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

Meeting #39

June 11, 2024

Agenda

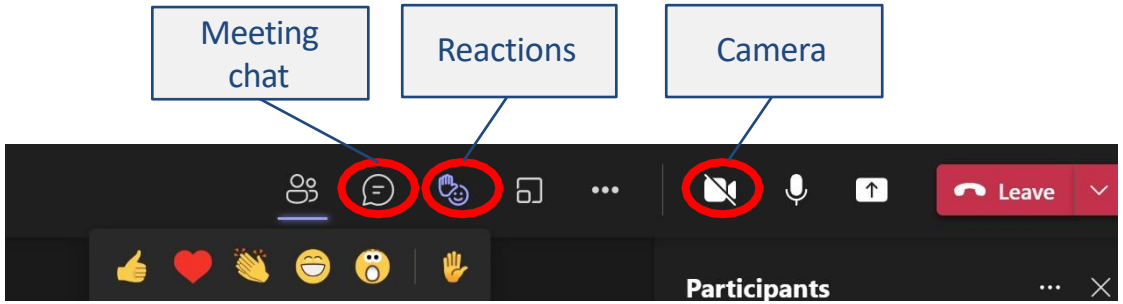
1. Welcome and Roll Call – 4 mins
2. Making Care Primary – 20 mins
3. Care Management Rates Update – 10 mins
4. Withhold Measure Nominations – 5 mins
5. Prenatal and Postpartum Care (F-Codes) – 10 mins
6. Provider Survey Participation – 5 mins
7. Wrap-up and Next Steps – 1 min

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)
Jordan Barnes	Director of Client Transformation CHESS Health Solutions	Provider (CIN)
Tara Kinard, RN, MSN, MBA, CCM, CENP, and Lawrence Greenblatt, M.D.	Associate Chief Nursing Officer Duke Connected Care	Provider (CIN)
Jason Foltz, DO	Chief Medical Officer ECU Physicians MCAC Quality Committee Member	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
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.



Reminders

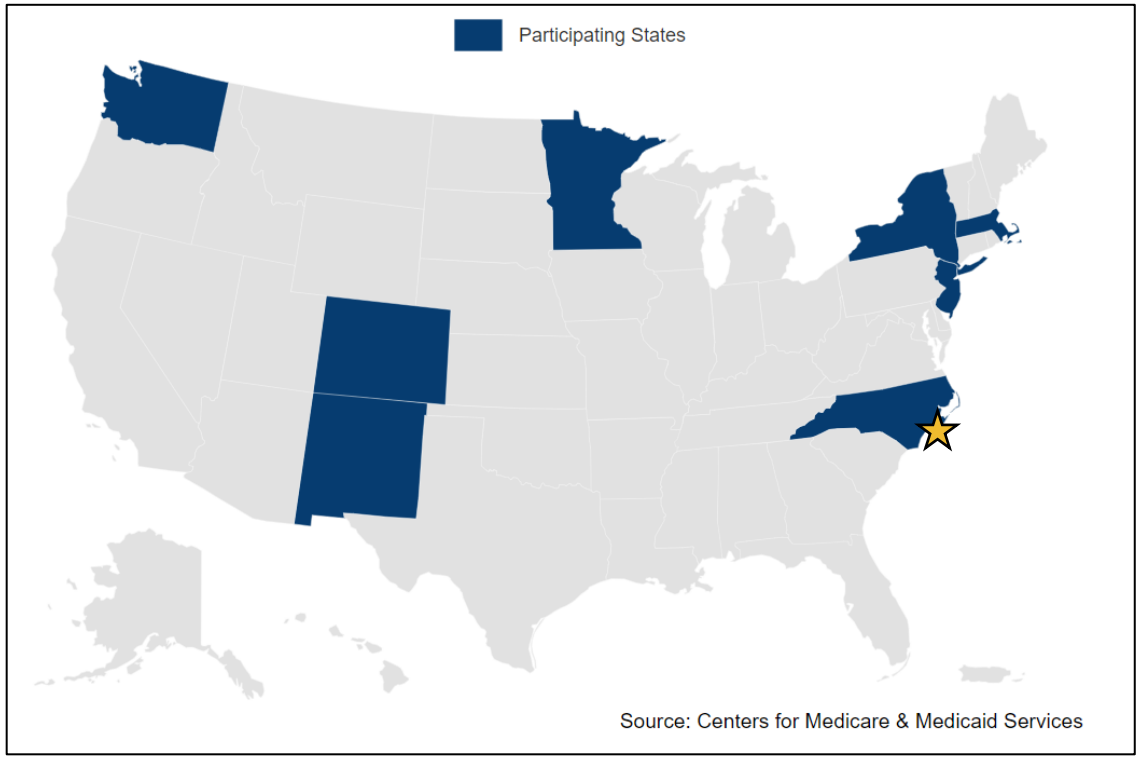
Please note that we are not recording this call, and request that no one record this call or use an AI software/device to record or transcribe the call. DHHS is awaiting additional direction from our Privacy and Security Office on how we need to support these AI tools. Thank you for your cooperation.

