North Carolina Department of Health and Human Services (DHHS)
Advanced Medical Home Technical Advisory Group (AMH TAG) In-Person Meeting #5
July 22, 2019

Meeting Attendees	Organization
TAG Members, North Carolina DHHS, and Manatt Project Team	
C. Marston Crawford, MD, MBA (*by phone*)	Coastal Children's Clinic – New Bern, Coastal Children's
David Rinehart, MD (*by phone*)	North Carolina Academy of Family Physicians
Gregory Adams, MD (*absent*)	Community Care Physician Network (CCPN)
Zeev Neuwirth, MD (*absent*)	Carolinas Physician Alliance (Atrium)
Amy Russell, MD (*by phone*)	Mission Health Partners
Peter Freeman, MPH (*by phone*)	Carolina Medical Home Network
Jan Hutchins, RN (*by phone*)	UNC Population Health Services
Joy Key, MBA (*in-person*)	Emtiro Health
Paul Rubinton, MD (*absent*)	AmeriHealth Caritas North Carolina, Inc
Michael Ogden, MD (*in-person*)	Blue Cross and Blue Shield of North Carolina
Michelle Bucknor, MD (*in-person*)	UnitedHealthcare of North Carolina, Inc
William Lawrence, MD *in-person*)	Carolina Complete Health, Inc
Thomas Newton, MD (*by phone*)	WellCare of North Carolina, Inc
Jason Foltz, DO (*by phone*)	ECU Physicians MCAC Quality Committee Member
Aaron McKethan, PhD (*absent*)	Advisor to the State
Kelly Crosbie, MSW, LCSW (*in-person*)	DHHS
Nancy Henley, MPH, MD, FACP (*in-person*)	DHHS
Jonah Frohlich, MPH (*by phone*)	Manatt Health Strategies
Sharon Woda, MBA (*in-person*)	Manatt Health Strategies
Emily Carrier, MD, MSc (*in-person*)	Manatt Health Strategies
Lammot du Pont, MIA (*in-person*)	Manatt Health Strategies
Edith Stowe, MPA (*in-person*)	Manatt Health Strategies
Adam Striar, MPA (*in-person*)	Manatt Health Strategies
Bardia Nabet, MPH (*in-person*)	Manatt Health Strategies
Public Attendees	
Kristen Dubay, MPP (*by phone*)	North Carolina Community Health Center Association
Atha Gurganus, MPH, CPHQ (*by phone*)	UnitedHealthcare
Jonathan Kea (*by phone*)	North Carolina Healthcare Association
Tara Kinard, RN, MSN, MBA, CENP (*by phone*)	Duke University Health System
Cynthia Reese, MS (*by phone*)	Mission Health Partners
Christine Wang (*by phone*)	UnitedHealthcare
Steven Bentsen, MD, MBA, DFAPA (*by phone*)	Blue Cross and Blue Shield of North Carolina

Agenda

- Recap: AMH TAG Meeting #4
- Overview and Discussion: AMH Oversight
- Discussion: Risk Stratification Examples
- Break
- Briefing and Discussion on Quality
- Update: Data Subcommittee Progress
- Public Comments
- Next Steps

Please refer to the July 22 AMH TAG Meeting #5 slide deck available here.

Recap: AMH TAG Meeting #4 (slides 4 – 5)

Dr. Nancy Henley of North Carolina DHHS convened the meeting at 11:30 am and welcomed meeting attendees. Dr. Henley asked attendees, including those participating by phone, to introduce themselves to the group. Dr. Henley then turned the floor over to Sharon Woda and Edith Stowe of Manatt Health Strategies to review the previous AMH TAG meeting. Ms. Woda and Ms. Stowe highlighted the following topics (**slide 5**):

- Tailored Plan Care Management
- Value-Based Payment (VBP) in Managed Care
- Accountable Care Organization (ACO) Model Design

More information on the discussion from the previous AMH TAG meeting can be found here. Ms. Woda then turned to Adam Striar to provide an overview and lead a discussion on AMH oversight.

Overview and Discussion: AMH Oversight (slides 6 – 13)

Mr. Striar began by reviewing the requirements surrounding oversight of the AMH model. Mr. Striar highlighted that PHPs are responsible for overseeing care management delivered by both individual AMHs and their clinically integrated networks (CINs) and other partners (**slide 8**). He also noted that although state policy to-date has focused on the oversight of individual AMHs, the TAG and other stakeholders have requested additional guidance surrounding oversight of CINs/other partners. Mr. Striar then highlighted proposed new prepaid health plan (PHP)-facing guidance on the oversight of CIN/other partners.

