North Carolina Department of Health and Human Services

Pat McCrory
Governor

Aldona Z. Wos, M.D.
Ambassador (Ret.)
Secretary DHHS

May 1, 2014

SENT VIA ELECTRONIC MAIL

The Honorable Ralph Hise, Co-Chair
Joint Legislative Oversight Committee on
Health and Human Services
Room 1026, Legislative Building
Raleigh, NC 27603

The Honorable Justin Burr, Co-Chair
Joint Legislative Oversight Committee on
Health and Human Services
Room 307A, Legislative Office Building
Raleigh, NC 27603-5925

The Honorable Mark Hollo, Co-Chair
Joint Legislative Oversight Committee on
Health and Human Services
Room 639, Legislative Office Building
Raleigh, NC 27603-5925

Dear Chairmen,

Section 12H.22 (a) of Session Law 2013-360 directs the Department of Health and Human Services (DHHS) to contract with North Carolina Community Care Networks, Inc. (NCCCN) to pay a performance-based Per Member Per Month (PMPM) payment to participating primary care providers beginning July 1, 2014. Prior to this mandate becoming effective, the Department must consult with your Committee on NCCCN's performance-based payment proposal and must successfully renegotiate and modify its existing contact with NCCCN or enter a new contract for this purpose. Until these two events occur, the Department is to continue making payments to CCNC primary care providers.

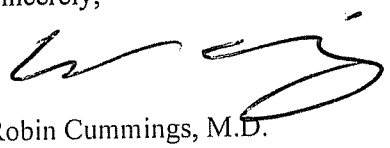
DHHS/DMA and NCCCN believe that performance-based payments are a worthy mechanism to incentivize improved quality of care provided to NC's Medicaid population.

If DMA is to move forward with the legislated performance-based payment proposal, a number of difficult adjustments would need to be made. DMA will need to amend its contracts with all of the Medicaid providers across the state to reflect the performance-based payments. NCCCN will subsequently need to amend its provider contracts so that they align and comport with the changes made by DMA to its master contract. And it is likely that a Medicaid State Plan amendment (SPA) will be needed to change the payments from a static, enrollment-based payment originating from DMA to one that is driven by performance and processed not by DMA, but by NCCCN.

The legislation discussed in this report was developed prior to the current proposal for NC Medicaid reform. While it anticipates some elements of reform and expects no change in expenditures, implementation would actually be costly in dollars and operational attention. Thousands of contracts would have to be changed, plus new ones developed. Significant costs would be incurred for systems changes for NCFAST and for NCTracks. DHHS would recommend directing these resources toward the same goals in the larger reform plan, rather than implementing the provision as it is currently enacted.

If you have any questions, please do not hesitate to contact me.

Sincerely,



Robin Cummings, M.D.

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April 30, 2014

Representative Justin P. Burr, Co-Chair
Joint Legislative Oversight Committee on Health and Human Services
NC General Assembly
Legislative Office Building, Room 307A
300 North Salisbury Street
Raleigh, NC 27603

Dear Chairman Burr:

Section 12H.22 (a)-(d) of Session Law 2013-360 directs the Department of Health and Human Services (DHHS) to contract with North Carolina Community Care Networks, Inc. (NCCCN) to develop and pay a performance-based Per Member Per Month (PMPM) payment to participating primary care providers. It also requires the Department to consult with your Committee on NCCCN's performance-based payment proposal. Our letter, along with the attached report and a separate letter from DHHS, fulfills this legislative requirement.

The attached report represents the end product of five months of work undertaken by NCCCN staff, input received from clinical leaders in Community Care's fourteen networks, consultation with the NC Academy of Family Physicians and the NC Pediatric Society, and several meeting with the Division of Medical Assistance (DMA). The report also provides an overview of the proposed payment model, an implementation, a description of how a tiered approach differs from the current payment model, and how the proposed performance criteria aligns with national and state measures, such as NCQA's *Patient-Centered Medical Home (PCMH)* program and BCBSNC's *Blue Quality Physician Program (PQPP)*. It also provides an estimate of how many providers will be negatively and positively impacted by this proposal.

