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

Meeting #33

November 14, 2023

Agenda

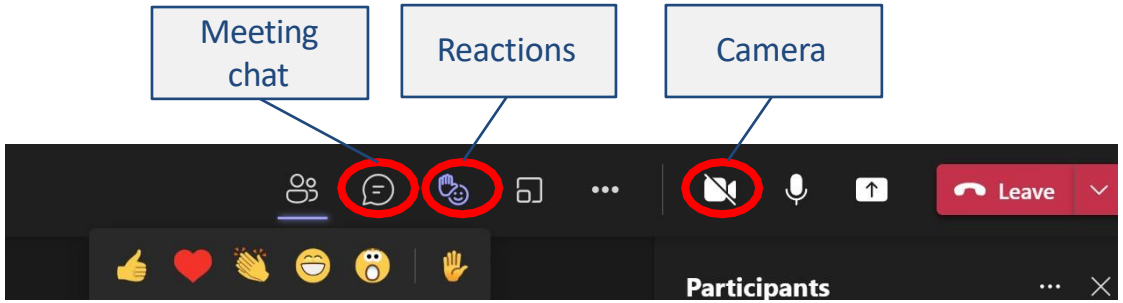
1. Welcome and Roll Call – 3 min
2. Improving Panel Management – 10 min
3. LME-MCO Consolidation – 10 min
4. Total Cost of Care Dashboard: Provider Access – 10 min
5. Medicaid Expansion Updates – 5 min
6. Update on the Health-Related Resource Needs Measure – 5 min
7. Technical Specifications Measure ID Options – 5 min
8. Standardization of AMH Interfaces Update – 5 min
9. Discussion – 5 min
10. Wrap-up and Next Steps – 2 min

AMH TAG Member Welcome and Roll Call

Name	Organization	Stakeholder
C. Marston Crawford, MD, MBA	Pediatrician Coastal Children's Clinic – New Bern, Coastal Children's	Provider (Independent)
David Rinehart, MD	President-Elect of NC Family Physicians North Carolina Academy of Family Physicians	Provider (Independent)
Rick Bunio, MD	Executive Clinical Director, Cherokee Indian Hospital	Provider
Gregory Adams, MD	Member of CCPN Board of Managers Community Care Physician Network (CCPN)	Provider (CIN)
Jennifer Houlihan, MSP, MA	Vice President Value-Based Care & Population Health Atrium Health Wake Forest Baptist	Provider (CIN)
Amanda Gerlach	Vice President Mission Health Partners (MHP)	Provider (CIN)
Lauren Lowery, MPH	Director of Operations Carolina Medical Home Network	Provider (CIN)
Joy Key, MBA	Director of Provider Services Emtiro Health	Provider (CIN)
Tara Kinard, RN, MSN, MBA, CCM, CENP	Associate Chief Nursing Officer Duke Population Health Management Office	Provider (CIN)
Diego Martinez	Interim Chief Executive Officer AmeriHealth Caritas North Carolina, Inc.	Health Plan
Michael Ogden, MD	Chief Medical Officer Blue Cross and Blue Shield of North Carolina	Health Plan
Carol Stanley, MS, CPHQ	Medicaid Transformation Manager NC Area Health Education Center (NC AHEC)	AHEC
Eugenie Komives, MD, Keith Caldwell, and Zach Mathew	WellCare of North Carolina, Inc.	Health Plan
William Lawrence, MD	Chief Medical Officer Carolina Complete Health, Inc.	Health Plan
Robert Rich, MD, and Atha Gurganus	United	Health Plan
Jason Foltz, DO	Medical Director, ECU Physicians MCAC Quality Committee Member	MCAC Quality Committee Member
Keith McCoy, MD	Deputy CMO for Behavioral Health and I/DD Community Systems, Chief Medical Office for Behavioral Health and I/DD	DHHS
Chris Magryta, MD	Chairman Children First of North Carolina	Provider

Meeting Engagement

We encourage those who are able to turn on cameras, use reactions in Teams to share opinions on topics discussed, and share questions in the chat.



