

Promoting Quality in Medicaid Transformation

J. Thomas Newton, Troy Hildreth

North Carolina's upcoming shift to Medicaid managed care will present the opportunity to build on the current quality of services in a system that is focused on whole-person treatment. WellCare of North Carolina, Inc. intends to use innovative approaches that combine aspects of successful programs in other states, tailored to fit North Carolina and improve the quality of care.

WellCare of North Carolina, Inc. is an affiliate plan of WellCare Health Plans, Inc., which is headquartered in Tampa, Florida. WellCare focuses primarily on offering government-sponsored health plan coverage for Medicaid, Medicare Advantage, and Medicare Part D beneficiaries. Currently, WellCare is in 13 states serving Medicaid beneficiaries, 17 states offering Medicare Advantage plans, and nationwide offering Medicare Part D. WellCare of North Carolina was one of five entities awarded contracts in February 2019 to manage Medicaid transformation in North Carolina as directed by the North Carolina General Assembly. As part of the process outlined in the request for proposals from the North Carolina Department of Health and Human Services (NC DHHS), the organizations selected to provide prepaid health plans (PHPs) were asked to collaborate with the North Carolina Institute of Medicine (NCIOM) to inform the provider community and other interested parties of different components of the new system planned for the state [1]. This article will outline WellCare's approach to promoting quality health care in the new Medicaid managed care system in North Carolina.

Quality health care delivery is largely determined by local providers and stakeholders making decisions in their communities. Good health outcomes rely heavily on the availability of local resources and programs. In areas with scarce resources, health outcomes have lagged behind [2]. However, North Carolina's most successful innovations have been at the local level, and we plan to continue to promote this level of engagement and participation through regional member and provider committees. To understand and address local and regional health disparities both in outcomes and resources, WellCare uses feedback gathered from its local Community Advisory Committee, Member Advisory Committee, Long-Term Supports and Services (LTSS) Member Advisory Committee, and Provider Advisory Committee. Each of these is a forum for members and providers to engage directly in changing operational approaches or designing initiatives to

advance quality outcomes in the various regions. We value input from and engagement with members, providers, and community leaders alike to shape our policies, programs, and support systems. Using local feedback to drive decision-making at the health plan ultimately leads to better quality health care for our members (patients), and better health outcomes.

To address unmet health needs and promote quality outcomes, WellCare employs a "high-touch, high-tech" provider engagement model, utilizes advanced analytics, and implements programs that support providers and members in improving outcomes, all with local feedback every step of the way.

WellCare Quality Strategies

Our core strategies include better care delivery, healthier people and communities, and providing the right setting for the right kind of care (see Table 1).

We use these strategies to implement a high-quality program by localizing our efforts in member communities, developing and using innovative programs and tools to support members and providers, and taking full advantage of advanced, proprietary analytics to pinpoint areas of need.

Programs to Drive High Quality Outcomes

WellCare has developed numerous programs aligned with the NC DHHS's Managed Care Quality Strategy [3]. The following programs will be implemented in close partnership with providers and members:

Electronic Medical Records (EMR) Exchange: The EMR team leverages its experience to build flexible connections with provider organizations and fit data solutions to the needs of the individual provider. Better communication between providers regarding our patients leads to more effective and better-quality care.

Rural Quality Strategy: Our Rural Quality Strategy aligns with the Centers for Medicare and Medicaid Services (CMS) Rural Quality Strategy to support communities and providers serving rural areas [4]. This program is comprehensive in its

Electronically published September 2, 2019.

Address correspondence to John Thomas Newton, c/o Clinton Medical Clinic, Inc., 403 Fairview Street, Clinton, NC 28328 (John.newton@WellCare.com).

NC Med J. 2019;80(5):280-284. ©2019 by the North Carolina Institute of Medicine and The Duke Endowment. All rights reserved. 0029-2559/2019/80505

TABLE 1.
WellCare Core Strategies

Better Care Delivery: We will enhance patient-centered care through Advanced Medical Homes and WellCare member and provider supports.

Healthier People, Healthier Communities: Our holistic approach helps improve quality health outcomes and promotes wellness, prevention, and quality of life for individuals, families, and communities.

Right Setting, Right Care: We will focus on outcome-based incentives, appropriate utilization, and reduction of administrative burden.

member supports, provider engagement, and local interventions, which are critical in rural areas that often lack resources found in urban/suburban areas. As readers are aware, many of our members (patients) that we serve reside in rural areas in North Carolina. We will focus on the needs of rural/underserved areas in order to eliminate health disparities.