Mr. Striar noted that DHHS recognizes that many CINs/other partners in the market are contracting directly with PHPs on behalf of AMHs (**slide 9**). Due to this contracting arrangement, CINs/others in this scenario are the delegates of care management functions. Mr. Striar also noted that in scenarios where CINs/other partners contract on behalf of one or more AMHs and are primarily responsible for delivering care management services, PHPs should conduct oversight of CINs/other partners directly. Moreover, PHPs must ensure they are not only monitoring against NCQA requirements, but also AMH program-specific requirements.

- AMH TAG Members highlighted that the NCQA requirements have a finer level of detail than the AMH requirements and sought clarification on whether one is preferred in lieu of the other. The Department clarified that although PHPs would be working to meet NCQA requirements, AMHs and CINs/other partners would need to perform to the level of NCQA standards, but not

become NCQA-certified. DHHS noted that it would stress this distinction in the final programmatic guidance.

Mr. Striar then highlighted how the Department seeks to ensure that AMH practices have transparency into the oversight process for contracted CINs/others (**slide 10**). The Department will require PHPs to: 1) provide direct notification to each AMH practice describing the CIN/other partner oversight process and 2) provide direct notification to each AMH practice with results of CIN/other partner-level audits.

- AMH TAG Members recommended establishing a timeframe of 90 days for PHPs to provide practices with information regarding CIN/other partner oversight processes.
- Members recommended establishing a 60 day window for providing AMH practices with the results of CIN/other partner audits.

Mr. Striar then highlighted the Department's proposed minimum timelines to ensure that AMHs and CINs/other partners have adequate time to remediate compliance issues identified by PHPs (**slide 11**). The Department proposed requiring PHPs to provide AMHs and CIN/other partners with a minimum of 30 days to remediate any identified issues. Additionally, PHPs and their care management delegates may establish longer remediation periods by mutual agreement.

- Members stressed the importance of ensuring that patient care is not impacted during this time.
- Members noted that a 30 day minimum would be sufficient and that PHPs would negotiate with affected AMHs and CINs depending on the issue that triggered the CAP. For example, if a technology issue, the PHP may provide a longer runway to address necessary changes at the AMH- or CIN-level.
- Members agreed that a maximum corrective action plan (CAP) timeline is not necessary, and such parameters should be worked out during the contracting process.

Next, Mr. Striar and Ms. Woda then discussed the re-classification of AMHs into a lower tier if the practice is not complying with program requirements and how CINs/other partners are accountable in this process. Ms. Woda stressed that the Department is in favor of minimizing AMH tier reclassification and prefers to provide AMHs an opportunity to ramp-up to meet the tier requirements. Mr. Striar and Ms. Woda then reviewed CIN/other partner corrective measures and AMH options in cases of CIN/other partner noncompliance with the AMH program requirements (**slide 12**).

- TAG Members agreed with the Department's overall approach, but identified that there may be variation between practices under a single CIN/other partner.
- The group agreed that CIN/other partner compliance policies should account for variation in the degree of compliance across practices, including addressing financial implications for CINs and AMHs.
- The Department stressed that financial implications would be at the discretion of the PHP and AMH.
- The Department also noted that it would consider adjusting the guidance to account for cases of variation in care management responsibility.

Ms. Woda then turned to Ms. Stowe for a discussion on the Department's draft practice-facing risk stratification guidance.

Discussion: Risk Stratification Examples (slides 14 – 19)

Ms. Stowe provided an oversight of risk stratification requirements and discussed the Departments proposed programmatic guidance on risk stratification for AMH Tier 3 practices. TAG Members

approved of the guidance and appreciated the attention to the varied experiences of AMH Tier 3 practices. Ms. Stowe asked TAG Members to identify a timeline for when the guidance should be released and methods for amplification of the messaging. TAG Members overwhelmingly agreed that the guidance should be released as soon as possible and possible methods of communication include a State webinar highlighting the guidance.

Ms. Stowe concluded by requesting any additional written feedback on the risk stratification guidance by Friday, July 26. Feedback will be provided to Bardia Nabet (bnabet@manatt.com) for aggregation and adjustment of the guidance.

Ms. Stowe then turned to Dr. Emily Carrier and Ms. Woda for a discussion on AMH quality.

Briefing and Discussion on Quality (slides 21 – 29)

Ms. Woda, Dr. Carrier and Ms. Crosbie highlighted the Department's AMH quality materials to date and the State's approach (**slide 22 – 23**). Ms. Crosbie and Dr. Carrier then discussed the North Carolina Medicaid Quality Framework, which defines and drives the overall vision for advanced the quality of care provided to Medicaid beneficiaries in North Carolina (**slide 24**). Ms. Crosbie also discussed the North Carolina quality measures and specific measures to assess AMH performance (**slide 25 – 26**).