Improving Panel Management:
Refining PCP/AMH Assignment and Attribution Process

Definitions

Assignment: Process involving Medicaid member selection of an Advanced Medical Home (or Primary Care Provider) or Department-initiated auto-assignment into an Advanced Medical Home for purpose of care delivery.

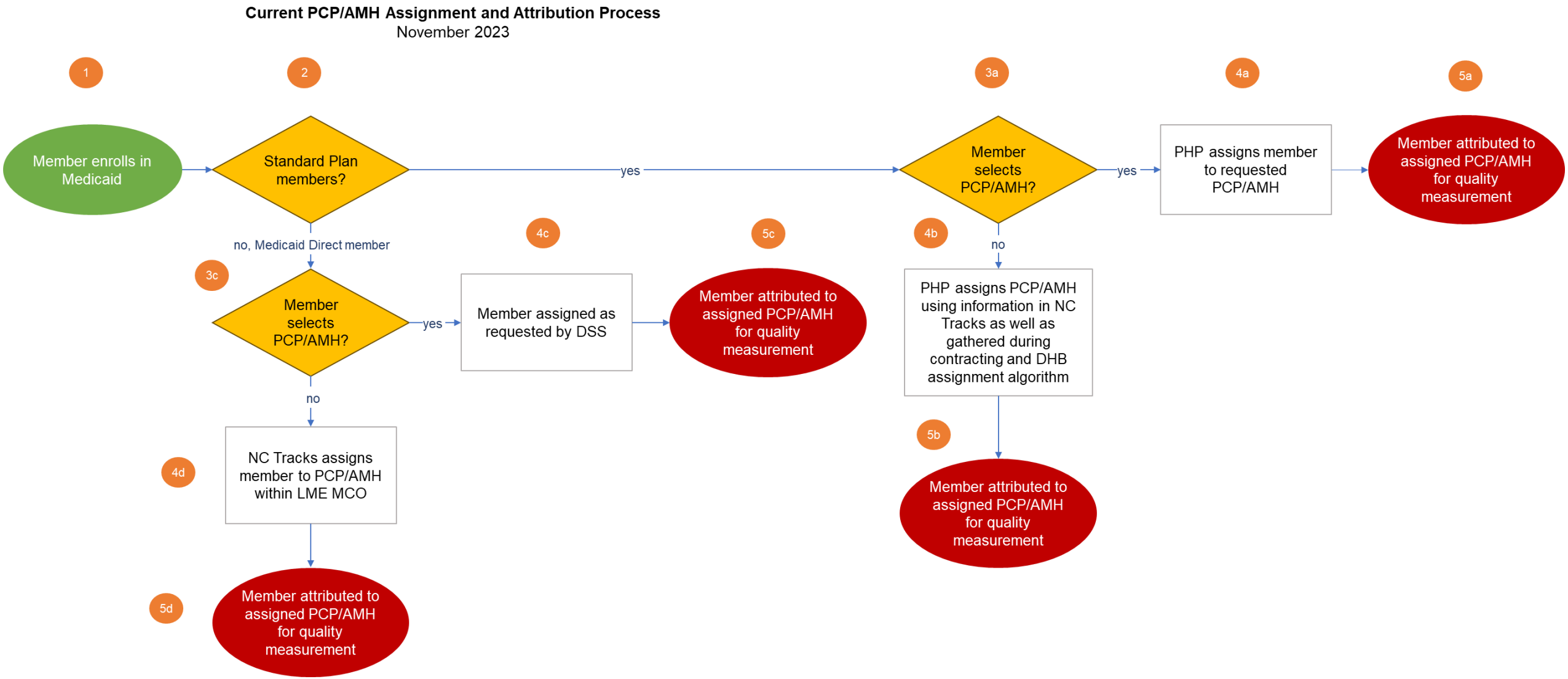
Attribution: Method by which a Medicaid member is included in a practice's denominator for quality measurement.

