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

Meeting #9: Pre-Launch AMH Program Updates

October 27, 2020 1:00 pm – 2:30 pm

AMH TAG Membership Introductions and Rollcall

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)
Ruth Krystopolski, MBA	Senior Vice President of Population Health Atrium Health	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.	PHP
Michael Ogden, MD	Chief Medical Officer Blue Cross and Blue Shield of North Carolina	PHP
Michelle Bucknor, MD, MBA	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
Jason Foltz, DO	Medical Director, ECU Physicians MCAC Quality Committee Member	MCAC Quality Committee Member

Welcome Back to the AMH Technical Advisory Group!

Today We Will:

- Review the Department's plans for supporting the ramp-up to AMH
- Discuss AMH design modifications and policies finalized since the Managed Care suspension in November 2019

Agenda

1. Pre-Managed Care Launch AMH Timelines
2. AMH Program Streamlining
3. AMH Program Incentives and Practice Supports
4. PCP/AMH Assignment
5. AMH Quality Measure Set
6. AMH Payment Model
7. AMH Contracting/Oversight
8. Next Steps

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Pre-Managed Care Launch AMH Timelines

Milestone	Dates
DHHS AMH "Fireside Chat" and launch of AHEC webinars for practices	November – December 2020
Updated AMH Provider Manual release	January 2021
PHP Open Enrollment begins	Mid March 2021
Start of 90 day AMH "glide path" incentive payment program tied to completion of contracting and data exchange (*see section 3)*	April 1 2021
Open enrollment ends	Mid May 2021
Auto enrollment to PHPs begins, followed by PCP/AMH assignment	Mid May 2021
Standard Plans launch	**July 1, 2021**

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- Streamlining oversight
- Standardizing care management reporting

AMH Streamlining aims

In response to feedback, DHHS looked at ways to streamline the AMH program.

Changes are designed to:

- Shift the focus from individual care management processes to penetration rate of care management in the population and outcomes
- Streamline oversight of care management
- Provide clarity on what “counts” as Care Management for tracking purposes

Streamlining how PHPs are held accountable for Care Management

DHHS looked at how to reduce burden associated with multiple SLAs while still maintaining oversight of care management in the market.

Changes to DHHS oversight of PHPs:

