned, are covered by Medicaid. Then, using system-level data, OHA creates a health complexity data set for each region. That data set are indicators of a child's medical and social complexity and are used to identify priority populations of children at risk for home placement and/or high costs.

From that data set, then it goes to level two for enhanced assessment and screening, and then based upon that enhanced assessment and screening, goes to a level three where there's integrated case management and child-centered planning, and throughout that, there are other goals, which are talking about APMs and health information exchange to kind of support that work across the populations that need those services. Additional InCK initiative basics can be found in the summary and visual resources referenced on this slide. Next slide. Here, because, again, I covered a lot of various Oregon child and health initiatives, I've given you the web links to each one. Each one of these, you can go deeper into for another hour or so at least, so these are some good resources to kind of build from.

Next slide. I want to say, "Thank you," and I'm happy to turn it over to Tom Curtis.

### Tom Curtis:

Great. Thank you so much, and my name is Tom Curtis. I'm manager of our Quality Improvement Program Development and our Medicaid Managed Care program in Michigan, and what we do is, we oversee quality and performance improvement of all our 10 Medicaid health plans serving over 2 million beneficiaries in Michigan. And what I'm going to talk about is just sort of some key ways in which we're collaborating with public health in particular and improving maternal and child health, but specifically looking at well-child rates and then give you all some perspective on how do we measure performance and ways that we incentivize improvement, particularly as it relates to racial inequities.

So let's go to the next slide, and I'll give you a quick background of just how Michigan is situated in terms of managed care, and some of these numbers are a little outdated due to COVID and the determination—we were not removing anyone from Medicaid at this point. So there's well-over 2 million people on Medicaid managed care in Michigan currently. We are a behavioral health carve-out state, so our Medicaid managed care organizations cover mostly physical health, dental health for most members and mild-to-moderate behavioral health for most members. There is nearly 950,000 beneficiaries enrolled in our Medicaid expansion project at this time, and we are currently 10 Medicaid health plans, but very soon, we will be going down to nine health plans, and there is quite a bit of variation and regional service area across our health plans. Region one, the Upper Peninsula, has one Medicaid health plan, whereas in region 10, there will soon be all nine health plans in region 10. And all health plans in our state have the exact same contract requirements.

Next slide. So here are some program characteristics when it comes to how we are working with public health and Medicaid here in Michigan to improve maternal-child health, and some of these efforts do have a direct connection to encouraging and improving well-child visits. In our state, public health has set up several perinatal quality collaboratives across the different regions, and these collaboratives have brought together health system leaders and Medicaid health plan leaders, and other community organization leaders to identify issues that are impacting that particular region—so really taking a population health approach to quality improvement, and our Medicaid health plans have representatives as leaders at each one of these perinatal quality collaboratives.

A few years ago, we also carved in the maternal-infant health program benefit, so this is an evidence-based home visiting program that is now being reimbursed by Medicaid through our Medicaid health plan, and it does serve thousands of pregnant women every year, and women who recently gave birth every year, with registered nurses and other types of home visitors, community health workers coming in and

assessing for social determinants and other determinants of health and promoting postpartum care visits, prenatal care visits and those well-child visits once the baby has been born.

The other innovative model that we've started here in Michigan, and it's not everywhere, but we do have what I refer to here as integrated care delivery locations, so for the most part, our local health departments in certain jurisdictions have combined the WIC, or women and infant nutritional supplement, benefits with clinical services, with blood lead screening, with well-child and primary care and preventive services.

So there's all of these family supports and preventive services that are in one location and some local health departments, and that has really helped families sort of take care of all of their needs in one area and not just their clinical health needs, but their food and nutrition needs and other types of social support needs. And, lastly, we are currently in the middle of a maternal infant health and equity improvement plan that was requested by our governor, and you'll see in a little bit how we in Medicaid are supporting that equity improvement plan.

Next slide. So I wanted to give you all a general sense of overall performance on well-child visits historically in our state. You can see on the left-hand side, this is well-child visits in the first 15 months of life, and we've hovered right around 71 percent, 71 and a 1/2 percent over the last 3 years. And on the right-hand side is that well-child visit, 3rd, 4th, 5th and 6th year of life. That's been right around 76, upwards of 77 percent, and these are following audited HEDIS rates and standardized application of the specifications by each of our health plans. Both of these rates for each year and each measure are consistently above the national 50th percentile and our programs.

