North Carolina Department of Health and Human Services (DHHS)
Advanced Medical Home Technical Advisory Group (AMH TAG) Meeting #24 (Conducted Virtually)
December 13, 2022, 4:00 PM ET

Attendees:

Name	Organization
David Rinehart, MD	President-Elect of NC Family Physicians North Carolina Academy of Family Physicians
Rick Bunio, MD	Executive Clinical Director, Cherokee Indian Hospital
Gregory Adams, MD	Member of CCPN Board of Managers Community Care Physician Network (CCPN)
Christopher Prouty, MBA (for Jennifer Houlihan, MSP, MA)	Associate Vice President Value-Based Care Operations Atrium Health Wake Forest Baptist
Amy Russell, MD	Medical Director Mission Health Partners
Kristen Dubay, MPP	Director Carolina Medical Home Network
Joy Key, MBA	Director of Provider Services Emtiro Health
George Cheely, MD, MBA	Chief Medical Officer AmeriHealth Caritas North Carolina, Inc.
Michael Ogden, MD	Chief Medical Officer Blue Cross and Blue Shield of North Carolina
Eugenie Komives, MD	Chief Medical Officer WellCare of North Carolina, Inc.
Jason Foltz, DO	Medical Director, ECU Physicians MCAC Quality Committee Member
Tara Kinard, RN, MSN, MBA, CCM, CENP	Associate Chief Nursing Officer Duke Population Health Management Office
Keith McCoy, MD	Deputy CMO for Behavioral Health and I/DD Community Systems, Chief Medical Office for Behavioral Health and I/DD
Deborah Dittberner, MD, MBA	Regional Medical Director Aledade
NCDHHS Staff and Speakers	**Title**

Kelly Crosbie, MSW, LCSW	Chief Quality Officer
Elizabeth Kasper, MSPH	Special Policy Advisor – Alternative Payment Models
Emma Sandoe, PhD, MPH	Associate Director, Strategy and Planning
Seirra Hamilton, MPH	Population Health Analyst

Agenda

- Welcome and Roll Call
- Health Equity & Language Access: Interpretation and Translation Services
- Value-Based Payment (VBP) Update
- Wrap-Up and Next Steps

Health Equity & Language Access: Interpretation and Translation Services

- The Department requested TAG members' feedback regarding new policy related to interpretation and language services.[1] These services are important to overcoming language barriers between members and providers, which improves patient satisfaction, adherence to health protocol(s), and reduces the occurrence of adverse events.
- Currently, NC Medicaid does not have a specific code that enables reimbursement for interpretation and language services and providers typically bill these as administrative costs. Thus, there is no clear system for providing and paying for these services, so many NC Medicaid members cannot understand their health information and thus cannot adequately access the health system as a whole.
- The Department proposed three new reimbursement options for interpretation and language services, to include:
    - Option 1: NC Medicaid contracts translators for spoken language interpretation services. Under this model, providers would make appointments for a pre-contracted translator during a patient visit, then submit reimbursement requests to NC Medicaid. There would be a limited budget for this service (not universal).
    - Option 2: NC Medicaid adds a code for reimbursement of both translation and interpretation services to the state plan, which would allow any Medicaid provider to bill for these services following delivery. Providers and practices would be responsible for hiring or contracting with interpreters and translators under this option. Both interpretation and spoken language translation would be universal benefits.
    - Option 3: NC Medicaid adds translation services into the state plan but keeps the current pilot program for interpretation services (Medicaid Communication Access Service Pilot). Similar to Option 2 but the two services (interpretation for deaf and hard of hearing and spoken language interpretation/translation) would be provided differently, rather than in a uniform way.

[1] Health Plans are required by the NC Medicaid contract to provide language assistance services, including the provision of qualified interpreters and translation services, and auxiliary aids and services.

- TAG members noted that Option 1 may lead to underutilization but practices may prefer to have the free service from the Department. TAG members also flagged that Option 2 may be more responsive to member needs as it would be a universal benefit and providers would have a clear reimbursement structure.
- The Department plans to conduct continued stakeholder work and encouraged TAG members to **submit additional feedback over email to Emma.Sandoe@dhhs.nc.gov**.