HIPAA-covered DHHS agencies which become aware of a suspected or known unauthorized acquisition, access, use, or disclosure of PHI shall immediately notify the DHHS Privacy and Security Office (PSO) by reporting the incident or complaint to the following link: https://security.ncdhhs.gov/

Making Care Primary

Overview of Making Care Primary (MCP)

In 2023, CMS selected North Carolina as one of 8 states to launch the MCP model – a voluntary primary care model focused on (1) ensuring integrated, coordinated, person-centered, and accountable care; (2) creating a pathway for primary care organizations to enter higher level value-based payment (VBP) arrangements; and (3) improving quality of care while reducing expenditures. NC Medicaid is already broadly aligned with Medicare on MCP's goals and has flexibility in how it may further adapt the model to the Medicaid landscape.



Selection of North Carolina is a recognition of our innovations and leadership in primary care, care management and addressing health-related social needs, and that NC Medicaid's existing population health priorities align with the goals of MCP

The Medicare MCP model is launching in July 2024.

Additional information on the MCP Medicare Model can be found on the CMMI website.

Timeline of MCP Medicare Model

- CMMI has finalized North Carolina participants for Medicare MCP, which will launch in July 2024.
- NC Medicaid could choose to launch an aligned model at any time, but CMS has indicated that Medicaid participation by 2026 would be preferred.

The Medicare model will run for 10.5 years, from July 1, 2024, to December 31, 2034.

Overview of MCP Medicare Requirements and Payment

Medicare MCP provides a pathway from Fee-for-Service (FFS) payment to prospective, population-based payment. Medicare MCP includes three tracks that provide opportunities for organizations with differing levels of care delivery and VBP experience to enter the model at a point that matches their capabilities. NC Medicaid has flexibility to consider which components of the Medicare MCP model to adopt and how the model might be modified to best advance the Medicaid primary care landscape.

Care Delivery Requirements

- Targeted Care Management
- Chronic Condition Management
- Specialty Care Integration
- Behavioral Health Integration
- HRSN Screening and Referral
- Community Supports and Service Navigation

Performance Measures

- Clinical Quality and Cost
- Care Delivery
- Health Equity

Track 1 Building Infrastructure	Track 2 Implementing Advanced Primary Care	Track 3 Optimizing Care and Partnerships
• **Fee-For-Service payments** • **Population-based payments** to support enhanced services and care management • **Performance incentive payments** linked to outcomes • **Start-up funding** for development of infrastructure and IT capabilities	• **Fee-For-Service payments** • **Population-based payments** to support enhanced services and care management • **Performance incentive payments** linked to outcomes • **Prospective payments** to support transition from FFS to population-based payment	• **Population-based payments** to support enhanced services and care management • **Performance incentive payments** linked to outcomes • **Prospective payments** to support transition from FFS to population-based payment

Level of VBP Experience

Alignment Across Care Delivery and Performance Measures

NC Medicaid Alignment with MCP

The MCP model aims to create multi-payer alignment across several priority areas including payment reform, quality measures and incentives, data sharing, and learning systems. The Advanced Medical Home (AMH) program is already well aligned with Medicare MCP.

The **AMH program is the core primary care medical home model** for over 2 million NC Medicaid members, and NC Medicaid has made **strong primary care investments** through this program.

The **AMH model already aligns with Medicare MCP in several ways**, including emphasis on **local care management**, addressing **health-related social needs**, and increasing investments in primary care through **payments beyond fee-for-service**.

NC Medicaid is considering ways to further align with Medicare MCP, and **any changes to payment, measurement, and care delivery requirements will be part of a broader evolution of the AMH program.**

Existing Alignment of AMH Program with the MCP Medicare

Many features of North Carolina's approach to whole person care and the AMH program already align with MCP.