Proposed by DHB but not implemented due to concerns raised by Plans:

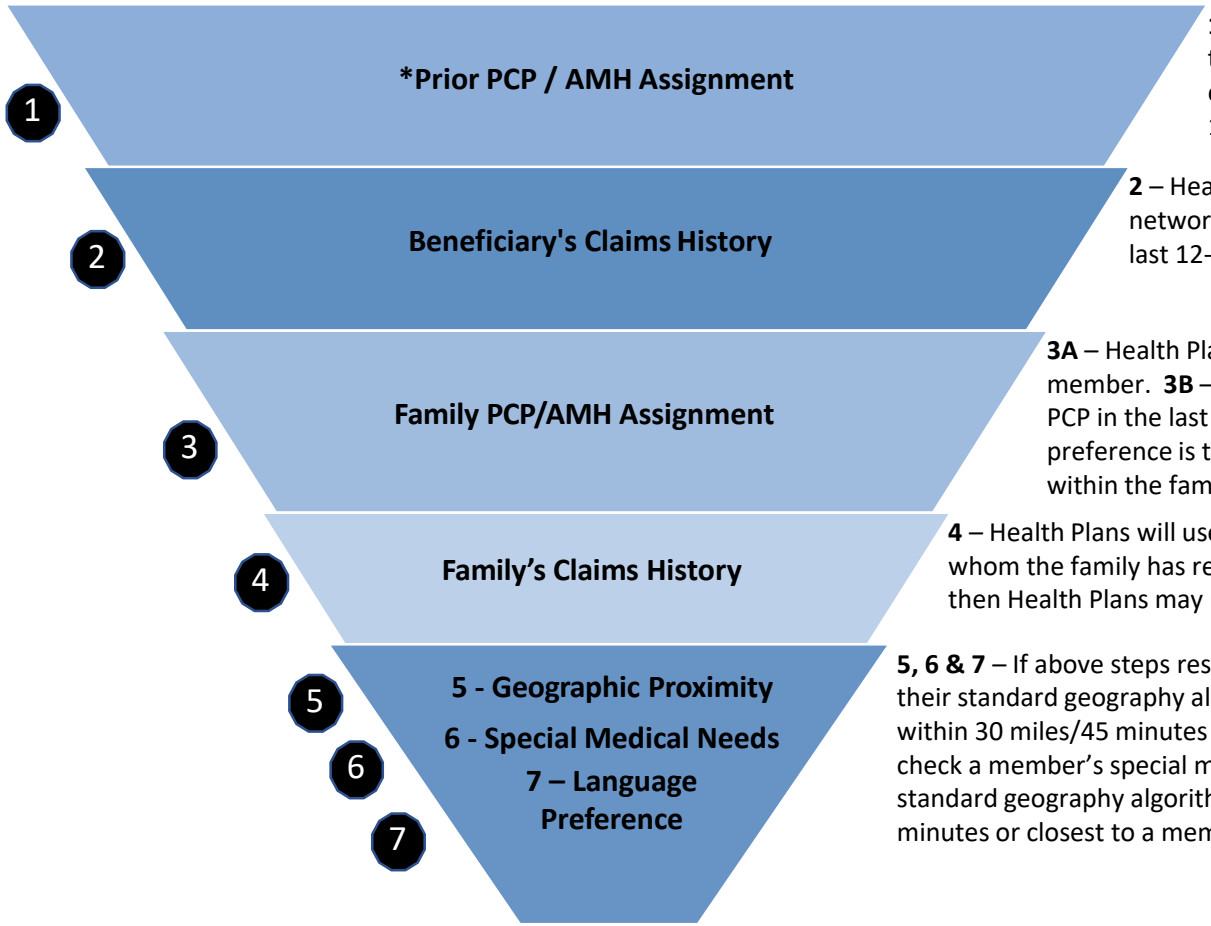
*A member may be **assigned** to more than one practices over the course of a year but will only be **attributed** to a practice to which they have been assigned for majority of year.*

- Goal: To ensure practice quality is assessed and quality incentive payments are calculated based on members for whom practices have had greatest opportunity to impact care and outcomes.
- NC Medicaid does not currently have a standard attribution process required for purposes of quality measurement.