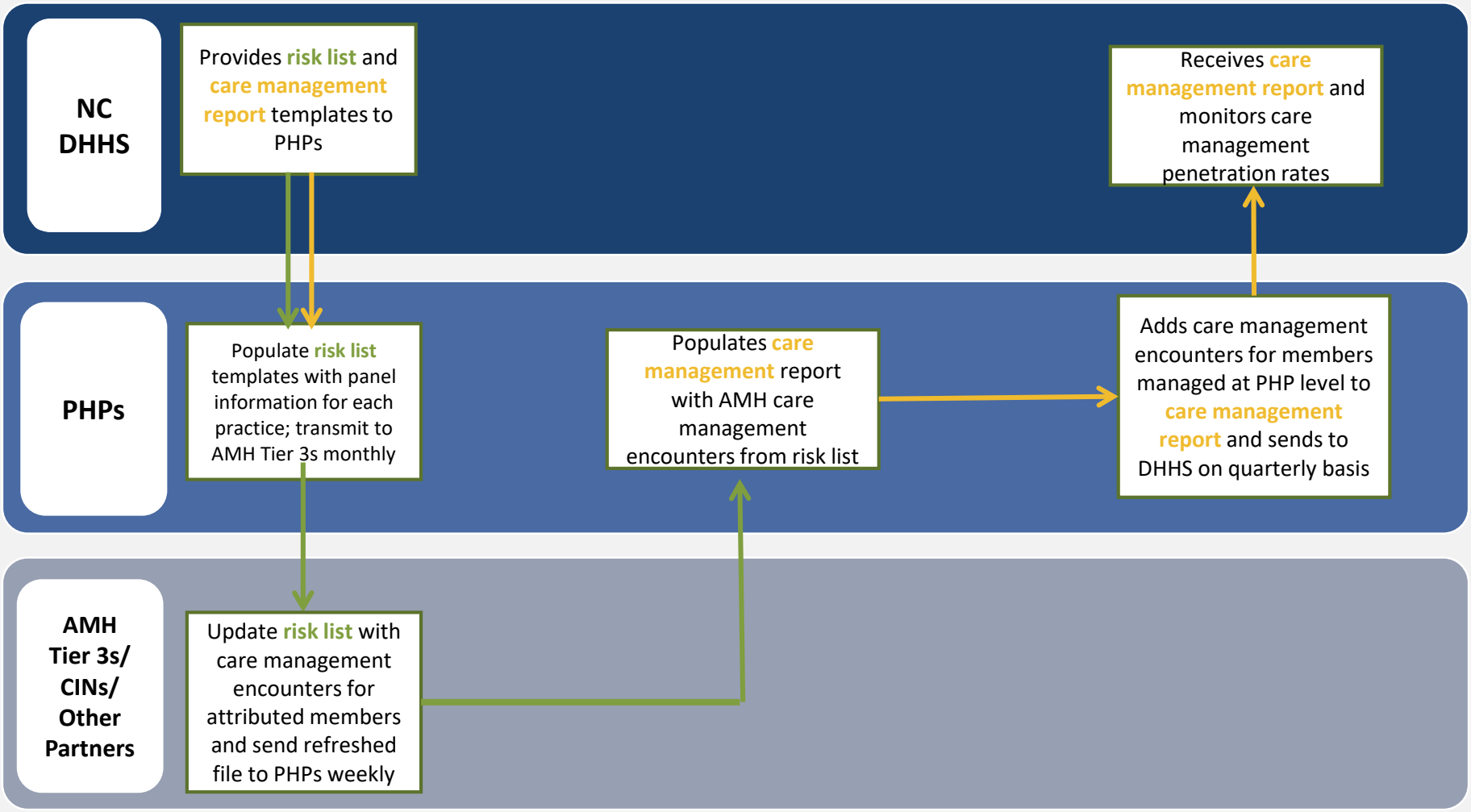
- DHHS had previously planned to impose liquidated damages on PHPs for failure to complete individual care management process requirements:

  (1) Failure to develop a Care Plan that includes all required elements
  (2) Failure to complete a Comprehensive Assessment
  (3) Failure to develop a Care Plan for members with LTSS needs
  (4) Failure to meet minimum transition care management requirements

- **PHPs will no longer be subject to liquidated damages associated with these individual care management process requirements.** Instead, DHHS will measure total penetration of care management in each PHP's population using the standardized reporting data (see next slides).

- DHHS expects that oversight provisions in provider contracts will be similar to those in the contract between DHHS and PHPs.

Streamlining Reporting Requirements



Risk List

The purpose of the Risk List template is to streamline how risk stratification information and care management encounters are shared between PHPs and AMH Tier 3s/CINs/Other Partners.

PHPs to AMH (Excerpt)

- **Frequency: Monthly**

Patient Identifier	CNDS ID	Medical ID
	Program Identifier	000=Null 001=CMARC 002=CMHRP 003=LTSS
	Priority Population	001=Unmet resources 002=Adults and children with special health care needs 003=Rising risk 004=Other priority population
	Maintenance Type Code	'001' is sent if there is a change or an update to an existing patient record '021' is sent for new patients
PHP Risk Profile	PHP Risk Score	H=High, M=Medium, L=Low
	PHP Risk Evidence	255 varchar limit of free text

PHPs will categorize all members into high/medium/low risk

AMHs to PHPs (Excerpt)

- **Frequency: Weekly**
- Tier 3 AMHs should report the latest Comprehensive Assessment/Care Plan created

CM Entity Risk Profile & Interactions	CM Entity Risk Score Category	H= High; M=Medium; L=Low
	Number of CM Interactions	#######
	Number of Face to Face Encounters	#######
	Date Comprehensive Assessment Completed	YYYYMMDD
	Date Care Plan Created	YYYYMMDD
	Date Care Plan Updated	YYYYMMDD
	Date Care Plan Closed	YYYYMMDD

Report templates shown above are near-final

Care Management Report

The Care Management Report is a standardized member-level report PHPs will file with DHHS quarterly, containing <u>all</u> care management encounters