Next slide. So since 2012, shifting gears just slightly, we in Michigan have required our health plans to take those audited HEDIS rates for a subset of HEDIS measures and stratify them by race/ethnicity and report them to us, which we then validate their submissions and conduct multiple calculations, including with comparing the African-American and Hispanic rates to the white reference population for the subset of HEDIS measures, and then also calculating, in general, difference of each racial subgroup to an overall program rate or an overall health plan rate to determine to what degree is a disparity occurring in aggregate across each racial subgroup.

And for this purpose, we do consider a rate above as a disparity, just as we consider a rate below as a disparity. And we have all of these reports published online, on the websites, right there on the slide there. And what folks will see, if they were to take a look at multiple years of reports is that, consistently, year-over-year, we have an African-American subpopulation in our Medicaid managed care program that disproportionately experiences lower quality of care than nearly every other comparison, including the white reference subpopulation.

And I'll give you just a sneak peek of one of the graphs in the report on the next slide here. So what we have here is a trend over time from 2012 in our state to 2018 showing the white reference population in the blue line, the dark blue line, the African-American rate in the red line, the Hispanic rate in the light blue line, and then we've also added our Medicaid managed care plan weighted average in the green line, our statewide weighted average, and then the HEDIS 50th National Percentile in the purple line there. So what we see with this rate is that the African-American rate decreased from 72 roughly percent in 2012 to 68 percent in 2018. The Hispanic rate has fluctuated over the years but really began around 76 percent, ended around 75 percent throughout that 2012, 2018 period while our white rate and our reference population did increase between that same time period from 74 to 75 percent. So we see here a racial disparity, particularly related to African-American and white reference population, increasing pretty substantially over this time period.

Next slide. So this is another snapshot from the health equity report, and so as I mentioned, we do make a comparison of each racial subpopulation to that overall measure rate, and so this top graph is what you see each racial subgroup in the well-child, 3 to 6 years of age compared to, in this case, we have the 50th percentile shown with the red line there. And this is an important graph to understand because there is a reason to have a white reference rate, for example, and there's a reason to have very specific pairwise

comparisons with that white reference population because if we were to aggregate differences across all racial subgroups, we might miss the fact that we have one particular racial subgroup, in this case, African-American, that is below all other groups and below the 50th percentile and below the overall measure rate.

So that is why we see it as an important part of our analysis, to take that very close pairwise comparison look for every measure, and in this case, we have this well-child visit rate that, if not looked at very closely, that African-American disparity would be sort of hidden amongst the other racial subgroups that are performing better. And then on the bottom there, you see a table that is also from a report, and that is concerning the 2018 white rate for well-child visits at almost 75 percent to that 2018 African-American rate at 68 percent with a negative-6-1/2-percentage-point difference, and that is statistically significant. Then we have that same comparison between the 2018 white rate and 2018 Hispanic rate of about 75 and a 1/2 percent, which we actually see a higher rate in Hispanic population, but it's not statistically significantly different, so they are statistically the same here.

Next slide. So what do we do with these data? And in our case, we are using them pretty substantially, particularly during this fiscal year '21 period that was impacted by COVID-19, so we recognized pretty early on that we were going to have overall utilization rates that were going to be lower. We were going to have quality-of-care metrics that were pretty incomparable to any other period in history, and we were going to potentially end up having some national benchmarks that were open to some scrutiny, at the very least, because of the way that the virus hit different areas of the country in different times and in different degrees and even hit our own state, parts of our state in different times and to different magnitudes.

So we transitioned to focusing solely on racial disparities in quality of care for fiscal year '21 using our claims and encounters to generate HEDIS specified measures. So while we cannot necessarily or reliably compare overall utilization or overall quality of care calculations to standardized benchmarks, we can still compare those rates distinguished by racial subgroups and measure that gap between the two and then incentivize or promote the reduction of that gap for each health plan relative to itself. So we wanted to create an incentive process that was allowing our plans to sort of start where they're at and reduce an inequity over time or reward them for achieving equity within a given performance period. So we are dedicating upwards of \$15 million in this current fiscal year to that effort, to reducing racial disparities, and well-child visits is one of the measures that we are incentivizing health plans on reducing the inequity over time.

