Advanced Medical Home (AMH) Technical Advisory Group (TAG)

Meeting #6: Managed Care Update, AMH Provider Contracting Messaging, Oversight, and Data Subcommittee Updates

September 18, 2019, 10:00 am – 1:00 pm

Williams Building, 1800 Umstead Drive, Room 123B

AMH TAG Membership Introductions and Rollcall

Name	Organization	Stakeholder
C. Marston Crawford, MD, MBA	Pediatrician Coastal Children's Clinic – New Bern, Coastal Children's	Provider (Independent)
David Rinehart, MD	President-Elect of NC Family Physicians North Carolina Academy of Family Physicians	Provider (Independent)
Gregory Adams, MD	Member of CCPN Board of Managers Community Care Physician Network (CCPN)	Provider (CIN)
Zeev Neuwirth, MD	Senior Medical Director of Population Health Carolinas Physician Alliance (Atrium)	Provider (CIN)
Amy Russell, MD	Medical Director Mission Health Partners	Provider (CIN)
Kristen Dubay, MPP	Senior Policy Advisory Carolina Medical Home Network	Provider (CIN)
Jan Hutchins, RN	Executive Director of Population Health Services UNC Population Health Services	Provider (CIN)
Joy Key, MBA	Director of Provider Services Emtiro Health	Provider (CIN)
Tara Kinard, RN, MSN, MBA, CCM, CENP	Associate Chief Nursing Officer Duke Population Health Management Office	Provider (CIN)
Paul Rubinton, MD	Chief Medical Officer AmeriHealth Caritas North Carolina, Inc	PHP
Michael Ogden, MD	Chief Medical Officer Blue Cross and Blue Shield of North Carolina	PHP
Michelle Bucknor, MD	Chief Medical Officer UnitedHealthcare of North Carolina, Inc	PHP
Thomas Newton, MD	Medical Director WellCare of North Carolina, Inc	PHP
William Lawrence, MD	Chief Medical Officer Carolina Complete Health, Inc	PHP
Jason Foltz, DO	Medical Director, ECU Physicians MCAC Quality Committee Member	MCAC Quality Committee Member

Agenda

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2	Discussion: AMH Managed Care Timeline	10:10 am – 11:15 am
3	Discussion: Prepaid Health Plan (PHP) Oversight of AMH Program	11:15 am – 12:00 pm
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Recap: AMH TAG Meeting #5

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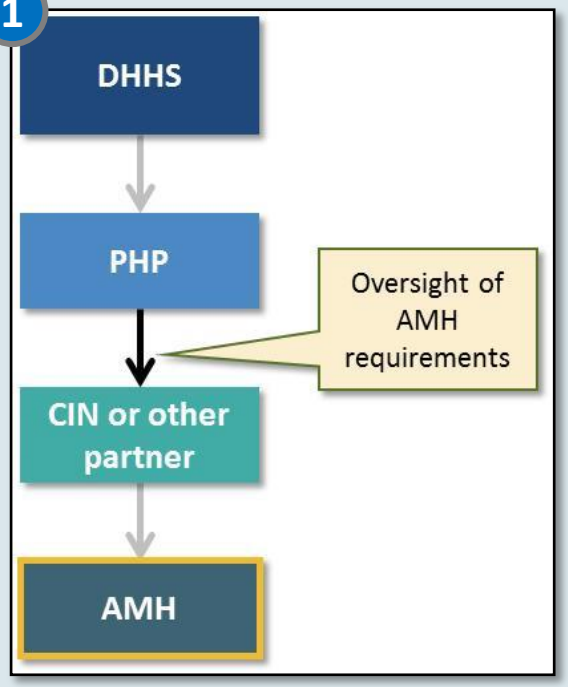

