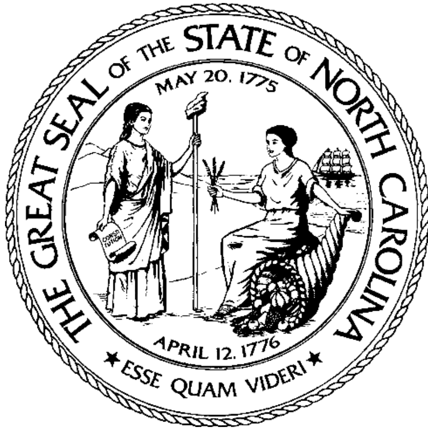

Advanced Medical Home Technical Advisory Group

Meeting #1: Kick-Off

April 1, 2019, 9:00 am – 12:00 pm

Brown Building, 801 Biggs Drive, Hearing Room #104

Agenda

1	Introductions	9:00 am – 9:30 am
2	Review Advanced Medical Home (AMH) Program	9:30 am – 9:45 am
3	AMH Technical Advisory Group (TAG) Charter	9:45 am – 10:00 am
4	Issues for the TAG	10:00 am – 10:45 am
5	Break	10:45 am – 11:00 am
6	Briefing on Issues for Meeting #2: Contracting	11:00 am – 11:40 am
7	Public Comments	11:40 am – 11:55 am
8	Next Steps	11:55 am – 12:00 pm
9	Appendix:	

- **Appendix A:** HCP LAN Framework

Agenda

1. **Introductions** — 9:00 am – 9:30 am
2. **Review AMH Program**
3. **AMH TAG Charter**
4. **Issues for the TAG**
5. **Break**
6. **Briefing on Issues for Meeting #2: Contracting**
7. **Public Comments**
8. **Next Steps**
9. **Appendix:**
   - **Appendix A:** HCP LAN Framework

Department of Health and Human Services (DHHS) and Facilitators

Kelly Crosbie, MSW, LCSW

Kelly Crosbie currently serves as the Deputy Director of Quality and Population Health. She has more than 20 years of public healthcare experience. During this time, she has served eight years in NC Medicaid. Previously she has overseen the success of and implemented various care models, such as PCCM and behavioral health MCO programs.

Nancy Henley, MPH, MD, FACP

Dr. Henley currently serves as the CMO for North Carolina Medicaid. She has more than 25 years of executive management experience with integrated delivery systems and large public and private insurers. She is an expert at convening and coaching change teams charged to address organizational imperatives and produce measurable results.

Advisor to the State

- **Aaron McKethan, PhD**

Facilitators

- **Melinda Dutton, JD – Partner, Manatt Health Strategies**
- **Sharon Woda, MBA – Managing Director, Manatt Health Strategies**
- **Edith Stowe, MPA – Senior Manager, Manatt Health Strategies**
- **Bardia Nabet, MPH – Consultant, Manatt Health Strategies**

Initial AMH TAG Membership

Name	Organization	Stakeholder
Sheryl Gravelle-Camelo, MD	KidzCare in Macon County	Provider (Independent)
David Rinehart, MD	North Carolina Academy of Family Physicians	Provider (Independent)
Gregory Adams, MD	Community Care Physician Network (CCPN)	Provider (CIN)
Zeev Neuwirth, MD	Carolinas Physician Alliance (Atrium)	Provider (CIN)
Calvin Tomkins, MD, MHA	Mission Health Partners	Provider (CIN)
Peter Freeman, MPH	Carolina Medical Home Network	Provider (CIN)
Jan Hutchins	UNC Alliance Network	Provider (CIN)
Glenn Hamilton, MD	AmeriHealth Caritas North Carolina, Inc	PHP
Vincent Pantone, MD	Blue Cross and Blue Shield of North Carolina	PHP
Robert Rich, MD	UnitedHealthcare of North Carolina, Inc	PHP
Thomas Newton, MD	WellCare of North Carolina, Inc	PHP
William Lawrence, MD	Carolina Complete Health, Inc	PHP
Eugenie Komives, MD	Duke Primary Care	MCAC Quality Committee Member

Agenda

1. Introductions
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Introduction to AMH

Vision for Advanced Medical Homes

Build on Carolina ACCESS to ***preserve broad access to primary care services*** *for Medicaid enrollees and* ***strengthen the role of primary care in care management, care coordination, and quality improvement*** *as the state transitions to managed care.*

Practices have <u>options</u> as AMHs:

- Current Carolina ACCESS practices may **continue as AMHs with few changes**; practices ready to take on more advanced care management functions **may be eligible for additional payments**
- Practices may rely on **in-house care management** capacity or **contract with a Clinically Integrated Network (CIN) or other partner of their choice**