EPSDT Program: Local dedicated staff focus on ensuring children receive early and periodic screenings, diagnosis, and treatment (EPSDT) [5]. Interventions will target children and their caregivers, providers, and community partners through member and provider education and outreach in person, telephonically, and by mail. It is well documented that early intervention in many pediatric conditions can lead to improved outcomes, and this type of support will also facilitate relationships between members/parents and primary care providers (pediatric and family physicians) [6, 7].

Healthy Pregnancy Program: Pregnant members are supported in receiving appropriate prenatal and postpartum care, education on healthy pregnancies, and pregnancy-related incentives in collaboration with local health departments. The Healthy Pregnancy Program supports the NC DHHS's Pregnancy Management Program (PMP) through our outreach and maternal health quality improvement team. More engaged pregnant members means better quality and better outcomes.

Community Connections Team (CCT): Regionally based teams work with telephonic supports to connect members to social safety net services, family caregiver supports, and other formal and informal supports, helping to address unmet health-related social resource needs that are at the core of the daily difficulties that many members experience when managing their health. Providers can refer to the CCT when needs are identified. Members will then be directed to existing social resources and referrals will be tracked for disposition and quality. Our program also will work with local community stakeholders to close gaps in the social safety net. We support NC DHHS's goals for addressing social resource needs of its Medicaid membership, including supporting NCCARE360 [8] and the Healthy Opportunities Pilots while leveraging our existing infrastructure.

P360: P360 is a continuous quality improvement program aimed at service delivery, quality care, and satisfaction. It is led by provider relations representatives and supported by quality practice advisors (QPAs), patient care advocates (PCAs), the practice transformation team, and care man-

agers. P360 is based on Plan-Do-Study-Act (PDSA) methodology that incorporates provider review of performance, assessment of readiness for change, development and implementation of tailored action plans, and tracking and monitoring of results for further intervention or improvements. The program supports providers who are interested in improving the quality of care they provide.

Advanced Analytics to Support Quality Interventions and Feedback

WellCare uses multiple advanced analytics tools to assist members and providers in the delivery of appropriate, high-quality health care in a patient-centered, holistic, and culturally competent care model. In the "new world" of health care, data is critical to the delivery of effective care, especially for improving care of members with Medicaid. We ensure that data analytics are in line with the state's quality expectations, and that they're meaningful and able to be easily used by providers to enhance care and outcomes. Several examples of these advanced analytic tools are described below.

Quality Performance Metric Engine (QPME): Clinical and medical records documentation, member survey results, claims, appeals, grievances, encounters, authorizations, quality of care incidents, population health documentation, pharmacy data, unmet social needs data, and other source data are incorporated and consolidated to enhance reporting and allow assessment of quality and appropriateness of care through: 1) alleviating excessive provider administrative burden, 2) prioritizing member care needs for providers, 3) precisely identifying members' medical and non-medical needs, and 4) reporting specific practice, provider, or member results.

Health Disparities Analytics: Our proprietary QPME and statistical modeling is performed by our statisticians to analyze Healthcare Effectiveness Data and Information Set (HEDIS) measures by disparities indicators to precisely target our efforts and resources. To enhance our ability to identify disparities at the state, regional, and community levels, our disparities dashboard allows us to quickly identify specific health disparities related to a wide variety of indicators including gender, race, ethnicity, geographic location, age, and disability status.

Behavioral Analytics for Customized Outreach: Members' past behavior, responsiveness to targeted campaigns, and care patterns are analyzed to identify the most effective method of member engagement.

Heat Maps: Geographic information technology is used to map care needs and related indicators across our populations. Heat maps identify regional, county, and ZIP code level variations in quality performance. Heat maps identify geographic "hot spots" of care needs while also tracking and trending geographic differences by population demographics and disparities.

HEDIS Provider Performance Profiles: Individual practices receive up-to-date practice level performance reports.

Reports identify underutilization of services for members with outstanding care needs such as medication adherence, visit reports showing missed annual physicals, as well as missed EPSDT services and immunizations. Care managers can use these reports to reach out to members needing to engage with the practice.

Interactive Partnership for Quality (P4Q) Scorecard Reports: Providers gain insight into actual and potential incentive earnings for their practices based on individual members and services. Scorecards show providers how they can maximize incentive dollars through improved quality.

Appointment Agendas: Individualized agendas provide prompts for everything that is needed to address the needs of each member during an appointment, based on their health concerns. For example, for a member with diabetes, we will provide an appointment agenda including a list of open care needs such as, for an annual HgbA1C check: blood pressure control, eye exams, and foot check. Our tools also help providers by suggesting potentially missed diagnoses inferred from other data sources.