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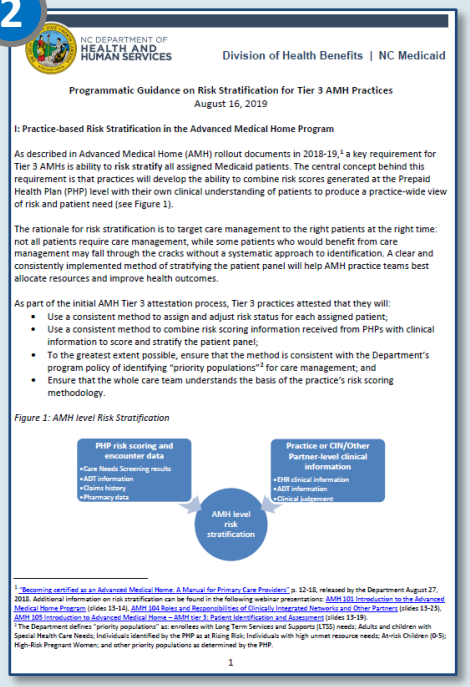

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES — Division of Health Benefits | NC Medicaid

Programmatic Guidance on Risk Stratification for Tier 3 AMH Practices
August 16, 2019

I: Practice-based Risk Stratification in the Advanced Medical Home Program

As described in Advanced Medical Home (AMH) rollout documents in 2018-19,[1] a key requirement for Tier 3 AMHs is ability to risk stratify all assigned Medicaid patients. The central concept behind this requirement is that practices will develop the ability to combine risk scores generated at the Prepaid Health Plan (PHP) level with their own clinical understanding of patients to produce a practice-wide view of risk and patient need (see Figure 1).

The rationale for risk stratification is to target care management to the right patients at the right time: not all patients require care management, while some patients who would benefit from care management may fall through the cracks without a systematic approach to identification. A clear and consistently implemented method of stratifying the patient panel will help AMH practice teams best allocate resources and improve health outcomes.

As part of the initial AMH Tier 3 attestation process, Tier 3 practices attested that they will:

- Use a consistent method to assign and adjust risk status for each assigned patient;
- Use a consistent method to combine risk scoring information received from PHPs with clinical information to score and stratify the patient panel;
- To the greatest extent possible, ensure that the method is consistent with the Department's program policy of identifying "priority populations"[2] for care management; and
- Ensure that the whole care team understands the basis of the practice's risk scoring methodology.

Figure 1: AMH level Risk Stratification

[1] "Becoming certified as an Advanced Medical Home: A Manual for Primary Care Providers" p. 12-18, released by the Department August 27, 2018. Additional information on risk stratification can be found in the following webinar presentations: AMH 101 Introduction to the Advanced Medical Home Program (slides 13-14), AMH 104 Roles and Responsibilities of Clinically Integrated Networks and Other Partners (slides 13-23), AMH 105 Introduction to Advanced Medical Home – AMH tier 3: Patient Identification and Assessment (slides 13-19).

[2] The Department defines "priority populations" as: enrollees with Long Term Services and Supports (LTSS) needs; Adults and children with Special Health Care Needs; Individuals identified by the PHP as at Rising Risk; Individuals with high unmet resource needs; At-risk Children (0-5); High-Risk Pregnant Women; and other priority populations as determined by the PHP.

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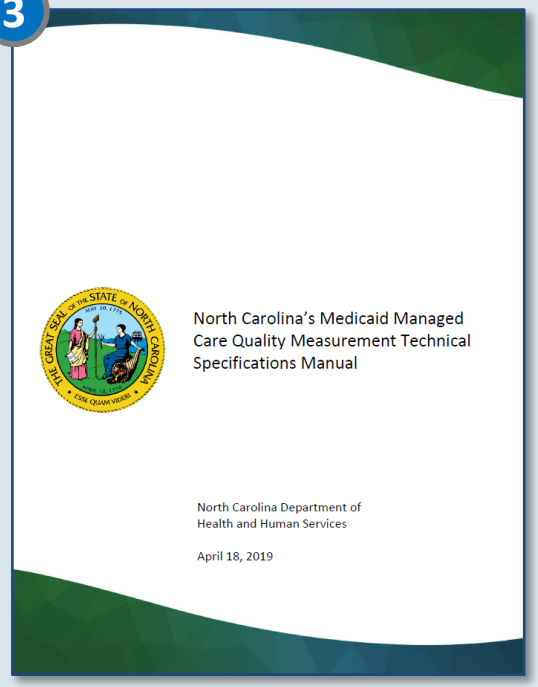

