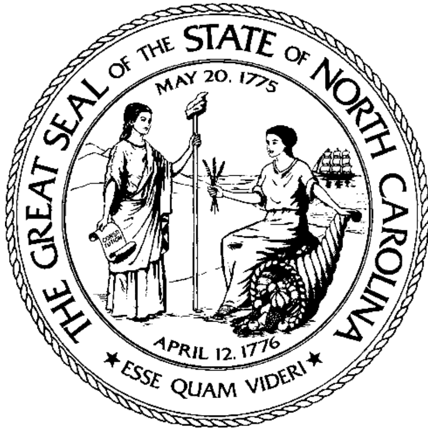


Advanced Medical Home (AMH) Technical Advisory Group (TAG)

Meeting #16:

- **UNC Sheps evaluation of North Carolina's 1115 waiver**
- **Topics for Upcoming AMH TAG Meetings**

December 14, 2021

Agenda

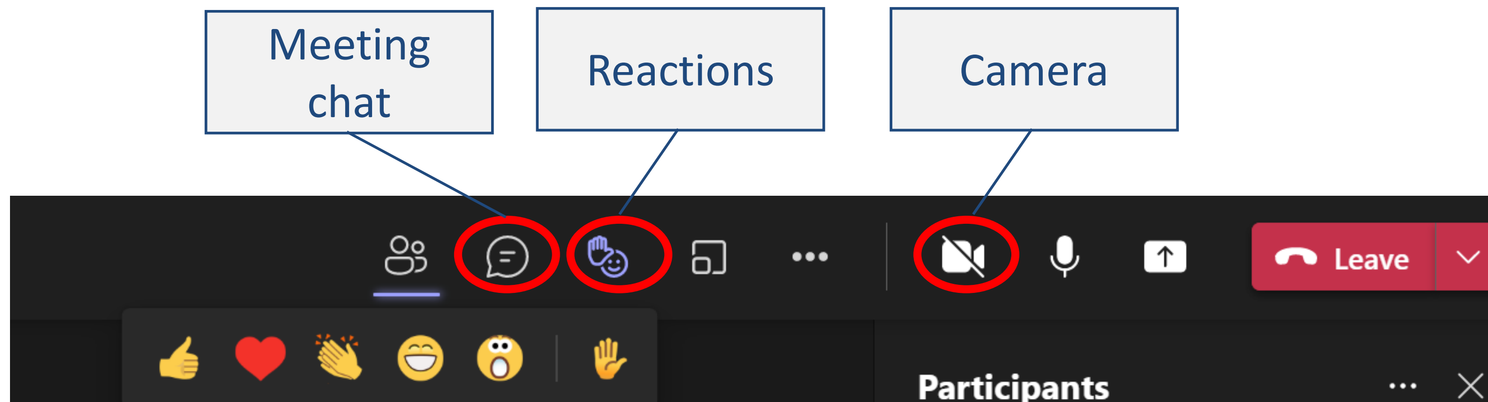
1. Welcome, Roll Call, Announcement (5 minutes)
2. UNC Sheps Evaluation of 1115 Waiver (45 minutes)
3. Potential Upcoming Topics for AMH TAG (5 minutes)
4. Wrap-Up and Next Steps (5 minutes)

AMH TAG Member Welcome and Roll Call

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)
Rick Bunio, MD	Executive Clinical Director, Cherokee Indian Hospital	Provider
Gregory Adams, MD	Member of CCPN Board of Managers Community Care Physician Network (CCPN)	Provider (CIN)
Jennifer Houlihan, MSP, MA	Vice President Value-Based Care & Population Health Atrium Health Wake Forest Baptist	Provider (CIN)
Amy Russell, MD	Medical Director Mission Health Partners	Provider (CIN)
Kristen Dubay, MPP	Director Carolina Medical Home Network	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)
George Cheely, MD, MBA	Chief Medical Officer AmeriHealth Caritas North Carolina, Inc.	Health Plan
Michael Ogden, MD	Chief Medical Officer Blue Cross and Blue Shield of North Carolina	Health Plan
Michelle Bucknor, MD, MBA	Chief Medical Officer UnitedHealthcare of North Carolina, Inc.	Health Plan
Eugenie Komives, MD	Chief Medical Officer WellCare of North Carolina, Inc.	Health Plan
William Lawrence, MD	Chief Medical Officer Carolina Complete Health, Inc.	Health Plan
Jason Foltz, DO	Medical Director, ECU Physicians MCAC Quality Committee Member	MCAC Quality Committee Member
Keith McCoy, MD	Deputy CMO for Behavioral Health and I/DD Community Systems, Chief Medical Office for Behavioral Health and I/DD	DHHS

Increasing Engagement

We encourage those who are able to turn on cameras, use reactions in Teams to share opinions on topics discussed, and share questions in the chat.