Current PCP/AMH Assignment and Attribution Process



Current Assignment Approach for Members Who Do Not Select a PCP/AMH



1A – If the member has a historically assigned PCP/AMH in the Health Plan's network, the Health Plan may assign that PCP/AMH to the member. **1B** – Health Plans may also check to see if the member was seen by that historically assigned PCP within the last 12-18 months. If no history is found, the Health Plans may move to Step 2.

2 – Health Plans will use member's claims history to assign the member to an in-network PCP/AMH from whom the member has previously received care in the last 12-18 months. If no history is found, the Health Plans may move to Step 3.

3A – Health Plans may assign member to a PCP/AMH assigned to another family member. **3B** – Health Plans may also check to see if the family member was seen by that PCP in the last 12-18 months. If not, the Health Plan may move to Step 4. For children, the preference is to assign an in-network pediatrician who is also assigned to any other child within the family.

4 – Health Plans will use family claims history to match to in-network PCPs/AMHs from whom the family has received care in the last 12-18 months. If no claims history exists, then Health Plans may move to Step 5, 6 & 7.

5, 6 & 7 – If above steps result in multiple or no PCP/AMH matches then Health Plans will use their standard geography algorithm to narrow the results to an in-network PCP/AMH that is within 30 miles/45 minutes or closest to a member's home. Otherwise, Health Plans will check a member's special medical needs and/or language preference and apply their standard geography algorithm to find an in-network PCP/AMH that is within 30 miles/45 minutes or closest to a member's home.

* Applies to Standard Plan beneficiaries who **did not select a PCP/AMH**

Age Misassignment Analyses

Age misassigned: >21 y.o. members assigned to providers limiting panel to members ≤ 21 y.o.

	Medicaid Direct	All Standard Plans	Grand Total
Age Misassigned Member Count	6,010	17,757	23,767
All Member Count	77,308	793,608	870,916
% of total members that are misassigned	7.80%	2.24%	2.70%

Preliminary Gender Misassignment Analyses

Gender misassigned: Male members assigned to providers limiting panel to female members

	Medicaid Direct	All Standard Plans	Grand Total
Female member count	4,201	24,226	28,427
Male member count	214	2,394	2,608
All member count	4,415	26,620	31,035
% of total members that are misassigned	4.85%	8.99%	8.40%

Audit of One Standard Plan's Assignment and Reassignment Process (Preliminary Analyses)

200 NEW Assignments

- >70% of the assignments were made at the **historical provider** relationship stage of the algorithm
- 23% according to age, gender or geographic proximity.
- ~5% were assignment based on family members' PCP/AMH assignments.

200 Reassignments

- Only two reassignment trigger categories were found
  - >76% of the triggers fell into the **PCP status change** category (AMH tier downgrade/contracting status change)
  - Remaining 23.5% of reassignments were in response to **provider-initiated changes**
    - All of these members were reassigned according to historical provider relationships

Next Steps

Sector	Action	Timeline
State	• Complete initial analyses of misassignments by age, gender • Complete audit of one Standard Plan to gain insight into algorithm step where assignment was made, triggers for reassignment and accuracy of those decisions • Begin tracking data submitted by Standard Plans on elements of assignment process • Launch project focused on improving assignment (guided by provider satisfaction) • Conduct environmental scan of current state of attribution (including other state Medicaid programs' approach to attribution)	• Q4 2023 • 2024
Standard Plans	• Begin submitting reports to state on elements of assignment process • Consider tests of change to improve reassignment process, including making standard electronic change request form available	• Q4 2023
Providers	• Update panel limitations by gender and age within NC Tracks https://www.nctracks.nc.gov/content/public/providers.html • Consider completing brief surveys on satisfaction with assignment process	• Q4 2023 • 2024

LME-MCO Consolidation

LME-MCO Consolidation

- On November 1, 2023, the NCDHHS Secretary announced a TP consolidation directive.
  - SECRETARIAL DIRECTIVE 2023-001 **-** **Tailored Plan Readiness & LME/MCO Streamlining Pursuant to SL 2023-134**

- We welcome questions regarding TP consolidation.