To be completed by PHPs

Member Name/ID	Number of AMH/PHP CM Encounters YTD	Any Face-to-Face AMH/PHP Encounters?	Risk Profile (High/Med/ Low)	Comprehensive Assessment Completed	Care Plan Created	CM Provided by PHP	CM Provided by AMH	Overall Numerator *	Face-to-Face Numerator **	Denominator ***	YTD Overall Penetration Rate	YTD Face-to-Face Penetration Rate
Member 1	3	Y	High	Y	Y	N	Y	1	1	1		
Member 2	0	N	Low	N	N	N	Y	0	0	1		
Member 3	2	N	Medium	Y	N	Y	N	1	0	1		
Member 4	0	N	Low	N	N	N	Y	1	0	1		
								3	**1**	**4**	**75%**	**25%**

Must include ALL of the PHP's members YTD.

Non AMH fields (e.g. CMHRP, CMARC) not shown

* Equal to 1 if member has 1 or more CM encounter; equal to 0 if member has no CM encounters
**Equal to 1 if member has had a face-to-face CM encounter
***Equal to total number of members in report

DHHS will use this report to monitor total level of care management provided to PHP members

Definition of "Care Management"

To ensure consistency in how PHPs, AMH Tier 3 practices and CINs/Other Partners report on care management encounters, the Department will roll out guidance on the types of care management activities that should included in care management encounter reporting.

ALL levels of care management—ranging from high intensity (e.g. care plan development and frequent face to face encounters) to low intensity (e.g. infrequent, telephonic contact)—should be reported as CM encounters.

"Counts" as care management

- In-person (including virtual) visit with care manager or member of care team; could include delivery of comprehensive assessment, development of care plan, or other discussion of patient's health-related needs
- Phone call or active email/text exchange between member of care team and member (e.g. to discuss care plan or other health-related needs); must include active participation by both parties; unreturned emails/text messages do NOT count
- Phone calls to set up appointments with providers that are three-way calls between care team, member and practice staff to arrange care visits

Does NOT "count" as care management

- Care manager leaves a voicemail with member or sends unreturned email/text message
- PHP/care manager sends mailer to member
- Phone calls between practice front desk staff and either the member or care team to schedule care visits
- Scheduled in-person visit to which the member fails to show up

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- AMH Tier 3 glide path payments
- AHEC coaching model

Program Incentives and Supports Aims

The Department considered ways to help AMH Tier 3 practices prepare for care management supported by use of claims and encounter data.

Changes will:

- Add new payment stream for practices in the run-up to launch
- Emphasize importance of data exchange to support AMH Tier 3
- Enhance options for practice supports after launch

AMH Tier 3 Glide Path Payments

DHHS will implement a new $8.51 PMPM payment stream to AMH Tier 3 practices 90 days prior to the launch of Managed Care to assist with and incent Tier 3 preparation

Tier 3 Glide Path Payment Eligibility Criteria

1. AMH Tier 3 within NC Tracks
2. **Contracting completed** with at least two PHPs
3. **Data exchange testing successfully completed** with at least two PHPs

4. Practice has completed attestation in NC Tracks provider portal that items 2-3 complete.

DHHS will release additional details on the above criteria prior to launch.

Payments will flow to practices in the same way as current CA II Payments. Qualifying practices will receive $8.51 PMPM direct from NC Tracks for each month in which they meet the conditions shown at left, up to three times.

To reinforce the importance of AMH Tier 3 data exchange, DHHS is also adding a new liquidated damage (enforceable after launch) on PHPs of $1,000 per occurrence for failure to transmit a beneficiary assignment file or claims to an AMH Tier 3 practice (or CIN/Other Partner) within the Department's published data specifications

Support for AMH Practices through AHEC

NC AHEC will offer practice support and education aligned with the AMH program.

AHEC practice supports will include:

AMH Practice Coaching

- Starting in January, AHEC coaches will work with individual practices to accelerate adoption of Tier 3 standards and facilitate transition, starting with a standardized assessment tool
- Available to primary care practices who are in network with at least one Standard Plan
- PHPs may refer practices that need assistance meeting AMH standards

Education

- AHEC will offer webinars, tip sheets, bulletins and other mass communications on the AMH program
- Education will be geared toward all interested Medicaid practices

First webinar: December 10, 2020. Registration information will be posted here.