North Carolina's Medicaid Managed Care Quality Measurement Technical Specifications Manual

North Carolina Department of Health and Human Services

April 18, 2019

1. PHP-Facing Guidance on AMH and CIN Oversight (to be discussed today)

2. Risk Stratification Guidance (final copy available here)

3. Quality Framework and Vision of Care (See here for Technical Specifications Manual)

4. Data Subcommittee Progress Report (to be discussed in greater detail today)

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Goals of Today's Discussion on Updated Managed Care Timeline

- ❑ ***Review the revised managed care timelines***
- ❑ ***Discuss planned provider-facing communications that will ensure AMH practices are contracted with PHPs, prepared for testing, and ready to accept Medicaid patients in 2020***

Key Takeaways: Medicaid Transformation Update

- **DHHS has moved from rolling out managed care in two phases to one statewide, transition. The State will launch statewide implementation on February 1, 2020.**
- **DHHS has extended the period for open enrollment for counties in Managed Care Launch Phase 1 (*see next slide*)**

Medicaid Transformation Milestones

Milestone	Regions 2 and 4	Regions 1, 3, 5, and 6
Enrollment Packets Mailed	*6/28/2019 (already occurred)*	10/1/2019
Open Enrollment Begins	*7/15/2019 (already occurred)*	10/14/2019
Provider Contracts Must be Signed for Inclusion in Auto-Assignment	**Mid-November**	
Open Enrollment Ends	12/13/19	
Auto-Assignment to PHPs and PCPs	Starting 12/16/19	
Standard Plan Effective Date	2/1/2020	

Provider-Facing Guidance (1): General Messages on Contracting

The Department is planning to issue further provider-facing guidance regarding contracting and beneficiary assignment

Why is important to contract with PHPs in advance of managed care launch (February 1, 2020)?

- Primary care providers (PCPs) that do not contract with PHPs in a timely fashion risk losing patients, as PHPs will assign beneficiaries to in-network providers
- Providers that do not contract with PHPs in a timely fashion may also miss out on the ability to earn per member per month (PMPM) payments through the AMH program

Are providers required to contract with all PHPs?

- No. Providers are not required with any particular PHP and do not need to contract with all PHPs, but providers that fail to do so risk losing patients and missing out on AMH payments

What are PHPs' responsibilities with respect to contracting with Medicaid PCPs?

- DHHS expects PHPs to negotiate with any willing provider in good faith regardless of provider or PHP affiliation.
- PHPs may only exclude eligible providers from their networks under the following circumstances:
    - Provider fails to meet Objective Quality Standards; or
    - Provider refuses to accept network rates

What are PHP responsibilities with respect to contracting with Medicaid PCPs that are Tier 3 AMHs?

- PHPs are required to contract with **all** AMH Tier 3 practices located in each PHP region

What are required payments for PCPs and AMHs?

- PHPs must reimburse physicians and physician extenders no less than 100% of Medicaid fee-for-service (FFS) rates unless they have mutually agreed to an alternative arrangement
- In addition to FFS payments, PHPs must also make directed payments to AMHs

Provider Facing Guidance (2): Key Messages on Timelines

OPEN ENROLLMENT BEGINS

- Beneficiaries in all managed care regions will have the option to choose a Medicaid PHP during the open enrollment period; **open enrollment is currently live in regions 3 and 5, and will open in the remaining regions on 10/14/2019**
- Beneficiaries may keep their current provider by signing up for a PHP that contracts with that specific provider and selecting the provider as their PCP

PROVIDER CONTRACTING

- PHPs generally require 2-3 weeks to load AMH/PCP contracts into their provider management and claims payment systems and ensure that all contracted providers are included in the PHP Network File transmitted on a daily basis to the Department; PHP Network file can only contain fully-loaded contracts
- **To ensure inclusion in auto-assignment, provider contracts must be executed no later than mid-November**