NC has been selected to participate in the HCP-LAN State Transformation Collaboratives (STCs)

INTRODUCING A LAN STRATEGIC INITIATIVE

State Transformation Collaboratives (STCs)

WHAT IS THE GOAL OF THE STCs?

The STCs will continue to shift the economic drivers away from fee-for-service to a value-based, person-centered approach to health through Medicaid and Medicare collaboration and partnership.

KEY COMPONENTS

3-4 distinct working groups, each dedicated to transforming health care in a specific state or region within a state

Comprised of payers, providers, health systems, purchasers, patient advocates, and community organizations

Locally-focused approach to addressing the needs of state populations through alternative health care payment

NOTIONAL GOALS	POTENTIAL VALUE
Shift 60% of payments to an APM for participating providers in a state	Integrate a greater diversity of community perspectives and needs into alternative payment initiatives
Reduce avoidable hospitalizations in a state	Support and/or expand ongoing state efforts seeking to impact health equity
Achieve measurable improvement in select health outcomes based on state-specific goals and needs	Harness the collective capabilities of state and federal government, private, and non-profit organizations to accelerate transformation

STC COLLABORATION WITH COMPLEMENTARY LAN INITIATIVES

The LAN's initiatives will build off each others' learnings and actions to implement and scale innovative models.

Health Equity Advisory Team (HEAT) will work with the STC and AC AC to:

- Identify promising APMs designed to reduce health disparities
- Provide guidance on APM design and implementation
- Prioritize, specify, and recommend key model design elements and implementation approaches

The Accountable Care Action Collaborative (AC AC) will work with STCs to:

- Provide forum for sharing cross-state knowledge and information, including guidance, resources, and subject matter expertise
- Collect and synthesize data on cross-state efforts
- Scale promising practices and learnings to the regional and/or national levels

1. Welcome and Roll Call
2. **UNC Sheps Evaluation of 1115 Waiver**
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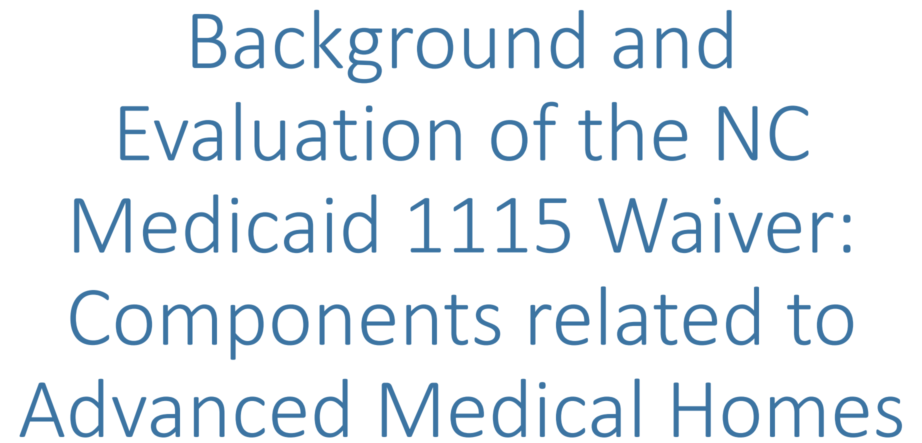

Background and Evaluation of the NC Medicaid 1115 Waiver: Components related to Advanced Medical Homes