Implementation of this performance-based PMPM initiative represents an important, first step towards meaningful payment reform, but more is needed to move our existing payment structure to one that rewards value and not volume. One example might include overhauling how we pay for primary care by replacing the current fee-for-service (FFS) and PMPM payments in favor of a three-part reimbursement that is based on quality, panel size/composition and fixed office costs. With the State poised to overhaul its Medicaid program, the timing is optimal to aggressively embrace these and other payment reform ideas.

Should you have any questions regarding this report, please feel free to contact Tom Wroth, MD, my Chief Medical Officer and Senior VP for Clinical Affairs. He can be reached at 919-745-2363.

Sincerely,

L. Allen Dobson, Jr., MD
President & CEO

Community Care of North Carolina

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LAD:mtb

Attachment

cc: Secretary Aldona Wos, DHHS
Dr. Robin Cummings, DHHS
Matt McKillip, DHHS
Adam Sholar, DHHS
Sandy Terrell, DMA
Nancy Henley, MD, DMA
Rick Brennan, DMA
Torlen Wade
Mark Benton
Tom Wroth, MD
John Thompson
Amy Hobbs
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Legislative Library

April 30, 2014

Representative Mark W. Hollo, Co-Chair
Joint Legislative Oversight Committee on Health and Human Services
NC General Assembly
Legislative Office Building, Room 639
300 North Salisbury Street
Raleigh, NC 27603

Dear Chairman Hollo:

Section 12H.22 (a)-(d) of Session Law 2013-360 directs the Department of Health and Human Services (DHHS) to contract with North Carolina Community Care Networks, Inc. (NCCCN) to develop and pay a performance-based Per Member Per Month (PMPM) payment to participating primary care providers. It also requires the Department to consult with your Committee on NCCCN's performance-based payment proposal. Our letter, along with the attached report and a separate letter from DHHS, fulfills this legislative requirement.

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April 30, 2014

Senator Ralph E. Hise, Co-Chair
Joint Legislative Oversight Committee on Health and Human Services
NC General Assembly
Legislative Building, Room 1026
16 West Jones Street
Raleigh, NC 27601

Dear Chairman Hise:

Section 12H.22 (a)-(d) of Session Law 2013-360 directs the Department of Health and Human Services (DHHS) to contract with North Carolina Community Care Networks, Inc. (NCCCN) to develop and pay a performance-based Per Member Per Month (PMPM) payment to participating primary care providers. It also requires the Department to consult with your Committee on NCCCN's performance-based payment proposal. Our letter, along with the attached report and a separate letter from DHHS, fulfills this legislative requirement.

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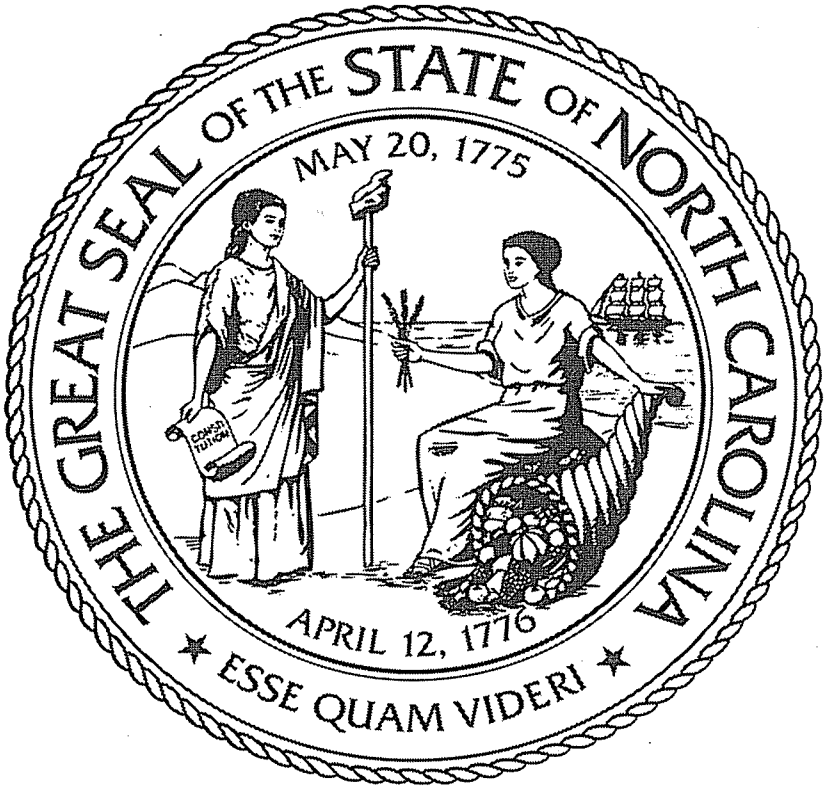
PERFORMANCE-BASED PER MEMBER PER MONTH PAYMENTS