OPEN ENROLLMENT ENDS / AUTO-ASSIGNMENT

- **Open enrollment closes on 12/13/2019**
- After the open enrollment period closes, beneficiaries who have not actively chosen a PHP will be automatically assigned one by DHHS; DHHS expects the vast majority of beneficiaries to be auto-assigned to PHPs
- PHPs will then be responsible for auto-assigning beneficiaries to PCPs (except for those who have selected one); DHHS has prescribed certain elements of the PCP auto-assignment algorithm in the PHP contract
- **PCP auto-assignment must be completed prior to mailing ID cards, which have to be shared with auto-assigned members by 1/9/2020**. After auto-assignment, any new members must by assigned within 7 days

Note: Dates are approximate and subject to change.

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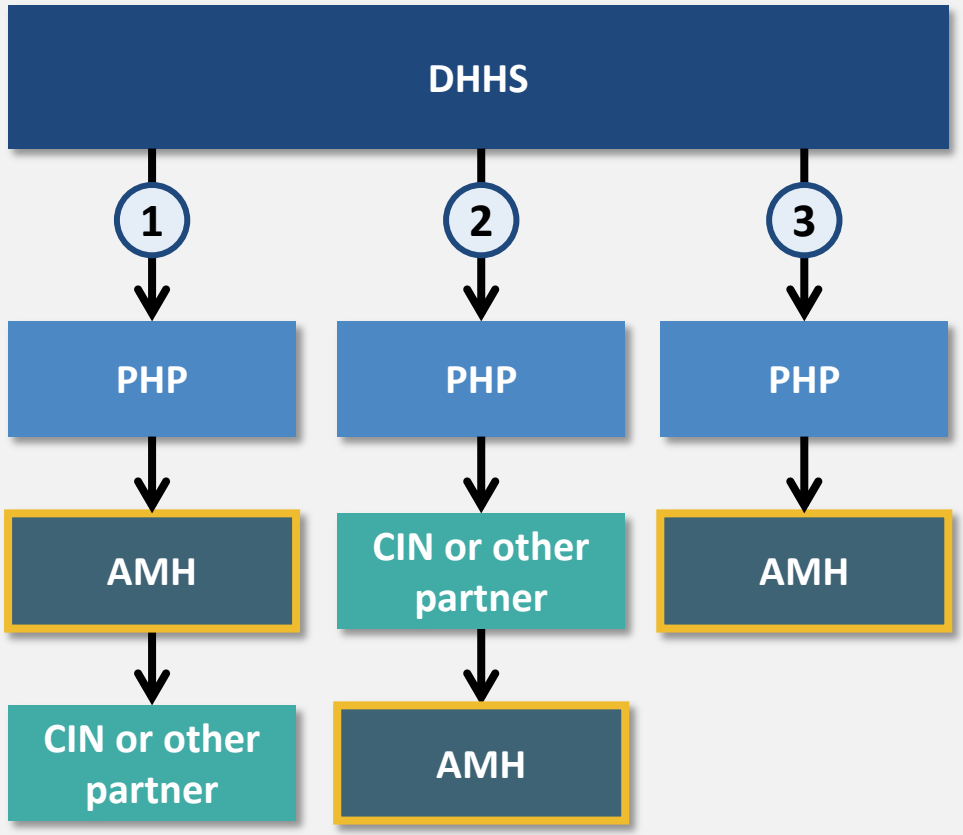
Goals of Today's Discussion on Oversight

- ***Review draft PHP-facing guidance on oversight of AMHs and CINs/other partners***
- ***Discuss release in advance of February Managed Care Launch***

Overview: PHP Oversight of AMH Practices and CINs/Other Partners

PHPs will be responsible for overseeing care management delivered by both individual AMHs and CINs/other partners

Contracting Options:



- State policy to-date has focused on oversight of individual AMHs
- The AMH TAG and other stakeholders have identified the need for more guidance around oversight of CINs/other partners
- In response to this feedback, the Department developed PHP-facing guidance that clarifies expectations around oversight of CINs/other partners