Marisa Elena Domino, PhD

HPM and Sheps

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Independent evaluation

1115 Waiver Evaluation requirements

- As Demonstrations, 1115 waivers carry with them the requirement for monitoring and evaluation
- Evaluations are intended to provide generalizable knowledge about what is and isn't working, and why, to encourage evidence-based policy making
- Required components include:
  - Hypotheses on each "large component" of the waiver
  - Research questions
  - Data sources
- Comparison strategies
- CMS guidance indicates: "*The principal focus of the evaluation of a section 1115 demonstration should be **obtaining and analyzing data on the process** (e.g., whether the demonstration is being implemented as intended), **outcomes** (e.g., whether the demonstration is having the intended effects on the target population), and **impacts** of the demonstration (e.g., whether the outcomes observed in the targeted population differ from outcomes in similar populations not affected by the demonstration).*

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Independent evaluation

1115 Waiver Evaluation requirements

- CMS expects evaluation designs to be rigorous, incorporate baseline and comparison group assessments, as well as statistical significance testing
- Waivers that include a substance use disorder (SUD) component, have additional structure
  - Additional goals, milestones and performance metrics

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Evaluation Design in a nutshell

- UNC / Sheps center has been selected as the Independent Evaluators for the 1115 Waiver
- The evaluation will use a mixed-methods approach to testing the evaluation hypotheses.
- The quantitative analyses will use a difference-in-differences approach to the extent possible.
- The quantitative approach will be informed through qualitative analyses by triangulating results from provider interviews and surveys and discussing preliminary results with providers and other stakeholders.
- The evaluation covers the entire period of the SUD and overall waivers, from November 2019 – October 2024.
- A baseline period will be from Oct 2015 – Oct 2019
- Monitoring reports are submitted to CMS quarterly and annually, with a final summative report due 18 months after the end of the demonstration.

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Evaluation Plans, Goals, Hypotheses

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Goals

Three Goals of the 1115 Waiver

- 1: Measurably improve health outcomes via a new delivery system
- 2: Maximize high-value care to ensure sustainability of the Medicaid program, and
- 3: Reduce Substance Use Disorder (SUD)

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Study hypotheses

- The following hypotheses were developed as part of the Evaluation Design in 2019 and approved by CMS in Jan 2020*.
- As the components of the waiver evolve, the evaluation design and study research questions and hypotheses will evolve as well.

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* https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nc/Medicaid-Reform/nc-medicaid-reform-demo-eval-des-appvl-01152020.pdf

Goal #1: Measurably Improve Health

Goal 1
Hypotheses

- **Hypothesis 1.1**: The implementation of Medicaid managed care will increase access to health care and improve the quality of care and health outcomes.
- **Hypothesis 1.2**: The implementation of Medicaid managed care will increase the rate of use of behavioral health services at the appropriate level of care and improve the quality of behavioral health care received.
- **Hypothesis 1.3**: The implementation of Medicaid managed care will increase the use of medication-assisted treatment (MAT) and other opioid treatment services and decrease the long-term use of opioids.

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Goal 1
Hypotheses

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Goal #1: Measurably Improve Health

- **Hypothesis 1.4**: Implementation of Advanced Medical Homes (AMHs) will increase the delivery of care management services and will improve quality of care and health outcomes.
- **Hypothesis 1.5**: The implementation of Medicaid managed care will reduce disparities (increase equity) in the quality of care received across rurality, age, race/ethnicity and disability status.
- **Hypothesis 1.6**: The greater use of value-based payments by standard plans will increase access to health care and improve the quality of care and health outcomes.

Goal #2: Maximize High-Value Care to Ensure the Sustainability of the Program

Goal 2
Hypotheses

- **Hypothesis 2.1**: The implementation of Medicaid managed care will decrease the use of emergency departments for non-urgent use and hospital admissions for ambulatory sensitive conditions.
- **Hypothesis 2.2:** The implementation of Medicaid managed care will increase the number of enrollees receiving care management, overall and during transitions in care.
- **Hypothesis 2.3**: The implementation of Medicaid managed care will reduce Medicaid program expenditures.

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Goal #2: Maximize High-Value Care to Ensure the Sustainability of the Program

Goal 2 Hypotheses

- **Hypothesis 2.4**: The implementation of Medicaid managed care will increase provider satisfaction and participation in the Medicaid program.
- **Hypothesis 2.5**: The implementation of value-based payments will affect the type of services used and reduce Medicaid program expenditures.

