Federal managed care rules require that the services delivered through Medicaid prepaid health plans are available, accessible, and continually being evaluated for improvement. Working with stakeholders, NC Medicaid created a Quality Strategy that serves as a roadmap to measure and oversee performance. NC Medicaid will make a variety of quality reports available including network access, annual quality measures, and provider survey results.

“Quality is never an accident; it is always the result of high intention, sincere effort, intelligent direction and skillful execution.” — Will A. Foster

Federal Rules for Medicaid Managed Care Oversight

It should come as no surprise that there are many federal requirements mandating state responsibilities for managed care oversight and accountability. The Code of Federal Regulations (CFR), in Title 42, Chapter IV, outlines all federal rules for state Medicaid services, including rules for managed care delivery and state oversight of prepaid health plans (PHPs) [1]. In particular, Electronic CFR 438, Subpart B outlines state responsibilities for internal managed care operations and PHP oversight and monitoring [2]. NC Medicaid’s contracts for PHPs detail the many compliance and accountability requirements of PHPs and all of the timelines and standards for completing those requirements, as well as the sanctions, penalties, and liquidated damages associated with non-fulfillment of those contractual responsibilities. Those contract compliance requirements, including information on contract violations and non-compliance, service level agreements (SLAs), and withhold (money withheld unless certain performance expectations are met), were published as part of the North Carolina Request for Proposal for Prepaid Health Plan Services [3]. The North Carolina Division of Health Benefits (DHB) has dedicated staff and processes prepared to steer compliance and oversight responsibilities of Medicaid managed care operations within the broader Medicaid agency.

Instead of focusing on that operational oversight, I will speak to quality management—both quality assurance and quality improvement as a crucial monitoring component of Medicaid managed care. Though operational and compliance oversight of Medicaid is key—it’s what ensures we actually have an adequately funded health care delivery system that protects both members and providers—it is not the end goal. The end goal is high-quality, accessible care, as Medicaid will be buying health with our PHP contracts.

Because health and health outcomes are the end goal, federal managed care rules also delineate requirements aimed at ensuring that the services delivered through PHPs are available, accessible, and continually being evaluated for improvement. In the aforementioned CFR, CMS sets specific PHP standards around access, availability, and provider selection; coordination and continuity of care; member appeals and grievances; and benefits coverage using evidence-based care standards [4]. CMS has also outlined quality measurement and improvement rules for managed care operations—both at the state and PHP level [5]. As part of this section of rules, CMS requires states to develop robust quality management programs and processes that address quality assurance, measurement, and quality improvement.

In federal regulations, states are directed to work with stakeholders to create a Quality Strategy—a governing document that discusses quality assurance requirements, measures, and required improvement activities to address the priority quality aims of the Medicaid program [6]. This document serves as a roadmap with which to measure and oversee PHP performance particularly in the areas of health access and health outcomes.

NC Medicaid Quality Strategy

As Required by the Quality Strategy Rule, “each state contracting with [a PHP] must draft and implement a written quality strategy for assessing and improving the quality of health care and services furnished by the [PHP]” (see Table 1) [6].

North Carolina’s Medicaid Quality Strategy [7] was developed by analyzing the quality areas of greatest importance to the North Carolina Medicaid population and where current data indicated opportunities for targeted improve-
The strategy serves as a measurement framework for the transformed Medicaid program—an innovative whole-person approach to care that aims to address both medical and non-medical drivers of health. The Quality Strategy distills the program vision into three central aims: Better Care Delivery, Healthier People and Communities, and Smarter Spending [7]. See Figure 1 for a visual representation of the strategy’s aims, goals, and objectives.

### Quality Assurance

### 42CFR, 438, Subpart D, PHP Standards

Before we launch into the measures and processes for quality improvement outlined in the Quality Strategy, it’s important to review some mandatory program standards for PHPs relating to access and availability of care per requirements in 42 CFR, 438, Subpart D [4]. A good quality framework has structural program components (policies and procedures) and adherence to those components is more likely to drive better outcomes. In order for DHB to monitor these program standards and impose necessary sanctions, PHPs are contractually required to submit timely encounter, quality, and administrative data, including policies and procedures. These standards include:

**Network adequacy standards.** PHPs are expected to maintain and monitor a network of appropriate providers that is sufficient to provide adequate access to all services covered under the Medicaid and NC Health Choice programs for all beneficiaries.

**Availability of services.** PHPs must contract with enough providers to ensure that all services covered under the contract are available and accessible to beneficiaries in a timely manner.

**Access to care during transitions of coverage and coordination and continuity of care.** PHPs have overall responsibility for ensuring that all beneficiaries have an ongoing source of care according to their needs. PHPs are responsible for coordinating services between systems (PHP to PHP, PHP to fee-for-service system) and settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays.