	AMH Program	MCP Medicare Model
General	• Three Tiers distinguished by care management delegation; Tier 1 now retired (2 years post-managed care launch) • Practices must meet legacy medical home requirements to be eligible	• Three Tracks with progressive movement towards more value • Practices must have over 125 Medicare FFS beneficiaries to be eligible; cannot participate in most other CMS VBP models
Care Delivery	All AMHs must meet legacy medical home requirements, such as: • 30 hours of direct patient care per week • Primary care and care coordination services (referrals, 24/7 coverage) AMH Tier 3s must meet additional requirements, such as: • Risk stratification • Care management, including developing a care plan, transitional care management, linkages to HRSN through Healthy Opportunities Pilot as applicable	Practices must meet care delivery requirements across three domains, with requirements becoming more advanced as practices "move up" the Tracks: • Care management • Care integration (behavioral health and specialty)* • Community connection and health-related social needs (HRSN)
Payment	• FFS payments (all AMHs) • Care management payments (Tier 3 only) • Performance incentive payments linked to outcomes (required for Tier 3; optional for Tier 1 & 2) • Medical home fees (all AMHs)	• FFS payments (Tracks 1 and 2) • Care management payments (all Tracks) • Performance incentive payments linked to outcomes (all Tracks, though considerably more significant in higher Tracks) • Upfront infrastructure funding (Track 1 only)* • Prospective primary care payments (Track 2 at 50%, Track 3 at 100%)*
Quality	• 10 core measures that plans can choose from to incorporate into performance incentive payments under their AMH contracts, including: clinical quality, pediatric, behavioral health, and care delivery.	• 11 required measures for PCPs including: clinical quality and cost, care delivery, SDOH/health equity,* and patient experience outcomes*

*Features in the MCP program, but not the AMH program

Community Partner Feedback on MCP Alignment in Medicaid

NC Medicaid received feedback from community partners on how NC Medicaid could best support providers and improve member care while driving alignment with elements of the Medicare MCP model. There were several areas of common feedback across both health plans and providers.

1. **NC Medicaid should use MCP alignment to address administrative burden and increase provider flexibility.** There was strong support among providers and health plans for efforts to streamline and standardize requirements across health plans and increase provider flexibility in caring for members.

2. **Rather than creating a new model, build upon existing primary care reforms, including the AMH program.**

3. **Consider the unique features of the NC Medicaid program and population.** There are important differences between the Medicaid population and populations served by other payers. Plans and provider shared specific considerations including deciding which performance metrics are best suited for a Medicaid population and how enrollment churn and Medicaid expansion could impact payment models that are tied to assignment.

4. **Invest in provider readiness and overall primary care payments if / when NC Medicaid considers prospective primary care payment.** Health plans and providers stressed that implementing a prospective payment model would be challenging without new investments in primary care.

Goals for Next Stage of Primary Care Reforms in the AMH

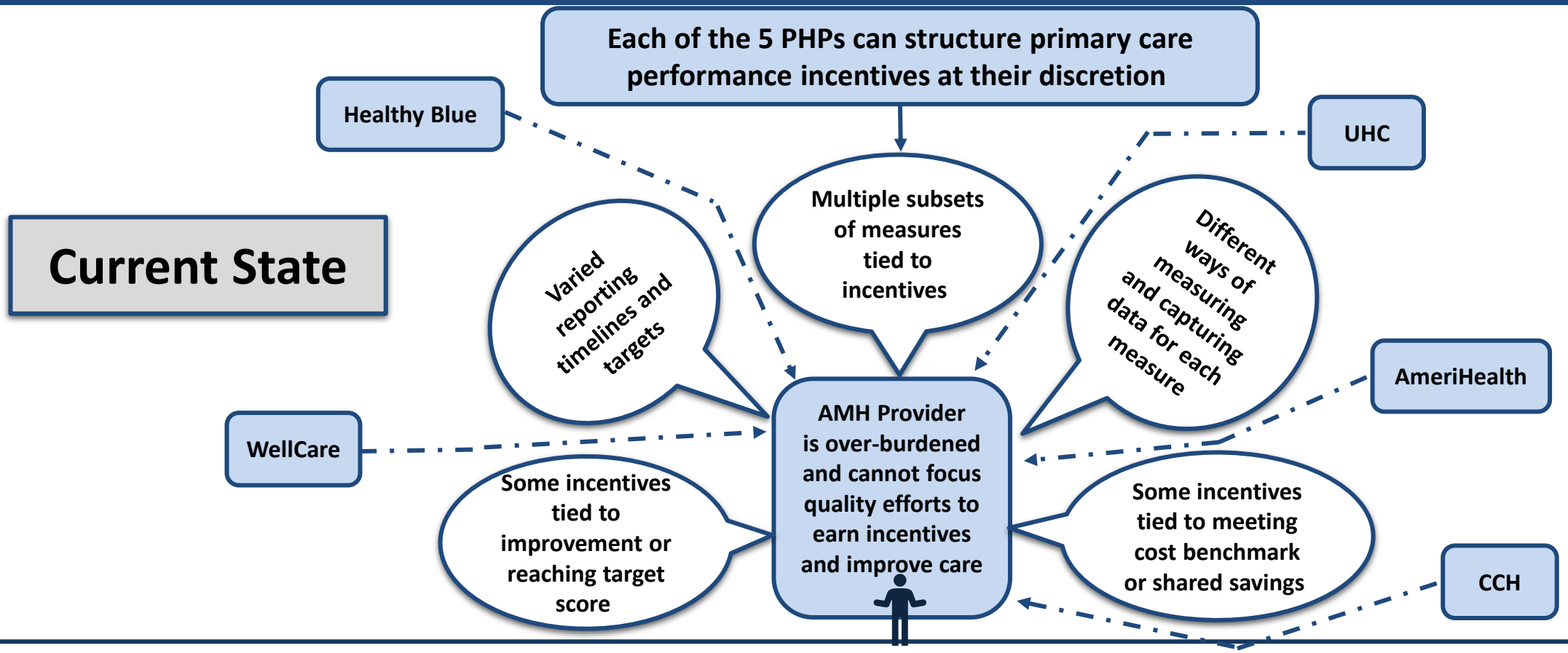
The next stage of primary care reforms in the AMH program should address gaps in the system and leverage opportunities to further improve the health of North Carolinians through an equitable, innovative, whole-person centered and well-coordinated system of care, which addresses both medical and non-medical drivers of health.