Value-Based Payment (VBP) Update

The Department's Vision for Primary Care Reforms

- The Department intends to pursue reform efforts around primary care and maternal and infant health and seeks stakeholder input on the direction of future reforms.
- On November 17th, 2022, the Department issued a white paper for public comment.
- The Department acknowledged previous stakeholder feedback on care delivery and payment reform in primary care:
    - Stakeholders highlighted several challenges with primary care delivery, including access issues in rural areas, local care management integration in current AMH model, and a lack of access to behavioral health.
    - There is wide variation in provider readiness for VBP arrangements. Stakeholders identified the need to move towards more flexible payments for PCPs, ensure data and patient panel attributions are correct, and ensure multi-payer alignment.
- The Department is interested in building on the AMH program. The Department's key strategies to improve the program focus on access, member engagement, payment, provider supports, data and panel management.
- The Department facilitated a discussion on local care management in the AMH model:
    - TAG members noted that the level of integration of local care management has varied across practices. Care managers are not always geographically local. It has been challenging to hire in-person care managers since the pandemic given strain on workforce generally and that some individuals chose remote work over in-person work.
    - TAG members noted that in an ideal state care managers would be embedded at the practice level and closely connected with providers. A TAG member noted reduced frequency of referrals after loss of practice-level care managers due to COVID.
    - TAG members recognized the need for flexible care management models across various types of practices, given that embedded care managers may not always be possible in smaller practices. In such cases, TAG member stressed the continued importance of local, personal relationships with care managers who know the community well.
    - TAG members highlighted the importance of Electronic Medical Record (EMR) integration with care management in order to improve information sharing and communication.
- The Department facilitated a discussion on payment within the AMH program:
    - TAG members noted the benefits of the care management and medical home fees for investing in the systems and staff capacity for delivering whole-person, coordinated care.

    - TAG members suggested that the care management, medical home, and performance incentive payment buckets remain separate and earmarked for payment allocation and accountability, especially for large systems in order to ensure that the infrastructure is invested in. It was mentioned that earning quality performance incentive payments has been challenging due to low quality data.
    - TAG members noted that additional payment supports and PMPM within the AMH model for areas such as integrated behavioral health and pharmacy, including prior authorizations, would be helpful for creating the infrastructure to support these areas.
    - TAG members suggested that prospective payment of physician fees, instead of fee-for-service, would improve flexibility for patient care in the longer term, but that interim supports for infrastructural improvements may be needed first in the shorter term.
- The Department highlighted additional questions for stakeholders on the topics of primary care connections to maternal health and behavioral health and encouraged TAG members to provide written feedback on these topics.
- The Department requests stakeholders provide feedback and respond to questions in the paper by **emailing Medicaid.NCEngagement@dhhs.nc.gov (subject line "VBP Feedback") by December 19th.**

Interim AMH Model

- As the Department considers ways to strengthen primary care (e.g., via the AMH program), it is considering implementing an interim step in evolving the AMH program. The Department is focused on recognizing and testing other pathways, beyond delegated care management, that AMH practices may be taking to achieve whole-person, coordinated care, such as participating in alternative payment models.
- The Department proposes to maintain the current AMH structure but create an **optional** new track for AMH Tier 3s that does not require accepting delegated care management and includes new alternative payment standards. Both Tier 3 tracks would still receive Medical Home fees. Care management fees would be paid only to the "Care Management" Track.
- The Department facilitated a discussion on the design of the interim AMH model:
    - TAG members noted that the benefit of this model for providers was not readily clear, as providers may already enter such APM arrangements. The Department clarified that although AMHs may participate in Alternative Payment Models (APMs) now, the alternative track recognizes and encourages higher level VBP arrangements.
    - TAG members highlighted the potential risk that this model may disrupt the AMH Tier 3 market. The Department indicated that it intends to minimize such risks given that the model is optional and there will be no required changes for current AMH Tier 3 practices.
    - TAG members noted that the interim model could de-emphasize the importance of local care management and that posing APM contracting as an alternative to local care management to obtain Tier 3 status does not make sense because care management and alternative payment models are not alternatives to each other. They are both unique and unrelated options for any practice to choose.

    - TAG members questioned which providers/organizations had requested this change. No providers or provider representatives on the TAG voiced a desire to pursue the model.
    - TAG members cautioned against making model changes that depend on venture-capital funded supports for VBP.
- The Department will send across the presentation to TAG members with details on the proposed interim AMH model and requests stakeholders to provide any feedback by **emailing Medicaid.NCEngagement@dhhs.nc.gov (subject line "AMH Interim changes") by December 30th.**

Wrap-Up and Next Steps

- The next AMH TAG meeting will be on Tuesday, January 10, 2022 from 4:00-5:00 PM. The agenda for the meeting is forthcoming.
- The meeting adjourned shortly after 5:00 pm.