NC DHHS Care Management Principles

Robust care management is a cornerstone of the State's managed care transition

Care Management Guiding Principles

- ❑ Medicaid enrollees will have access to **appropriate care management**
- ❑ Care management should involve **multidisciplinary care teams**
- ❑ **Local care management** is the preferred approach
- ❑ Care managers will have access to **timely and complete enrollee-level information**
- ❑ Enrollees will have access to **programs and services that address unmet health-related resource needs**
- ❑ Care management will align with **statewide priorities for achieving quality outcomes and value**

AMHs are designed to serve as **a vehicle for executing on this approach in a managed care context**

AMH Tiers

Tiers 1 and 2

- PHP retains primary responsibility for care management
- Practice requirements are the same as for Carolina ACCESS
- **Providers will need to coordinate across multiple plans:** practices will need to interface with multiple PHPs, which will retain primary care management responsibility; PHPs may employ different approaches to care management

AMH Payments
(paid by PHP to practice)

- **PMPM medical home fees**
  - Same as Carolina ACCESS
  - Non-negotiable

Tier 3

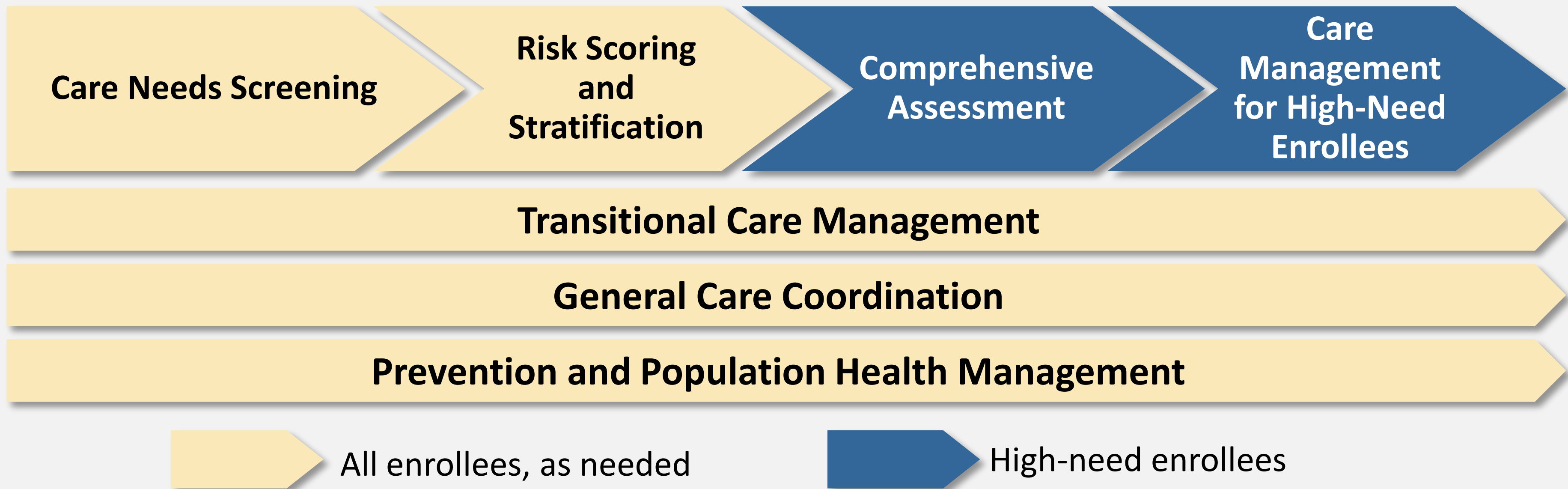
- PHP delegates primary responsibility for delivering care management to the practice level
- Practice requirements: meet all Tier 1 and 2 requirements plus take on additional Tier 3 care management responsibilities
- **Single, consistent care management platform:** Practices will have the option to provide care management in-house or through a single CIN/other partner across all Tier 3 PHP contracts

AMH Payments
(paid by PHP to practice)

- **PMPM medical home fees**
  - Same as Carolina ACCESS
  - Non-negotiable
- **Additional PMPM care management fees**
  - Negotiated between PHP and practice

Care Management Approach

The State has developed a process to ensure that high-need individuals and those transitioning out of the hospital will receive appropriate, local care management



Tier 3 AMH practices are responsible for a range of local care management functions; CINs/other partners can assist practices in fulfilling some or all of these responsibilities

AMH Tiers and Value-Based Payment (VBP)

The AMH program will provide clear financial incentives for practices to become more focused on cost and quality outcomes for populations, increasing accountability over time

Goals of AMH Program

- Preserve broad access to primary care services to Medicaid enrollees
- Strengthen the role of primary care in care management, care coordination and quality improvement
- Allow practices to implement a unified approach to serving Medicaid beneficiaries, minimizing administrative burden

