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

Meeting #3: Contracting, Oversight, and Data Strategy

May 29, 2019, 12:00 – 3:00 pm

Williams Building, 1800 Umstead Drive, Room 123B

AMH TAG Membership Rollcall

Name	Organization	Stakeholder
Sheryl Gravelle-Camelo, MD	Pediatrician KidzCare in Macon County	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)
Calvin Tomkins, MD, MHA	Assistant Medical Director Mission Health Partners	Provider (CIN)
Peter Freeman, MPH	Vice-President/Executive Director 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)
Glenn Hamilton, MD	Vice President of Corporate Medical Policy 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
Eugenie Komives, MD	Senior Medical Director for Duke Connected Care MCAC Quality Committee Member	MCAC Quality Committee Member

Agenda

1	Review: Contracting and Oversight Guidance	12:05 pm – 1:30 pm
2	Discussion: Risk Stratification	1:30 pm – 1:45 pm
3	Break	1:45 pm – 2:00 pm
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Contracting and Oversight Guidance

Goals of Today's Discussion on Contracting and Oversight

- ***Review upcoming guidance: AMH Contracting Information for Practices Webinar on May 30th (tomorrow)***
- ***Discuss PHP oversight of AMHs and interest in streamlining activities across PHPs***

Recap: Discussion on Contracting and Oversight from Meeting #2

- **AMH Accountability:** Ultimate responsibility lies with the PHPs, which must meet the requirements outlined by the State. PHPs may delegate care management responsibilities to AMHs, and AMHs may choose to have their care management operations supported by CINs/other partners
- **AMH Standard Terms and Conditions:**
  - ***Risk Scoring:*** PHPs are encouraged to include some explanation of their risk scoring methodology to help AMHs reconcile multiple PHP risk scores with their practice-wide approaches
  - ***Risk Stratification:*** Practices must have a risk-stratification method that they use consistently and incorporates clinical judgement
- **Upcoming AMH Practice Facing Guidance:** Members identified a need to highlight key dates for practices to be aware of as part of an upcoming webinar

AMH Contracting: Discussion Questions

Do the webinar slides sufficiently capture current AMH contracting issues and guidance?

- *Will stakeholders understand the timelines and their implications for contracting?*
- *What questions are practices likely to ask in response to the webinar?*

PHP Oversight: Key Messages of DHHS Guidance to Date

PHPs will be responsible for ongoing oversight of contracted Tier 3 AMHs

- PHPs may assess AMHs/CINs by performing **on-site reviews, telephone consultations, documentation reviews, and other virtual/off-site reviews**
- Even if contracting through a CIN/other partner, **AMHs are ultimately accountable to the PHP** for fulling **contractual obligations** and achieving quality outcomes
- If an AMH is unable to perform activities associated with its assigned tier, **PHPs may re-classify the practice (to Tier 2) and cease AMH payments** (PHPs must send notices of cancellation of Medical Home Fees to both the State and the AMH)
- **AMH practices have the right to appeal reclassifications** for underperformance through each PHPs appeal process
- **The State and PHPs do not regulate CINs** – they will not maintain lists of CINs/other partners, validate their authenticity, etc.
- Practices will have broad flexibility to use CINs/other partners and **may wish to utilize them to help negotiate AMH contracts with PHPs**
- **PHPs may not:**
  - Lower the tier level of all AMH practice locations associated with the same organizational NPI or TIN 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

Discussion

DHHS has begun discussing oversight methods with PHPs and gauging interest in which areas, if any, to address standardization

Routine oversight of AMHs/CINs

- Audits
- Site visits
- Compliance checks
- Chart reviews

States generally do not standardize details but does the TAG see any "low hanging fruit"?

Corrective action plans, Tier reassignment

- Corrective Action Plans
- Tier reassignment

DHHS could further address standards for Tier reassignment and common elements of CAPs. If it does so, what should those elements be?

AMH/CIN to PHP reporting requirements

- Collection of care management encounter data
- Additional quarterly or biannual reporting

DHHS is interested in minimizing duplication and reducing reporting burden on practices. What would be reasonable parameters?