Goals for Primary Care Reforms in the AMH Program in Alignment with MCP
 Improve quality outcomes, equitably
 Maintain strong access to primary care and member engagement
 Further integrate behavioral health and health-related resource needs in primary care
 Increase provider flexibility and transparency and lower administrative burden
 Support continued investments in primary care

Key Challenge: AMH Incentive Variation

PHPs are required to offer most primary care providers bonus payments based on their performance on a defined set of measures, but these arrangements vary significantly in practice, introducing significant provider burden and diluting the impact of these arrangements to improve care.

NC Medicaid identified this variation as a key problem that can be addressed through near-term changes.



Proposed Approach to AMH VBP Reforms in Alignment with MCP

Require Standard Plans and Tailored Plans to offer a **standardized, aligned performance incentive program** to primary care providers to provide consistency between NC Medicaid prepaid health plans and to the Making Care Primary model.

Future State

Standard Plans and Tailored Plans are required to offer a standardized, aligned performance incentive to primary care providers

Providers may choose to participate in other VBP arrangements offered by the health plan, as appropriate.

Aligned performance incentive arrangements will include:

1. One aligned, targeted subset of key quality measures across health plans
2. Aligned approach to attributing members to providers for the purposes of calculating quality performance
3. Consistent measure targets/benchmarks
4. A consistent methodology for calculating incentives; not contingent on meeting cost goals or shared savings
5. A standard, transparent dollar amount of potential incentives to be earned *(depending on the value of the incentives, more funding may be needed)*

AMH Provider is focused on actionable quality improvement, with lower administrative burden

Discussion Questions: Model Design

For Discussion:

1. What initial reactions do you have to NC Medicaid's approach to MCP alignment?
2. What should NC Medicaid be considering as it designs the aligned AMH incentive model?
3. What changes would most effectively reduce the burden on primary care providers relative to value-based contracting with Standard and Tailored Plans?
4. How should NC Medicaid approach attribution for the purpose of measuring quality in an aligned incentive model?

Discussion Questions: Implementation

For Discussion:

1. What challenges do you foresee with the implementation of a standardized performance incentive model across all Medicaid Standard and Tailored Plans? How would you recommend NC Medicaid address these challenges?
2. What operational or administrative investments are needed to support this approach that the Department should consider?

Request for Community Partner Feedback

We encourage community partners to provide written feedback to this proposal by emailing Medicaid.NCEngagement@dhhs.nc.gov (subject line "MCP Feedback") by June 28, 2024.

For more information, refer to the Medicaid Provider Bulletin article Value-Based Payment Update: Making Care Primary (MCP) Model Alignment in NC Medicaid.

Timeline & Next Steps

Timeline and Next Steps

- NC Medicaid proposes launching an aligned AMH incentives model no sooner than July 2025
- NC Medicaid will continue to meet and collaborate with community partners and CMS throughout the design and implementation process, leveraging the State Transformation Collaborative and other shared learning forums
- MCP is a 10-year model; NC Medicaid will continue to consider additional VBP reforms to further align with the Medicare model and improve primary care payment and quality for providers and members

Care Management Rate Update

Care Management Rate Update

Background

- The Department has previously provided public information on the care management components of the Standard Plan capitation rates, to inform negotiations between plans and Advanced Medical Homes serving as delegated care management providers (Tier 3 AMHs)
- Previous releases of this information have occurred after the start of the rate year (state fiscal year), due to delays in the rates being finalized and other factors
- Our goal for this upcoming fiscal year and future years is to release this information as part of the rate setting process ahead of the start of the year on July 1

Care Management Rate Update

SFY 2025 Memo Release

- **Updated care management rate memo for SFY 2025 is now available on the AMH webpage (rates effective 7/1/24)**
  - The public memo language has been simplified and streamlined from previous versions
- In the State Fiscal Year 2025 capitation rates, **$10.66 PMPM** is built in for care management staffing needs in accordance with the Department's requirements and assumed average care management need levels within the Standard Plan populations.