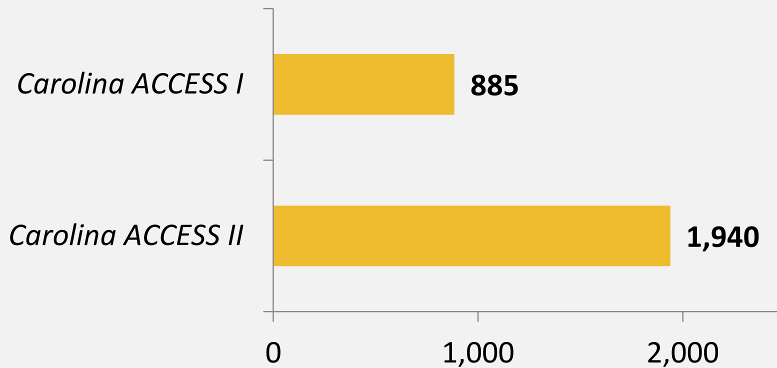
Over time, the AMH program provides a pathway for practices to have a larger role in managing the health outcomes and cost for their patient populations. The AMH TAG will consider these aspirations broadly in its initial sessions.

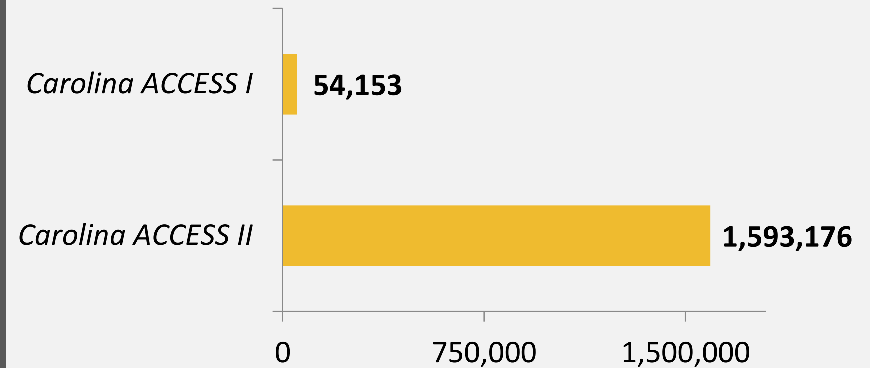
Note: North Carolina's VBP Strategy is under development and the TAG will be briefed on VBP design and discuss impacts to the AMH program in future sessions.

AMH Facts and Figures

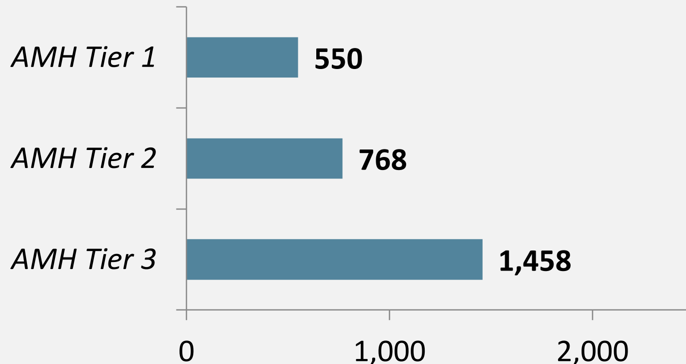
In September 2018, practices were grandfathered into AMH Tiers 1 and 2.
Between 12/18 and 3/25, the majority of practices used NCTracks to attest into AMH Tier 3*