SESSION LAW 2013-360, SECTION 12H.22(c)



Prepared by

North Carolina Community Care Networks, Inc.
and
Division of Medical Assistance
NC Department of Health and Human Services

May 1, 2014

PERFORMANCE-BASED PER MEMBER PER MONTH PAYMENTS

SUMMARY

The 2013 budget bill directs the Department of Health and Human Services to contract with Community Care of North Carolina to replace the existing monthly per member per month payments made to primary care practices with a series of tiered payments that are based on performance. The design and development phases of that task are complete and reflect input from clinical leaders across the state as well as consultation from the NC Academy of Family Physicians and the NC Pediatric Society.

The proposed plan establishes three payments levels – Bronze, Silver and Gold – that reflect whether a primary care physician is achieving basic or enhanced levels of performance and those achieving the highest standards as well as meeting a series of quality measures. It also sets a zero payment for those physicians that do not meet basic accountability standards. Where practical, the proposed plan aligns with the performance tiers established for primary care by NC's largest commercial insurer and a nationally recognized accrediting body. And unlike the current system that pays the practice, the intent of the proposed plan is to directly compensate the primary care physician.

Approximately 2,200 primary care practices (that employ 6,000+ physicians) receive a monthly, per member per month payment to serve just over 1.3 million Medicaid recipients. That payment is in addition to any fee-for-service reimbursement they may bill for office visits, procedures and tests. Under the proposed plan, roughly 400 of those practices will no longer receive a monthly/quarterly payment unless they are willing to take on an expanded set of responsibilities and meet specific outcome and performance measures. Those practices have the potential of losing $480,000 in Medicaid revenue annually. We anticipate a little less than a third of the remaining practices will fall short of fully meeting the performance measures (Bronze) and, as a result, will experience a 20% reduction in their payments. Roughly half of the practices are expected to see no change in their payments as they're expected to meet the enhanced accountability standards (Silver), and the remaining 20% are expected to exceed performance expectations (Gold) and will receive their full payment plus a bonus payment from a newly created incentive pool.

Legislation sets the implementation date of the proposed plan to no earlier than July 1, 2014, but conditions the start date to several factors: consultation with the Joint Legislative Oversight Committee on Health and Human Services and, at a minimum, execution of a contract (or contract amendment) between DHHS and Community Care. Community Care and the Division of Medical Assistance (DMA) staff have explored the necessary changes for the State Plan, contracts and enrollment and claims systems in order to implement this legislation. They are extensive, as detailed in the body of the report.

Implementation of this tiered, performance-based initiative represents an important, first step towards meaningful payment reform, but more is needed to move Medicaid's existing payment structure to one that rewards value and not volume. One example might include overhauling how we pay for primary care by replacing the current fee-for-service (FFS) and per member per month payments with a three-part reimbursement methodology that is based on quality, panel size/composition and fixed office costs. With the State poised to overhaul its Medicaid program, the timing is optimal to aggressively embrace various payment reform ideas.

DMA and Community Care agree that performance-based payments are a worthy mechanism to incentivize improved quality of care provided to NC's Medicaid population. We also believe that any value-based payments (such as the tiered plan described herein) should be aligned and implemented

concurrently with the larger Medicaid reform plan that will be rolled out over the next few years.

LEGISLATIVE MANDATE

Section 12H.22 (a)–(d) of Session Law 2013-360 directs the Department of Health and Human Services (DHHS) to contract with North Carolina Community Care Networks, Inc. (NCCCN or Community Care) to develop and implement a performance-based reimbursement plan for primary care physicians. This plan is set to begin on July 1, 2014, following consultation with the Joint Legislative Oversight Committee on Health and Human Services (JLOC).