Care Management Rate Update: Key Points

1. Rate calculations are the same for SP or AMH3 care management

- This rate figure is agnostic to the entity responsible for the delivery of care management and represents the expected cost to either a Standard Plan or an AMH Tier 3 practice of delivering care management
- Under the AMH Tier 3 program, Standard Plans must delegate certain care management functions and responsibilities to certified practices that meet the program's requirements.
- Standard Plans are expected to pay care management fees sufficient to support the delegated activities. AMH Tier 3 practices are expected to comply with the requirements outlined in the Department's Advanced Medical Home Manual.

Care Management Rate Update: Key Points

2. The care management rate component is based on averages.

- The buildup is based on a set of assumptions about care manager staffing ratios by care management need level and qualifications, which should be understood as averages rather than policies about how each care team must be constructed.

Care Management Rate Update: Key Points

3. The care management rate is not required in contracts between SPs and AMH 3s.

- The Department has not established minimum care management fees and maintains the expectation that Standard Plans and providers will arrive at mutually agreeable rates that are commensurate with the intensity and breadth of the care management being provided.

Care Management Rate Update: Key Points

4. Care management rate buildup reflects whole-person care management activities

- The $10.66 PMPM is an expected average cost for whole-person care management activities in accordance with the Department's requirements and assumed average care management need levels within the Standard Plan populations.

Care Management Rate Update: Expansion Considerations

What About Expansion Members?

The updated memo does not distinguish between rates for expansion and non-expansion members.

- While we previously released separate expansion rates for the partial FY in which expansion members were added (due to non-expansion rates already being set), in this memo (and going forward) they will be included in the overall rate.
- While some intermediate results may illustrate differences between the non-Expansion and Expansion population, these two population groups are not thought of separately within the model and are aggregated together as part of the development of the overall, Standard Plan care management loads.
- This need for consistency is required within the CMS rate development guide.

Care Management Rate Update: Expansion Considerations

What About Expansion Members? (cont'd)

For SFY 2025, the Department assumes approximately 23 percent of beneficiaries will receive care management, and the need level will vary by population.

- This is a small increase from the previous assumption of 22 percent.
- The number is an average across all populations, with higher penetration expected for adults. The average rate therefore increased with additional adults under expansion.

Reminder: Withhold Measure Nominations

Withhold Program Description and Purpose in North Carolina

In a withhold arrangement, **a portion of plans' expected capitation payment is withheld**. To earn back these withheld dollars, plans must meet targets, such as **quality performance targets** specified in their contract, to receive funds from the state at the end of the performance period.

By implementing a withhold within the Standard Plan program, the Department aims to **improve measure performance and promote health equity in partnership** with plans and their contracted providers.

The Department is withholding **1.5 percent of capitation** from Standard Plans in 2024. For the first year of the withhold program, the Department is focused primarily on rewarding quality measure performance improvement, although operational performance measures may be added in future years.

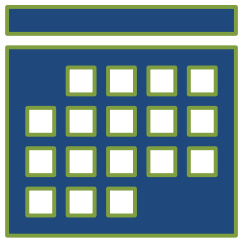
The Department withholds payment from SPs, *not* from providers. Providers may see increased emphasis by PHPs on the performance measures included in the Withhold Program, for example through quality incentive programs.

Withhold Measure Nominations

Reminder to submit your Withhold measure nominations for Year 3 (2026)!
More details available in May 2024 AMH TAG materials

The Department has invited stakeholders, including PHPs, and providers, to submit nominations for new withhold measures through the nomination form by June 21st! Nominations will be considered using NC Medicaid's withhold measure rubric.

Next Steps Following June 21st



1. **Fall 2024**: DHHS will engage in further conversations with stakeholders on potential measures before selecting 2026 measure set for internal review and formal approval

2. **January 2025**: New measures for the 2026 Withhold Program will be published in the annual Quality Technical Specifications Manual

Prenatal and Postpartum Care (F-Codes)

Background: The Problem

- NC Medicaid has historically underperformed on the NCQA HEDIS® *Prenatal and Postpartum Care (PPC)* quality measure

Figure 1. Comparison of Timeliness of Prenatal Care rates between the national average (Medicaid HMO) and NC Medicaid from 2017-2022.