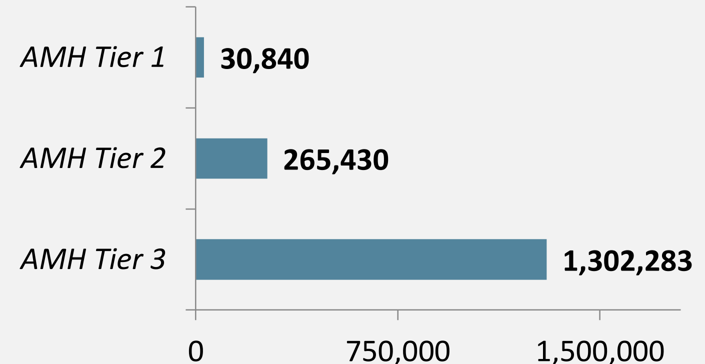
Pre-Managed Care





Today





** Data as of 3/25/2019. Practice and beneficiary counts are subject to change daily.*

AMH Attestation Facts and Figures

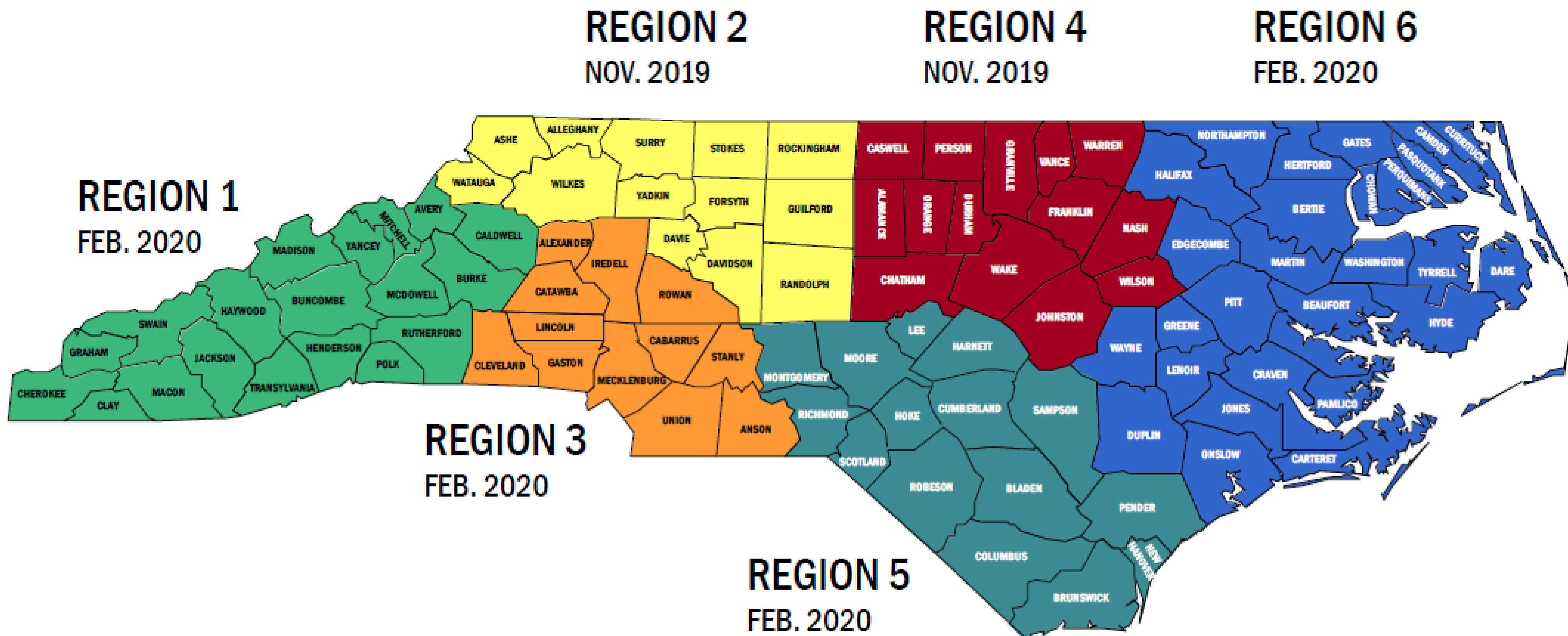
AMH practices are distributed across the state with robust AMH Tier 3 participation

Tier 3	Practices	Beneficiaries
Current	174	128,423

Tier 3	Practices	Beneficiaries
Current	209	214,577

Tier 3	Practices	Beneficiaries
Current	283	262,507

Tier 3	Practices	Beneficiaries
Current	154	169,893



Tier 3	Practices	Beneficiaries
Current	370	308,714

Tier 3	Practices	Beneficiaries
Current	256	217,570

** Data as of 3/25/2019. Practice and beneficiary counts are subject to change daily.*

Agenda

1. Introductions
2. Review AMH Program
3. AMH TAG Charter — 9:45 am – 10:00 am
4. Issues for the TAG
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   - **Appendix A:** HCP LAN Framework