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Increased flexibility for PHPs around PCP/AMH Assignment

DHHS will allow PHPs additional flexibility in PHPs' PCP/AMH assignment policies to help PHPs better engage members.

Existing Policy in Standard Plan contract (p. 126):

- When a member does not select an AMH/PCP at the time of enrollment, the PHP will assign an AMH/PCP.
- The PHP's methodology for assignment must include the following components, in this order, to the extent that the information is available:
  1. Prior AMH/PCP assignment
  2. Member claims history
  3. Family member's AMH/PCP assignment
  4. Family member's claims history
  5. Geographic proximity
  6. Special medical needs
  7. Language/cultural preference
- In contract year 2, DHHS may direct the methodology to include AMH status.

Proposed Flexibility:

- For Step 1 of the assignment methodology, PHPs may look at prior AMH/PCP assignment <u>together with</u> claims history at the assigned PCP/AMH (Step 2).
- PHPs may set a lookback of no shorter than 18 months (non-ABD) or 12 months (ABD) to review claims at the assigned PCP/AMH.
- If a member has a prior AMH/PCP assignment but has no claims history with the assigned AMH/PCP within the lookback period, the PHP may assign to another AMH/PCP, following components 3-7.

Any changes PHPs choose to make to their auto-assignment policies will need to be re-submitted to DHHS for approval

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AMH Quality Measures

DHHS has streamlined the AMH Measure Set to simplify AMH quality reporting and performance incentive payment arrangements. PHPs will be required to use only these measures to develop AMH performance incentive payments.

Updated AMH Measure Set

- Adolescent Well-Care Visit
- Childhood Immunization Status (Combination 10)
- Immunization for Adolescents (Combination 2)
- Screening for Depression and Follow-up Plan
- Well-Child Visits in the First 15 Months of Life
- Cervical Cancer Screening
- Chlamydia Screening in Women
- Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)
- Controlling High Blood Pressure
- Plan All Cause Readmission-Observed to Expected Ratio

Other Measures

PHPs will also be required to share total cost of care information with AMH practices. DHHS will publish additional guidance on sharing total cost of care information with practices at a later date.

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- Care management fee
- Performance incentive payments and AMH measure set
- Timeline for payment changes

AMH Tier 3 Payments

The Department is finalizing several policies regarding Year 1 AMH Tier 3 payments:

1. **No care management fee rate floor**—the Department will **not** impose a rate floor on the care management fee. Care management fees that PHPs pay to AMHs will be set through negotiations between PHP and Tier 3 practices. Guidance from July 24, 2019 on the capitation rate assumptions still applies and can guide negotiations.*
   - As stated in the PHP contract, PHPs are still expected to contract with all AMH Tier 3 practices
2. **Guaranteed care management fees**—PHPs may not place Tier 3 practices' care management fees at risk based on AMH performance or any other metrics. PHPs must pay the full negotiated care management fee amount to all contracted Tier 3 practices.
3. **Timeline for changing payment terms—**PHPs must submit any changes to AMH payment terms for approval at least 90 days before implementing the changes.

*Note: PHPs will NOT be subject to liquidated damages for failure to contract with all AMH practices

AMH Tier 3 Payments (cont.)