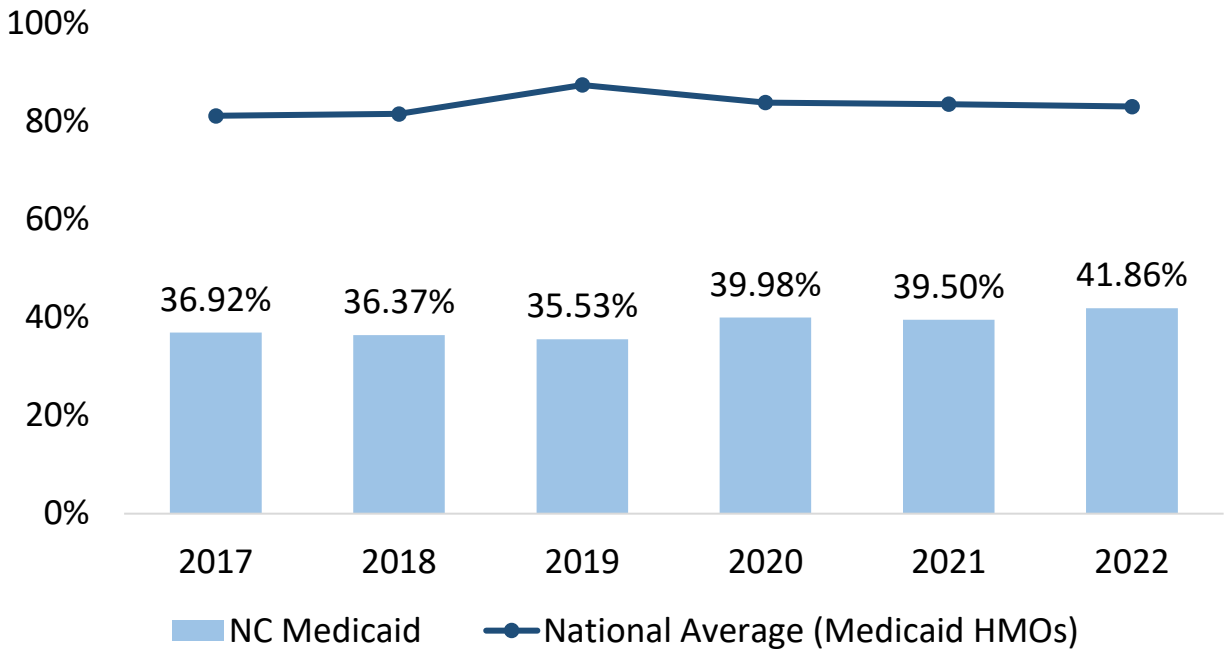
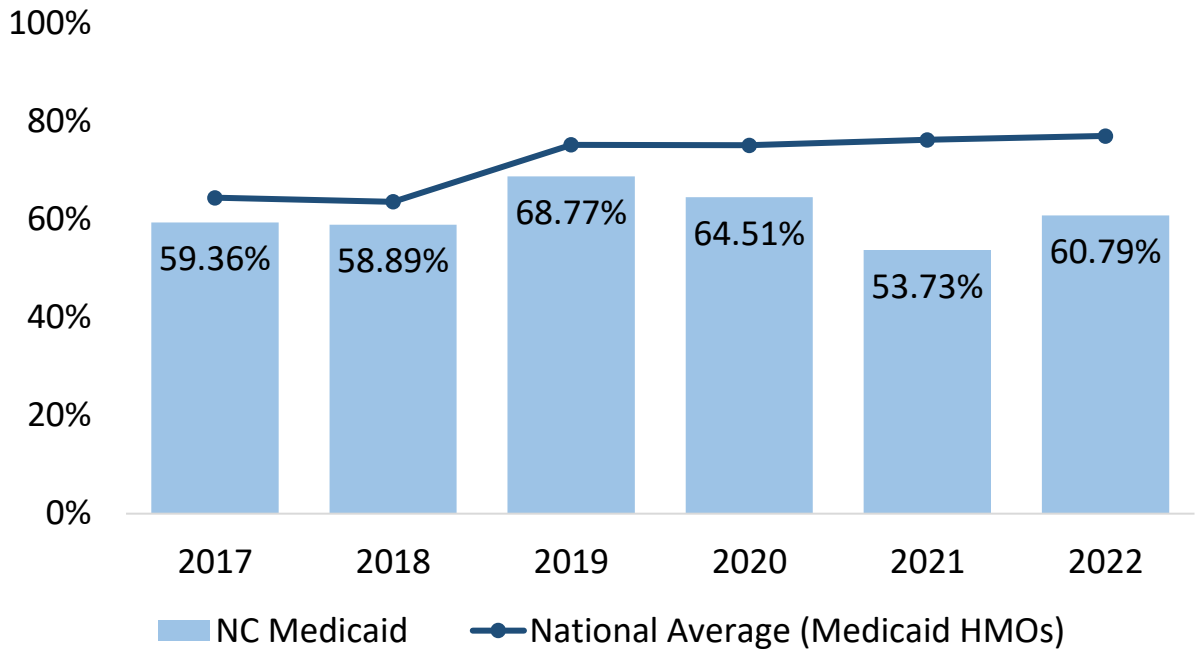


Figure 2. Comparison of Postpartum Care rates between the national average (Medicaid HMO) and NC Medicaid from 2017-2022.