Section 12H.22 (c) of the session law requires that the consultation with JLOC include a report that answers four specific questions:

1. How will the proposed, performance-based PMPM payments differ from the existing payments to primary care providers?
2. Does the proposed payment plan rely upon national performance and quality measures (e.g., HEDIS) and, if so, which measures?
3. What is the structure and frequency of payments under the proposed plan?
4. As compared to the existing payment plan, what impact will the new plan have on primary care providers?

OVERVIEW OF CURRENT MODEL

Medicaid primary care practices are currently enrolled as either Carolina Access I or Carolina Access II providers. These practices receive a per member/per month (PMPM) payment that reflects a basic versus expanded set of responsibilities and expectations. Together, these payments total roughly $50 million annually. A high-level description of those differences is outlined in the following chart:

	Carolina Access I	Carolina Access II
PMPM Payment	$1	$2.50 – 5.00
# Practices approx	400	1,800
# Medicaid Recipients approx	40,000	1,300,000
Annual Value of Payments approx	$0.48 Million	$49.5 Million
General Responsibilities	• Be available to see patients a minimum of 30 hours weekly • Serve as the basic medical home • Provide sick and preventive care • Ensure the availability of "after hours" medical advice	Same responsibilities as Carolina Access I plus all of the following: • Agree to enroll with one of the 14 Community Care Networks • Provide complex care management (e.g., medication reconciliation, transitional care, etc.) • Actively engage in evidence-based best practices, including statewide disease management initiatives • Participate in a variety of quality initiatives to improve patient outcomes, including random chart audits

NOTE: For Access II practices, a higher PMPM is provided to those that care for the "Aged, Blind and Disabled" (ABD) population a group of Medicaid recipients with complex and costly medical needs.

OVERVIEW OF PROPOSED MODEL

In collaboration with clinical leaders across the state and the NC Academy of Family Physicians and the NC Pediatric Society, Community Care has developed a plan to implement a value-based payment plan for its enrolled primary care providers. The plan begins with the recognition that there are currently two types of Medicaid medical homes (Carolina Access I and II) and it phases in a new plan for both that rewards performance on a series of expectations that increase steadily over a three year period.

Level	Payment	Phase 1	Phase 2	Phase 3
	0%	Basic Accountability standards not met (~400 Practices)	Basic Accountability standards met, but not Enhanced	Accountability or Quality Improvement standards not met
Bronze	80%	✓ Basic Accountability Met (~ 540 Practices)	✓ Enhanced Accountability	✓ Enhanced Accountability ✓ Basic Quality Outcomes
Silver	100%	✓ Enhanced Accountability Met (~ 910 Practices)	✓ Basic Quality Outcomes	✓ Enhanced Quality Outcomes
Gold	100% + share of Incentive Pool	✓ Basic Quality Outcomes Met (~ 350 Practices)	✓ Enhanced Quality Outcomes Met or ✓ Cost and Utilization Outcomes Met	✓ Cost and Utilization Outcomes

NOTES: (1) "%" refers to the percentage of base PMPM payment paid out under new plan. (2) Incentive pool for physicians in Gold level consists of undistributed PMPM payments from Bronze physicians and former Carolina Access I payments. (3) Physicians must meet the criteria for lower tiers when moving up (ex. Silver criteria must be met to qualify for Gold)

Embedded in the proposed plan are a series of domains that address accountability, quality and cost/utilization. Over time, additional domains must be met to remain at or advance to the next payment level. A brief description for each domain is outlined below:

- **Basic Accountability** – Physician/practice participates in the primary care case management model, as demonstrated by meeting standards for access to timely, comprehensive primary care
- **Enhanced Accountability** – Physician/practice participates in the primary care case management model, as demonstrated by meeting standards for enhances access and accountability
- **Basic Quality Outcomes**– Physician/practice actively pursues quality improvement (QI) through involvement with network QI activities, PCMH recognition, Meaningful Use (MU) attestation, and others
- **Enhanced Quality Outcomes** – Physician/practice demonstrates an advanced level of quality improvement standards, such as NCQA PCMH Level 3, BCBSNC BQPP, or other comprehensive QI achievements
- **Cost and Utilization Outcomes** – Physician/practice demonstrates quality performance in value-based outcomes measures by achieving an established threshold or improvement in risk-adjusted Key Performance Indicators (KPIs).