Ms. Woda and Dr. Carrier then highlighted how PHPs will be required to share interim and gap reports with AMH providers on select quality measures (**slide 27**). Interim reports provide information on quality measure performance trends throughout the year. Gap reports identify specific members who are not listed as receiving recommended care based on PHP records. PHPs will deliver these reports to AMH practices, as appropriate. Ms. Crosbie noted that interim reporting requirements may be examined by the AMH TAG Data Subcommittee.

Next, the Department highlighted the timeline for quality measurement and contracting (**slide 28**). Quality measure reporting will begin with the launch of managed care. For each contract year, PHPs will submit quality performance data measured during the calendar year that began in the January before the beginning of that contract year. Ms. Crosbie noted that although withholds are not implemented until Contract Year 3, providers should expect PHPs to implement VBP / performance incentive programs earlier to prepare for the withhold period. Moreover, the withhold period will, in practice, align with the contract year.

- TAG Members sought clarification on the development of baselines and benchmarks for practice improvement. TAG Members identified that there may be fixed levels of improvement or variable levels depending on the practice's current status (i.e., a strong practice may only be able to improve a limited amount). TAG Members identified that measures and incentives may be contingent on gap closure as opposed to fixed benchmarks. Ms. Crosbie noted that the Department's calculation of baselines and benchmarks was approaching completion.
- TAG Members also highlighted that quality measurement reporting to PHPs may require additional technological and infrastructure updates to transmit the requested information to the PHPs. TAG Members noted that additional standardization of the quality feed to each PHP may be necessary and beneficial for AMHs and CINs. The Department recognized the challenge of aggregating the quality measurement data.
- The Department also sought feedback on whether there were any gaps in knowledge in the field regarding the quality strategy or measures. TAG Members noted that the field may be aware, but noted that the market may require additional communication regarding each metric and the requirements for meeting them. TAG Members suggested the development of a digestible

communication, such as a webinar, that allow practices to understand the requirements being asked of them.

Ms. Woda then turned to Ms. Crosbie and Lammot du Pont, of Manatt Health Strategies, to discuss the progress of the AMH TAG Data Subcommittee and upcoming meeting topics.

Update: Data Subcommittee Progress (slides 30 – 37)

Mr. du Pont began by highlighting how the Department is taking an active role on aligning details of data sharing across PHPs where alignment is critical to population health management at the practice/CIN level (**slide 31**). Mr. du Pont discussed how the AMH TAG identified the most critical data elements to be addressed by the Data Subcommittee, which included the transmission of beneficiary assignment and pharmacy lock-in files and encounter data to AMHs/CINs. Mr. du Pont noted the development and finalization of the specifications and the Department's strategy for ongoing maintenance and monitoring of the specifications (**slide 33 – 34**). Mr. du Pont then discussed the proposed timeline for finalizing, implementation, and testing of beneficiary assignment/pharmacy lock-in and encounter data specifications (**slide 35**).

Finally, Mr. du Pont discussed the data elements that the Department is considering for the next AMH TAG Data Subcommittee meeting. Mr. du Pont emphasized that the Department does not expect standardized specifications to be developed for every data element that will be exchanged in support of the AMH care management processes (**slide 36**).

- AMH TAG Members agreed on the approach for the upcoming meeting, but sought clarification on the expectations for standardization of the twelve data elements. The Department stressed that the intent is not to develop and impose standard specifications on the every attribute of data that will be exchanged in support of the AMH care management processes; rather it is to listen to stakeholders' experiences, identify the challenges, and, discuss the value, options, considerations and costs of standardization. AMH TAG Members asked if any future standardized specifications would have to be implemented by the PHPs and AMHs prior to the launch of managed care in November. The Department indicated that any standardized specifications for data types beyond the beneficiary assignment/pharmacy lock-in and encounter data would likely occur after the launch of managed care.

Next Steps

After opening the floor for public comment (of which there were none), Ms. Crosbie asked Ms. Woda to highlight next steps:

- ***DHHS:***
  - Finalize and share pre-read materials for upcoming sessions of TAG Data Subcommittee (August 21; 11:30 am – 2:30 pm) and AMH TAG (September 18; 10 am – 1 pm)
- ***Members:***
  - TAG Members to share discussion key takeaways with stakeholders and probe on pressing issues related to managed care launch
  - TAG Members to continue communication with DHHS TAG leads to identify topics for discussion in meetings resuming in September
  - TAG Members to share feedback on practice-facing risk stratification guidance by Friday, July 26 with Bardia Nabet (bnabet@manatt.com).

AMH TAG Members are encouraged to send any additional feedback or suggestions to Kelly Crosbie (Kelly.Crosbie@dhhs.nc.gov) of DHHS.

The meeting adjourned at 2:30 pm.