Background: The Problem (Continued)

- These services are often recorded using global billing codes that are not billed until the end of the pregnancy, meaning the first instance of prenatal care and subsequent postpartum care are often not adequately captured in claims and encounters data

Table: Impact of Global Billing on HEDIS® Timeliness of Prenatal Care Numerator Compliance (June 2016-June 2023).

Presence of Global or Package Code	HEDIS Numerator Compliant	Number of (%) Distinct Medicaid IDs
Yes – Global or Package Code Found	Compliant	69,248 (25.53%)
	Not Compliant	137,825 (50.81%)
No – No Global or Package Code	Compliant	44,058 (16.24%)
	Not Compliant	63,487 (23.40%)

A higher proportion of people that were not numerator compliant had a global or package code for pregnancy-related services

Note: The percentage of distinct Medicaid IDs totals over 100% as members may have been eligible for this measure more than once during this time period.

Background: The Solution

Two new F codes have been added to NC Medicaid's clinical policy (revision of NC Medicaid Obstetrical Services Clinical Coverage Policy No: 1E-5):

- **0500F** for Initial Prenatal Visits and
- **0503F** for Postpartum Care Visits

Both codes are defined in the NCQA HEDIS® value sets and are meant to support more accurate and complete data collection

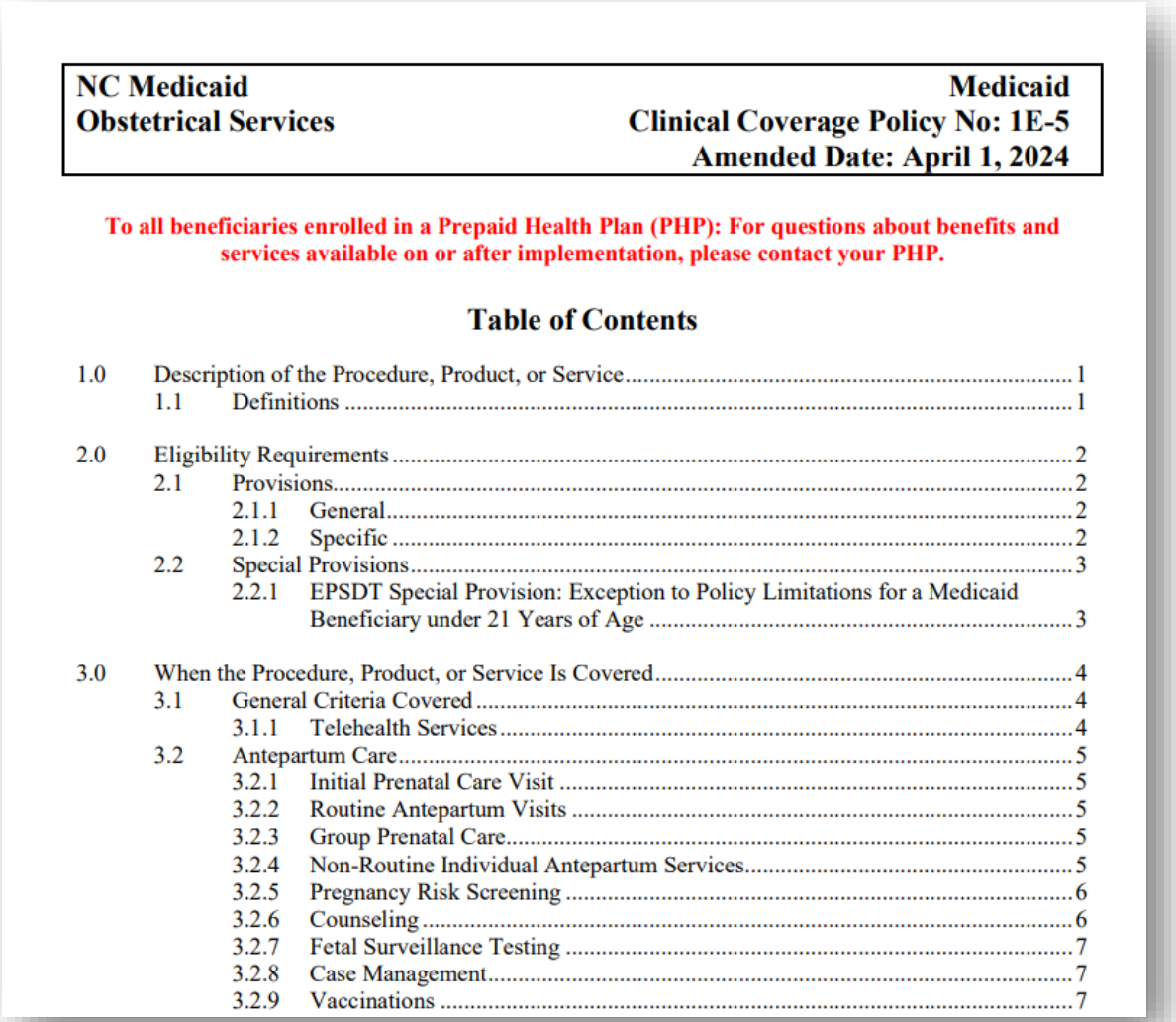
New F Codes for Capturing Prenatal and Postpartum Care			
CPT Code	**Type**	**Description**	**Physician/NPP/LHD Services Guidelines**
0500F	Individual	Initial Prenatal Care Visit	Code reported to identify initiation of prenatal care. Report at first prenatal encounter with healthcare professional providing obstetrical care. Report date of visit and in a separate field the date of the last menstrual period (LMP).
0503F	Individual	Postpartum Care Visit	Code reported to identify postpartum care visit. Postpartum visit can be to an OB/GYN or other prenatal care practitioner, or PCP. Do not include postpartum care provided in an acute inpatient setting.