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**TABLE 1. CMS Requirements for States’ Medicaid Quality Strategies**

| Requirement                                                                 | Example | Source                                                      |
|----------------------------------------------------------------------------|---------|------------------------------------------------------------|
| 1. The state-defined network adequacy and availability of services standards (for PHPs) and examples of evidence-based clinical practice guidelines the state requires, |         | Electronic Code of Federal Regulations. Title 42: Public Health, Chapter IV, Subchapter C, Part 438, 4438.340 Managed care State Quality Strategy. https://www.ecfr.gov/cgi-bin/text-idx?rgn=div5&node=42:4.0.1.1.8#se42.4.438_1340. Updated June 14, 2019. Accessed June 18, 2019. |
| 2. The state’s goals and objectives for continuous quality improvement which must be measurable and take into consideration the health status of all populations served by the PHP |         |                                             |
| 3. A description of:                                                      |         |                                             |
| a. the quality metrics and performance targets to be used in measuring the performance and improvement of each PHP, |         |                                             |
| b. the performance improvement projects to be implemented, including a description of any interventions the state proposes to improve access, quality, or timeliness of care for beneficiaries, |         |                                             |
| c. arrangements for annual, external independent reviews of the quality outcomes and timeliness of, and access to, the services covered under each PHP |         |                                             |
| d. the state’s plan to identify, evaluate, and reduce, to the extent practicable, health disparities based on age, race, ethnicity, sex, primary language, and disability status |         |                                             |

Source. Electronic Code of Federal Regulations. Title 42: Public Health, Chapter IV, Subchapter C, Part 438, §438.340 Managed care State Quality Strategy. https://www.ecfr.gov/cgi-bin/text-idx?rgn=div5&node=42:4.0.1.1.8#se42.4.438_1340. Updated June 14, 2019. Accessed June 18, 2019.
Beneficiaries have the right to pursue a formal appeal of an adverse benefit determination through their PHP, or through a state fair hearing upon exhaustion of the PHP process. Beneficiaries also will be provided the opportunity to file a grievance with their PHP to express their dissatisfaction with any other issue (eg, concerns regarding quality of care or behavior of a provider or PHP employee).

**Accreditation**

Beyond mandatory federal program standards, DHB also requires that PHPs receive NCQA Health Plan Accreditation status by the third year. Obtaining and maintaining accreditation status with a nationally recognized body is another way that North Carolina intends to ensure the quality of processes and programs in place at the PHP level. As part of accreditation, PHPs are required to calculate performance measures and develop internal quality improvement programs; these will complement DHB quality measurement and improvement requirements. While accreditation is not required per CMS regulations, if PHPs are accredited (and they are, per DHB contract), CMS does require that all PHP accreditation reports be posted publicly.

**Quality Measurement**

**Landscape Measures, Priority Measures, Withhold Measures**

The most commented-on and reviewed section of North Carolina’s Quality Strategy was the required PHP performance measure set [7]. The measure set was developed with thoughtful analysis of current Medicaid performance and significant input from the North Carolina Institute of Medicine’s Task Force on Health Care Analytics [8]; NC Medicaid’s Medical Care Advisory Committee (MCAC), in particular the Quality Subcommittee [9]; providers; beneficiaries; and other stakeholders.

PHPs will be expected to report, and be held accountable for performance against, measures aligned to the Quality Strategy’s aims, goals, and objectives. A complete explanation of the measurement approach, as well as the technical specification for calculation of each measure, is laid out in the North Carolina Medicaid Managed Care Quality Measurement Technical Specification Manual [10]. Measures used in the Quality Strategy serve two main purposes—as a means of landscape scanning (maintaining current quality) and as a means for driving improvement.

First, the larger measure set (67 quality measures) serves as a landscape scan of PHPs’ processes and performance; these measures are one way of ensuring that quality is maintained as we transition from fee-for-service to managed care. A smaller subset of these measures (about 32) are designated as priority measures. Priority measures serve as the basis for PHP quality improvement projects and for the quality withhold programs. These measures may change from year to year as DHB considers PHP performance on the larger measure set. Beginning in the third contract year, DHB will measure PHPs’ performance against select withhold measures, for which PHPs will be financially accountable. The withhold measures will be drawn from the priority measure set. See Figure 2 for how the measures sets nest.

**Structural, Process, and Outcome Measures**

DHB will use a variety of measure types in order to assess progress toward our aims, goals, and objectives. Here are some examples:

**Structure measures.** These measures, though not outcome measures, help us track that PHPs are putting systems in place to identify priority needs of our populations in order to intervene. Examples include screening for social determinants of health (assessing whether PHPs are screening all members to determine whether they have needs in the areas of housing, safety, transportation, and food insecurity), and screening for pregnancy risk (capturing whether PHPs’ contracted pregnancy care providers are administering pregnancy risk screenings in a timely manner).