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Goals of Today's Discussion on Risk Stratification

- ***Respond to AMH TAG feedback that the market is looking for more guidance on risk stratification expectations under the AMH Tier 3 model***
- ***Discuss a strategy for clarifying and providing practice examples***

Recap: PHP level Risk Scoring

PHPs will use a combination of claims, clinical screening information and other data to assign each enrollee a risk score

PHP Risk Scoring Requirements

- PHPs will be responsible for using their plan-specific risk scoring methodologies to **identify members of "priority populations" and assign risk scores to all PHP members;** priority populations include:
  - Enrollees with Long-Term Services and Supports (LTSS) needs
  - Adults and children with "special health care needs," a category that includes enrollees with HIV/AIDS
  - Enrollees at rising risk
  - Enrollees with high unmet resource needs related to social determinants of health
  - Any other priority groups identified by the PHP
- The State will monitor scoring methodologies to ensure that the PHP methodologies **adequately identify priority populations**
- PHPs will share risk scoring results and information on priority populations with all AMHs
- AMH Tier 3 practices must use the risk score to stratify their patient panels and inform decisions about which patients would benefit from care management
- PHP risk scoring methodologies must have, at least, the following:
  - Incorporate Care Needs Screening results
  - Claims history and analysis
  - Pharmacy data
  - Immunizations
  - Lab results
  - ADT feed information
  - Provider, social service, member and self-referrals
  - Member's zip code
  - Member's race and ethnicity

Recap: AMH Tier 3 level Risk Stratification Requirements

Tier 3 AMH practices must risk stratify empaneled patients to identify those who may benefit from care management

AMH Risk Stratification Requirements

- Use a consistent method to **assign and adjust** risk status
    - AMHs may integrate the PHP's risk scoring results with their own
- Use a consistent method to **combine risk scoring information** received from PHPs with clinical information to score and stratify their patient panel
- Identify **priority populations**
- Ensure entire care team **understands the basis of the risk scoring** methodology
- Define the process of **risk score review and validation**

Recap: Working with CIN/other Partners on Risk Stratification

CINs/other partners can assist AMH Tier 3 practices with Risk Stratification

AMH Risk Scoring Requirements

- **Compile risk scoring results from multiple PHPs** and combine them into a single, actionable risk stratification score
- Incorporate risk scoring/stratification findings **into the Care Plan**, once a risk level has been assigned to an enrollee
- Use analytics to develop more **detailed risk assessments and customized care management** approaches

Risk Stratification Case Examples Outside North Carolina

Depending on their size, capabilities, or patient populations, AMHs may conduct risk stratification and scoring in a multitude of ways

	SAMA Healthcare Services (independent practice)	Montefiore ACO (large health system)
System Background 	• Independent four-physician family practice located in rural southeast Arkansas • Clinic's four physicians care for approximately 19,000 patients, many who travel from the surrounding rural communities for health care	• Next Generation ACO with 55,000 patients in Bronx, New York, featuring an integrated delivery system • Includes low-income, long-term patients of Montefiore Health System
Components of Risk Stratification 	• Physicians train nurses using the risk stratification feature in Allscripts and the AAFP six-level risk stratification tool • Care team agreed on a set of diagnoses as risk factors • Level of risk accounts for AAFP levels and site risk (low, medium, or high) • When patients make appointment, the team care coordinator reviews the risk score before the appointment	• ACO receives claims files from payers, attribution file from CMS, social data (e.g., U.S. Department of Housing and Urban Development data on housing), and other social determinants information to develop algorithms for stratification • Patient claims data and EHR are run through proprietary, in-house risk stratification algorithm, using clinical risk group (CRG) methodology (results are updated monthly) • Patient's identified through algorithm are segmented by disease state and separated into one of five "pods" that specializes in specific patient populations • Care management programs are then designed to meet the needs of the patients in each pod

Sources: *Comprehensive Primary Care Practice Spotlight, CMS: https://innovation.cms.gov/files/x/cpcipsl-sama.pdf; How Accountable Care Organizations Use Population Segmentation to Care for High-Need, High-Cost Patients, Commonwealth Fund: https://www.commonwealthfund.org/sites/default/files/2019-01/OMalley_ACOs_segmentation_high_need_high_cost_ib.pdf.*

Providing Examples to the NC Market

What is a good strategy for clarifying risk stratification requirement through examples?