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Goal 3
Hypotheses

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Goal 3: Reduce Substance Use Disorder

- **Hypothesis 3.1**: Expanding coverage of SUD services to include residential services furnished in IMDs as part of a comprehensive strategy for treating SUD will result in improved care quality and outcomes for patients with SUD.
- **Hypothesis 3.2:** Expanding coverage of SUD services to include residential services furnished in institutions for mental diseases (IMDs) as part of a comprehensive strategy for treating SUD will increase the use of MAT and other appropriate opioid treatment services and decrease the long-term use of prescription opioids.

Goal 3
Hypotheses

Goal 3: Reduce Substance Use Disorder

- **Hypothesis 3.3:** Expanding coverage of SUD services will result in no changes in total Medicaid and out-of-pocket costs for people with SUD diagnoses, increases in Medicaid costs on SUD IMD services, increases in SUD pharmacy, outpatient, and rehabilitative costs, and decreases in acute care crisis-oriented, inpatient, ED, long-term care and other SUD costs.

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Methods

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Qualitative component

- The qualitative evaluation will examine perspectives from:
  - primary care and specialist providers including family medicine, internal medicine, pediatrics, and Ob/Gyn, behavioral health specialists, community-based organizations (CBOs) (e.g., focusing on food and transportation accessibility)
  - state health agency officials, and Prepaid Health Plans (PHPs) impacted by the NC Medicaid transformation.
- This examination will reveal detailed insights into the transformation that are not easily captured through claims and surveys; for example, how providers are preparing for the transformation and what can be done to improve their satisfaction with the Medicaid program.

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Qualitative component

- We have recruited a sample of provider practices to follow during the life of the evaluation, using semi-structured interviews.
- This approach will facilitate a detailed examination into whether/how external circumstances (e.g., support provided by the plans, patient needs, community resources) change over time as well as how providers adjust to the transformation during the early implementation phase and the longer term.
- Our sample will include approximately 50 practices from across the state
- These practices will be interviewed annually through 2024

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Quantitative Component

- The quantitative evaluation plan will focus on the trends in and analysis of a large number of metrics from each of the hypotheses.
- We will use conduct analyses of metrics that are feasible on a monthly basis and reporting results to NC DHHS through a data dashboard to be developed as part of the Evaluation.
- This approach will allow for the best possible estimates in the shortest possible time, to provide feedback to DHHS and PHPs to allow for short-term quality improvements in plan delivery.

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Quantitative Component

Diff-n-diff

RD

- We will use a number of quantitative techniques:
- **Difference-in-differences**
  - Through the use of a contemporaneous comparison group, and pre-intervention data, many of the models estimated for the evaluation will follow a difference-in-differences approach.
  - Specific comparison groups are still in progress but may include Marketplace Exchange plan enrollees or Medicaid beneficiaries in another state with similar pre-implementation trends in measures
- **Regression Discontinuity**
  - PHPs, AMHs, and/or CINs are required to implement a risk stratification system in order to identify Medicaid and Health Choice enrollees who might benefit from care management.
  - Individuals on either side of the risk threshold can be examined for differences in outcomes

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ITS

Quantitative Component

- **Interrupted Time Series**
  - This analysis is different from difference-in-differences analyses in two ways:
    - it only includes intervention observations, from pre- and post-implementation
    - it specifically tests for changes in the slope of the time trends, in addition to an average shift in the level of the outcome for each measure.
  - Because an ITS approach is subject to confounding from events such as the availability of treatments or changes in the health services environment that occur during the post-period, it is not our preferred approach to analysis.
  - However, it may be used for quantitative analyses when a contemporaneous comparison group is not available, such as in analyses of the provider survey.