Under the proposed plan, Carolina Access I physicians would be encouraged to enroll in Carolina Access II, affiliate with a Community Care Network and assume more responsibilities. The existing $1 PMPM payment would be eliminated for any Carolina Access I provider that is unwilling to take on the expanded set of "medical home" responsibilities. Those physicians would not be dis-enrolled from NC's Medicaid

program; rather, they would be limited to receiving only a FFS payment and they would be ineligible to receive any performance and/or quality-driven supplemental payment. And the soon-to-be defunct Carolina Access I payments would be used to partially underwrite a new incentive pool to reward the highest performing primary care practices.

The remaining practices (Carolina Access II) would be tiered into one of three levels, "Bronze", "Silver", and "Gold." Practices will only receive the "Gold" designation if they are achieving the highest level of cost, utilization, and quality outcomes; are accredited for Patient-Centered Medical Home (PCMH); and are actively engaged with NCCCN's care management.

Chief Differences between the Current and Proposed Plans

There are several key differences between the current and proposed payment plans to primary care physicians. The chief differences are outlined below as an expression of what the new plan offers to the State:

1. Payments are performance-based
2. Standards and outcomes increase over time
3. Aligns with commercial and national plans
4. Bonuses available for high achieving physicians
5. Low performers receive smaller or zero payment
6. Reflects input from a variety of clinical stakeholders
7. Incents providers towards continuous improvement
8. Plan is flexible, allows for integration of new measures
9. Payments are made quarterly, not monthly
10. Intent is to pay physicians directly, not practices

Alignment with National Performance and Quality Measures

The outcomes under consideration for the proposed payment plan are based on quality metrics from nationally recognized programs such as NCQA HEDIS and CMS eQMs, as well as risk-adjusted key performance indicators already in use by Community Care.

The quality improvement process measures under consideration are modeled after those from programs such as NCQA *Patient-Centered Medical Home* (PCMH) and BCBSNC's *Blue Quality Physician Program*, as well as ongoing quality improvement work with Community Care and other state partners.

Frequency of Payments under the New Plan

The current PMPM payments are paid on a monthly basis to primary care practices and they reflect the mix of Aged, Blind and Disabled (ABD) recipients and non ABD recipients enrolled with the physicians affiliated those practices. It is the intent of the proposed performance-based plan to make those payments on a quarterly basis and pay them directly to the physician, not the practice. To alleviate any concerns regarding cash flow, payment could be made at the beginning of the quarter, based upon a previous quarter's performance and outcomes.

Financial Impact of the Proposed Plan

Section 12H.22 (a) of Session Law 2013-360 requires that "one hundred percent (100%) of the funds [currently] allocated to PMPM payments to primary care providers" be allocated under the new, performance-driven payment plan. The same section also requires that the new plan "adopt a payment level of zero dollars ($0.00) for providers who do not satisfactorily participate in CCNC care management initiatives." Together, this language ensures three things from a financial perspective: (1) the State would pay out no more under the new plan than it would have paid out under the old plan; (2) 100% of the funds will be distributed among participating primary care physicians; and (3) some physicians will receive more payments in the future, while others will receive less.

Approximately 2,200 primary care practices are receiving monthly, per member per month payments to serve just over 1.3 million Medicaid recipients that total approximately $50 Million. These payments are in addition to any fee-for-service reimbursement they may bill for office visits, procedures and tests.

Under the proposed plan, roughly 400 of those practices will no longer receive a monthly payment unless they are willing to take on an expanded set of responsibilities and meet specific performance measures. Those practices, together, have the potential of losing $480,000 in Medicaid revenue annually.

We anticipate a little less than a third of the remaining practices will fall short of fully meeting the performance measures (Bronze) and, as a result, will experience a 20% reduction in their former monthly payment. Roughly half of the practices are expected to see no change in their former monthly payments as they're expected to meet the enhanced accountability standards (Silver), and the remaining 20% are expected to exceed performance expectations (Gold) and will receive their full payment and a bonus payment from a newly created incentive pool. Payments from the incentive pool will be based upon shares attributed to each physician. Doing so will ensure that total bonus payments always equal (and never exceed) what's available to distribute from the pool.

