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

Meeting #34

December 12, 2023

Agenda

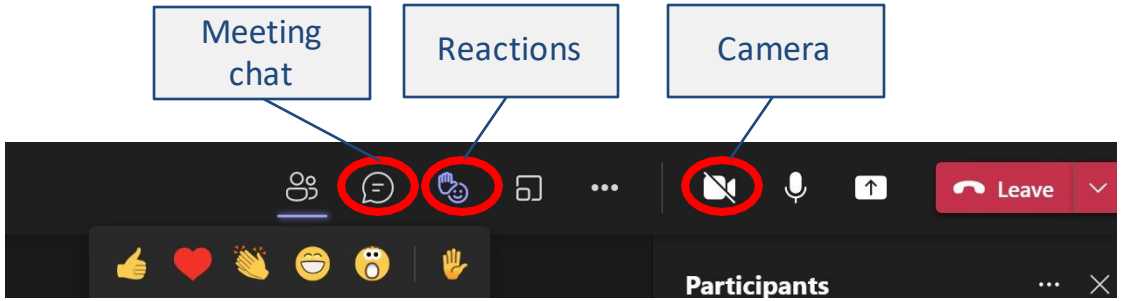
1. Welcome and Roll Call – 3 min
2. Healthy Opportunities Program (HOP) Value-Based Payment Period 3 Updates- 15 min
3. Incorporating the Medicaid Expansion Population into Quality Measurement and Incentive Programs – 15 min
4. Updates and Discussion - 15 min
5. Wrap-up and Next Steps – 2 min

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)
Amanda Gerlach	Vice President Mission Health Partners (MHP)	Provider (CIN)
Lauren Lowery, MPH	Director of Operations 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)
Diego Martinez	Interim Chief Executive Officer AmeriHealth Caritas North Carolina, Inc.	Health Plan
Michael Ogden, MD	Chief Medical Officer Blue Cross and Blue Shield of North Carolina	Health Plan
Carol Stanley, MS, CPHQ	Medicaid Transformation Manager NC Area Health Education Center (NC AHEC)	AHEC
Eugenie Komives, MD, Keith Caldwell, and Zach Mathew	WellCare of North Carolina, Inc.	Health Plan
William Lawrence, MD	Chief Medical Officer Carolina Complete Health, Inc.	Health Plan
Robert Rich, MD, and Atha Gurganus	United	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
Chris Magryta, MD	Chairman Children First of North Carolina	Provider

Meeting 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.



Please note that we are not recording this call, and request that no one record this call or use an AI software/device to record or transcribe the call.
DHHS is awaiting additional direction from our Privacy and Security Office on how we need to support these AI tools.
Thank you for your cooperation.

Healthy Opportunities Pilot (HOP)
Value-Based Payment Period 3 Updates

HOP Value-Based Payment (VBP) Period 3 Overview

- CMS has instituted a detailed value-based payment design for HOP's VBP Period 3
- VBP Period 3 was scheduled to begin on 12/1/23, but is currently delayed to allow time for Standard Plan and local care management entity contracting. The Department will communicate a new start date to the measurement and withhold period, which will run through 10/31/2024 (the conclusion of the current 1115 waiver). DHHS will evaluate all HOP-participating entities' performance on VBP measures, including Standard Plans, HOP-participating local care management entities, Network Leads, and HSOs during this period.*
- The Department will make incentive payments to Standard Plans and their HOP-participating local care management entities for meeting performance targets that align with and further the state's overarching priorities for HOP based on learnings and implementation to date, including promoting HOP enrollment, increasing referrals to HOP services within underutilized domains, and supporting overall HOP evaluation.
- In addition to incentive payments, as required by CMS, the state will apply withholds to Standard Plans and HOP-participating Tier 3 AMHs/CINs tied to meeting minimum performance targets related to the percentage of HOP enrollees that received a service to address an unmet resource need.

*Network Leads and their contracted Human Service Organizations (HSOs) will be subject to a different set of VBP measures.

Incentive Payment Milestones and Weights for SPs/Local CM Entities

Below are VBP Period 3 milestones and weights for Standard Plans and their HOP-contracted care management entities.