Member and Provider Supports

In addition to the above analytical tools to collaboratively help direct care, WellCare employs “boots on the ground” specialists to assist members and providers in achieving the best quality health care outcomes possible, regardless of location in North Carolina. In our experience, providers welcome WellCare’s quality support so that they can get back to the business of individual health care. Data is only useful if it is used to improve quality, and our staff are specially trained for this purpose. Quality staff include:

Quality Practice Advisors (QPAs)

QPAs are local, experienced experts in quality and population health who collaborate directly with providers to assess performance on quality metrics and provide assistance in addressing areas of weakness.

Patient Care Advocates (PCAs)

PCAs work side by side with practices to engage members and link to services through telephonic outreach and in-person education, again allowing providers to focus on prevention and treatment.

Quality Improvement (QI) Care Needs Coordinators

This position involves outreach, education on recommended care needs, and scheduling assistance for those not engaged in other outreach programs promote member engagement in their care, and therefore better-quality outcomes. QI Care Needs Coordinators also support the EPSDT program.

Practice Transformation Specialist (PTS)

Our PTS Team assists providers in achieving higher Advanced Medical Home (AMH) Tier designation. PTS

Specialists are skilled in helping providers with practice operations issues, value-based systems, and population health, and are supported by practice transformation QPAs and PCAs.

Other Manager Roles

The Maternal Child Health/EPSTD Manager will focus on the needs of women and children; the Complex Populations Program Manager will focus on complex members who are receiving LTSS and those who are aged, blind, or disabled (ABD); and the Behavioral Health Program Manager will focus on complex behavioral health needs and coordination of care with Local Management Entities (LMEs).

WellCare’s QI Program in Action

Racial Disparities in Follow-up to Mental Health Inpatient Discharges

Using our QPME and statistical analysis in Georgia, we identified a statistically significant difference in the rate of mental health follow-up care between patients who identified as African American, white, and other. Our PDSA analysis of the measure revealed a lack of access to providers with follow-up appointment availability, lack of member understanding of the benefits of follow-ups, and lack of behavioral screening of members presenting to the emergency department.

Interventions included introducing new member incentives for follow-up visits, conducting targeted caregiver and parent education to combat stigma of treatment, conducting provider support on appointment availability, and enhancing provider incentives for documenting services.

PCAs created follow-up appointments upon discharge, focusing outreach on the African American community.

Overall Impact: The impact is far-reaching, as we saw increases in rates for the “other” race category and our overall rate exceeded the NCQA 50th percentile (WellCare internal data). Based on our success, we created a new role, BH QI Program Managers, to oversee these outcomes. We are also refocusing our education efforts on reaching out to the African American community, while piloting a new program for on-call behavioral health assessment when a member presents at the ER. Our PCAs are creating follow-up appointment availability in our provider practices so that when a member is discharged, they have guaranteed appointments with quality providers. In addition, we are redesigning our member material to include culturally relevant messaging and language as well as diverse images

Racial Disparities in Postpartum Care Rates

Using our QPME and statistical analysis in Kentucky, we identified a statistically significant difference in timeliness of postpartum care rates between people who identified as African American, white, and other. Our PDSA analysis of the measure revealed a lack of member knowledge of recommended postpartum visits with cultural norms influencing perception of needed care, training needs for HEDIS docu-

mentation, and unmet health-related resource needs in low access areas, disproportionately affecting racial groups.

Interventions included implementing a postpartum discharge planning program to provide targeted outreach, increasing education channels for postpartum care, implementing a First Year of Life program, conducting targeted provider training on identified health disparities, and conducting targeted postpartum outreach to members.

Overall Impact: Overall compliance with prenatal and postpartum care increased, in some instances significantly. As a result of our focused efforts, *our postpartum care rate increased by an average of 14% for all racial groups* while the disparity was reduced or remained constant (WellCare internal data). We determined a continued need to hone our focus on the African American community and plan to conduct community health fairs and connect members with providers who best understand the cultural norms of the communities we serve. In addition, we are redesigning our member material to include culturally relevant messaging and language as well as diverse images.

Gender Difference in Diabetes Care

Using our QPME and statistical analysis in Illinois, we identified a statistically significant difference in HgbA1c testing between men and women. We identified gender disparities of over four percentage points as women are more likely to get HgbA1c testing than men (WellCare internal data). Our PDSA analysis of the measure revealed a lack of men’s understanding of testing or buy-in among men, and an overall lower rate of men receiving annual wellness checkups.

Intervention included launching an outreach and education campaign about maintaining a healthy lifestyle while living with diabetes, outreach by PCAs to members to provide direct education and schedule wellness checkups, preventive services outreach and text reminders, and targeted “unable to contact” outreach conducted by our community partners and QI Care Needs Coordinators.