Question for AMH TAG: Should DHHS prepare a webinar, module, office hours, and/or an informal briefing on these issues with potential examples?

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Data Sharing

The Data Subcommittee will be charged to formulate technical standards recommendations and priorities to be communicated to North Carolina Medicaid

Recap: Discussion on Data Strategy from Meeting #2

- **Data Subcommittee:** DHHS will convene a TAG Data Subcommittee of SMEs that will be charged with formulating data and information sharing policy recommendations for consideration by the TAG and DHHS

- **Highest Priority Data Flows for AMH Tier 3s at Program Launch:**
  - ***Beneficiary assignment information*** (information contained in ANSI X12 834 files)
  - ***Encounter data*** (information contained in ANSI X12 837 files)

    - DHHS has developed detailed PHP requirements for both information types
    - Work is under way to better understand CIN readiness to receive and use beneficiary assignment and encounter information as soon as possible
      - *Since the last TAG meeting, DHHS has communicated with select CINs about their readiness*

- **Other Key Comments from Meeting #2:**
  - **Machine readability:** DHHS should consider requirements; it can be challenging to integrate PHP information into CINs' own systems when the information is contained within a PDF
  - **Timing of PHP-calculated risk scores to AMHs:** PHP risk scores will be most useful at AMH launch as practices will not have enough historical data to make their own risk calculations
  - **Common quality measure performance information from PHPs:** some CINs are capable of performing care gap analyses based on claims data (when timely claims data are available), which renders payer-developed care gap reports less important for those CINs

AMH TAG Data Subcommittee

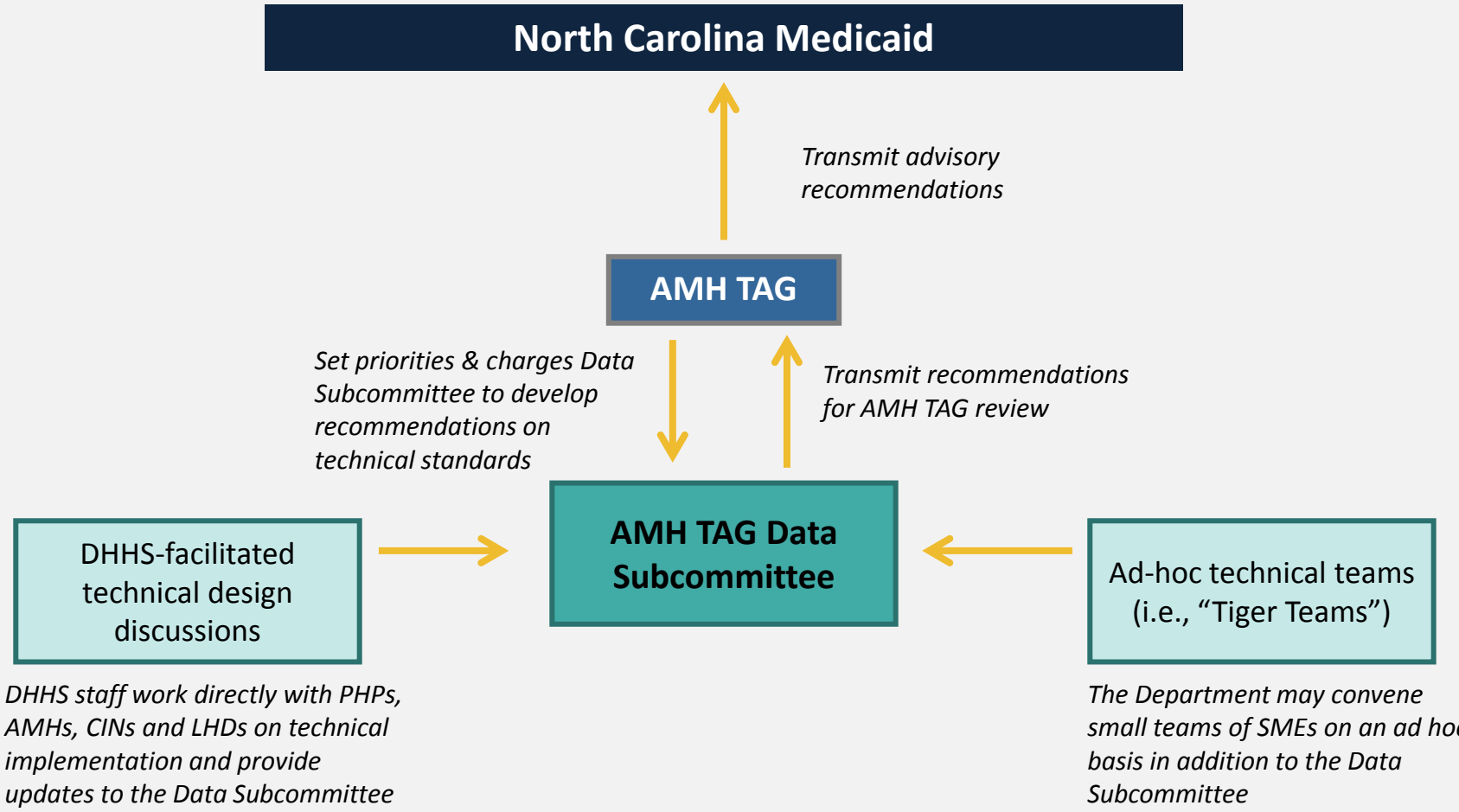
The Data Subcommittee will support the AMH TAG by making informed recommendations on critical care management data issues