#	Milestone	% Weight
1	Meet or exceed a total Pilot enrollment target for the measurement period, as set by the Department for each Standard Plan for at least 3 months (months do not have to be consecutive) during VBP Period 3.	40%
2	20% increase in service referrals generated and sent within non-food domains from a baseline period of 7/1/2022 – 6/30/2023.	25%
3	90% of Pilot enrollees are re-assessed for their ongoing Pilot eligibility and service needs within 6 months of Pilot enrollment.	35%
	Total	**100%**

Incentive Payment Funding Split Between SPs and Local CM Entities

Below are VBP Period 3 funding splits between SPs and their HOP-contracted local care management entities. Funding splits are based on Department data of the portion of HOP care management provided by SPs and Local CM Entities.

#	Milestone	SP Portion	Local CM Entities Portion	Total
1	Meet or exceed a total Pilot enrollment target for the measurement period, as set by the Department for each Standard Plan for at least 3 months (months do not have to be consecutive) during VBP Period 3.	40%	60%	100%
2	20% increase in service referrals generated and sent within non-food domains from a baseline period of 7/1/2022 – 6/30/2023.	40%	60%	100%
3	90% of Pilot enrollees are re-assessed for their ongoing Pilot eligibility and service needs within 6 months of Pilot enrollment.	40%	60%	100%

Withholds for Standard Plans and HOP-Participating AMHs/CINs

As required by CMS, the Department will apply withholds to Standard Plans and HOP-Participating Tier 3 AMHs/CINs tied to meeting minimum measures related to the percentage of HOP enrollees that received a services to address an unmet resource need. HOP-participating Local Health Departments are not subject to withholds.

- **Measurement Approach & Period:**
  - The Department will measure this by setting a baseline measurement of the percentage of HOP enrollees with an unmet resource need that have received at least one HOP service, and comparing that to the percentage of HOP enrollees with an unmet resource need that received a HOP service during the VBP Period 3 measurement period.
  - If the overall percentage of HOP enrollees that received a service to address an unmet resource need shows an improvement of at least 5% through the measurement period, the Department will pay out the amount withheld.
- **HOP Payments Subject to Withhold**: HOP administrative payment and HOP care management PMPM payment, for Standard Plans and local CM entities, respectively.
- **% of HOP Payments to be Withheld:**
  - 1% of HOP administrative payments will be withheld from Standard Plans.
  - 1% of HOP care management PMPM payment will be withheld from local CM entities

Incorporating the Medicaid Expansion Populations into Quality Measurement and Incentive Programs

Medicaid Expansion, Quality Measurement, and Incentive Programs

Expansion began on December 1, and the Department anticipates that 600,000 adults will be eligible. Expansion members who meet continuous enrollment criteria in their Standard Plan for 2024 will be included in quality measure calculations.

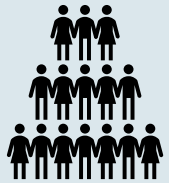
Situation

- Providers are expressing concern about having the Expansion population included in their quality measure calculations for 2024, fearing quality measure performance will be adversely affected by an influx of enrollees who have not received regular care in the past and for whom limited data are available on previous care.
- Standard Plans have asked if the Expansion population will be included in measurements for the Standard Plan withhold program.

Medicaid Expansion Members and Quality Measurement

Research on states that have previously expanded Medicaid *do not* suggest systematic decreases in plan-level[1] or safety-net hospital level[2] quality performance.

However, the Department recognizes practices may have concerns about taking accountability for Expansion members:



Some Medicaid Expansion members may not have had a **regular source of care** in the past and providers will have less time in the first year to close care gaps for new members.

The Department will have **little or no data** on many Medicaid Expansion members' previous care.

To alleviate providers' concerns, the Department intends to issue a policy update that:

1) Creates a **fair quality measurement methodology** that does not introduce a disincentive for practices to serve Expansion members; and

2) Encourages engagement of new Expansion members **to close care gaps.**

1. Ndumele CD, Schpero WL, Trivedi AN. Medicaid Expansion and Health Plan Quality in Medicaid Managed Care. Health Serv Res. 2018 Aug;53 Suppl 1(Suppl Suppl 1):2821-2838. doi: 10.1111/1475-6773.12814. Epub 2017 Dec 12. PMID: 29230801; PMCID: PMC6056574.
2. Chatterjee P, Qi M, Werner RM. Association of Medicaid Expansion With Quality in Safety-Net Hospitals. JAMA Intern Med. 2021;181(5):590–597.