Updated Policy

The revised NC Medicaid Obstetrical Services Clinical Cover Policy No: IE-5 has been published here

a. A bulletin highlighting key changes was published in mid-April here

b. The policy requires providers to follow billing for both 0500F and 0503F by July 1, 2025



NC Medicaid
Obstetrical Services

Medicaid
Clinical Coverage Policy No: 1E-5
Amended Date: April 1, 2024

To all beneficiaries enrolled in a Prepaid Health Plan (PHP): For questions about benefits and services available on or after implementation, please contact your PHP.

Table of Contents

Next Steps

1. We will be covering this topic at a few upcoming venues:
   a. Area Health Education Center (AHEC) Webinar in late July (scheduling TBA)
   b. Medicaid Managed Care Webinar Series: Fireside Chat in the Fall (scheduling TBA)
2. We are receiving final approvals on the Prenatal and Postpartum Care Fact Sheet that we will then share with health plans, AHEC, and publish online
3. We are also in the process of developing a Frequently Asked Questions (FAQ) document that we intend to have available by the AHEC Webinar

Important Notes and Clarifications

1. Information in the Clinical Coverage Policy only applies to Medicaid Direct claims; however, the Health Plan Billing Guide is being updated to include this requirement for health plans as well by the July 1, 2025 deadline
    a. Updates to the billing guide will likely occur this summer or fall
2. This billing guidance has been shared by NC Medicaid's Clinical Policy Team with the Triad Team
3. This policy applies to *all* delivery claims (not just those that are globally billed)
4. Delivery charges will be denied if 0500F is not in the history after the July 1, 2025 deadline

Questions?

Please email questions to Medicaid.Quality@dhhs.nc.gov by Tuesday, June 18th.

Provider Survey Participation

Provider Survey Participation

- All practices and organizations that provide primary care and Ob/Gyn services would have received an email, in addition to a physical mail, invitation to participate in the survey in April or May of 2024.
- For practices employed by a larger organization (e.g., UNC or Duke practices), the invitation would have gone to the organization central office.
- If anyone has not received an invitation to participate, they can email csrl@unc.edu and indicate they would like to complete the Medicaid Survey and the name of their practices.
  - Example verbiage: "I would like to complete the Medicaid Survey. Can you send me the link? My practice name is: XXXXX. Address is: XXXXX. Phone number: XXXXX."

Provider Survey Participation (Continued)

- The survey has been extended and will remain open for responses up to June 30th.
- Participation in this survey is vital to understanding how primary care and Ob/Gyn providers experience and are satisfied with North Carolina's Medicaid program and with each PHP.
- This survey aids in identifying areas for improvement with the intention of bettering PHP relationships with providers and reducing the administrative burden of contracting with PHPs.

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, July 9, 2024 4:00-5:00 PM
Tuesday, August 13, 2024 4:00-5:00 PM
Tuesday, September 10, 2024 4:00-5:00 PM

Potential Upcoming AMH TAG Topics

- Provider Experience Survey Results
- VBP Arrangements
- AMH Interim Evaluation Results
- Medicaid Expansion Population into Quality Incentive Programs