Submit additional questions and concerns via email to: Medicaid.TailoredCareMgmt@dhhs.nc.gov

Total Cost of Care Dashboard: Provider Access

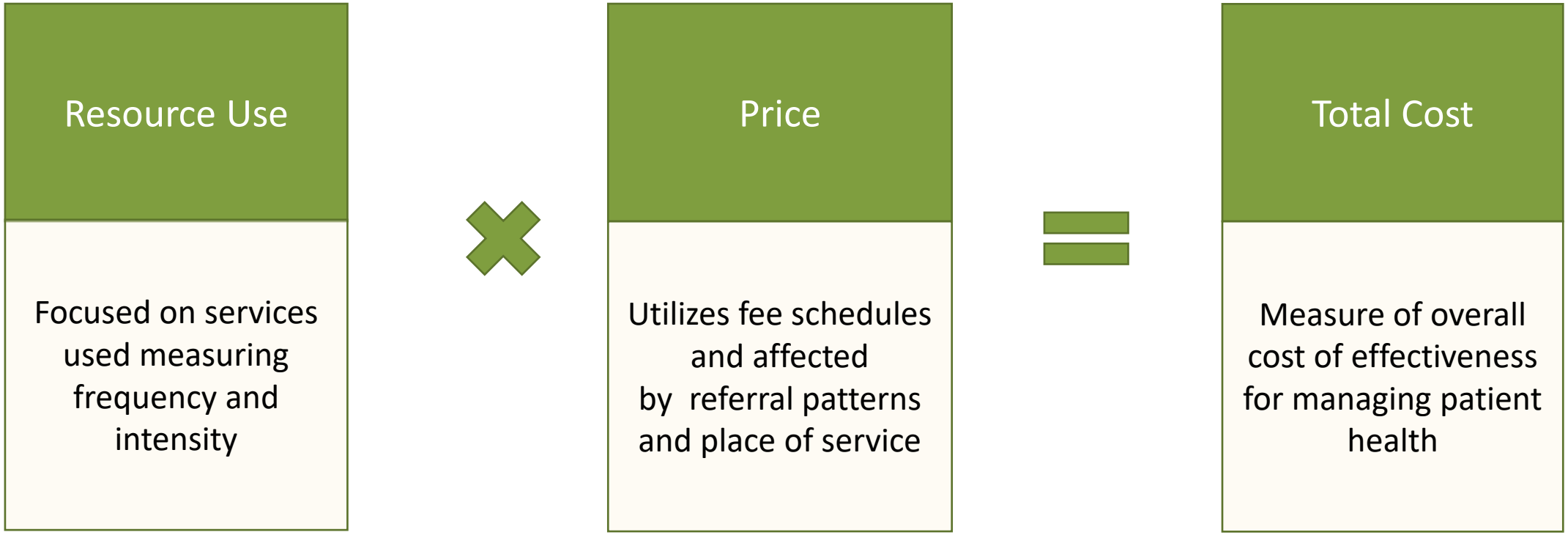
Background

- *Total Cost of Care* is included in the AMH measure set
- To operationalize this measure, HSAG is developing a dashboard tool that uses HealthPartners' open-source Total Cost of Care and Resource Use (TCOC) framework
  - Currently, PHPs may choose to use TCOC as a performance incentive measure for AMHs using the TCOC data from HSAG or their own methodology

Objectives & Goals of TCOC Dashboard

- Objective
  - Enable providers to achieve the Institute for Healthcare Improvement's Triple Aim:
    - Improving health
    - Enhancing patient experience
    - Making health care more affordable
- Goals
  - Assist providers in making informed decisions when entering into VBP arrangements with PHPs
  - Help providers understand patterns and drivers of potential overuse and/or inefficiency

HealthPartners Total Cost of Care Overview



Total Cost measure is designed to highlight potential cost-saving opportunities, as well as identifying inefficiencies or overuse of health care delivery.