Changes to Guidance Since AMH TAG #5

In response to AMH TAG feedback, the Department made several revisions to the previous draft of the AMH Oversight Guidance

TAG #5 Draft	Key Change
• PHPs must notify AMHs in instances where the AMH is underperforming • PHPs must also notify AMHs of relevant CIN/other partner oversight policies and share results of CIN/other partner audits	• Within 90 days of contracting, PHPs must share with each CIN/other partner-affiliated AMH practice a description of the oversight process that they will be employing at the CIN/other partner-level, including the process for "Corrective Action Plans" (CAPs), or the equivalent • Direct notification within 60 days (or sooner, as appropriate) to each AMH practice with results of CIN/other partner-level audits, including any corrective actions imposed
• PHPs will provide care management delegates with the opportunity to remediate any identified issues through a defined process (CAP or similar nomenclature) • The Department will require PHPs to provide AMHs and CIN/other partners with a minimum of thirty (30) days to remediate any identified issues • PHPs and their care management delegates may establish longer remediation periods by mutual agreement	• Remediation period policies must be specified in written CAPs and procedures that PHPs share with AMHs/CINs

• PHPs may "re-classify" AMHs into a lower tier if the practice is not complying with program requirements;
• PHPs must establish such policies specific to CINs/other partners
• CIN/other partner policies should specify impact on individual AMH practices
• Practices associated with noncompliant CIN/other partners have option of following:
  ○ Direct Tier 3 contracting
  ○ Contract with a different CIN/other partner
  ○ Revert to Tier 2
	• Established process for reversion to Tier 2
	• Requires PHPs/practice to notify Department of decision
	• PHP must supply documentation if notifying on behalf of practice

Oversight of AMHs and CINs/other Partners: Discussion Questions

- ***Does the Guidance require further clarification?***
- ***How should this oversight guidance be communicated in advance of the February Managed Care Launch?***

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Recap: AMH Data Governance Process

When necessary, the Department will support the development of specifications and guidance that facilitate the exchange of data that are critical to care management

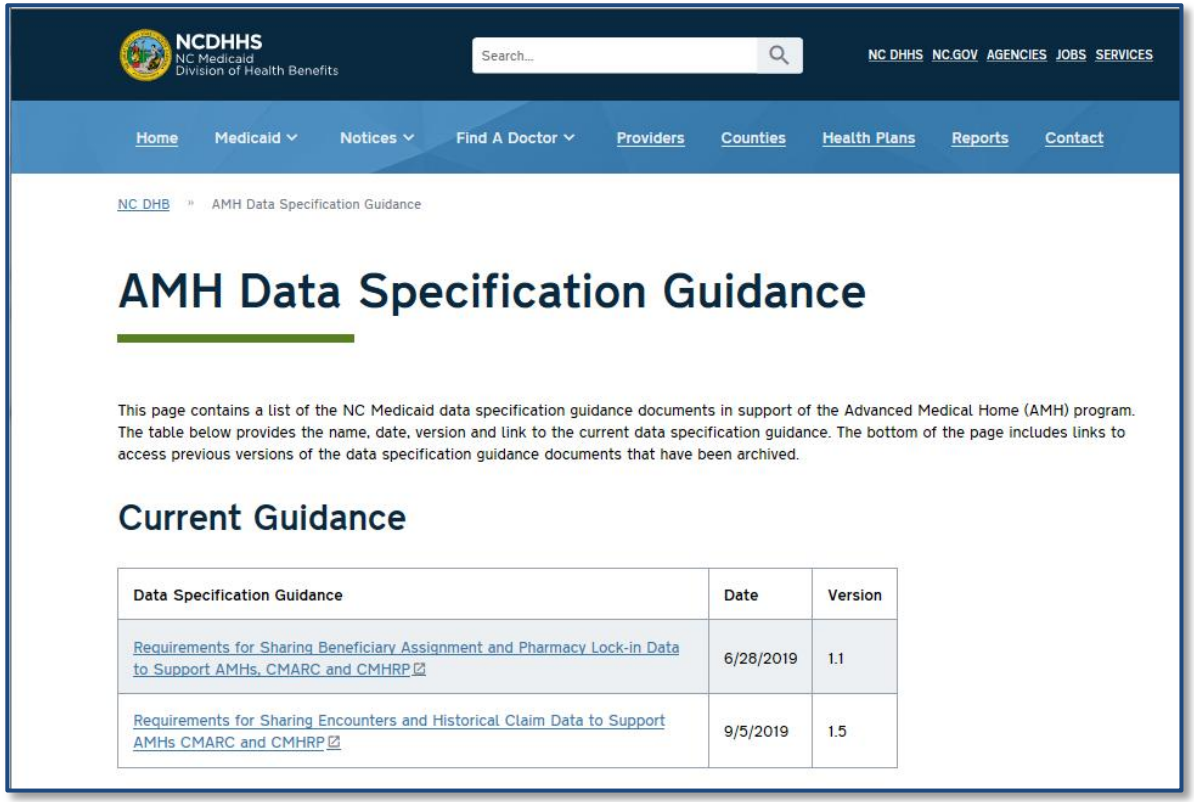
Steps	Actions
1: Issue Identification	Identify the data access, flows, sources, and targets; data infrastructure, data, vendor, and system management
2: Issue Definition	Define key considerations, cross-cutting dependencies
3: Issue Resolution	Utilize policy guidance, requirements, regulations, or other mechanisms to facilitate data exchange testing as appropriate
4: Ongoing Management	Monitor implementation, assess and enforce compliance as applicable, update and modify guidance as needed