Performance Incentive Payments

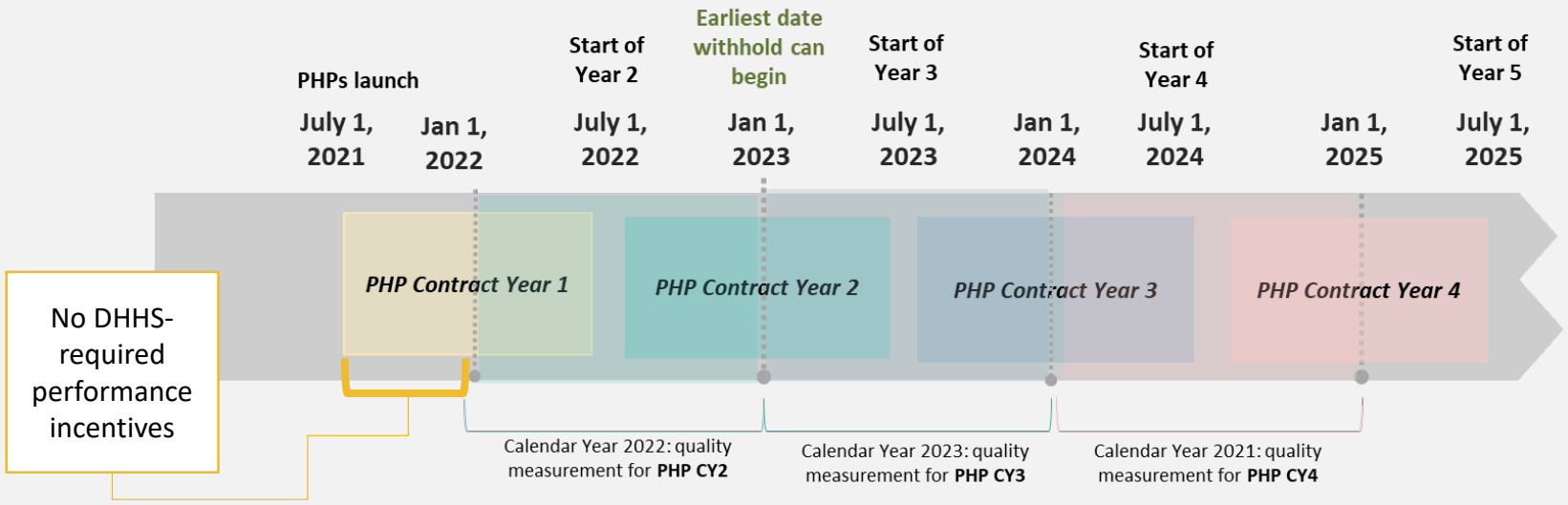
4 **Use of AMH Measure Set for Tier 3 Performance Incentives**—PHPs must offer performance incentive payments in all Tier 3 contracts. These payments must be based only on the AMH measure set, and may not factor in performance on measures beyond those included in the AMH measure set.

- PHPs must also use the AMH measure set for any (optional) performance incentive arrangements made with AMH Tier 1 and 2 practices.
- PHPs are free to use other measures from the broader quality measure list for VBP arrangements other than AMH contracts.

AMH Tier 3 Payments (cont.)

Performance Incentive Payments

- **Year 1 Performance Incentive Timing**—Due to differences in PHP contract year and quality measurement reporting period timing, **Department-required incentive programs, including performance incentive payments for AMH Tier 3, will start six months after managed care launch (at the latest).**



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- Removal of liquidated damages for AMH contracting
- Tier 3 contract audits
- Timeline for Tier status changes
- Oversight transparency

AMH Contracting and Oversight Policies

DHHS is moving ahead with policies that promote streamlining and transparency.

Contracting and Oversight Updates

1. **Tier 3 contract audits**—For year 1, PHPs may not condition Tier 3 contracts on audits or other monitoring activities that go beyond what is necessary to meet AMH Tier 3 standards (e.g. NCQA Complex Case Management)

2. **Timeline for corrective actions and AMH Tier "Downgrades:**
   - PHPs must allow AMHs and CINs/Other Partners at least 30 days for remediation of non-compliance with AMH Tier 3 standards before pursuing a downgrade.
   - Practices may "self downgrade" using the process on the AMH website.
   - However, DHHS is NOT finalizing the 90-day "hold harmless period" discussed last November.

3. **Oversight processes transparency**—PHPs must share their oversight processes with AMH practices. Further, PHPs must provide notice to the AMH of any actions taken against that AMH's contracted CIN/Other Partner.

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Next Steps

1. **What are the major areas that the AMH TAG should focus on?**
   TAG Members can provide any additional feedback based on today's discussion to Krystal Hilton (krystal.hilton@dhhs.nc.gov)

2. **Next AMH TAG:** December 1, 2020 from 1:00-2:30 PM
   - ***AMH Data Subcommittee to reconvene: date being finalized***

3. **Upcoming webinars:**
   - **AMH Fireside Chat: November 5, 2020 at 5:30 PM**
   - **AHEC AMH Webinar #1: December 10, 2020 at 5:30 PM**