We have also used a similar approach in our Auto Assignment Algorithm, so this is another incentive program where members who enroll in Medicaid and then get a period of time to select a health plan, if they do not select a health plan, they are automatically assigned to one in their region, and we made those assignments based on health plan scores on quality of care metrics. And one of ways we're incentivizing that is particularly in region 10, which is our metro Detroit area.

We are focusing on access to care for African-American adults and scoring health plans related to their ability to meet or drive the regional weighted average in that measure, and we're using claims and encounters again for that, so really incentivizing health plans on promoting access to care for that subpopulation, which—you don't see that graph on this presentation—but access to care for adults, African-Americans consistently is well-below, again, all other comparison groups in Michigan, and region 10 is where predominant... There's a large focus of the African-American population in that region.

And, lastly, contract compliance, so we are deriving HEDIS measure rates using claims and encounters, and we are validating these rates in collaboration with our health plan, so we want to make sure that when we are using claims and encounters for measuring performance that particularly, if we're stratifying by race/ethnicity, that we have health plans in a position so they can generate those performance rates themselves, so they can monitor their own performance and incentivize providers or work with providers on improving that performance, so creating that sort of vertical alignment of measurement systems from the state and policy level down to that program level and prevent the possibility that we may be measuring something at the state level that really no one is capable of measuring themselves. And it sort

of ends up being we're just sort of measuring things for the sake of measuring them. So that validation process is very important in being able to implement measures of claims and encounters.

Next slide. So I'll touch on this very briefly, but I did want to give folks a sense of where we're heading. We will continue to expand our use of performance with using claims and encounters and stratified by race/ethnicity, COVID-19 vaccinations, and that is actually one place where we're focusing on racial disparities by county, and we will likely need to do a similar approach with childhood immunizations, as we've seen a precipitous drop in those in our state in the pandemic period. We're also going to look at expanding our efforts around declining racial disparity measures regionally. So one of the things we have noticed, particularly and when it comes to, in our case, low birth rate outcomes by race/ethnicity, the racial disparity is different depending on which region of the state we look at, and so there are ways to prioritize the direction of QI efforts in that manner, and there are ways to use regionally defined measures in racial disparities to incentivize health plans collaborating with one another.

And so rather than incentivize the health plans for focusing only on their own health plan membership, we are using regionally defined—and what I call “plan-agnostic” benchmarks and measurements to force health plans to work together and address a population health problem. We're also looking at racial disparity reduction in our physical/behavioral health integration efforts, and we have expanded use of community health workers by focusing on requiring a ratio, a one-to-5,000-member ratio, for Community Health Workers—which amounts to about 400 Community Health Workers funded by Medicaid dollars in Michigan—and giving plans and incentives, if they choose to contract out for those community H=health worker services.

So we don't require them to contract out, and we won't require them to hire internally, but we do want to encourage, should that be of value to the health plan, to work with maybe an FQHC or a community-based organizations to make sure those community health worker services are available for their members. And, lastly, we are looking at using our directed payment programs to pursue more outcome-based measures when it comes to what typically used to be pass-through payments with hospitals and providers, and seeing if—and this is very exploratory—but there may be opportunities to look at addressing racial disparities in these types of specialty payment programs that are directed by the state. I think that is my last slide.

**Jodi Anthony:**

Thank you, Tom, and... over to Jaimica.

**Jaimica Wilkins:**

Good afternoon, everyone, and greetings. I'm Jaimica Wilkins, the Deputy Director of Quality and Population Health at North Carolina Medicaid. Next slide. So jumping right into talking about North Carolina, North Carolina is a non-expansion state, and up until 7/1/2021, we were a non-managed-care state. We have about 2 million beneficiaries, of which 1.6 million are in our standard plan population that was launched in July, and that includes our five prepaid health plans as well as our Eastern Band of Cherokee Indians tribal option. The majority of our Medicaid population consists of women and children with over 50 percent under the age of 16, and politically, we are a purple state.

Next slide. So we're going to talk a little bit about our Keeping Kids Well intervention. This is one of our interventions in reaction to the public health emergency during 2020, and we'll discuss it in the next few slides.