AMH TAG Overview

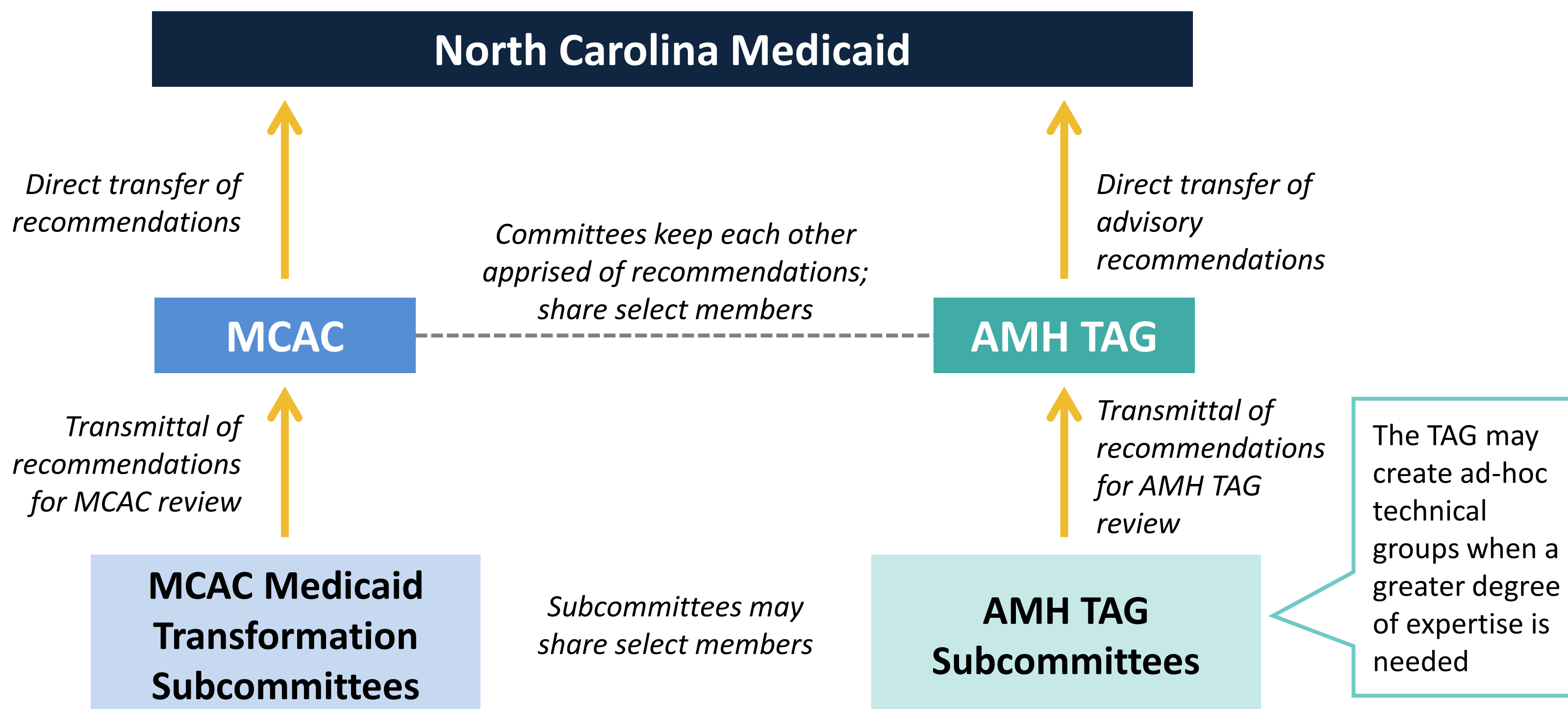
The AMH TAG will help North Carolina Medicaid make informed policy decisions on the development of the program

What is the AMH TAG?

- An advisory body chaired by DHHS and consisting of a group of approximately fifteen (15) invited representatives from PHPs, AMH practices, and other AMH stakeholders including CINs
- The AMH TAG will weigh in on **strategic and policy issues** in the AMH program and will develop **recommendations** for North Carolina Medicaid's consideration
- The TAG will coordinate with the State's Medical Care Advisory Committee ("MCAC") *(see next slide)*
- The TAG may create ad-hoc technical groups ("subcommittees"), as needed, to develop formal recommendations on technical aspects of the program that require greater degrees of expertise

AMH TAG Structure within North Carolina Medicaid

The TAG sits parallel to the Medical Care Advisory Committee (MCAC) within NC Medicaid



TAG Meetings

Initial TAG meetings will introduce the key AMH implementation topics and set expectations regarding the nature and scope of issues to be addressed

- The TAG will meet about once per month through Tailored Plan (TP) launch or July 2021, whichever is sooner
- The recommendations of the TAG are advisory only
- Decisions to act upon any recommendations are made at the sole discretion of NC Medicaid
- A majority of membership is required for a quorum
- Recommendations should be made as much as possible based on consensus but can be forwarded to NC Medicaid for consideration with majority vote
- If a consensus cannot be reached, the TAG will provide NC Medicaid with a summary of the issues
- Agendas and materials will be circulated to membership up to a week in advance of convening and publicly posted

Member Expectations

TAG members will actively participate in conversations on key policy and design issues related to AMH implementation

Additional Member Expectations

- TAG Members will begin serving in March 2019
- Members will have a one-year term from (March 2019 to March 2020) with an optional second year
- At the one year mark (March 2020), members may choose to continue serving on the TAG or forfeit their seat to NC Medicaid to select a replacement candidate
- Members are expected to attend in person consistently and participate in meetings to provide meaningful feedback on policy and programmatic issues related to AMH implementation
- Members will take issues raised in the TAG back to their organizations to promote dialog and communication between the TAG and a broader group of stakeholders
- **Members must not discuss pricing**

