North Carolina Department of Health and Human Services (DHHS) Advanced Medical Home Technical Advisory Group (AMH TAG) Meeting #17 (Conducted Virtually) April 5, 2022, 4:00 PM ET

Attendees:

Name	Organization	Stakeholder
David Rinehart, MD	President-Elect of NC Family Physicians North Carolina Academy of Family Physicians	Provider (Independent)
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
Anthony Meacham	Assistant Director of Third-Party Payor Relations and Provider Credentialing, ECU Physicians	*For Jason Foltz, DO*
Keith McCoy, MD	Deputy CMO for Behavioral Health and I/DD Community Systems, Chief Medical Office for Behavioral Health and I/DD	DHHS
Representative	Cherokee Indian Hospital	Provider

NCDHHS Staff and Speakers		
Kelly Crosbie, MSW, LCSW	Chief Quality Officer	NC Medicaid
Vikas Gupta	Consultant	Accenture
Loul Alvarez, MPA	Associate Director	NC Medicaid
Jahaziel Zavaleta, MPA, MSW	Senior Program Manager – Population Health	NC Medicaid

Agenda

- Welcome and Roll Call (all AMH TAG members present except: C. Marston Crawford, Rick Bunio, and Gregory Adams)
- Report-out from February 8 and April 1 AMH TAG Data-Subcommittee Meetings
- Discussion of Dedicated AMH/PHP Feedback Loop
- Discussion of Local Care Management
- Wrap-Up and Next Steps

Report-out from February 8 and April 1 AMH TAG Data-Subcommittee Meeting (10 minutes)

Key Takeaways

- The AMH TAG Data Subcommittee was relaunched on 2/8/22 to review and provide recommendations on critical AMH data exchange requirements and concerns to the Department. To inform the prioritization of additional data-related topics, Data Subcommittee members provided survey feedback on seven data issues with respect to the issues' (1) impact, (2) urgency for resolution, and (3) potential solutions.
  - The meeting presentation and slides can be found on the AMH TAG website here.
  - All data subcommittee representatives have access to the survey data.
- Beneficiary Assignment and Patient Risk List were identified as having the highest impact on operations and the most immediate urgency. The other significant issues raised in the data subcommittee were the timing of AMH-PHP data transmissions, the CIN/AMH relationship, the care needs screening, claim files, and quality measures.

Discussion of Dedicated AMH/PHP Feedback Loop

Key Takeaways

- PHPs make direct referrals for follow-up on urgent cases and PHPs need accurate email addresses and phone numbers of AMH Tier 3 practices.
  - There are many common use cases for PHPs to reach out to AMHs, including hospital inpatient discharge, nursing facility discharge, care coordination for behavioral health services, and findings of the Care Needs Screen.

- TAG members noted that there should be different expectations for responsiveness based on the urgency of the situation.
- The AMH provider manualcontains relevant requirements for AMH Tier 3 practices. DHHS will review the current standards and develop a proposal for review by the AMH TAG to assess whether the proposal meets providers' and plans' needs and aligns with current best practices.

Discussion/Feedback from AMH TAG Members on Dedicated AMH/PHP Feedback Loop

- TAG members identified that there should be different expectations for responsiveness based on the urgency of the situation.
  - Discharge planning from an inpatient setting was identified as an urgent need where the PHP and AMH need a way to connect quickly.
  - Urgent needs can also come up on the Care Needs Screening.
- TAG members also noted the need to identify which situations require a "warm handoff" versus the situations that can be managed using existing data feeds, such as the patient risk list and ADT (admission-discharge-transfer) feeds.
  - Providers also have different expectations on follow-up with the referring entity based on the urgency of need and type of referral (electronic, phone, etc.).
- Attribution issues can create a barrier during transitions. PHPs need to have accurate data on which AMH a Medicaid member is attributed to.

Discussion of Local Care Management

Key Takeaways

- COVID-19 altered the care management model with many providers shifting to virtual (telephone or video) care management visits. Utilization of virtual care management visits has remained high.
- TAG members agreed that even when delivered virtually, care management should remain "local" and connected to a Medicaid member's own AMH Tier 3 provider.
- Broad band access limits Medicaid members' ability to use video visits for care management.

Discussion/Feedback from AMH TAG members on Local Care Management

- At the beginning of the COVID-19 pandemic, TAG members expected the transition to virtual care management to be short-term. However, Medicaid members and providers continue to find virtual care management to be valuable. TAG members identified several reasons to maintain virtual care management, including:
  - Concerns about disrupting existing, effective virtual care management
  - Medicaid member and family hesitancy to return to provider offices
  - Insufficient office space for physically embedding care managers
  - Staffing shortages and difficulty hiring more care managers
  - Lengthy travel distances required of care managers working in rural areas
- Due to their higher acuity needs, higher risk Medicaid members may require more face to face interactions or home visits.
- Some TAG members practicing in areas with higher social needs experienced greater difficulty with virtual care management, especially video based. Some Medicaid members were not able

to participate in telephonic or video care management due to lack of access to cellphone data or insufficient cellphone minutes.

Wrap-Up and Next Steps

- The Department shared dates and potential topics for upcoming AMH TAG meetings.
- There were no public comments.

AMH TAG Members are encouraged to send any additional feedback or suggestions to Loul Alvarez (loul.alvarez@dhhs.nc.gov) or Jahaziel Zavaleta (jahaziel.zavaleta@dhhs.nc.gov) of DHHS.

Relevant Sections: Advanced Medical Home Manual 2.4.1 (February 2022)

Appendix A. Standard Terms and Conditions for AMH Tier 1 and 2 Contracts

Health Plan will be required to include the following language in all contracts with AMH practices. These contracts terms are independent of practices' agreements with the Department and CCNC around Carolina ACCESS, and will not affect those agreements. The Department will review all Health Plan/AMH practice contract templates prior to use to ensure that standard contract terms are incorporated:

…

Provide or arrange for Primary Care coverage for services, consultation or referral, and treatment for emergency medical conditions, twenty-four (24) hours per day, seven (7) days per week. Automatic referral to the hospital emergency department for services does not satisfy this requirement

Appendix B. Standard Terms and Conditions for Health Plan Contracts with AMH Tier 3 Practices

Unless otherwise specified, any required element may be performed either by the Tier 3 AMH practice itself or by a Clinically Integrated Network (CIN) with which the practice has a contractual agreement that contains equivalent contract requirements.

c. Tier 3 AMH practices must use a documented Care Plan for each high-need patient receiving care management.

ix. The Tier 3 AMH practice or CIN must implement a systematic, clinically appropriate care management process for responding to certain high-risk ADT alerts (indicated below).

1. Real time (minutes/hours) response to outreach from EDs relating to patient care or admission/discharge decisions, for example arranging rapid follow up after an ED visit to avoid an admission.
2. Same-day or next-day outreach for designated high-risk subsets of the population to inform clinical care, such as beneficiaries with special health care needs admitted to the hospital;
3. Within a several-day period to address outpatient needs or prevent future problems for high risk patients who have been discharged from a hospital or ED (e.g., to assist with scheduling appropriate follow-up visits or medication reconciliations post discharge)