Overall Impact: Overall the disparity between men and women decreased by half while increasing the overall HEDIS rate (WellCare internal data). We are partnering with major

lab vendors to provide at-home testing kits, integrating the Center for Disease Control and Prevention (CDC) 6|18 Diabetes Prevention Initiative [9], and continually conducting targeted outreach to increase testing rates while eliminating the disparity.

What Will WellCare Measure in North Carolina?

NC DHHS has issued a list of priority measures for PHPs to focus on in the coming years. WellCare will put a significant focus on these measures, helping our providers and members improve quality across the state. The priority measures most relevant to provider efforts and taken from the NC DHHS NC Quality Strategy for Medicaid Managed Care can be seen in Table 2.

Conclusion

WellCare is dedicated to maximizing quality outcomes for our members. A great deal of time, technology, and staff are invested at the local level to provide quality feedback which aids providers in improving member outcomes. WellCare recognizes that one size does not fit all with quality improvement, so we are dedicated to aligning financial incentives along with collaborating with providers, community organizations, and patients alike in innovative programs such as those described in this article. WellCare is excited to be a part of Medicaid transformation in North Carolina and looks forward to partnering with the state, providers, and our members to improve health. **NCMJ**

J. Thomas Newton, MD medical director, WellCare of North Carolina, Raleigh, North Carolina.

Troy Hildreth, MBA state president, WellCare of North Carolina, Raleigh, North Carolina.

Acknowledgments

Potential conflicts of interest. J.T.N. and T.H. are employees of WellCare of North Carolina, which has been selected to serve as a pre-paid health plan for Medicaid transformation in North Carolina. The authors have no other relevant conflicts of interest.

References

1. NC Medicaid. Prepaid Health Plan Request for Proposal Fact Sheet. NC Medicaid website. <https://files.nc.gov/ncdhhs/Medicaid-Fact>

TABLE 2.
NC DHHS Quality Improvement Priority Measures for PHPs

Ensuring Timely Access to Care	Ensuring High-value and Appropriate Care
Addressing Behavioral and Physical Health Comorbidities	Promoting Patient Engagement in Care
Maximizing LTSS Population’s Quality of Life	Maintaining Medicaid Provider Engagement
Improving Diabetes Management	Linking Patients to Care Management Stations
Improving Hypertension Management	Promoting Women’s Health
Addressing the Opioid Crisis	Improving Behavioral Health Care
Reducing Health Disparities	Improving Asthma Management
Addressing Unmet Resource Needs	Addressing Tobacco Use
Addressing Obesity	

Source: North Carolina’s Quality Strategy for Medicaid: https://files.nc.gov/ncdma/documents/Quality_Strategy_4.5.19.v2.pdf

- sheets-RFP-8.9.18.pdf. Published August 9, 2018. Accessed July 1, 2019.
2. Hoffman A, Holmes M. Regional Differences in Rural and Urban Mortality Trends. Chapel Hill, NC: NC Rural Health Research Program; 2017.
 3. North Carolina Department of Health and Human Services. Quality Management and Improvement. NC DHHS website. <https://medicaid.ncdhhs.gov/quality-management-and-improvement>. Accessed June 18, 2019.
 4. Centers for Medicare & Medicaid Services (CMS). CMS Rural Health Strategy. Baltimore, MD: CMS; 2018. <https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Rural-Strategy-2018.pdf>. Accessed July 1, 2019.
 5. McManus M. Bright Futures and EPSDT: A National Review. August 26, 2018. <https://downloads.aap.org/DOFA/NationalEPSDTReport.pdf>. Accessed July 2, 2019.
 6. Centers for Medicare & Medicaid Services. Early and Periodic Screening, Diagnostic, and Treatment. Medicaid.gov. <https://www.medicicaid.gov/medicaid/benefits/epsdt/index.html>. Accessed July 2, 2019.
 7. Centers for Medicare & Medicaid Services (CMS). Paving the Road to Good Health: Strategies for Increasing Medicaid Adolescent Well-Care Visits. Baltimore, MD: CMS; 2014. <https://www.medicicaid.gov/medicaid/benefits/downloads/paving-the-road-to-good-health.pdf>. Accessed July 2, 2019.
 8. Thomas A, Ferguson E. NCCARE360 - Building healthier communities through collaboration. N C Med J. 2019;80(5):308 (in this issue).
 9. Centers for Disease Control and Prevention. Evidence Summary: Prevent Type 2 Diabetes. CDC website. <https://www.cdc.gov/sixteenteen/diabetes/index.htm>. Accessed July 2, 2019.