Agenda

1. Introductions
2. Review AMH Program
3. AMH TAG Charter
4. Issues for the TAG — 10:00 am – 10:45 am
5. Break
6. Briefing on Issues for Meeting #2: Contracting
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Discussion Guide

Imagine that we are discussing the AMH program in three years:

- ***What policy issues were critical to address early to ensure the program's success in strengthening the role of primary care in care management, care coordination, and quality improvement?***

- ***What were the roadblocks in early implementation of the program?***

Issues for AMH TAG

The AMH TAG will help North Carolina Medicaid make informed policy decisions on the development of the program

Issues for AMH TAG, Continued

AMH Issues	Potential Strategy/Policy Questions for AMH TAG Recommendations
Certification & Contracting	• What further market education and guidance should DHHS consider issuing?
Data Sharing	• How should DHHS approach standardization of data flows between PHPs and CINs? • How should DHHS approach standardization of data flows between PHPs and individual AMH practices? • How should DHHS require practices to capture care management encounters?
Quality	• How could DHHS set policies to align measurement approaches across PHPs? • How should DHHS approach hybrid measure reporting and reporting of measures that require clinical data within the AMH program?
Program Oversight & Evaluation	• How can DHHS track and evaluate "local" care management?
Program Design	• What is the role of AMH practices in Healthy Opportunities Pilots? • What is the role of AMH practices in BH I/DD TP care management? • How should DHHS approach ongoing training and practice support? • How can DHHS ramp up VBP incentives for practice level population health, quality, and awareness of total cost of care? • How could DHHS consider aligning its VBP strategy with other NC payers?

What other policy issues are "top of mind" for your organizations and stakeholders?

Planned TAG Topics, March – June 2019

For each topic, DHHS will *brief* the TAG and then through a *discussion,* solicit recommendations from a range of options

Meeting #1
4/1, 9 am – 12 pm

1. TAG Overview

- ***Discussion:*** Introductions and Overview of TAG; discussion on pressing AMH issues

2. AMH Attestation and Contracting

- ***Briefing:*** Review of guidance to date
- ***Discussion:*** Identification of most pressing contracting issues

Meeting #2
5/3, 1 pm – 4 pm

1. AMH Attestation and Contracting

- ***Discussion:*** TAG recommendations for further DHHS market guidance/ education

2. Data Strategy

- ***Briefing:*** DHHS data strategy to support AMH success
- ***Discussion:*** Identification of most pressing data issues

Meeting #3
5/29, 12 pm – 3 pm

1. Data Strategy

- ***Discussion:*** Discussion of key issues in data re: standardization, sharing

2. Value-Based Payment *(tentative)*

- ***Briefing:*** DHHS direction on VBP
- ***Discussion:*** Identification of deeper dive topics for discussion on 6/25

Meeting #4, 6/25, 1 – 4 pm: Discussion Topic TBD

Agenda

1. **Introductions**
2. **Review AMH Program**
3. **AMH TAG Charter**
4. **Issues for the TAG**
5. **Break** — **10:45 am – 11:00 am**
6. **Briefing on Issues for Meeting #2: Contracting**
7. **Public Comments**
8. **Next Steps**
9. **Appendix:**
   - **Appendix A:** HCP LAN Framework

Agenda

1. Introductions
2. Review AMH Program
3. AMH TAG Charter
4. Issues for the TAG
5. Break
6. **Briefing on Issues for Meeting #2: Contracting** — 11:00 am – 11:40 am
7. Public Comments
8. Next Steps
9. Appendix:
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Questions for Discussion

- ***Are the current guidelines clear?***
- ***What concerns or unintended consequences do you see with the current guidelines?***
- ***How should this guidance be further communicated to the field?***
- ***What other issues are "top of mind" for your stakeholders related to attestation and contracting?***

PHP Contracting Requirements

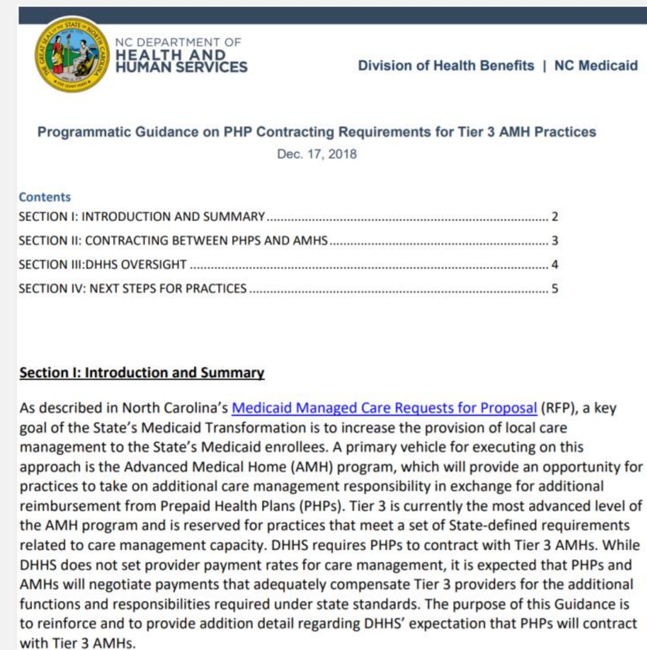
DHHS' general expectation is that PHPs will contract with ALL certified Tier 3 practices at a Tier 3 level