Updates and Modification Processes

Communication of Updates Will Depend Upon the Modification

1. For minor modifications (e.g., correction to a misspelling of a file name), DHHS will communicate changes through email to the applicable parties and provide an update via a FAQ posted on the DHHS website.

2. For significant modifications (e.g., changes to the required fields, format, valid values), DHHS will revise the existing specification guidance, transmit the revised guidance via email to the affected parties and Data Subcommittee, and post the revised guidance on the DHHS website.



Request to Require PHPs to Include Payment Amount Information

Background, Recommendations, and Next Steps

Background

- **CINs** indicated that payment information will inform their care management processes, and improve their ability to understand total cost of care and prepare for value-based arrangements
- **PHPs** indicated that some of their contracts with health systems contain non-disclosure clauses that prevent them from sharing paid claims amount with any entities other than DHHS
- Currently, **DHHS** neither prohibits nor mandates that PHPs disclose payment amount information to AMHs and/or CINs/other partners

Recommendation and Next Steps

1. DHHS will not require PHPs to include payments to specific providers in the encounter data they transmit to Tier 3 AMH practices, CINs/other partners in the short term
2. **To ensure that providers have the information they need to support participation in value-based payment (VBP), DHHS will engage the AMH TAG and Data Subcommittee to:**
   - **review the options to make actionable and appropriate financial information available; and**
   - **develop consensus regarding the optimal options and timeframe for moving forward**

Data Subcommittee Next Steps

1. **Next Data Subcommittee session: October 3, 10:00 am – 1:00 pm**
2. **The Department is updating process for communicating data specifications**
3. **The Department will continue cataloguing and examining potential data topics and flows for standardization (ongoing)**

   Upcoming key issue: reporting Care Management Encounters via the "Beneficiary Extract"

4. **The Department is establishing an open forum for PHP, CIN, and AMH testing partners to discuss data testing-related topics (in process)**

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Next Steps

1. **TAG Members to provide any additional feedback on Oversight Guidance**
2. **TAG Members to continue communication with DHHS TAG leads to identify topics for future meetings**
3. **DHHS to finalize and share pre-read materials for upcoming sessions of**
   - **AMH TAG Data Subcommittee (October 3; 10 am – 1 pm), and**
   - **AMH TAG (October 16; 11:30 am – 2:30 pm)**