North Carolina Department of Health and Human Services (DHHS)
Advanced Medical Home Technical Advisory Group (AMH TAG) Meeting #35 (Conducted Virtually) April 9, 2024

AMH TAG Attendees:

- Coastal Children's Clinic
- North Carolina Academy of Family Physicians
- Community Care Physician Network (CCPN)
- Atrium Health
- Mission Health Partners
- Carolina Medical Home Network
- CHESS Health Solutions
- Duke Population Health Management Office
- AmeriHealth Caritas North Carolina, Inc.
- Blue Cross and Blue Shield of North Carolina
- North Carolina Area Health Education Centers (AHEC)
- WellCare of North Carolina, Inc.
- Carolina Complete Health (CCH)
- United Healthcare
- MCAC Quality Committee Member
- Children First of North Carolina

NC DHHS Staff and Speaker's Name	Title
Evelin Lazaro	Advanced Medical Home Program Specialist
Loul Alvarez	Population Health Associate Director
Andrea Price-Stogsdill	Healthy Opportunities Pilot Program Manager

Agenda

- Welcome and Roll Call (5 minutes)
- Sheps Interim Evaluation Report (10 minutes)
- Tailored Plan Launch (15 minutes)
- HOP Engagements with Expansion Members (20 minutes)
- Wrap-Up and Next Steps (5 minutes)

Sheps Interim Evaluation Report

- DHB shared initial findings related to AMH performance in the Sheps Center's interim evaluation of the Department's 1115 Waiver.
- The evaluation found there was no statistically significant difference in the patterns of care and health outcomes for members based on AMH Tier (e.g., AMH Tier 3 compared to AMH Tiers 1 and 2)

    - However, Tier 3 practices were associated with greater access to care management, compared to AMH Tier 1 and 2 practices
    - There was a significant increase in the number of practices that attested to being a Tier 3 AMH, likely related to increased payments for care management activities
- Questions/Comments from AMH TAG participants:
    - An AMH TAG member asked whether there were any statistically significant differences in quality performance on discrete measures, or if the analysis was on all quality measures in aggregate.
    - An AMH TAG member shared challenges with attribution, challenges with reporting quality care gap closures through PHP-specific portals, and lack of clinical data feeds to providers may be barriers to understanding the full picture of performance.
    - An AMH TAG member asked if quality measures were the only outcome of interest in the report.
    - An AMH TAG member asked how many members are in each AMH Tier, and another member asked what the denominator was for the calculation.
    - An AMH TAG member asked what "counts" as receiving care management.
    - DHB response: these initial findings are part of a larger report, which will be shared in full in the coming months. and will offer data on outcomes across the NC Medicaid program.

Tailored Plan Launch

- DHB provided information on the July 1st Tailored Plans launch, including:
    - A timeline for provider contracting, enrollment, the beneficiary primary care and assignment period, and eventual launch of the plans
    - An overview of Tailored Care Management (TCM) and existing partnerships with LME-MCOs
    - An overview of Tailored Plan contracting responsibilities with providers and with Standard Plans
    - An overview of required Tailored Plan payments to AMHs
    - An overview of required performance incentive payments that Tailored Plans must offer to AMH Tier 3s and AMH+s that are primary care providers
- Questions/Comments from AMH TAG participants:
    - An AMH TAG member asked if there is transition messaging that should be shared with primary care providers that are not planning to contract with Tailored Plans and ways they can help families during the transition.
        - DHB encourages all primary care providers to contract with Tailored Plans and recommended that plans work together to make sure necessary documents are being shared with the new Tailored Plans.
        - DHB also encouraged providers who aren't contracting with Tailored Plans to work with patients in advance of the primary care choice period

to help them find a new primary care provider that will be in network with their Tailored Plan, rather than be assigned a primary care provider.

- An AMH TAG member asked if DHB has an estimate for the portion of beneficiaries who will choose their primary care provider compared to those who will be auto-assigned.
    - DHB indicated that it does not have data on this issue, and encourages TCM providers to work with their members to raise awareness of the primary care choice period.
- An AMH TAG member asked if a practice can accept their current Tailored Plan patients but close their panel to receiving patients through auto-assignment.
    - DHB confirmed that it is a priority to ensure adequate panels for existing members and encouraged providers to discuss this during contract negotiations with Tailored Plans.
- An AMH TAG member asked if there will be additional medical home PMPM funding to support the transition of members from other plans to Tailored Plans.
    - DHB confirmed there will not be an enhanced PMPM add-on for this transition, but clarified that they do not expect many members receiving TCM services to move plans, but rather be receiving care under a different contract (LME-MCO vs. Tailored Plan).
- An AMH TAG member asked how a primary care provider or AMH will know which of their attributed members are covered by a Tailored Plan and TCM, and if there is contract information to support care coordination.
    - DHB shared that information on whether a member is enrolled in a Tailored Plan or is receiving TCM will be included in the enrollee report that primary care providers receive through NC Tracks.
        - If there is no care management entity listed, the plan would be the correct contact for understanding who is providing care management.
- An AMH TAG member asked if DHB anticipates being able to know if a patient is receiving care management.
    - DHB shared that reports on care management claims will function in the same way for Tailored Plans as it does for Standard Plans.
- An AMH TAG member requested there be a formal process in place for ensuring TCM care managers are “picking up” care for members when they are referred, highlighting experiences where TCM-referred beneficiaries have not transitioned to receiving care from a TCM provider in over three months, leading to the member’s previous care manager continuing to support them.
    - DHB suggested that providers reach out to the ombudsman (Medicaid.ProviderOmbudsman@dhhs.nc.gov or Phone: 866-304-7062) and submit examples of when they are managing a member who should be receiving services through TCM but have not yet been connected to a

TCM care manager. The ombudsman will create a Help Center ticket in your behalf.
        - The ombudsman can also be contacted for provider inquiries, concerns, or inquiries regarding health plans
    - An AMH TAG member shared that Tailored Plans do not have similar data sharing requirements as SPs, making adoption of performance incentive payment arrangements challenging for providers.
        - DHB shared they are working on materials for Tailored Plans regarding Value-Based Payment (VBP) requirements and will take this point into consideration as those are developed.
    - An AMH TAG member asked if the requirements for AMH performance incentive payments contradicts language regarding performance incentive payments for AMH+s or CMAs in TCM.
        - DHB clarified that the requirements for TCM performance incentive payments are different from the requirements for AMH primary care performance incentive payments.

HOP Engagements with Expansion Members

- DHB shared an overview of the HOP program and announced that HOP services will be available to TP members starting July 1st.
- DHB shared data on HOP service delivery, including:
    - Over 288,000 HOP services have been delivered to over 20,000 members since March 2022
    - Over 80% of authorization requests have been approved by health plans
- DHB shared data on HOP services for Medicaid Expansion members since December 1, 2023, as reported by Standard Plans, including:
    - Service authorizations have increased substantially since Medicaid Expansion
    - Over 2,000 HOP services have been delivered
- DHB shared HOP "success stories", and shared the HOP story bank, where individuals can share stories about the successes and challenges of HOP implementation.
    - Link to story bank: https://gcv.microsoft.us/99RKsGk6GB