- There are **two scenarios** that DHHS will accept as reasons for **not contracting** with Tier 3 AMH practices:

  1. *The PHP and AMH practice are unable to reach an agreement on AMH payment amounts (i.e., Care Management Fees and Performance Incentive Payments); or*

  2. *The PHP determines through its own auditing process that the State-certified AMH practice lacks the required capabilities set by DHHS for Tier 3*

- DHHS **will not review each contract** between PHPs and AMHs. However, DHHS **will closely monitor the progress of contracting** between PHPs and AMH practices through reporting requirements on PHPs


NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

Division of Health Benefits | NC Medicaid

Programmatic Guidance on PHP Contracting Requirements for Tier 3 AMH Practices

Dec. 17, 2018

Contents

SECTION I: INTRODUCTION AND SUMMARY 2
SECTION II: CONTRACTING BETWEEN PHPS AND AMHS 3
SECTION III:DHHS OVERSIGHT 4
SECTION IV: NEXT STEPS FOR PRACTICES 5

Section I: Introduction and Summary

As described in North Carolina's Medicaid Managed Care Requests for Proposal (RFP), a key goal of the State's Medicaid Transformation is to increase the provision of local care management to the State's Medicaid enrollees. A primary vehicle for executing on this approach is the Advanced Medical Home (AMH) program, which will provide an opportunity for practices to take on additional care management responsibility in exchange for additional reimbursement from Prepaid Health Plans (PHPs). Tier 3 is currently the most advanced level of the AMH program and is reserved for practices that meet a set of State-defined requirements related to care management capacity. DHHS requires PHPs to contract with Tier 3 AMHs. While DHHS does not set provider payment rates for care management, it is expected that PHPs and AMHs will negotiate payments that adequately compensate Tier 3 providers for the additional functions and responsibilities required under state standards. The purpose of this Guidance is to reinforce and to provide addition detail regarding DHHS' expectation that PHPs will contract with Tier 3 AMHs.

See Programmatic Guidance on PHP Contracting Requirements for Tier 3 AMH Practices for more information: https://files.nc.gov/ncdma/documents/Providers/Programs_Services/amh/AMH_Programmatic_Guidance_Contracting_12.17.18.pdf.

PHP Contracting Requirements, Continued

PHPs will be permitted to assess Tier 3 practices as part of the initial contracting process, prior to managed care go-live and on an ongoing basis

- Activities by PHPs may include conducting an onsite review, telephone consultation, documentation review, or other virtual/offsite reviews
- PHPs may perform evaluations of the CIN/other partner instead of or in addition to the AMH if the AMH contracts with a third party to provide any of the Tier 3 care management required services.
- **However, PHPs cannot:**
    - Lower the tier level of all AMH practice locations associated with the same organizational NPI without an assessment of each individual practice location
    - Lower the tier level of an AMH practice location based on a different PHP’s findings and reclassification
    - Change an AMH’s certification status with respect to other PHPs
    - Reclassify practices to Tier 1 status

PHP Contracting Requirements, Continued

If the AMH is not able to perform the activities associated with their AMH tier, DHHS will permit the PHP to change (lower) the tier status of the AMH and stop making applicable AMH payments

- After managed care launch, and in the event that an AMH practice is unable to perform the activities of the AMH tier to which it initially attested, the **DHHS will require the PHP to send a notice to the AMH practice**
  - *Note: For other aspects of underperformance not related to care management or other AMH functions, such as fraud or negligence, PHPs and the DHHS would follow their usual processes.*
- **DHHS is expecting that PHPs will contract with every Tier 3 except in specified instances**
- DHHS will also be **monitoring the tier level of contracts** in each region across certified Tier 3 practices and the **dollar amounts associated with those contracts**
- As part of this process, DHHS will **ensure that PHPs are not excluding Tier 3 practices** in ways that are in **conflict with the spirit of the AMH program**

AMH Tier 3 Contracting: Negotiating Care Management Fees

Tier 3 AMHs will need to consider care management responsibilities, regional cost variation, and other factors when negotiating Care Management Fees