Expansion Members May Affect Performance on Certain Measures

DHB has set annual quality performance targets for some of the 13 AMH measures in 2024 (5% relative improvement from prior year baseline). These targets are informational and do not have direct financial implications for practices, but PHPs can use these AMH measures for VBP arrangements.

8 out of 13 AMH measures will include members of the Expansion population in 2024 performance rates. The remaining measures are limited to previously-eligible/enrolled populations (i.e., children and pregnant enrollees).

Measure Name	Will Include Newly Expansion-Eligible Population in 2024 Performance Rates
Cervical Cancer Screening (CCS)	**Yes**
Child and Adolescent Well-Care Visits (WCV)	No
Childhood Immunization Status (Combination 10) (CIS)	No
Chlamydia Screening in Women (CHL)	**Yes**
Colorectal Cancer Screening (COL)	**Yes**
Controlling High Blood Pressure (CBP)	**Yes**
Glycemic Status Assessment (GSD)	**Yes**
Immunizations for Adolescents (Combination 2) (IMA)	No
Plan All-Cause Readmissions (PCR)	**Yes**
Prenatal and Postpartum Care (PPC)	No
Screening for Depression and Follow-Up Plan (CDF)	**Yes**
Total Cost of Care	**Yes**
Well-Child Visits in the First 30 Months of Life (W30)	No

Withhold Performance Will be Minimally Affected by Expansion

The first year of the Standard Plan Withhold Program will begin in January 2024. Withhold performance targets do not have a direct financial implications for practices, but will affect plans.

Neither of 2 pay-for-performance withhold measures will include members of the Expansion population in 2024 performance rates. The HRRN Screening measure will be assessed based on data quality in the primary withhold calculation and will include Expansion members, but their screening rates will only be considered in calculation of the Bonus Pool.

Measure Name	Includes Newly Expansion-Eligible Population	Affect on PHP Performance and Potential Withhold Payout
Childhood Immunization Status (Combination 10) (CIS)	No	None; includes **child population who were previously eligible** for Medicaid
Prenatal and Postpartum Care (PPC)	No	None; includes **mothers who were previously eligible** for Medicaid
Health-Related Resource Needs Screening (HRRN Screening)	**Yes**	Limited; HRRN is **scored as pay for reporting** in the base capitation program and the bonus pool awards the highest performing plan **(not compared to a baseline that excludes Medicaid Expansion members).**

Policy Update

For measurement year 2024 (Jan-Dec), the Department will require PHPs to:

- **Stratify** the 8 AMH measures that may include Expansion members to generate 2 performance rates : 1) including Expansion members; and 2) excluding Expansion members. In contracting with practices, PHPs will hold providers accountable for the **performance rate of <u>whichever stratum performs better</u>**.
- For any **VBP arrangement** with providers, PHPs will use the **<u>better-performing stratum</u>** in reference to performance against AMH measure targets.
- For the **Standard Plan Withhold Program**, performance will not be stratified for the Expansion population.

This is a temporary policy that the Department will revisit once performance data for the Medicaid Expansion population becomes available.

Updates and Discussions

For Discussion...

- Update
  - AMH Interface Timeline Standardization Workgroup Kick-off on 12/8/23
- Medicaid Expansion
  - Only two weeks into Expansion, would like to hear about it is going.
  - A couple of things we've heard so far:
    - Members showing up for appointments without Medicaid cards
    - One provider raised an issue with some of its practice locations receiving member assignment even though they had reached panel capacity
  - Want to remind providers to communicate with your PHP and update panel limits directly with PHPs. Also update information in NC Tracks as plans must use Age, Gender, and taxonomy information from NCTracks during PCP Assignment.
    - If you're not accepting any more members, please indicate in NCTracks that that you are not accepting members and communicate directly with your PHP so they are aware.
    - Please confirm that the Age and Gender limits that you have set in NCTracks are accurate.
- Tailored Plan Launch
  - Tailored Plans are expected to launch on July 1, 2024. It is critical that we have primary care network adequacy. We encourage providers to compete contracting with TPs in a timely manner to ensure member assignment.
  - Any concerns/questions about contracting with TPs.

Questions

Wrap-Up

AMH TAG Wrap Up and Future Topics

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

Upcoming 2024 Meetings

Tuesday, January 9, 2024
4:00-5:00 PM

Potential Upcoming AMH TAG Topics

- NC Medicaid alignment with CMMI's Making Care Primary (MCP) Model
- PHP/TP Guidance for Provider Patient Termination