Total Cost of Care Measures

- Population-based measure
- Calculated as the average risk adjusted cost for the health care of an attributed population.
- Total per capita costs and/or resources used by attributed members.
  - Includes all care delivered
    - Professional, Outpatient, Inpatient and Pharmacy
  - Includes all allowed amounts
    - All payments made by the patient and the insurer
- Stratification level reporting measured against a benchmark
- Based on the patented algorithm of HealthPartners, Inc. adjusted for a Medicaid population

Dashboard Insights

- How do my results compare to peers and state averages?
- How do the demographics of my member panel compare to peers and state averages?
- Are there particular demographics of my member panel that are driving my results?
- Are there particular disease conditions based on the CDPS+RX condition grouping algorithm that are driving my results?
- How does my high-level claims cost distribution and TCOC index compare to peers and state averages?
- Is there a particular COS driving my results?

Provider Access for the Total Cost of Care Dashboard

- Each AMH will select two Dashboard Administrators
  - These Administrators will be permissioned to see their AMH's data in the dashboard and will manage permissions for other dashboard users within their AMH
- NC Medicaid will email out a survey link to collect this information from all AMHs
  - The email will go to the Authorized User email address in NC Tracks
  - Survey asks you to validate your affiliated AMH by entering NPI, Location Code, and other information
- If you do not receive the survey link in the coming weeks:
  - Please first check with your practice's NC Tracks Authorized User to confirm whether they received the survey
  - If your NC Tracks liaison did not receive the survey, please reach out Medicaid.Quality@dhhs.nc.gov

Upcoming Technical Assistance Opportunities for Providers

- HSAG will be hosting a series of demos for dashboard users
- Once details are finalized, NC Medicaid will share registration links with all Dashboard Administrators
  - NC Medicaid will also advertise these events in its regular provider forums
- Discussion Questions:
  - How can you see yourselves using this data?
  - How would you recommend we message information about the TCOC dashboard to AMH providers?

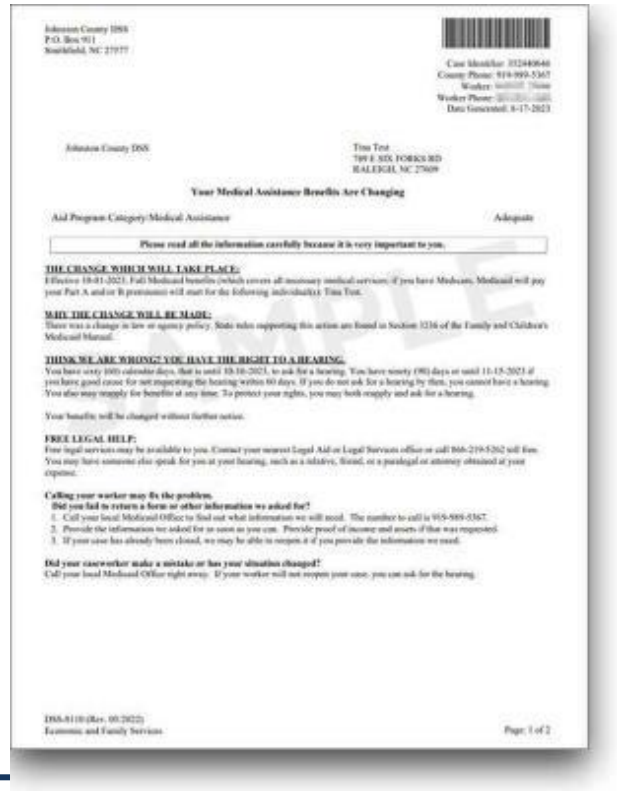
Medicaid Expansion Updates

Medicaid Expansion Updates

Beginning December 1, 2023**, more than 600,000 North Carolinians**, ages 19 through 64 years with higher incomes **can get health coverage through Medicaid**. New program aid categories will be created for beneficiaries eligible due to Medicaid expansion.

NCDHHS has started contacting the approximately 260,000 people enrolled in Medicaid's limited Family Planning program that will be eligible for full benefits starting December 1. These communications inform Members to look out for a letter from their local DSS (pictured right) and include:

- ✓ Text Messages
- ✓ Phone Calls
- ✓ E-mails



Your Medical Assistance Benefits Are Changing

Please read all the information carefully because it is very important to you.

THE CHANGE WHICH WILL TAKE PLACE:

WHY THE CHANGE WILL BE MADE:

THINK WE ARE WRONG? YOU HAVE THE RIGHT TO A HEARING.