Estimate of the Financial Impact of Proposed Plan

Level	% of Former PMPM Payment	Phase 1	Phase 2	Phase 3
	0%	~ 400 Practices 40,000 Medicaid recipients ($0.5 M)	~250 Practices 152,300 Medicaid Recipients ($5.7 M)	~ 150 Practices 91,400 Medicaid recipients ($3.4 M)
Bronze	80%	~ 540 Practices 396,400 Medicaid recipients ($3.0 M)	~ 200 Practices 121,800 Medicaid recipients ($4.0 M)	~ 300 Practices 182,700 Medicaid recipients ($6.8 M)
Silver	100%	~ 910 Practices 668,100 Medicaid recipients $0.0 M	~ 1,450 Practices 883,200 Medicaid recipients $0.0 M	~ 1,500 Practices 913,700 Medicaid recipients $0.0 M
Gold	100% + share of Incentive Pool	~ 350 Practices 235,500 Medicaid recipients $3.5 M	~ 300 Practices 182,700 Medicaid recipients $9.7 M	~ 250 Practices 152,200 Medicaid recipients $10.2 M

NOTES: (1) All numbers are approximate; (2) Dollars are net annual amounts and rounded to nearest million, losses are expressed with "( )"; (3) For this chart only, each phase is assumed to be one year in length; (4) For this chart only, the number of practices, average number of recipients per practice and average annual payment per recipient have been held constant. Practices are used as the unit of analysis in order to allow comparison to current PMPM payments.

IMPLEMENTATION

Legislation sets the implementation date of the proposed plan to no earlier than July 1, 2014, but conditions the start date to several factors: consultation with the Joint Legislative Oversight Committee on Health and Human Services and, at a minimum execution of a contract (or contract amendment) between DHHS DMA and Community Care. An in depth assessment of the contingencies for fully implementing the legislation as written reveals the following:

Federal Requirements and Need for State Plan Amendment: DMA staff opinion is that changing the method of payment for the PCCM provider PMPM is rate setting (42 CFR 447.201) and must be retained by the Single State Agency. Additionally, a Medicaid State Plan Amendment (SPA) would likely be needed to change the payments from a static, enrollment-based payment originating from DMA to one that is driven by performance and processed by Community Care.

Contracts: DMA will need to amend its Carolina Access contracts with *all* of the Medicaid primary care providers across the state to reflect the performance-based payments coming from a third party. The DMA master contract with Community Care will need to be amended to reflect responsibility for this new payment function/responsibility for Community Care. Community Care will subsequently need to amend its current contract with networks and provider groups so that they align and comport with the changes made to the DMA master contract, as it currently states that DMA is responsible for paying the practice PMPM. New, 2-party contracts between Community Care and the individual physicians to effectuate the new performance-based PMPMs will also be needed.

NCTracks: Implementing outcomes-based performance criteria can only occur once claims data is operational and comprehensive. Community Care providers rely on reports based on this data to understand the full picture of their patients' health and health care utilization. A subset of the reports would be used to assess relative performance. DMA will also need to prepare, submit and prioritize a change order to NCTracks to redirect the current PMPM payments presently paid to primary care practices to Community Care.

NCFAST: Following the NCTracks and NCFAST conversions in 2013-14, Community Care's enrollment data has been inaccurate. This impacts practices' and care managers' ability to target high cost beneficiaries and makes it difficult to attribute patients to Community Care practices. While these issues continue to improve, implementing a performance-based payment structure would only be feasible once the monthly enrollment is accurate. Further, a systems change to EIS/NCFAST would be needed to associate a Medicaid recipient to a specific physician and not to a practice.