**Process measures.** These measures help us look at evidence-based care provided in the field. Higher performance on these standard of care process measures correlates to higher health outcomes in members. These are also nationally recognized measures that cross multiple payers. Priority process measures for North Carolina include well-child visits in the third, fourth, fifth, and sixth years of life; breast cancer screening; prenatal and postpartum care; and follow-up after hospitalization for mental illness.

**Outcome measures.** Outcome measures that tell us if all of the policies, programs, and structure that we put into place are leading toward the best health outcomes. Not surprisingly, it can be challenging to come to consensus on how to measure outcomes in health care and who to hold accountable. People are complex and health is a factor of many things, including a person’s unmet resource needs (social determinants of health), the availability of health care and other resources, and a person’s health behaviors and personal choices. In North Carolina we are looking at some key outcome measures areas including avoidable emergency department and inpatient utilization, live births in which the baby weighs less than 1,500 or 2,500 grams, clinician satisfaction with PHPs, and member experience of care.

In initial years, PHPs will be measured against historic state-level performance compared to national Medicaid benchmarks. DHB will provide historical baselines for all measures for which comparable historical data are available.
at the state level. DHB will then set benchmarks, representing optimal performance levels, for all priority measures. For withhold measures, DHB will calculate performance targets, representing the level PHPs must achieve to receive some or all of their quality withhold amount. As our analysis and familiarity with the PHP data grows, DHB will be better able to weight particular measures and set targets, including targets based on disparities across groups.

Health Equity

The North Carolina Department of Health and Human Services (NC DHHS) expects that PHPs will ensure that improvements in quality will be equitably distributed and that no group of members is ignored. To provide a clear picture of health disparities and a foundation for additional granularity for measure-reporting and target-setting, PHPs will be required to report measures stratified by race; ethnicity; geography (rural/urban); aged, blind, disabled (ABD) or non-ABD (as a proxy for individual with long-term services and supports needs); age; and primary language spoken. In later contract years, DHB will hold PHPs financially accountable for ensuring equity improvements for selected measures.

Quality Assessment and Performance Improvement (QAPI)

So, how do we go from measurement to actual improvement in health and health care delivery? We analyze; we plan; we do; we study; and we act. DHB requires that each PHP develop and implement a continuous quality assessment and performance improvement program. Per federal regulations, the comprehensive quality assessment and performance improvement (QAPI) program must include at least the following elements: “(1) Performance improvement projects, both clinical and non-clinical designed to achieve significant improvement, sustained over time, in health outcomes and enrollee satisfaction” and “(2) Collection and submission of performance measurement data” [10].

DHB will approve PHP programs for systemic data collection, analysis, and development of interventions to improve quality. PHPs are required to examine the root cause of underperformance and to develop targeted interventions, typically with providers and members, to address ineffective processes or standard of care issues. DHB is working with PHPs to analyze current data and historic Medicaid performance and to develop clinical improvement projects with the aim of aligning improvement work across regions and developing creative ways to incentivize provider and member performance.

External Oversight of PHP Quality

In addition to DHB oversight of quality programs at the PHP level, CMS requires that the state contract with an External Quality Review Organization (EQRO). The EQRO must perform 1) validation of performance improvement projects each year; 2) validation of PHP performance measures calculated each year; 3) a review, every 3 years at a minimum, to determine the PHP’s compliance with the standards set forth in subpart D and the quality assessment and performance improvement programs; and 4) validation of PHP network adequacy each year [11].

This external level of validation and oversight is a good thing. The EQRO will produce publicly available reports that point out areas of non-compliance or underperformance. DHB will take EQRO findings and work with PHPs on corrective action and improvement plans. The EQRO can also

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FIGURE 2.
NC Medicaid Quality Measure Set

![Figure 2](image-url)

Source. NC DHHS.
provide input to DHB on how we can do a more effective job at quality assurance and improvement measurement and monitoring.

Transparency and Continuous Quality Improvement

One of our greatest opportunities for oversight and improvement comes from being transparent. As mentioned above, EQRO evaluation reports are publicly available. In addition, DHB will make a variety of quality reports available including but not limited to accreditation progress and results, annual quality measures at the PHP level, and provider survey results.

DHB has created a NC Medicaid Quality Management and Improvement webpage and has used it as a vehicle for posting documents (in both final and draft versions) related to managed care quality design and implementation [12]. The creation of a statewide Quality Strategy and operationalization of a Medicaid quality management and improvement structure takes significant support and input from DHB and PHP staff, our MCAC Quality Subcommittee, medical thought leaders, and most importantly from those working in the field, where quality care happens in partnership between members and providers every single day.

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