FREE LEGAL HELP:

Calling your worker may fix the problem.

Did you fail to return a form or other information we asked for?

Did your caseworker make a mistake or has your situation changed?

Note: **Not everyone with limited Family Planning Program benefits will be automatically enrolled in full coverage through NC Medicaid.** Some people may have income that exceeds the new Medicaid eligibility levels, even though qualifying income levels are higher than the past.

Medicaid Expansion Updates

Medicaid expansion member identifier in the 834 file: The Benefit Enrollment and Maintenance file (834 file) will be ingested as they do today. Plans will be able to identify Medicaid expansion eligible members on the 834 file through the 2300 Loop, when M7 is sent in REF01, and any of the Medicaid expansion eligibility codes (Table 1) are shared on REF02.

Medicaid expansion member identifier in the Beneficiary Assignment (BA) file: Providers will be able to identify Medicaid Expansion members on the BA file based on the 2300 Loop REF02 segment, with the Medicaid expansion eligibility codes.

Standard Plans have between **Nov 6th and Nov 14th to run PCP assignment for Expansion Members.** Assignments will show on the **daily BA Files** shared with AMH providers **starting on November 7th.**

Loop 2300 Segment Layout in BA file:

Eligibility Codes	2300	REF02	127	Program Category Code	50	REF01='M7'
	2300	REF02	127	Living Arrangement Code	50	Living Arrangement will have the label **LA**
	2300	REF02	127	Admin County Code	50	Administrative County Code label **ADMCO**
	2300	REF02	127	Residential County Code	50	Residential County label **RESCO**
	2300	REF02	127	Behavioral Health Administrative Entity	50	Behavioral Health Administrative Entity label **BHADM**
	2300	REF02	127	Sub Program 01	10	label **SUBPGM1**
	2300	REF02	127	Sub Program 02	10	label **SUBPGM2**
	2300	REF02	127	Sub Program 03	10	label **SUBPGM3**
	2300	REF02	127	Sub Program 04	10	label **SUBPGM4**
	2300	REF02	127	Eligibility Status Code	10	Eligibility Status Code label **ELIGSTAT**
	2300	REF02	127	Managed Care Status Code	20	Managed Care Status label **MCSTATUS**
	2300	REF02	127	Tailored Plan Eligibility	20	Tailored Plan Eligibility Type label **TLRD PLAN**

Medicaid Expansion Updates

Table 1: Medicaid Expansion eligibility code:

From Value	Thru Value	Short Description	Long Description
MXPNN	MXPNN	MXPNN	Adult Medicaid Expansion, Categorically Needy
MXPFN	MXPFN	MXPFN	Adult Medicaid Expansion, Categorically Needy – Non-Qualified Alien, Emergency Services Only
MXPGN	MXPGN	MXPGN	Adult Medicaid Expansion, Categorically Needy – Qualified Alien
MXPHN	MXPHN	MXPHN	Adult Medicaid Expansion, Categorically Needy – Qualified Alien, Emergency Services Only

Update on the Health-Related Resource Needs Measure

HRRN Measure - Update

- **New name:** *Screening for Health-Related Resource Needs (HRRN) (*previously called *Rate of Screening for Unmet Resource Needs*). Measure specification aligns with Healthy Opportunities.
- **Update:** For this measure, DHB originally proposed that a screening may be administered by the PHP, a member's assigned AMH, or the AMH's contracted care management entity.
- However, for 2024, this measure (including for plan-level withholds) will be based only on screenings done by plans. Additional work is needed to ensure consistent mapping of provider-level screening information.

For more information on this measure, see page 72 of the 2023 Quality Measurement Technical Specifications (Verion 1.6, updated in October 2023) here.

