NC InCK
NC INTEGRATED CARE FOR KIDS

NCDHHS
NC Medicaid
Division of Health Benefits

March 2023

# NC InCK Alternative Payment Model (APM) Data Companion Guide for Providers

## Ambulatory Care: Emergency Department (ED) Visits

## Measure at a Glance

| Measure Name | Ambulatory Care: ED Visit |
|---|---|
| **Measure Abbreviation** | AMB-CH |
| **Measure Type** | HEDIS (NOTE: The NC InCK APM uses slightly different continuous enrollment criteria than the standard HEDIS measure, and, thus, rates are not directly comparable.) |
| **Data Source** | Administrative |
| **Measure Description** | Rate of emergency department (ED) visits per 1,000 beneficiary months among children up to age 19 |
| **Numerator** | Number of ED visits (multiplied by 1000) |
| **Denominator** | Number of beneficiary months |

## ED Visits: Clinical and Public Health Significance

Emergency department visits are a high-intensity service and have higher unit costs than other levels of care. Some ED events may be attributed to preventable or treatable conditions. Preventable ED visits may reflect lack of access to alternative sources of timely care, adequate primary care, or care management.

## Why does this measure matter to NC InCK?

Seeking emergency care can be a stressful experience for a family. The NC InCK model is specifically designed to promote early identification and treatment, increasing the likelihood that conditions and needs are identified and addressed before they develop into emergency situations. By bridging services across sectors, NC InCK Family Navigators may be able to play a unique role in preventing avoidable ED visits.

For example, a Family Navigator may be able to connect a family to resources that reduce indoor air pollutants in the home, thus reducing the risk of severe asthma exacerbations. They may also be able to connect a child to behavioral health services to prevent a mental health concern from turning into an emergency. Family Navigators can help a family understand what situations warrant a visit to the emergency department rather than a call to a primary care provider or visit to urgent care. This measure emphasizes NC InCK's focus on prevention, holistic care management, and resource navigation.

## What data will I be receiving on this measure for the NC InCK APM?

In Spring 2023, Prepaid Health Plans (PHPs), Clinically Integrated Networks (CINs), and Advanced Medical Homes (AMHs) will receive data on this measure for calendar year 2021. These data will serve as the baseline for APM performance year 2023. In future years, this baseline will be calculated using an average of data from two years. For example, performance year 2024 will use data from 2021 and 2022 for the baseline.

Your CIN will receive member-level information, generated by the department, indicating the number of ED visits and number of beneficiary months for each NC InCK member. CINs will calculate AMH-level rates for this measure. Payment will be based on an AMH's performance, pooled across PHPs. CINs will distribute member-level information and quality performance rates to each AMH. The member-level information will also include numerator and denominator indicators, demographic information, and billing provider information so that CINs and practices can use the data as a tool to support further opportunities for action.

### How should I interpret my data?

Among Medicaid beneficiaries ages 0-19 in 2021, statewide performance on the AMB-CH HEDIS measure was 32.9604 visits per 1,000 member-months. For this measure, a lower rate indicates better performance.

NOTE: The statewide rate is not directly comparable to your NC InCK rates due to a difference in the inclusion criteria used related to continuous enrollment in Medicaid. This difference may make NC InCK rates look slightly lower.

### How is this measure linked to quality payments?

In order to earn incentive payments, an AMH must meet the following targets for the AMB-CH measure. These targets were set by the NC InCK external APM Workgroup that included representatives from PHPs, CINs, NC Medicaid, physicians, and NC InCK staff.

| Tier 1 (50% Quality Payment) | Tier 2 (75% Quality Payment) | Tier 3 (100% Quality Payment) |
|---|---|---|
| Stable compared to baseline | 2.5% lower than baseline | 5% lower than baseline |

The data PHPs and CINs receive in Spring 2023 serve as the baseline and can help AMHs determine the specific targets that they'd need to hit in performance year 2023 to earn incentive payments.

#### Example Calculations to Determine Incentive Targets

| | AMB-CH: Baseline | *Tier 1 Target* | *Tier 2 Target* | *Tier 3 Target* |
|---|---|---|---|---|
| **Example** | **20.0** | **20.0*1=20.0** | **20.0*0.975=19.5** | **20.0*0.95=19.0** |

### How can I improve my practice's performance on this measure?

The list below contains a menu of options that have been used in different settings. Different interventions may work for different patient groups and different clinic settings.

## Provide clear education to families regarding when to seek care in the clinic as opposed to the ED

- Encourage patients to contact their primary care office before going to the ED, including in the evenings and on weekends
- Ensure families have the clinic's number immediately available in their cell phone and easily accessible
- Have staff triage lines after-hours and consult with the on-call physicians prior to recommending the ED to any family
- Call families back the day after they visit the ED. This will close the loop on care and provide education about clinic use.

## Make it easier for families to see a provider, which can prevent unnecessary ED visits

- Create strong continuity with a single provider for patients at your practice
- Be open in the evenings and weekends at your clinic and create schedule templates that allow for same-day or walk-in appointments
- Assure 24/7 bilingual clinical assistance with guidance provided to patients in a family's preferred language
- Consider contracting with a service to provide after-hours virtual care in patients' homes
- Provide mental health support within your clinic through implementation of a collaborative care model
- Schedule regular chronic disease management appointments for specific conditions to optimize control and prevent ED visits when possible (examples: asthma, constipation, chronic headaches)
- Adjust care management outreach strategies to encourage more families to attend preventive visits

## Build partnerships so that patients have options besides the emergency department

- Develop a relationship with a local urgent care and provide families with their address and hours of operation