CONCLUSION

In summary, DHHS/DMA and Community Care believe that performance-based payments are a worthy mechanism to incentivize improved quality of care provided to NC's Medicaid population. In order to act now, DMA will need to amend its contracts with all of the Medicaid providers across the state to reflect the performance-based payments. We will also need to amend the master contract with Community Care to reflect responsibility for this new payment function/responsibility. Community Care will subsequently need to amend its provider contracts so that they align and comport with the changes made by DMA to our master contract. And it is likely that a Medicaid State Plan amendment (SPA) will be needed to change the payments from a static, enrollment-based payment originating from DMA to one that is driven by performance and processed not by DMA, but by Community Care.

The legislation discussed in this report was developed prior to the current proposal for NC Medicaid reform. While it anticipates some elements of reform and expects no change in expenditures, implementation would actually be costly in dollars and operational attention.. Thousands of contracts

would have to be changed, plus new ones developed. Significant costs would be incurred for systems changes for NCFAST and for NCTracks. With the agreement of the General Assembly, DHHS would recommend directing these resources toward the same goals in the larger reform plan.

CCNC Value-Based Payment Plan – Accountability

Achievement of Accountability domains require that the practice demonstrates participation in the primary care case management model, as demonstrated by meeting the following level requirements:

Domain	Accountability Criteria
Basic Accountability	Requires that practice meet CCNC standards for access to timely, comprehensive primary care and meaningful participation with the network, as evidenced by meeting ALL of the following:
	1. Provide 24 hour availability via phone triage (must be real person, not recorded message)
	2. No automatic ER referrals
	3. Office hours of at least 30 hours per week across all practice locations
	4. Has policy in place that addresses patients with emergent and urgent care needs.
	5. Practice has process in place to refer patients to CCNC care managers, share relevant patient information and respond to patient needs identified by care management staff

Enhanced Accountability	Requires that practice meet all of the Basic Accountability metrics, as well as ALL of the following:
	1. See enrolled patients within the following standards of appointment availability:
	a. Routine sick care – within 3 days of presentation or notification
	b. Routine well care – within 90 days of presentation or notification (15 days if recipient is pregnant)
	c. Hospital discharge – within 1-2 weeks of discharge for high risk patients
	2. Has a policy in place to maximize continuity with patient's selected primary care provider

CCNC Value-Based Payment Plan – Basic Quality Outcomes

Achievement of Basic Quality Outcomes domain requires that the practice demonstrates engagement in meaningful quality improvement standards, as evidenced by EITHER of the following tracks:

Track 1	Track 2
NCQA PCMH certification (any level) or other nationally recognized PCMH certification (URAC, Joint Commission, etc.) AND Engagement with CCNC Care Management staff criteria (Must pass two of 5a-c)	Achievement of **24 points** from the following criteria, including the four MUST PASS metrics:

Category	Basic Quality Outcomes Criteria	Points
Continuous Quality Improvement	1. Established practice-based QI team that meets at least quarterly with supporting documentation. Network QI staff should be invited to these meetings. **(MUST PASS)**	4
	2. At least one practice-based QI initiative evaluated quarterly with supporting documentation using an evidence-based QI model such as Model for Improvement, Six Sigma, Lean, etc. **(MUST PASS)**	4
	3. Practice uses population level data either from EMR, Provider portal, care alerts or other sources to do population management for at least one of the following populations: **(MUST PASS)** a. Chronic disease, including behavioral health conditions b. Prevention c. Medications d. Patients without a recent visit e. CCNC Transitional Care Priority patients f. ED High Utilizers	4
	4. Practice conducts patient satisfaction surveys and analysis	2
	5. Provider participates in MOC-IV module during measurement year	2
CCNC Engagement	6. Engagement with CCNC care management staff: **(MUST PASS AT LEAST TWO OF THE FOLLOWING)**	
	a. Practice grant care managers access into EHR systems, if applicable	2
	b. Practice utilizes case conferences with care managers around complex patients	2
	c. Practice has process for rapid response to medication therapy management issues identified by network staff	2
Continuing Education	7. Provider completes a CCNC-endorsed QI training during measurement year, such as IHI Model for Improvement, Lean, Six Sigma, etc.	2
	8. Provider or practice staff attends at least 1 CCNC or Network meeting or CCNC-sponsored training event a year (ex. Network Medical Management, practice-level meetings, steering committee meetings, other educational opportunities provided by network). **can attend any for 1pt each, with a max of 4.*	1 (max of 4)
Technology	9. Successful Meaningful Use attestation:	