Overview of Care Management Fees

- Tier 3 **involves PHPs passing care management responsibilities down to the practice leve**l; additional costs associated with these activities are intended to be covered by Care Management Fees
- The State **has not set minimum payment amounts for Care Management Fees** paid to Tier 3 practices by PHPs; these will be negotiated between PHPs and AMHs
- **AMHs are ultimately responsible** for any commitments made to a PHP

Potential CIN/Other Partner Tasks

- Subject to applicable laws, AMHs may choose to delegate contracting for Care Management Fees to CINs/other partners
- AMHs that delegate contracting should understand and set terms/conditions for funds flow; example up-front questions include:
  - *How should the Care Management Fees be shared between the CIN/other partner and the AMH?*
  - *What must AMH practices do to meet Care Management and Performance Incentive Payment milestones?*

* *Medical Home Fees have state-prescribed floors but can be negotiated up by mutual agreement between the PHP and the AMH.*

AMH Tier 3 Contracting: Performance Incentives

PHPs must offer Tier 3 AMHs the opportunity to earn Performance Incentive Payments

Tier 3 Performance Incentive Guidelines

- Payment arrangements must be guided by the **Health Care Payment Learning and Action Network (HCP LAN) Categories 2 through 4**, which reflect varying levels of value-based payments*
- Practices and PHPs may negotiate arrangements that include downside risk (i.e., "risk of losing money"), but PHPs must also give practices the option of upside only
- Incentives must be **based on the State-approved AMH quality measure set***

Roles of CINs/Other Partners

- Subject to applicable laws, CINs may support negotiation, management and monitoring of performance incentive contracts across multiple PHPs
- CINs can help AMHs understand performance incentive payment terms and potential risks and benefits associated with different arrangements
- CINs may assist practices in choosing performance reporting measures

** See Appendix A for HCP LAN Framework and categories.*

Biannual Assessment of Contracting

DHHS will establish a denominator of Tier-3 certified AMHs and use this for assessing whether PHPs have contracted with ALL certified Tier 3 practices at a Tier 3 level

Assessment Process

- This denominator for assessing PHPs on the this contracting requirement will be **refreshed bi-annually**; the refresh would be invisible to providers (i.e., the process will appear rolling)
- Following each refresh, PHPs will have ~**6 months to contract** with practices in the new denominator
- **At the conclusion of the 6 month contracting period**, PHPs will be required to submit a **bi-annual report on contracting progress** to DHHS
    - For each practice listed in the denominator, PHP must indicate whether they have executed a Tier 3 contract and payment amounts
    - DHHS will then utilize these reports to monitor compliance with the expectation that PHPs offer contracts to all certified Tier 3 practices

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7. **Public Comments** — **11:40 am – 11:55 am**
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Next Steps

1. DHHS to finalizing upcoming meeting agendas
2. DHHS to finalize and share pre-read materials for upcoming session
3. TAG Members to share discussion key takeaways with stakeholders and probe on pressing issues related to upcoming topics
4. TAG Members to continue to consider key questions (*see next slide*)

Questions for Consideration

- ***What policy issues must be addressed immediately for the AMH program to be successful over the next year?***
- ***What policy issues must be addressed over the next year for the AMH program to be successful over the next 3 – 5 years?***

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Appendix A: HCP LAN Framework

HCP LAN Framework

HCP LAN Alternative Payment Models (APM) Framework			
The HCP LAN APM framework is a tool used by many states, and supported by the Centers for Medicare and Medicaid Services (CMS), to better align multi-payer efforts by classifying value-based payment into four categories that each contain sub-categories largely based on the level of risk assumed by providers.			
Category 1 Fee-for-service – No Link to Quality and Value	**Category 2** Fee for Service – Link to Quality and Value	**Category 3** APMs Built on Fee-for-Service Architecture	**Category 4** Population-based Payment
	A	**A**	**A**
	Foundational payments for infrastructure and operations (e.g., care coordination fees and payments for health information technology investments)	APMs with shared savings (e.g., shared savings with upside risk only)	Condition-specific population-based payment (e.g., per member per month payments, payments for specialty services, such as oncology or mental health)
	B	**B**	**B**
	Pay for reporting (e.g., bonuses for reporting data or penalties for not reporting data)	APMs with shared savings and downside risk (e.g., episode-based payments for procedures and comprehensive payments with upside and downside risk)	Comprehensive population-based payment (e.g., global budgets or full/percent of premium payments)
	C		**C**
	Pay-for-performance (e.g., bonuses for quality performance)		Integrated finance and delivery system (e.g., global budgets or full/percent of premium payments in integrated systems)
		3N	**4N**
		Risk based payments NOT linked to quality	Capitated payments NOT linked to quality

Source: http://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf