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

Meeting #29

July 11, 2023

Agenda

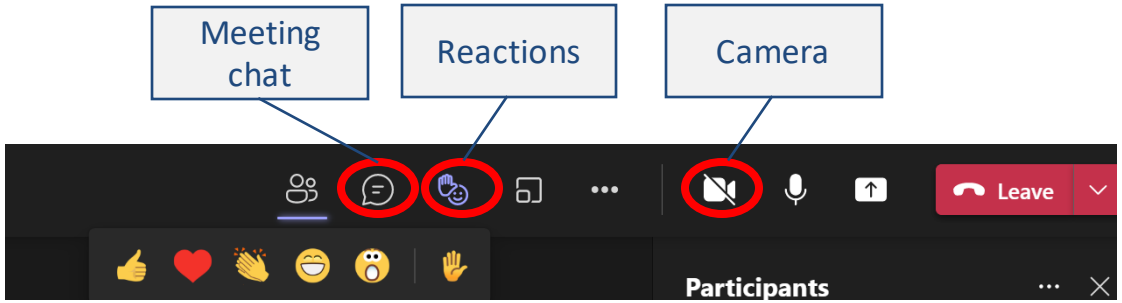
1. Welcome and Roll Call
2. TP Update
3. NCQA Health Plan Accreditation Update
4. TCM for non-TCM Providers
5. TCM Resources
6. Q & A
7. Wrap-up and Next Steps (5 minutes)

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)
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)
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
Carol Stanley, MS, CPHQ	Director, Center for Quality Improvement and Practice Support	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.



Tailored Plan Update

NCQA Health Plan Accreditation Update

Today's Objectives

DHHS will share a planned policy change to address conflicting requirements between the National Committee for Quality Assurance's (NCQA) Health Plan Accreditation requirements for Standard Plans ("PHPs") and delegated care management programs.

1. Provide background on the intersection between PHP NCQA Health Plan Accreditation requirements and those of entities to which PHPs delegate care management functions (e.g., Advanced Medical Home Program (AMH), Care Management for High-Risk Children, etc.)

2. Share a planned policy change and respond to TAG members' questions.

Background

DHHS

DHHS requires PHPs to perform *or delegate* care management functions. In addition, DHHS requires PHPs to achieve NCQA's Health Plan Accreditation by PHP Contract Year 4 (2025).

To become accredited, a PHP must be evaluated by NCQA against a set of detailed requirements related to the provision of and functions of managed health care services, including care management. **When accredited entities delegate care management services, NCQA has specific requirements about how they should oversee delegated entities.**

PHPs

In certain cases, PHPs must delegate required functions, such as care management, to providers that <u>are not required to follow NCQA standards</u>. Instead, the Department requires these providers to implement different care management processes tailored to local needs.

In the AMH program, PHPs must <u>delegate</u> care management to AMH Tier 3s and perform these functions <u>directly</u> for enrollees in AMH Tiers 1 and 2. AMH Tier 3 practices are expected to attest to a set of capabilities outlined in the AMH Tier 3 manual, which differ from NCQA's standards.

Care Management Entities

For Example:

- AMH Tier 3s
- Clinically Integrated Networks (CINs)
- Local Health Departments (LHDs)
- Care Management for High-Risk Pregnancies (CMHRP) providers
- Care Management for At-Risk Children (CMARC) providers
- Healthy Opportunities Pilots (HOP) providers
- Integrated Care for Kids (InCK) providers

Planned Policy Approach (1/2)

The Department has worked with NCQA to develop a policy whereby NCQA will deem Population Health Management (PHM)[1] activities related to oversight of care management performed by delegated entities **'not applicable'** for select functions. This policy will be in place until Standard Plan accreditation is complete in 2025.

- NCQA will only review PHM activities for eligible members where the PHP directly (rather than through a delegated entity) identified the need for complex care management *and* directly oversaw the member's care management through the end of the year
- North Carolina **will release guidance prohibiting PHPs from performing audits or other monitoring activities of entities** to which they delegate care management functions for requirements enumerated in the NCQA PHM 5 module (in previous slides) as part of Health Plan Accreditation. The Department had a **similar prohibition in place for the first year of managed care.**[1]

1. PHM 5 addresses the care management activities that PHPs are required to perform or delegate; PHM 7 addresses requirements for PHPs' oversight of delegated care management activities.
2. Notice of AMH Policy Changes requiring modifications to Advanced Medical Home (AMH) Provider Contract Templates

Planned Policy Approach (2/2)

- The prohibition means that **NCQA's review of plan performance on the care management elements of accreditation would not use documentation from delegated care management providers,** easing provider burden and allowing delegated providers to be held only to the criteria for the care management programs, not NCQA's criteria.
- Standard Plans may continue to monitor delegated entities' care management activities against other care management or program requirements (e.g., Advanced Medical Home care management requirements). [1]
- Plan activities for care management they are responsible for (e.g., for AMH Tier 1 and 2 members) would still be reviewed as part of the accreditation process (for members whose case was opened for at least 60 days during the look-back period).
- **This approach will be implemented by a contract update** during the next available amendment (January 2024) as well as communication in writing to plans and providers prior to the amendment.

1. **This policy does not change DHHS' requirements related to direct or delegated provision of care management services. This policy only addresses NCQA review as part of Health Plan accreditation.**

Looking Ahead

- NCQA Health Plan Accreditation must be renewed every three years.
- For future accreditation rounds, the Department is considering the possibility of an oversight approach developed in partnership with NCQA and coordinated among PHPs to allow plans to achieve accreditation with minimal burden on providers.
- We will continue to communicate with plans, including by providing written information as details are finalized.

Please contact Giovanna Cloney (giovanna.cloney_acn@dhhs.nc.gov) and Anna Wadhwani (anna.wadhwani@dhhs.nc.gov) with any follow-up comments or questions about NCQA Health Plan Accreditation.

Questions?

Tailored Care Management for Non-TCM Providers

Tailored Care Management and Tailored Plan Key Dates

December 1, 2022
Tailored Care Management Launch for Medicaid Direct Members

April 1, 2023
Additional Populations Included in Medicaid Direct, eligible members assigned a Tailored Care Management entity.

Tailored Plan launch postponed

What is Tailored Care Management?

Tailored Care Management is built around the six core Health Home services:

- Comprehensive care management
- Care coordination
- Health promotion
- Comprehensive transitional care/follow-up
- Individual & family support
- Referral to community & social support services

Note: Under Tailored Care Management, members will have a single care manager who will be equipped to manage all of their needs, spanning physical health, behavioral health, I/DD, TBI, pharmacy, LTSS, and unmet health-related resource needs.

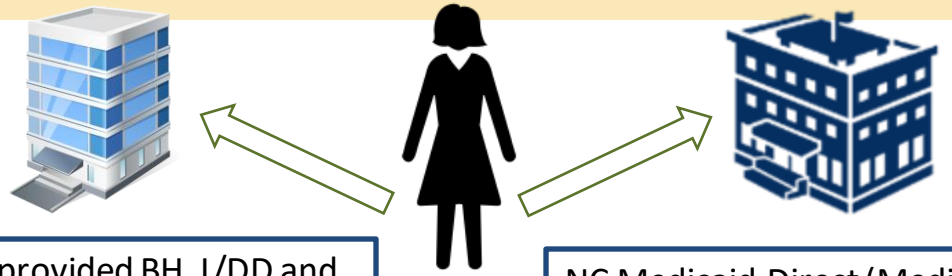
Why is it called "Tailored Care Management? Because care mangers will be serving:

- Individuals enrolled in NC Medicaid Direct (e.g., dual eligibles) who would otherwise be eligible for a Tailored Plan if not for belonging to a group delayed or excluded from managed care.
- All LME/MCO Members eligible for Tailored Plans, including individuals enrolled in the 1915(c) Innovations and TBI waivers.

Transition to Whole-Person Care

Managed care products will offer whole-person care and enable the delivery of physical and behavioral health through one plan.

Historical Environment

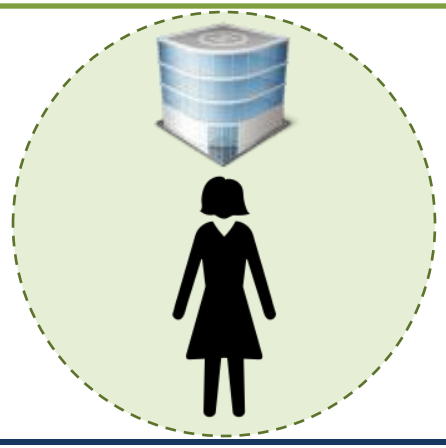


LME-MCOs provided BH, I/DD and TBI services

NC Medicaid Direct (Medicaid FFS) provided physical health services

Integrated Managed Care Environment

Plans will provide whole-person care



Core Principles of Tailored Care Management Model

Tailored Care Management is the primary care management model for Tailored Plans.

Core Principles

- Broad access to care management
- Single care manager taking an integrated, whole-person approach
- Person- and family-centered planning
- Provider-based care management
- Community-based care management
- Community inclusion
- Choice of care managers
- Consistency across the state
- Harness existing resources

Three Approaches to Delivering Tailored Care Management

Department of Health and Human Services

Establishes care management standards for Tailored Plans aligning with federal Health Home requirements.

The Tailored Plan will act as the Health Home and will be responsible for meeting federal Health Home requirements

Tailored Plan (Health Home)

Care Management Approaches

Tailored Plan beneficiaries will have the opportunity to choose among the care management approaches; all must meet the Department's standards and be provided in the community to the maximum extent possible.

Approach 1:
"AMH+" Primary Care Practice
Practices must be certified by the Department to provide Tailored Care Management.

Approach 2:
Care Management Agency (CMA)
Organizations eligible for certification by the Department as CMAs include those that provide BH or I/DD services.

Approach 3:
Tailored Plan-Based Care Manager

The Department will allow – but not require – AMH+ practices and CMAs to work with a **CIN or other partner** to assist with the requirements of the Tailored Care Management model, within the Department's guidelines.

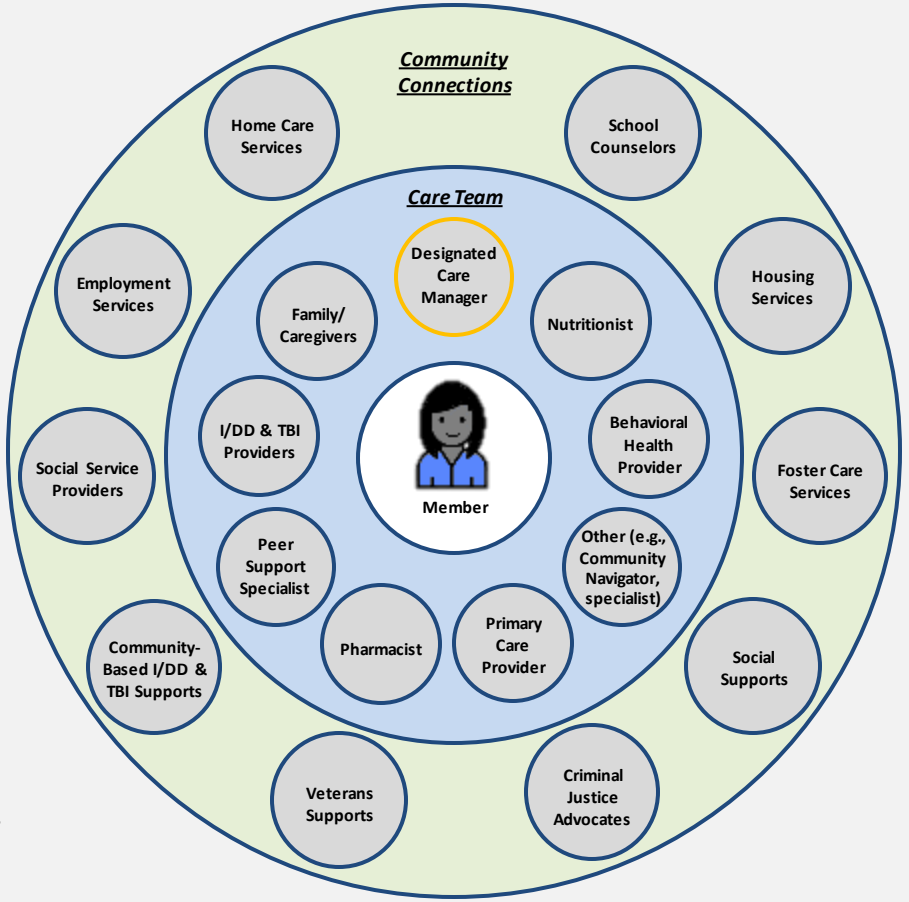
What is integrated Care Management?

Under Tailored Care Management, members will have a single care manager who will be equipped to manage all of members' needs, spanning physical health, behavioral health, I/DD, TBI, pharmacy, LTSS, and unmet health-related resource needs.

Integrated care management places the person at the center of a multidisciplinary care team and recognizes interactions across all of their needs—ranging across physical health, behavioral health, I/DD, TBI, LTSS, and unmet health-related resources—developing a holistic approach to serve the whole person.

In integrated care management, care managers:

- **Coordinate a comprehensive set of services** addressing all of the member's needs; members will not have separate care managers to address physical health, behavioral health, TBI, and I/DD-related needs.
- **Provide holistic, person-centered planning.** Members receive a care management assessment that evaluates all of their needs—from physical health, behavioral health, I/DD, and TBI services to employment and housing—and drive the development of a care plan that identifies the goals and strategies to achieve them.
- **Address unmet health-related resource needs** (e.g., housing, food, transportation, interpersonal safety, employment) by connecting members to local programs and services.
- **Are part of multidisciplinary care teams** made up of clinicians and service providers who communicate and collaborate closely to efficiently address all of the member's needs.
- **Utilize technology** that bridges data silos across providers and plans.



What Tailored Care Managers Do

Under TCM, beneficiaries will have a single care manager equipped to manage all the beneficiary's needs, spanning physical health, behavioral health, I/DD, TBI, pharmacy, long-term services and supports (LTSS) and unmet health-related resource needs.

Tailored Care Managers may be an Advance Medical Home Plus (AMH+), Care Management Agency (CMA) or provided through the beneficiary's health plan. Tailored Care Managers will:

- Develop care management comprehensive assessments and care plans/individual support plans with beneficiaries
- Coordinate/refer/monitor all services (medical, pharmacy, behavioral health, waiver services, food, housing, transportation, community resource supports)
- Support beneficiaries in a crisis (with planning supports)
- Arrange for annual physicals
- Innovations and TBI waiver care coordination (if applicable)
- Convene and consult with a multidisciplinary care team
- Provide management for beneficiaries with chronic, high-risk, high-cost care management needs
- Help with medication monitoring
- Address unmet health-related resource needs
- Educate on chronic health conditions and support self-health management (eating healthier
- Monitor Hospital Admission Discharge and Transfer (ADT) alerts and ensure beneficiaries with any admissions, discharges or transfers are followed
- Support transitions out of hospitals and nursing facilities

Tailored Care Management Eligibility

- **All Tailored Plan Members are eligible for Tailored Care Management, including individuals enrolled in the 1915(c) Innovations and TBI waivers.**
- **Individuals enrolled in Medicaid fee-for-service (e.g., dual eligibles) will also have access to Tailored Care Management, if they otherwise would be eligible for a Tailored Plan if not for belonging to a group delayed or excluded from managed care.**

The Department has determined that the below services are duplicative of Tailored Care Management and an individual will not be allowed to receive both simultaneously:

- Case management provided through Assertive Community Treatment (ACT)
- Case management provided through Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-IIDs)
- Care management provided through the High-Fidelity Wraparound program
- Care Management for At-Risk Children (CMARC)

How PCPs Will Interact with TCM Care Managers for Members They Serve

A care manager may contact your office to:

- Identify the agency and the member they represent and present release of information documentation
- Explain their role in the member's care and talk about participation in the member's care team
- Ask questions about symptoms, medication and treatment
- Share concerns about/from the member
- Ask questions about lifestyle changes that would promote better health for the member
- Request support for referral to another provider

How do I Know Who My Patient's TCM Provider is?

The Enrollee Report for Primary Care Practices:

- The Advanced Medical Home (AMH) NC Medicaid Direct/NC Medicaid Managed Care Primary Care Provider (PCP) Enrollee Report (Enrollee Report) contains information on members assigned to PCPs in Medicaid Direct and Managed Care

- The Enrollee Report has been updated to include members assigned to TCM providers and it allows PCPs to know their assigned member list

- The Enrollee Report is delivered each month to the NCTracks Secure Provider Portal Message Inbox

TCM Resources

- Tailored Care Management Factsheet
- Enrollee Report Updates for Primary Care Practices in Advance of Tailored Plan Launch Factsheet
- Panel Management for Primary Care Providers Factsheet
- TCM Provider List

Questions?

AMH TAG Wrap Up and Future Topics

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 2023 Meetings
Tuesday, August 8, 2023 4:00-5:00 PM
Tuesday, September 12, 2023 4:00-5:00 PM
Tuesday, October 10, 2023 4:00-5:00 PM

Potential Upcoming AMH TAG Topics

- Updates to Quality Measure Technical Specifications
- Standard Plan Workaround for Interim Care Gap Reporting
- Standard Plan Withholds Program

Appendix

Intersection Between NCQA and NC's Local Program Requirements

The Department's local care management program requirements do not correspond directly to NCQA's Population Health Management (PHM) requirements that PHPs (and later Tailored Plans) will be required to meet as part of Health Plan accreditation. PHPs can deliver their own care management in accordance with NCQA accreditation standards, but they cannot require delegated entities to do so.

NCQA Health Plan Accreditation PHM 5: Complex Case Management Module	NCQA PHM 5 Key Requirement(s)	EXAMPLE: Whether PHM 5 Requirement(s) Overlap with AMH Program Care Management Requirements (i.e., completely, partially, not explicit in AMH guidance)
A. Access to Case Management	The organization has multiple avenues for members to be considered for complex case management services.	Not explicitly outlined in AMH guidance; Standard Plans may be performing these functions in collaboration with AMHs and CINs
B. Case Management Systems	The organization uses case management systems that support: 1. Evidence-based clinical guidelines or algorithms to conduct assessment and management 2. Automatic documentation of staff ID, and the date and time of action on the case or interaction 3. Automated prompts for follow-up	Partial; AMH care management systems include evidence-based clinical guidelines for assessment and management
C. Case Management Process	The organization's complex case management procedures address the following, for e.g., initial assessment of member health status, evaluation of community resources, development of individualized case management plan, etc	Partial; AMH care management procedures include some of the same requirements
D. Case Management – Initial Assessment	The organization follows its documented processes for completing the following within 60 calendar days, for e.g., initial assessment of member health status, initial assessment of social determinants of health, evaluation of caregiver resources and involvement, etc.	Partial; AMH care management processes include some of the same requirements
E. Case Management – Ongoing Management	The organization follows its documented processes for: 1. Development of case management plans that include prioritized goals 2. Identification of barriers to meeting goals and complying with the case management plan 3. Development of schedules for follow-up and communication with members 4. Development and communication of member self-management plans 5. Assessment of progress against case management plans and goals	Partial; AMH program requires development of care plans and tracking progress against goals

Analogous differences exist for other PHM requirements (1-4, 6-7), but for those requirements PHPs are also conducting parallel processes that are expected to accord with NCQA standards. DHHS expects that NCQA will assess the other PHM requirements at the PHP-level.

Note: NCQA uses the term "complex case management" to refer to what NC considers "care management"

Example NCQA Review Scenarios

Key	
	Assigned to AMH Tier 3 (Responsible for Care Management)
	Assigned to AMH Tier 1 or 2 (Care Management by PHP)

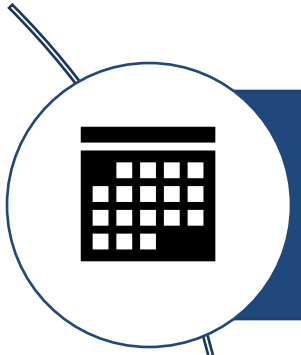
Scenario 1: A member was initially assigned to an AMH Tier 3 practice in January and re-assigned to an AMH Tier 2 practice in February. The member's PHP records indicate that no initial assessment of care management needs was conducted. In this case, NCQA will exclude the member's file from review because they were not identified as eligible for care management by the PHP. *In this case, NCQA would only review the member's file if the PHP had conducted its own comprehensive assessment **and** identified the member as eligible for care management during the 12-month look-back period.*

January	February	March	April	May	June	July	August	September	October	November	December

Scenario 2: A member was initially assigned to an AMH Tier 3 practice in January and re-assigned to an AMH Tier 1 practice in November. The member's PHP does not indicate contact with care managers or receipt of care management services. In this case, NCQA will exclude the member's file from review as they were not identified for care management by the PHP and has not been assigned to the plan for more than 60 days. *In this case, NCQA would only review the member's file if the PHP had conducted its own comprehensive assessment and identified the member as eligible for care management, **and** if the member's file had been open with the PHP for more than 60 days during the 12-month look-back period.*

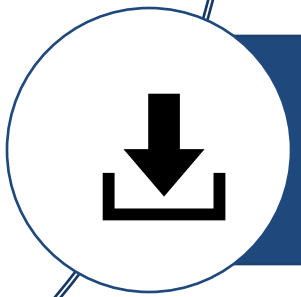
January	February	March	April	May	June	July	August	September	October	November	December

NCQA's File Review Process



NCQA will randomly select 50 files for care management review, to allow a sample of 30 care management files with up 20 files as an oversample to ensure an appropriate number of files for review.

Files are selected from active or closed member cases that were identified by the PHP during the look-back period (12 months) and remained open for at least 60 calendar days during the look-back period, from the date when the member was identified for care management.



The organization must provide the identification date for each case in the file universe.

AMH+ and CMA Definitions

Advanced Medical Home Plus (AMH+)

Definition: Primary care practices **actively serving as AMH Tier 3 practices**, whose providers have experience delivering primary care services to the Tailored Plan eligible population or can otherwise demonstrate strong competency to serve that population. To demonstrate experience and competency to serve the Tailored Plan eligible population, **each AMH+ applicant must attest that it has a patient panel with at least 100 active Medicaid patients who have an SMI, SED, or severe SUD; an I/DD; or a TBI**.

AMH+ practices may, but are not required to, offer integrated primary care and behavioral health or I/DD services.

To be eligible to become an AMH+, the practice must **intend to become a network primary care provider for Tailored Plans**.

Care Management Agency (CMA)

Definition: Provider organizations with **experience delivering behavioral health, I/DD, and/or TBI services to the Tailored Plan eligible population**, that will hold primary responsibility for providing integrated, whole-person care management under the Tailored Care Management model.

To be eligible to become a CMA, an organization's **primary purpose** at the time of certification must be the delivery of NC Medicaid, NC Health Choice, or State-funded services, other than care management, to the Tailored Plan eligible population in North Carolina. The "CMA" designation is new and will be unique to providers serving the BH I/DD Tailored Plan population.

The Tailored Plan must contract with all organizations in its region that receive AMH+ or CMA certification to provide Tailored Care Management.

AMH+ practices or CMAs must not be owned by, or be subsidiaries of, Tailored Plans.