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Comparisons for AMH research questions

- There are several dimensions on which we could compare AMH metrics:
  - Examine the contrast between AMHs and CCNC (pre-post analysis)
  - Examine differences in trends across AMHs

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Drilling down on AMH specific components

Measure	Measure custodian	Numerator	Denominator	Data Sources	Process / Outcome
Research question 1.4.a Does the implementation of AMHs increase the probability of receiving care management services?					
Number or Percent of Practices on the PHP panel that Attest to being a Level 3 AMH	--	AMH Tier 3 providers	Providers	PHP Network data	Process
Number of Enrollees Attributed to an AMH	--	Enrollees attributed to an AMH	All	Claims / Encounters	Process
Number of Enrollees Receiving Care Management	--	Evidence of care management receipt	All	Care management databases	Outcome
Rate of Screening for Unmet Resource Needs	--	Managed Care enrollees for whom the plan completed a social determinants of health screening within 90 days of enrollment	All	Claims / Encounters / Care Needs Screening Report	Outcome
Access to Additional Services Using Provider Resource Directory - Connecting Primary Care to SUD Service Offerings	--	Had a PCP visit in the 30 days following the SUD visit	SUD visits that did not have an inpatient or residential SUD stay for 30 days after the visit	Claims / Encounters	Process

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Drilling down on AMH specific components

- **Research question 1.4.b Does the implementation of AMHs improve the quality of care received?**
- **Measures examined:**
  - **Flu Vaccinations for Adults Ages 18 and Older**
  - **Asthma Medication Ratio**
  - **Antidepressant Medication Management**
  - **Follow-up After Hospitalization for Mental Illness: 7 and 30 days after discharge**
  - **Follow-up Care for Children Prescribed ADHD Medication**
  - **Well-Child Visits***
  - **Childhood Immunization Status***
  - **Diabetes Care***
  - **Cervical Cancer screening***
  - **Chlamydia Screening***

* = AMH Measure Set

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Drilling down on AMH specific components

- **Research question 1.4.c Does the implementation of AMHs improve health outcomes?**
- **Measures examined:**
  - **Plan All-Cause Readmissions***
  - **Controlling High Blood Pressure**
  - **Diabetes Short-term Complication Admission Rate**
  - **Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate**
  - **Heart Failure Admissions Rate**
  - **Asthma Admission Rate**
  - **Gastroenteritis Admissions Rate**
  - **Urinary Tract Infection Admissions Rate**

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* = AMH Measure Set

Drilling down on AMH specific components

— Our qualitative work (provider and stakeholder interviews) will ask:

Advanced Medical Home & Care Coordination	*What are the core components of your Advanced Medical Home?* *Does your practice have plan to increase AMH level?* *Have there been any changes in the way that care coordination is being provided?*

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Limitations

- Efforts to create a managed care waiver were initiated by North Carolina's General Assembly some time before the baseline time period incorporated here. If provider behavior changed as a result of expectations of upcoming changes, then our baseline period would not capture a true baseline, but rather a baseline under increasing expectation of managed care implementation.
- Any deficits in quality of encounter data would confound the PHP analyses, since they would be contemporaneous to the implementation of capitated care.
- Finally, the evaluation will not be able to assess all aspects of the Demonstration due either to data limitations or statistical limitations.

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In Summary…

- The goal of the evaluation is to create an evidence base for what works and what doesn't so we can improve health of Medicaid beneficiaries

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Discussion Questions

- Are there other metrics that AMHs are using to evaluate the success of their own work?

1. Welcome and Roll Call
2. UNC Sheps Evaluation of 1115 Waiver
3. **Potential Upcoming Topics for AMH TAG**
4. Wrap-Up and Next Steps

Potential Upcoming Topics for AMH TAG

Potential AMH TAG Topics
• Topics for Data sub-committee, which may include data standardization and data completeness • Cost data • Review of member file • Standardization of monitoring protocols/delegation protocols • PHP Accreditation timeline and timing of AMH delegation audits • AMH Quality Measures Attribution Model • Potential APM updates • Other AMH model updates for Year 2 of Managed Care

1. Welcome and Roll Call
2. UNC Sheps Evaluation of 1115 Waiver
3. Potential Upcoming Topics for AMH TAG
4. **Wrap-Up and Next Steps**

AMH TAG Meeting Cadence

AMH TAG meetings will generally take place the second Tuesday of each month from 4-5 PM.

Upcoming 2022 Meetings

Tuesday, January 11, 2022
4:00-5:00 PM

Tuesday, February 8, 2022
4:00-5:00 PM

Next Steps

AMH TAG Members

- Share today's discussion key takeaways with your networks

Department

- Prepare for January 11 AMH TAG session