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

Meeting #24: Health Equity & Language Access, Interpretation and Translation Services; Value-Based Payment Update

December 13, 2022

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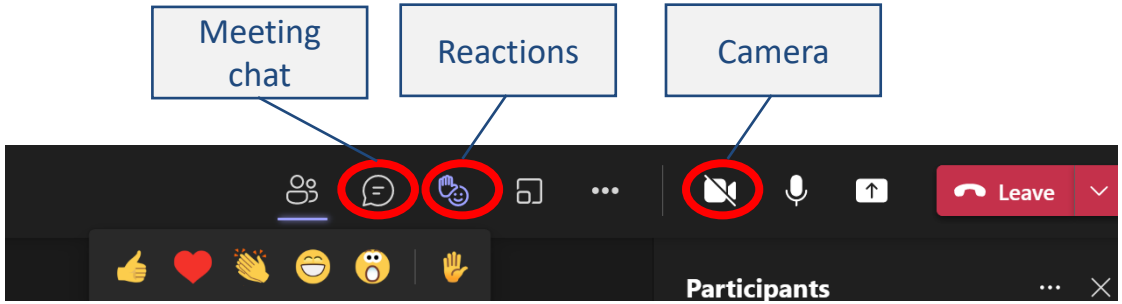
AMH TAG Member Welcome and Roll Call

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

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.



Health Equity & Language Access:
Interpretation and Translation Services

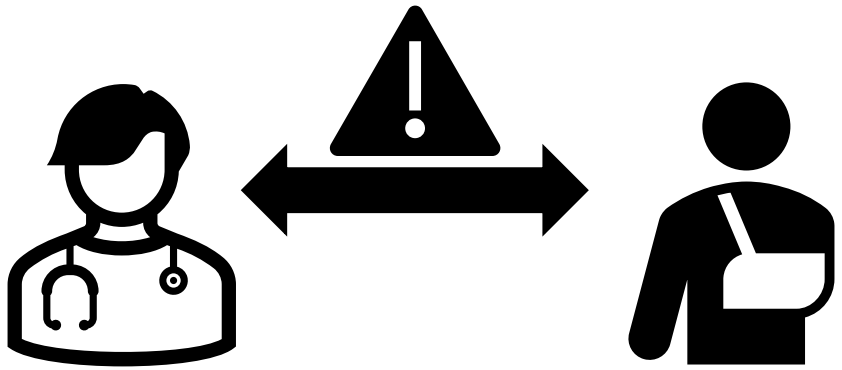
Presenters: Maria Perez and Emma Sandoe

Background:
Why are translation and interpretation services important?

- **To break language and hearing barriers to understanding heath information**
- **Breaking this barrier subsequently:**
  - Increases patient satisfaction
  - Improves adherence to health protocol and outcomes
  - Reduces the occurrence of adverse events

Background:
Why are translation and interpretation services important?

- **A lack of these services causes:**
  - Exacerbated health inequities
  - Worsened language barriers
  - Increased anxiety around visiting a doctor for marginalized populations



NC Medicaid's contracts with the health plans state:

"The PHP shall provide language assistance services, including the provision of qualified interpreters and translation services, and auxiliary aids and services to Members in accordance with translation and interpreter services requirements in the Contract to achieve effective communication."

42 C.F.R. § 438.10(d).

Background:
What does the current system for spoken language interpretation look like?

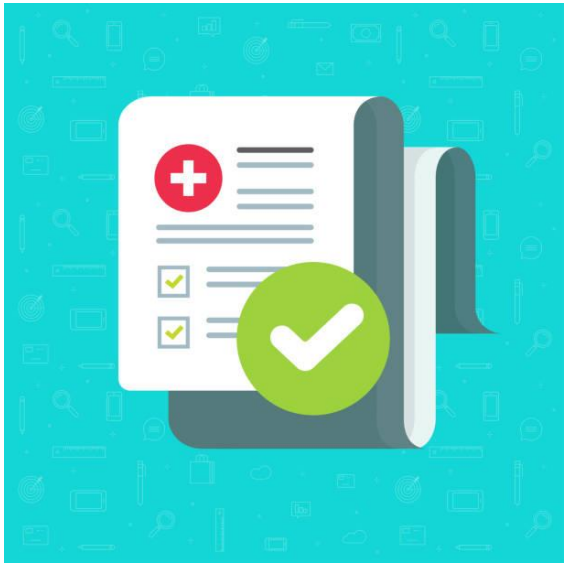
- NC Medicaid doesn't have a specific code for reimbursement of these services
- Providers usually bill the services as 'administrative costs'

There is no clear system for providing and paying for this services, so many NC Medicaid beneficiaries cannot understand their health information and thus cannot adequately access the health system as a whole.

Option 1: NC Medicaid contracts translators for spoken language interpretation services.

- Similar program for spoken language translation as the current Medicaid Communication Access Service Pilot for hard of hearing interpretation
- Providers make appointments for a pre-contracted translator during patient visit, then submit reimbursement requests to NC Medicaid
- Specified and limited budget for the contracts and reimbursement of the service
- Not a universal benefit
- Likely used most by stand-alone practices rather than in hospitals

Option 2: Add a code for reimbursement of both translation & interpretation services to the state plan.



- Any NC Medicaid provider could bill for these services after providing them
- Providers & practices would be responsible for finding the interpreters and translators
- Both interpretation and spoken language translation would be **universal benefits**
- Increases access to translation & interpretation services the same way
- Puts less strain on NC Medicaid's staff in contracting and coordination

Option 3: Add translation services into the state plan but keep current pilot program for interpretation services.

- Implement Option 2 (add code for reimbursement to state plan) only for spoken language interpretation and translation services
- 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

Feedback? Questions?

Medicaid Delivery Reform and Value-Based Payment Update

Presenter: Liz Kasper

Agenda for Today's Presentation

- Context and Summary of Stakeholder Feedback *(10 min)*
- Department Vision for Primary Care Reforms: Discussion *(35 min)*
- Interim AMH Model: Discussion *(25 min)*
- Next Steps *(5 min)*

Context and Purpose of Today's Discussion

Context

The Department has implemented several transformative changes building from the launch of Managed Medicaid in July 2021.

Medicaid Transformation Goal

To improve the health of North Carolinians through an innovative, whole-person centered and well-coordinated system of care, which addresses both medical and non-medical drivers of health.

Recent Transformation Efforts

- Standard Plans
- Medicaid Managed Care Quality Strategy
- Advanced Medical Home (AMH) Program
- Healthy Opportunities Pilots
- Value-Based Payment (VBP) Strategy for Standard Plans and Providers
- Tailored Plans (*forthcoming*)
- Children and Families Specialty Plan (*forthcoming*)

Delivery Reform and Value-Based Payment Update

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.
- Specifically, the Department seeks feedback on its intention to pursue reform efforts around **primary care and maternal and infant health**, including the integration of physical health and behavioral health and addressing members' medical and non-medical needs.
- The Department encourages stakeholders to provide feedback and respond to questions in the paper by emailing Medicaid.NCEngagement@dhhs.nc.gov by **December 19th.**
- As an interim update, the Department plans to launch an optional new pathway in the AMH structure while broader reforms are being considered.
- **Focus of today's discussion:**
  - Validate what we have heard from stakeholders to date
  - Have a robust discussion of the **key questions laid out in the white paper** around delivery reform and VBP, focusing on primary care transformation
  - Discuss the proposed design for an optional interim AMH model

Summary of Stakeholder Feedback on Primary Care

Stakeholder Feedback 2020-2022: Primary Care and Care Delivery Reform

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. However, stakeholders noted the high quality of care given by PCPs overall and various opportunities for care delivery reform.

Challenges	Opportunities
• Providers limited in their **capacity and time** with patients. Stakeholders request administrative simplification. • Difficulty **coordinating care management** across the different health plans. Some practices are not connected to their care manager. • **Telehealth** helped increase access to care during the pandemic, but access to internet/broadband is still a challenge in rural areas. • Lack of communication between physical health and behavioral health providers and a shortage of **behavioral health providers**	• Stakeholders noted **strong quality of providers and care delivered.** More support and time, especially for non-clinical care, could further expand quality of care. • Continued flexibility for **telehealth** • Importance of a **flexible, community-based workforce** (e.g., CHWs and doulas) • Enhanced **behavioral health services** overall (e.g., collaborative care) and more access to BH providers

Stakeholder Feedback 2020-2022: Primary Care and Payment Reform

There is wide variation in provider readiness for VBP arrangements, but stakeholders expressed interest in the potential for payment reform to support care delivery flexibilities and health equity. Stakeholders identified the need to move towards more flexible payments for PCPs and ensure multi-payer alignment.

Challenges

- **Administrative burden** is a challenge. Providers desired simplified documentation requirements.
- Significant **divide in readiness** between providers in smaller, independent practices and those in systems
- **Pediatric voices** expressed strongest reticence, partly due to lack of VBP experience and uncertainty about value proposition.
- **Aggressive VBP timelines** could leave some providers behind, furthering disparities.
- All providers concerned with **VBP implementation,** including panel reliability, accurate data, and risk adjustment.
- Need for **alignment across payers** for payment models and quality metrics

Opportunities

- Strong interest from adult medicine providers to entertain **prospective payment** for primary care
- Broad interest on how VBP could drive **health equity**
- Desire for payment models that allow for more flexible payment for **diverse care team members** (e.g., CHWs)
- Desire to **consider impact of uncompensated activities** related to providing care for under-resourced patients (e.g., telephonic care by nurses, CHWs addressing SDOH)

QUESTION: *Are any key ideas based on stakeholder feedback missing here?*

Department Vision for Primary Care Reforms: Discussion

- *Key Strategies*
- *Care Management*
- *Payment*
- *Connections to Maternal Health*
- *Connections to Behavioral Health*

Primary Care: Key Strategies

The Department is interested in building on the Advanced Medical Home (AMH) program, which provides a medical home to greater than 95% of Standard Plan members.

Department's Key Strategies

- **Access** - Ensure Medicaid members have timely access to high quality primary care
- **Member engagement** - Meaningfully engage members in their own care by building trusted member relationships with a community-based care team
- **Payment** - Create financial flexibility and increase incentives for primary care and the community-based care team to focus on whole-person, integrated member needs
- **Provider supports** - Engage and support providers by ensuring adequate service payment, investing in provider capacity for payment and care delivery reform, and reducing administrative burden
- **Data** - Support and incentivize actionable data at the point of care, improve data sharing, and ensure data is accurate and reliable
- **Panel management** - Create predictability and transparency for providers regarding panel assignment, attribution and management

QUESTIONS:

- *Should the Key Strategies listed be the focus of the Department's further efforts to improve and advance whole-person primary care?*
- *How do we make sure these key strategies work for particularly historically underserved populations and independent, small, and Historically Underutilized Providers (HUPs)?*
- *What are specific policy or payment interventions that would help advance these strategies?*

*Note: Please refer to the white paper for more details and the complete wording of these Key Strategies.

Primary Care: Care Management

The Department has prioritized community-based, local care management in the design of the AMH model as an important tool in supporting coordinated, whole-person care.

Discussion

1. How has the currently implemented care management model worked in supporting members?
    - Is local care management through AMHs being implemented in a way that is truly integrated with local primary care providers?
    - Do AMH providers believe they are better supported to meet the needs of their patients and coordinate their care under this care management model?
2. What changes are needed in the policies around practice-level care management to better support members in accessing coordinated, whole-person care?

Note: These discussion questions match those in the white paper.

Primary Care: Payment

The AMH program uses fee-for-service payments with additional payments for medical home fees, care management fees, and performance incentive payments.

Discussion

1. Current payment for AMH:
    - How are the medical home fees, care management fees, and performance incentive payments working to deliver coordinated, whole-person care now?
    - Which payments do AMH providers receive directly, and how are these payments being used to support coordinated, whole-person care?
    - Is there continued rationale to maintain this structure of multiple separate payments?
2. Flexibilities in current state:
    - Are AMH providers able to use some or all these payments to better serve patients and increase access?
    - Do they provide enough flexibility to support whole-person care (for example, to employ a robust care team that includes care managers and community health workers)?
    - What alternative payment models are practices currently participating in and how do they increase flexibility to support whole-person care?
3. Changes:
    - What additional changes are needed to payment to support coordinated, whole-person care?

Note: These discussion questions match those in the white paper.

Primary Care: Connections to Maternal Health

The 12-month postpartum coverage extension provides increased opportunities for postpartum women to access primary care.

Discussion

1. How can care management help ensure connections to primary care in the postpartum period?
2. How can connections be more seamless for interconception care?
3. How can primary care be leveraged to ensure early prenatal access to care?
4. How can postpartum women's connection with pediatrics for their babies be leveraged to ensure care for postpartum women?
5. What payment considerations are needed to help improve coordination?

Primary Care: Connections to Behavioral Health

A critical part of whole-person care is behavioral health care. While the Department will be doing a focused effort around this critical issue, today we want to discuss how to support the role of primary care in advancing behavioral health, particularly through strategies of integrated care.

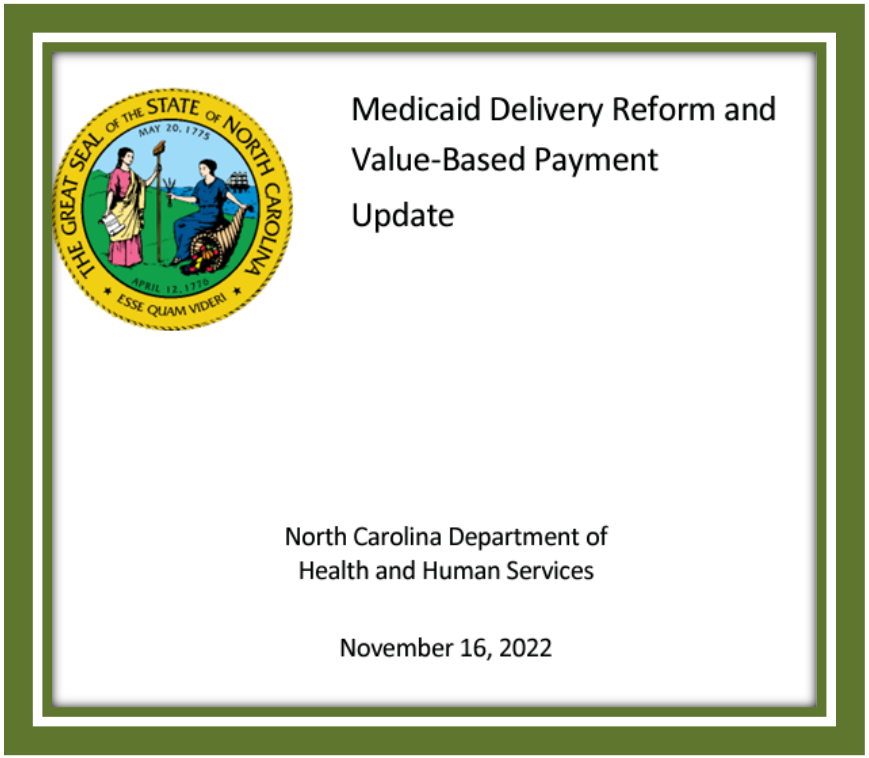
Discussion

1. What are reasonable expectations for integrating behavioral health care into the primary care setting? How should these expectations vary by AMH tier? Some potential expectations include evidence-based screening tools, behavioral health treatment such as MAT within the primary care practice, or evidence-based integrated models such as collaborative care.
2. What additional supports would your practice need to meet these behavioral health integration expectations? Some potential supports include access to consultations with behavioral health experts, or investments in health information technology/data sharing.
3. Are there alternative payment models or new care management models that the Department should consider implementing to advance behavioral health integration in primary care?

Interim AMH Model: Overview and Proposed Design

Context: Delivery and Payment Reform Work to Date

As the Department considers ways to strengthen primary care (e.g., via the AMH program) and maternal and infant health in North Carolina Medicaid, laid out in the white paper just discussed, it is considering implementing an interim step in evolving the AMH program.



As an interim step towards advancing the AMH program, the Dept. is focused on recognizing and testing other pathways AMH practices may be taking to achieve whole-person, coordinated care, such as participating in alternative payment models.

This approach is outlined on the following slides.

Context: Identified Issue and Approach to Addressing Market Feedback

While all AMHs may participate in Alternative Payment Models (APMs) now, there is currently no formal component of the program that requires or encourages higher level VBP or APM arrangements.

The Dept. intends to offer an optional new pathway in the AMH structure to recognize innovation and testing of new models of payment and care delivery.

Landscape of AMHs (as of Sept. 2022)

Tier	AMHs
Tier 1	236
Tier 2	407
Tier 3	677
Total	**1320**

AMH APM SP Contracts (June 2021 – June 2022)

AMHs	HCP-LAN 2 (FFS Linked to Quality/ Value)	HCP-LAN 3 (APMs w/ Shared Savings)	HCP-LAN 4 (Pop. Based Payment)
Tier 1 - 2	877	203	0
Tier 3	2,435	950	2
All AMHs	3,312	1,153	2

NOTE: See appendix for detailed descriptions of HCP-LAN categories

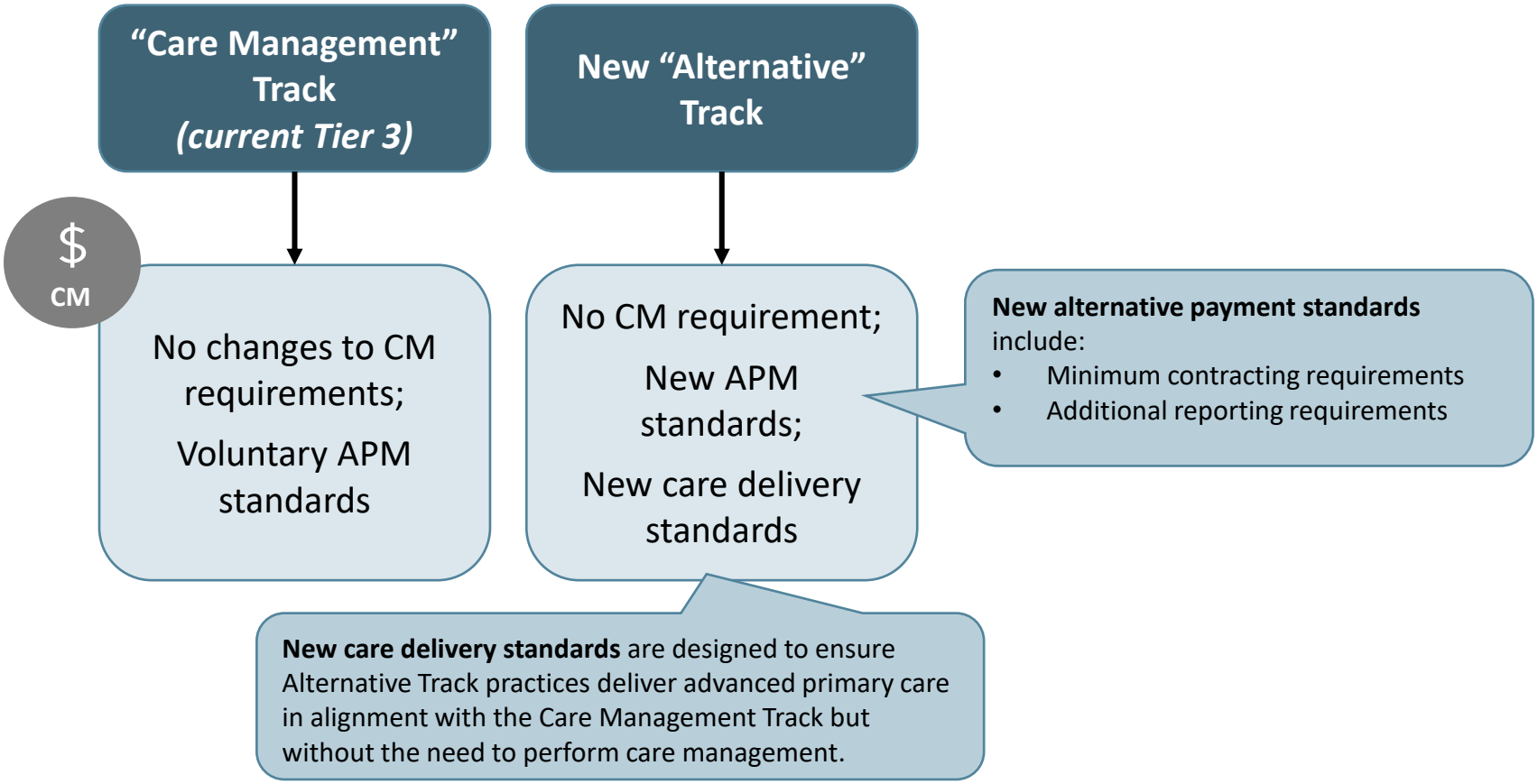
Context: Goals for Interim AMH Updates

The Department aimed to balance and pursue the goals outlined below and welcomes stakeholder engagement on how well the following interim updates accomplish these goals:

- ❑ Improve enrollee experience, patient engagement, and access to care
- ❑ Improve health outcomes for enrollees and incentivize progress on closing gaps in health disparities
- ❑ Continue to encourage and financially support community-based care management delivered by AMH Tier 3 practices
- ❑ Allow flexibility in ways in which providers who do not opt to provide delegated care management can improve primary care delivery for their patient panels
- ❑ Encourage APM adoption, especially models that can meaningfully improve care access and equitable outcomes
- ❑ Ensure changes to the AMH program remain fully optional for all AMH practices and are operationally feasible

Overview of Proposal: Updated Tier 3 Model with Two Tracks

The Dept. proposes to maintain the current AMH structure but create an optional new track for AMH Tier 3s that does not require care management and includes required 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.



Proposed Requirements for AMH Tier 3 Alternative Track

Recommended New Tier 3 APM Standards for Alternative Track, Voluntary for CM Track

Tier 3 Alternative Track practices would be required to attest that they meet all the following APM standards. Care Management track practices (i.e., current AMH Tier 3s) can voluntarily attest to these standards.

1) Practices must have at least two APM payer contracts in place during previous contract year
   - At least one of these APM contracts must be a Medicaid contract in HCP-LAN Cat. 2B or higher
   - Any non-Medicaid APM contract(s) must be in HCP-LAN Cat. 3 or higher
2) Starting with the contract year in which a practice joins the Alternative Track, at least one Medicaid contract must be in HCP-LAN Cat. 3 or higher
   - If panel size at the NPI level under Medicaid APM contract(s) is less than 125 patients, practice must partner with CIN or other partner that agrees to spread risk associated with eligible APMs across multiple practices
3) Medicaid APM contract(s) counted above must link performance on AMH quality measures, or a subset of AMH quality measures, to payment
4) Practices must report the following three data points via attestation on all APM contracts noted above:
   - Percent of total practice revenues covered under APM contracts
   - Percent of total practice revenues under APM contracts that were value-based payments
   - Percent of total revenues under APM contracts that were linked to performance on AMH quality measures, or subset of AMH quality measures

Recommended New Tier 3 Care Delivery Standards for Alternative Track Only

Tier 3 Alternative Track practices would be required to meet all the following care delivery standards as part of the attestation process. These standards are not additive to the Care Management track (i.e., current AMH Tier 3s) because they already exist in some form in that track/current Tier 3 requirements.

1) Must receive claims data feeds (directly or via a CIN) and meet Department-designated security standards for their storage and use
2) Must have process to ensure reliable flow of information and track transitions of care between practices, hospitals, and emergency departments including through access to admission, discharge and transfer (ADT) data feed
3) Must have a mechanism to identify empaneled patients at higher risk, including assessing physical, behavioral, and social needs.

These requirements are consensus best practices for those implementing advanced primary care and are not dependent on a practice performing care management.

Requirements That Do Not Change With Interim Update

This interim update is designed to be fully optional for current AMH Tier 3 practices. No changes are required for any current AMH practices in any Tier. However, if practices would like to participate in the Alternative Track pathway, they will now have the option to do so.

1) No changes to AMH Tier 1 and 2 requirements
2) No changes to AMH Tier 3 Care Management requirements
   - Care Management Track practices (i.e., current AMH Tier 3s) will still be required to abide by the current CM requirements in order to receive care management fees
   - Because Alternative Track practices do not provide delegated care management, these requirements are not applicable to these practices
3) Practices of any AMH Tier that are interested in pursuing APMs but do not meet the Alternative Track APM standards, can still pursue APMs on their own accord

Discussion of Proposed Design

Feedback on the recommendations?

Does this design meet the previously identified goals?

Any other considerations before recommending this design for implementation/operationalization?

Next Steps

Next Steps

The Department values feedback from stakeholders on the outlined approach to future reforms in Medicaid in the focus areas of Primary Care and Maternal and Infant Health.

- **Vision for primary care reforms in the white paper -** The Department requests stakeholder input on whether the approaches noted effectively balance the needs of the field and whether other considerations should be factored into future state-driven reforms and initiatives.
  - Comments on the focus areas, goals, and opportunities stated, as well as additional detail on the current landscape of reform efforts in the market, specific opportunities to align across payers, and the timing of and market readiness for future reforms are appreciated.
  - **We encourage stakeholders to provide feedback on the white paper by emailing Medicaid.NCEngagement@dhhs.nc.gov (subject line "VBP Feedback") by December 19th.**
- **Interim AMH Model** – The Department plans to integrate stakeholder feedback and refine design for future implementation. **We request stakeholders to provide any feedback by emailing Medicaid.NCEngagement@dhhs.nc.gov (subject line "AMH interim changes") by December 30th.**

QUESTION: *Do you have any other feedback or suggestions?*

AMH TAG Meeting Cadence

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

Upcoming 2023 Meetings
Tuesday, January 10, 2023 4:00-5:00 PM
Tuesday, February 14, 2023 4:00-5:00 PM

Potential Upcoming AMH TAG Topics

- Community health workers
- Screening and Referrals for the Healthy Opportunities Pilots
- Strategies to advance health equity
- Strategies to address SDOH
- Standardization of monitoring protocols/delegation protocols
- PHP Accreditation timeline and timing of AMH delegation audits

Wrap Up

- Share further feedback on today's topic with
  - Emma.Sandoe@dhhs.nc.gov
  - Maria.Perez@dhhs.nc.gov
  - Elizabeth.Kasper@dhhs.nc.gov

Department

- Review feedback from today's discussion and share with Department leadership
- Prepare for upcoming AMH TAG sessions

Appendix:
Detailed Overview of Proposed Requirements

No Changes to Tier 1 and 2 Requirements for All AMHs

Current Requirement	Status Under New Interim AMH Model
1) Accept enrollees and be listed as a PCP in the Health Plan's enrollee-facing materials for the purpose of providing care to enrollees and managing their health care needs.	***DHHS proposes no changes in this update for Tier 1 and 2 AMHs;*** *modernization of these requirements is expected in a future full update, which may include moving some of the new Tier 3 requirements focused on care delivery into Tier 2 requirements and replacing / deleting other requirements.*
2) Provide Primary Care and Patient Care Coordination services to each enrollee	
3) Provide or arrange for Primary Care coverage for services, consultation or referral, and treatment for emergency medical conditions 24/7. Automatic referral to ED for other services	
4) Provide direct patient care a minimum of 30 office hours per week	
5) Provide preventive services *(see Provider Manual for full list)*	
6) Establish and maintain hospital admitting privileges or a formal arrangement for management of inpatient hospital admissions of enrollees	
7) Maintain a unified patient medical record for each enrollee following the Health Plan's medical record documentation guidelines	
8) Promptly arrange referrals for medically necessary health care services that are not provided directly and document referrals for specialty care in the medical record	
9) Transfer the enrollee's medical record to the receiving practice upon the change of PCP at the request of the new PCP or Health Plan (if applicable) and as authorized by the enrollee within 30 days	
10) Authorize care for the enrollee or provide care for the enrollee based on the standards of appointment availability as defined by the Health Plan's network adequacy standards	
11) Refer for a second opinion as requested by the patient, based on Dept guidelines and Plan standards	
12) Review and use enrollee utilization and cost reports provided by the Health Plan for the purpose of AMH level utilization management and advise the Health Plan of errors, omissions, or discrepancies if they are discovered	
13) Review and use the monthly enrollment report provided by the Health Plan for the purpose of participating in Health Plan or practice-based population health or care management activities	

Recommended New Tier 3 APM Standards for Alternative Track, Voluntary for CM Track

APM Requirements	AMH Tier 3 Track		Rationale
	Alternative Track	Care Management Track	
1) Must have at least two Alternative Payment Model (APM) payer contracts in place during previous contract year ("historical contracts") • At least one of the historical APM contracts must be a Medicaid contract in HCP-LAN Category 2B or higher • Any non-Medicaid historical APM contract(s) must be in HCP-LAN Category 3 or higher	**Required**	**Voluntary**	*To ensure practices have VBP experience, including in Medicaid and are ready to participate in higher level APMs, and to encourage alignment across payers* *Medicare's CPC+ and PCF models also require experience with VBP to participate.*
2) Starting with the contract year in which a practice joins the Alternative Track ("current contracts"), practice must hold at least one Medicaid contract categorized in HCP-LAN Category 3 or higher	**Required**	**Voluntary**	*To ensure Alternative practices are accountable to both cost and quality outcomes, including in Medicaid.*
3) If panel size at the NPI level under current Medicaid APM contract(s) is less than 125 patients, practice must partner with CIN or other partner that agrees to spread risk associated with eligible VBP arrangements across multiple practices.	**Required**	**Voluntary**	*To ensure results from higher level VBP models are meaningful and reliable, and practices are able to accept risk.* *Mirrors CPC+, PCF panel size requirements.*
4) All current and historical Medicaid APM contract(s) counted above must link performance on AMH quality measures, or a subset of AMH quality measures, to payment.	**Required**	**Voluntary**	*To ensure practices entering higher level APMs are focused on quality and patient outcomes relevant to AMHs – not just on savings*

CPC = Comprehensive Primary Care Initiative
CPC+ = Comprehensive Primary Care Plus Model
PCF = Primary Care First Model

Recommended New Tier 3 APM Standards for Alternative Track, Voluntary for CM Track (cont'd)

APM Requirements	AMH Tier 3 Track		Rationale
	Alternative Track	Care Management Track	
5) Must report percent of total practice revenues covered under all APM contracts in the previous contract year, including the value of fee-for-service payments and value-based payments such as incentives, shared savings payments, or prospective payments • Practice with less than 40% of total revenues covered under all APM contracts must develop an approach to increase APM contracting (in Medicaid and/or across payers) over the next 2 contract years, and make such approach available to the Department in writing upon request	**Required**	**Voluntary**	*Allows DHHS to learn about how meaningful APM contracts are for a practice and how likely they are to produce real changes to care delivery, and to encourage alignment across payers.* *Research suggests higher % revenue in prospective APMs is more sustainable for PCPs, and the Dept. is considering encouraging prospective payment in future AMH updates.*
6) Must report percent of total practice revenues under all APM contracts in the previous contract year that were value-based payments in the previous contract year, including the value of any incentives, shared savings payments, or prospective payments and not including the value of any fee-for-service payments	**Required**	**Voluntary**	*Allows DHHS to learn about how meaningful APM contracts are for a practice and how much funding is supporting care delivery changes via APM contracts.* *Mirrors PCF requirement.*
7) Must report percent of total revenues under all APM contracts in the previous contract year that were linked to performance on AMH quality measures, or a subset of AMH quality measures, including the value of any quality performance incentives • Practice with less than 10% of total revenues linked to AMH quality performance must develop an approach (in Medicaid and/or across payers) to increase incentives linked to AMH quality measures over the next 2 contract years, and make such approach available to the Department in writing upon request	**Required**	**Voluntary**	*Allows DHHS to learn about how meaningful APM contracts are for a practice and how likely these contracts are to drive improvements in quality, rather than just encouraging cost savings. Sets the Dept. up to set a target in future years, if desired, based on a better understanding of where the market is.*

Recommended New Tier 3 Care Delivery Standard for Alternative Track Only

These standards are not applicable to the Care Management track (i.e., current Tier 3 AMHs) because they already exist in some form in that track/current Tier 3 requirements. These are consensus best practices for those implementing advanced primary care and are not dependent on a practice performing care management.

Care Delivery and Other Requirements	AMH Tier 3 Track		Rationale
	Alternative Track	Care Management Track	
1) Must receive claims data feeds (directly or via a CIN) and meet Department-designated security standards for their storage and use	**Required**	**N/A** *Mirrors existing requirement for CM Track*	*Improves core functionality for care delivery, and increases likelihood of success in VBP arrangements.*
2) Must have process to ensure reliable flow of information and track transitions of care between practices, hospitals, and emergency departments including through maintaining active access to an admission, discharge and transfer (ADT) data feed that correctly identifies when empaneled patients are admitted, discharged or transferred to / from an emergency department or hospital in real time or near real time; and, follow up as appropriate following discharge to connect patients back to primary care	**Required**	**N/A** *Care transitions and ADT feeds are existing requirements for CM Track*	*Promotes evidence-based, clinical best practices that are likely to result in improved outcomes and quality of care; improves core functionality for care delivery; and, increases likelihood of success in VBP arrangements.* *Consistent with NY, OR, CPC, CPC+, PCF.* *Tracking of care transitions and appropriate follow-up is lighter touch than the relevant Tier 3 Original/CM Track requirements, which require much more engagement in transition planning.*
3) Must have a mechanism to identify empaneled patients at higher risk, including assessing physical, behavioral, and social needs.	**Required**	**N/A** *Risk assessment is existing requirement for CM Track*	*Promotes evidence-based, clinical best practices that are likely to result in improved outcomes and quality of care; improves core functionality for care delivery; and, increases likelihood of success in VBP arrangements.* *Consistent with OR, OH, TN.*

Requirements for AMH Tier 3 Care Management: No Changes for CM Track, Not Applicable to Alternative Track

Current Care Requirements	AMH Tier 3 Track		Rationale
	Alternative Track	Care Management Track	
1) Be able to risk stratify all empaneled patients and use risk stratification to identify patients who may benefit from care management	**Not Required**	**Required**	*Core CM functionality; no change from current standard*
2) Define the process and frequency of risk score review and validation	**Not Required**	**Required**	*Core CM functionality; no change from current standard*
3) Perform a Comprehensive Assessment on each patient identified as a priority for care management to determine care needs	**Not Required**	**Required**	*Core CM functionality; no change from current standard*
4) Have North Carolina licensed, trained staff organized at the practice level (or at the CIN level but assigned to specific practices) whose job responsibilities encompass care management and who work closely with clinicians in a team-based approach to care for high-need patients	**Not Required**	**Required**	*Core CM functionality; no change from current standard*
5) Use a documented Care Plan for each high-need patient receiving care management (parameters for Care Plan outlined in Provider Manual)	**Not Required**	**Required**	*Core CM functionality; no change from current standard*
6) Periodic evaluation of the care management services provided to high-risk, high-need patients, and refinement of care management services as necessary	**Not Required**	**Required**	*Core CM functionality; no change from current standard*
7) Tracking of empaneled patients' utilization in other venues covering all or nearly all hospitals and related facilities in their catchment area through active access to ADT data feed	**Not Required**	**Required**	*Core CM functionality; no change from current standard*
8) Be able to provide short-term, transitional care management along with medication reconciliation to all empaneled patients who have an ED visit or hospital admission / discharge / transfer and who are at risk of readmissions and other poor outcomes	**Not Required**	**Required**	*Core CM functionality; no change from current standard*
9) Use electronic data to promote care management	**Not Required**	**Required**	*Core CM functionality; no change from current standard*

Sources

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