	a. Stage 1	2
	b. Stage 2 or above	4
	10. Practice connection to NC- HIE	5
	11. Practice use of CCNC Provider Portal at least monthly (at a minimum)	3
	12. E-prescribing	3
Behavioral Health Integration	13. Practice demonstrates behavioral health integration by:	
	a. Providers screen for substance use using validated tools (AUDIT, DAST, CRAFFT, CAGE, etc.) and utilize the SBIRT (Screening, Brief Intervention and Referral to Treatment) approach	2
	b. Providers screen for Depression using validated tools such as the PHQ2/PHQ9 and utilize depression protocols dependent on the results of the screening	2
	c. Practice has process for referring and communicating with behavioral health providers and LME/MCOs	2
	d. Practice utilizes tele-psychiatry for direct patient care and consultation	2
	e. Collocated Behavioral Health specialist(s) in PCP office or embedding primary care provider in Behavioral Health Clinic (Reverse Collocation)	2

CCNC Value-Based Payment Plan – Enhanced Quality Outcomes

Achievement of Enhanced Quality Outcomes domain requires that the practice demonstrates an advanced level of quality improvement standards, as evidenced by EITHER of the following tracks:

Track 1	Track 2
Meet the Enhanced Quality Outcomes criteria through either an advanced recognition program or achievement with clinical quality measures AND Engagement with CCNC Care Management staff criteria	Achievement of **40 points** from the Basic Quality Outcomes criteria, including the three MUST PASS metrics

Category	Enhanced Quality Outcomes Criteria
Enhanced Quality Outcomes	Requires that practice demonstrates participation in enhanced quality improvement standards by meeting either criteria #1 or criteria #2: 1. Achievement of one of the following advanced recognition programs: a. NCQA PCMH Level 2 or 3 b. BCBSNC Blue Quality Physician Program (BQPP) Level 2 or 3 c. NCQA Diabetes Recognition Program (DRP) d. NCQA Heart/Stroke Recognition Program (HSRP) OR 2. Achievement of performance goal or improvement threshold in clinical quality measures[1] in one of the following diseases: a. Asthma b. Diabetes c. Ischemic Vascular Disease
CCNC Engagement	3. Engagement with CCNC Network, as demonstrated by ALL of the following: a. Practice grant care managers access into EHR systems, if applicable b. Practice utilizes case conferences with care managers around complex patients c. Practice has process for rapid response to medication therapy management issues identified by network staff d. Provider or practice staff attends at least 1 CCNC or Network-based meeting per year

[1]Clinical quality measures have not been established at this time but will consist of NQF-endorsed measures for prevalent chronic conditions such as those listed.

CCNC Value-Based Payment Plan – Cost and Utilization Outcomes

Achievement of Cost and Utilization Outcomes domain requires that practice demonstrates performance in value-based outcomes measures by achieving an established threshold or improvement target in the following:

Cost and Utilization Outcomes Criteria
Practice's risk-adjusted performance must be in the top decile for all practices, or demonstrate substantial improvement relative to other practices for at least one of the following Key-Performance Indicators: 1. Total Medicaid Cost 2. Emergency Department Visits 3. Inpatient Admissions

The following is a brief summary of CCNC's risk-adjustment methodology:

- Cost and Utilization Outcomes will be risk adjusted based on the practice's Case Mix Index.
- All members are assigned a Clinical Risk Group (CRG) based on their historical inpatient, outpatient, physician and pharmacy claims data. Each individual's CRG is associated with a weight – a numerical reflection of how sick the person is, and hence how much they would be expected to spend.
- Each practice's Case Mix Index is a product of the individual CRG weights for each member, and how long they were enrolled in that practice.
- Actual cost/utilization is summed based on the cost/utilization incurred during months in which the members were enrolled in the practice.
- Outliers are capped using a CRG-based method where each CRG receives a different cap amount based on the cost/utilization distribution for that CRG. If an individual's spending exceeds this amount, they only contribute the capped amount to the PMPM.
- A Risk-Adjusted Index is then calculated, which is the practice's actual costs or utilization divided by the costs or utilization that would be expected given the practice's case mix.