What is the Data Subcommittee?

- An **advisory body** chaired by DHHS that consists of care management data and information system subject matter experts from participating AMH TAG member organizations
- The Data Subcommittee will respond to requests from DHHS and the AMH TAG to provide input, identify opportunities, risks and challenges and formulate **recommendations** to the AMH TAG and DHHS regarding data and information sharing issues
- The Data Subcommittee will be informed by **ad-hoc "tiger teams"** that will be organized to rapidly address specific, time-sensitive data issues

Data Strategy and Implementation Roles and Relationships

The Data Subcommittee will support the AMH TAG and help guide ongoing data work



Data Subcommittee Meetings

Data Subcommittee meetings will focus on high-priority data topics. Participants will review proposals from DHHS and relevant input from ad-hoc "Tiger Teams"

- The Subcommittee meetings schedule and timing will be driven by the nature and urgency of the data topics; the first meeting will be held **June 21, 2019**
- The Subcommittee will have a one-year term from (June 2019 to May 2020)
- Recommendations are advisory in nature
- Decisions to act upon any recommendations are made at the sole discretion of NC Medicaid
- Recommendations should be made as much as possible based on consensus
- Agendas and materials will be circulated to membership in advance of convening and publicly posted

Expectations of Subcommittee Participants

Subcommittee participants will actively engage in assessments of the key data issues related to AMH implementation

Additional Participant Expectations

- Participants will have a one-year term from (June 2019 to May 2020)
- Participants encouraged to attend in person and consistently to provide meaningful input on data issues related to AMH implementation
- Participants encouraged to take issues raised in the Subcommittee back to their organizations to promote dialog and communication with a broader group of stakeholders
- **Members must not discuss pricing**

Data Subcommittee Representatives

AMH TAG members were asked to identify candidates to participate in the Data Subcommittee; to date the following individuals have been nominated:

Organization	Nominated Representative(s), Title(s)
AmeriHealth Caritas North Carolina, Inc	
Blue Cross and Blue Shield of North Carolina	Seth Morris, RVP Provider Solutions and Provider Lead Carla Slack, IT Account Management
Carolina Complete Health, Inc	
Carolina Medical Home Network	
Carolinas Physician Alliance (Atrium)	
Community Care Physician Network (CCPN)	
Duke Primary Care	Mary Schilder, Analytics Customer Solutions, Analytics Center of Excellence
KidzCare in Macon County	
Mission Health Partners	Ryan Maccubin, Team Lead, Senior Analyst
North Carolina Academy of Family Physicians	
UNC Alliance Network	Shaun McDonald, Enterprise Architect, Analytics
UnitedHealthcare of North Carolina, Inc	Michael Rogers, IT Director
WellCare of North Carolina, Inc	

Issues for the Data Subcommittee

The AMH Data Strategy will address the range of AMH data elements set out in last year's "Data Strategy to Support the AMH Program"* policy paper and discussed at the last TAG

Data Element
1. Beneficiary Assignment
2. Encounter Data
3. Initial Care Needs Screen Results
4. Comprehensive Assessments
5. Risk Stratification Scores
6. Care Plans
7. Quality Measure Performance Information
8. Care Management Performance Information
9. Admission, Discharge, Transfer Information
10. Clinical Data
11. Unmet Health Resource Needs
12. Sharing Data With Patients and Caregivers

** Available at https://files.nc.gov/ncdhhs/AMH-Data-PolicyPaper_FINAL_2018720.pdf.*

Agenda for June 21 Kickoff:
Final Feedback on Beneficiary Assignment and Encounter Data Sharing

DHHS has been collecting information from select CINs and is seeking to finalize guidance regarding data sharing between PHPs and AMHs/CINs in June

Ad Hoc "Tiger Team"

Information Collection: DHHS & Manatt conducted interviews and collected feedback from seven CINs (*May 14 – 28*)

Initial Feedback:

- Most CINs are already receiving encounter and beneficiary information from plans for other business and are prepared to receive and process flat files
- There would be benefit from further defining the required content and agreeing on protocols for how these files are transmitted between PHPs and AMHs/CINs

Data Subcommittee

In preparation for the inaugural Data Subcommittee on June 21st AMH TAG members should:

- Confirm their own and/or a member of their organization's availability to participate

If members have not done so already, please identify a member of your organization with the relevant technical expertise who can help provide feedback to DHHS on proposed AMH data standards

In preparation for the first Data Subcommittee meeting, DHHS will:

- Distribute summary findings from the CIN data collection effort
- Distribute an Executive "Dashboard" that summarizes the status of the AMH Data Strategy elements
- Distribute detailed "Dossiers" on the beneficiary assignment and encounter data that provide information on the key decisions to date and considerations for the open issues

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Next Steps

1. TAG Members to continue to share key Subcommittee information with organization members for AMH TAG Data Subcommittee
2. TAG Members to share discussion key takeaways with stakeholders and probe on pressing issues related to upcoming topics
3. DHHS to finalize and share pre-read materials for upcoming sessions of AMH TAG and TAG Data Subcommittee

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Questions sent to CINs in mid May 2019 for Feedback

Beneficiary Assignment Questions

1. *What is the minimum required content (i.e., specific data fields) needed to support care management?*
2. *Should the State require a standard "floor" for the format or transmission method for beneficiary assignment information?*
3. *If the State requires a standard format or transmission method "floor," should PHPs and AMHs/CINs be permitted to use alternative methods if it is mutually agreeable to both parties?*

Encounter Data Questions

1. *What is the minimum required content (i.e., specific data fields) needed to support care management?*
2. *Should the State require PHPs to use consistent formats for both the historical claims and ongoing encounter data?*
3. *Should the State require a standard "floor" for the format or transmission method for encounter data?*
4. *If the State requires a standard format or transmission method "floor," should PHPs and AMHs/CINs be permitted to use alternative methods if it is mutually agreeable to both parties?*
5. *At what frequency should PHPs be required to transmit encounter and pharmacy data to AMHs/CINs?*