Next slide. On March 10th, 2020, our governor declared COVID-19 pandemic state of emergency and released stay-at-home orders and protections that went into effect the end of March 2020. As a result, North Carolina saw underutilization of well-child visits as well as missed opportunities to proactively identify manageable and treatable physical, developmental and behavioral health concerns. We leveraged our partnerships, and there were existing partnerships to overcome this and ensure community education and outreach to prevent a situation that could lead to future outbreaks of preventable disease.

Next slide. Through our partnership, we identified five areas of focus to increase childhood vaccination, one of the which was telehealth. We modified our North Carolina Medicaid service policies to include telehealth, and eligible providers were encouraged and recommended to see children who were under the age of 24 for in-person visits for the vast majority of their well-child services, and for children aged 24 months and older, we recommended providers consider telemedicine to deliver a broad range of their well-child services as clinically appropriate. We also implemented three enhanced payments from January to June of 2021, and in reducing health disparities, we continue to look at our stratified data, and for Keeping Kids Well, we targeted the African-American, or Black, and Latinx populations. For education and outreach to parents and providers, we targeted virtual education via webinar, social media, news outlets on educating them around required vaccination as well as our new telehealth coverage policies and, lastly, to address the barriers to visiting their PCPs, or your primary care provider.

Next slide. So on this slide, it really shows overall our childhood immunization rates for 2019 and 2020. We wanted to point out with the green arrow the decline at the point that the stay-at-home order was put into place at the end of March, beginning of April, and you will see, as we implement it, and we'll talk a little more about Keeping Kids Well, towards the fall, around August area, you'll start to see that there is an increase that's linked to interventions in place.

Next slide. For this slide, we really just want to point out as relation to our weekly proportion of the population receiving childhood immunizations, this is broken down by race, week-over-week, and we want to note here on this graph the decline, of course, around March or April of 2020, but also the disparity gap amongst our white and African-American, or Black, populations.

Next slide. So to help increase well-child visits and immunization rates, Community Care of North Carolina, or CCNC, and the North Carolina Area Health Education Centers, which we refer to as AHEC, work partnership with us at the Department to launch Keeping Kids Well program. And we worked with practices with the greatest number of care gaps to improve measures and increase awareness. We also created a resource page with patient and provider-facing materials as well as frequently asked questions for their reference.

Next slide. In supporting quality performance, we want to touch on some highlights of the Keeping Kids Well program. The Keeping Kids Well program launched August 3rd of 2020 as a three-pronged approach to address the decrease in pediatric well-child visits as well as immunization. The approach included patient outreach in both English and Spanish to address any language barriers and also addressed the disparity in our historically marginalized populations including African-American, or Black, and Latinx. Our partners, CCNC and NCAHEC, use their practice coaches to work one-on-one with 300 targeted practices who had over 500 care alerts, and we established an advisory group of internal as well as external key players in the well-child care arena, including our North Carolina Academy of Family Physicians, our North Carolina Pediatric Society, Reach Out and Read to encourage as literacy for beneficiaries at their physician offices as well as our sister divisions in local health departments.

We also established partnerships with health systems and pharmaceutical companies, specifically with Pfizer with their Vaccine Adherence for Kids program, and we used that to send reminder vaccination notices to practices that were prepopulated with their information, and they would add the beneficiaries' information and mail them out, so it took some of the burden off of the practices. Lastly, the providers could choose from nine interventions, and EHR panels were mainly the choice for a lot of the interventions that were chosen by the 300 practices, and most importantly, we want to point out on this slide that, as a takeaway, Keeping Kids Well really helped to stabilize the downward trend of immunizations, and you can see on the graph that every colorful dot that's spotted across the graph, that was an intervention. And where you see those interventions, the data improves over time.

Next slide. So as we move into managed care in our transformation, we launched into additional performance improvement areas while maintaining our focus on children's immunizations as part of our holistic view of well-child care. Keeping Kids Well was officially ended on June 30th of 2021, but we continue our efforts now with NC AHEC and our health plans as well as our tribal options for continuous



quality improvement in areas of adult, child and maternal health, and we'll still work with the Pfizer VAKS program for efforts to improve in our quality improvement areas.

Next slide. Some of the lessons learned from Keeping Kids Well, and I'll just highlight a few challenges and wins. There was some practice resistance in the beginning, of course, because most practices have reduced staff and increased burden during the public health emergency, so we had to get over that barrier first. And then we also recognized that Keeping Kids Well was not a short-term fix or a one-size-fits-all effort, and this is the reason we continue our efforts in managed care with North Carolina AHEC and the health plans to offer a menu of services of interventions as we do with Keeping Kids Well. Some of our wins, we talked about stabilizing our rates. We returned them to pre-COVID rates and better. There was mutual sharing of knowledge across our practices as well as our coaches and the practice relation representatives, and then we really were able to create a nice foundation for moving into managed care and our advanced medical home work, especially around our AMH tier three.

At the end of August, which is an update from what's on this slide, we sent over 58,000 postcards out to providers, which accounted for almost 200 provider offices, and we continue to want to work with our VAKS program with either to move that forward and also explore some of their materials around vaccine hesitancy. Next slide. So we have three provider incentive efforts to promote primary care access and address disparities, including nine Healthy Opportunities screening and referral payments, health equity payments and our Glidepath payments.

Next slide. So, for our Healthy Opportunities screening and referral payments, they were reimbursed based on providers identifying at least one unmet resource need from our department's priority domains of food, housing and utilities, transportation and interpersonal safety. And we used billing and coding to identify those claims using Z codes and our G9919 billing codes for a place to start. Next slide. So you'll see depicted on the screen in the map, the orange represents areas that received payments. More payments were received by providers in our rural areas versus our urban areas, and with our standard plans, we expect that all plans continue to complete screening and monitor the extent to which these forms are completed over time for our beneficiaries. We learned from our January-to-June, 6,400 claims were processed for Healthy Opportunities payments and that the top needs addressed around these payments were access to food, bill payments for heat, electric and water and non-emergency transportation to medical care.

Next slide. The next type of provider-based incentive is our Health Equity Payment, and these payments were available for 3 months, April through June of 2021, to all eligible providers who serve high-need areas based on Census poverty rate data provided in a Poverty Tier 1 area, which included a poverty score of 17 to 21 percent, received a \$9 per member per month, and providers in a Tier 2 area, with a poverty score greater than 21 percent, received \$18 per member per month. So between the time that we were issuing these payments, there were 53.9 million payments distributed across over 1,800 primary care practices, and the providers who received these payments also were providers who contracted with more than one health plan. And, as we know, with poverty levels, it also brings up our historically marginalized populations which we saw the beneficiaries receiving these payments at the practices were a part of those populations.

Next slide. Now, we'll look at health equity and reducing disparities in managed care. You can jump to the next slide, and we'll talk about our Advanced Medical Home Glidepath payments. So North Carolina Medicaid offered time-limited payments for Advanced Medical Home Tier 3s who demonstrated successful readiness for AMH Tier 3 responsibilities. So to receive these payments, as far as eligibility, they had to attest to Tier 3 level and actively contribute into the system for the provider portal their MPI numbers as well as their location codes, and complete contracting with at least two of our health plans at the Tier Three level and be able to successfully exchange data with those health plans. We conducted validation prior to initiating payments for each month. We paid over 32.4 million in Glidepath payments within a 3-month time span, which covered 1.38 million of our standard plan beneficiaries.

Next slide. So lastly, I want to touch on how we're moving into managed care and continuing our continuous quality improvement through our benchmarking and attention to addressing health equity and commitment to developing our targets for all plan-reported measures. So our approach, contract years 1 and 2, the Department's benchmark for each plan-reported quality measure will be a five percent relative improvement over the prior year's statewide performance for that measure and we'll risk-adjust as appropriate. For contract years 3 and beyond, the department will hold our health plans accountable financially for improvements that narrow quality gap or eliminate health disparities through our quality withhold program as well as physician incentive program.

In addition to our quality measure targets, we also have incremental disparity targets, and we expect 10 percent relative improvement in the performance of the group of interest, so whether that's Latinx or African-American, we want to see a performance improvement for at least 2 years and until the gap between the group of interest and the overall population is less than a relative 10 percent. All practices or AMHs are eligible to earn negotiated performance improvement incentive payments, and it's based on our advanced medical home measure set, and these performance incentive payments are optional for our advanced medical home Tiers 1 and 2, but they must be offered to our Tier 3 AMHs who take on a lot more responsibility in our hierarchy of advanced medical homes. So standard plans are required to use all of our advanced medical home measures and must draw from that set to provide any performance improvement payments. So that concludes my slides, and I'll turn it back over to you, Jodi, for questions.

**Jodi Anthony:**

Yes, thank you. That was great. Okay, so as we said... Next slide. As we said in the beginning, if you would like to submit a question, use the Q and A function. We only have a few minutes, and we had decided to have three presentations—excellent presentations—this afternoon, but that means we have less time for Q and A. So with that being said, I'll kick us off with a couple questions that we already have. And this is to Tom, and it's a two-layered question, and it's about the data that you use to identify and address disparities. The first question is, have you looked at data when the member selects more than one race? And, if so, have you noted any differences? And then, also, to just explain a little bit more about why the white rate is considered the benchmark when, in one of the slides that you showed, the Latinx rate is actually much higher. So, Tom, can I hand that over to you?

**Tom Curtis:**

Yep, absolutely. So the first question was related to individuals who select two or more races. Do I have that right?

**Jodi Anthony:**

Yes.

**Tom Curtis:**

Okay, so what we see in our eligibility and enrollment data, which is derived from Medicaid applications, and we are looking into whether this is, in fact, the case, but we have a very, very small percentage of individuals selecting the two or more races category, and we actually have a racial diversity, ethnic diversity breakdown in our annual HEDIS reports every year that are showing that difference in the completion rate overall of people completing what their race or ethnicity is. I think one note maybe along the lines of this question is that we do roll Hispanic ethnicity into one group, so whether somebody selects white Hispanic, because they are rolled into that Hispanic group or population. The second question, I'm sorry. Could you repeat it?

**Jodi Anthony:**

Yeah, we recently...

Tom Curtis:

Oh, the white reference rates, right?

Jodi Anthony:

Mm-hmm, mm-hmm.

Tom Curtis:

Yep, so we do consider the white reference population as the standard because of the way race and power is in our society, and that the white population is the dominant population in terms of influencing and making decisions that are related to resource allocation and empowerment, and so we do use that as that reference population. We would not consider a methodology that changes the reference population or subgroup depending on, you know, who has the highest rate for each measure. That's not necessarily a reflection of how race and power works in our society, and that's sort of the intent of the Health Equity project, is to directly use data to show that difference.

Jodi Anthony:

Great. Thank you, Tom. Okay, I'm going to ask one more question, and that is to Lisa. Lisa, can you just briefly explain how you determine which metrics to incentivize?

Lisa Bui:

I'll be brief, but it's best just to go to the website. The metrics and scoring committee is made up of external members. It includes three representatives in CCO, measurement experts, et cetera. That committee meets regularly, and they have the decision power of which measures are selected and benchmarking methodology and targets setting. Each year, throughout the year, the committee hears presentations of various different performance on measures, on different initiatives, and then annually, they go through a process that's quite lengthy in which they first adopt measures, then they set— from the adoption of the measures—then they set the benchmarks, and then from the benchmarks, they set targets, and that whole methodology is over a course of many months.

Jodi Anthony:

Okay, great. Thank you, Lisa. Okay, well, we're going to have to end it there with questions. Our presenters did include a lot of links to resources. You will have this presentation, along with all of the others, on Medicaid.gov, and with that, I'll hand it over to Alyssa for announcements and next steps.

Alyssa Bosold:

Thanks, Jodi. You can go to the next slide. As Jodi mentioned, in closing, I would just like to remind everyone to visit the Medicaid.gov Infant Well-Child Care landing page displayed here and in the chat for more information about the webinars as well as the Affinity Group.

Next slide. And as I mentioned, we will post the transcript and a recording from this webinar and the initial webinars in our series on the page as well as information and registration links for our upcoming webinar, which is an information session describing the Infant Well-Child Visit Affinity Group. The Affinity Group fact sheet and expression of interest form are also linked on the page, so if you are a state Medicaid agency interested in participating in the Affinity Group, you should complete that expression of interest form by September 30th at 8:00 p.m. Eastern Time.

Next slide. And, finally, just wanted to thank you all for attending, and as you exit the webinar, please remember to take a moment to complete the evaluation, which would show up for you in a separate browser. If you have any questions, or if we didn't have time to get to your question today, please e-mail us at [MACQualityImprovement@mathematica-mpr.com](mailto:MACQualityImprovement@mathematica-mpr.com). Thanks again for your time, and have a great afternoon.