Measure Summary

Measure Type: Process

Data Collection Method: Administrative

Steward: NC DHHS

Brief Description of Measure:
The percentage of enrollees who received and completed a screening for unmet health-related resource needs using the NC DHHS Standardized Screening Questions.
Three rates are reported:

1. Screening attempts within 90 days of health plan enrollment
2. Successful screening within 90 days of health plan enrollment
3. Successful screening within the calendar year

NC DHHS Standardized SDOH Screening Questions	Yes	No
Food		
1. Within the past 12 months, did you worry that your food would run out before you got money to buy more?		
2. Within the past 12 months, did the food you bought just not last and you didn't have money to get more?		
Housing/ Utilities		
3. Within the past 12 months, have you ever stayed: outside, in a car, in a tent, in an overnight shelter, or temporarily in someone else's home (i.e. couch-surfing)?		
4. Are you worried about losing your housing?		
5. Within the past 12 months, have you been unable to get utilities (heat, electricity) when it was really needed?		
Transportation		
6. Within the past 12 months, has a lack of transportation kept you from medical appointments or from doing things needed for daily living?		
Interpersonal Safety		
7. Do you feel physically or emotionally unsafe where you currently live?		
8. Within the past 12 months, have you been hit, slapped, kicked or otherwise physically hurt by anyone?		
9. Within the past 12 months, have you been humiliated or emotionally abused by anyone?		
Optional: Immediate Need		
10. Are any of your needs urgent? For example, you don't have food for tonight, you don't have a place to sleep tonight, you are afraid you will get hurt if you go home today.		
11. Would you like help with any of the needs that you have identified?		

Figure 1: NC DHHS Standardized SDOH Screening Questions

Technical Specifications Measure ID Options

Technical Specifications Measure ID Options

- The Department is currently preparing the 2024 Technical Specifications, including tables of all measures calculated by the Department and health plans. The Department recognizes that plans, practices and other stakeholders may incorporate data from these tables for their internal processes.
- In previous versions the National Quality Forum (NQF) number was used to identify each quality measure. Effective March 2023 NQF is no longer the consensus-based entity (CBE) for CMS. The new phase of work will be conducted by Battelle, which has formed the Partnership for Quality Measurement (PQM) to oversee CBE-related processes. NQF numbers have been redesignated as CBE numbers. *To date, the PQM has not indicated an intention to change NQF's original numbering system, although they could do so in the future.*
- CMS maintains a separate database of measures, the CMS Measures Inventory Tool (CMIT) for all measures used in CMS programs. At this time, CMIT numbers are sometimes, **but not always**, identical to CBE numbers.
- Going forward, the Department can either use CBE numbers or CMIT numbers to identify measures in the technical specifications.

For Vote: Would you prefer that the Department lists the CBE number or the CMIT number with the quality measures in the Technical Specifications?

Examples and Survey

Measure Name	CBE# (previously NQF#)	CMIT #
Child and Adolescent Well-Care Visits (WCV)	1516	24
Childhood Immunization Status (CIS)	0038	124
Cervical Cancer Screening (CCS)	0032	118
Controlling High Blood Pressure (CBP)	0018	167
Breast Cancer Screening (BCS)	2372	93
Prenatal and Postpartum Care (PPC)	1517	581

Link to survey: https://gcv.microsoft.us/kGIGKbbmwx
The survey is one question and should take less than a minute to complete.
Please complete the survey by Tuesday, November 21st.

Standardization of AMH Interfaces Update

Standardization of AMH Interfaces: Recap

Issue:

PHPs have different schedules for sharing data through the standard AMH interfaces. AMHs and/or their CINs/Data Partners are challenged with the varying schedules for data transfers to automate their ETL processes.

Solution:

DHB will update the AMH Data Specifications to provide descriptive guidance for **file generation and data delivery transfers** between PHPs and AMHs/CINs.

- Resolves core reporting issues raised by AMH/CINs by implementing a long-term structural solution.
- Streamline when data moves from PHPs and AMHs potentially improving data timeliness.
- Aligning the SP AMH interface submission timelines with the TP AMH interface submission timelines.

DHB is postponing the implementation of the standard timings of data transfers through AMH interfaces. In the interim, the DHB requests your participation in a workgroup.

Standardization of AMH Interfaces: Workgroup

DHB's Strategy

Purpose

- The purpose of the workgroup is to work collaboratively with all stakeholders (PHPs, AMH providers, CINs/Data partners) and inform the implementation of a standardized timeline for the submission of AMH interfaces. The workgroup will work collectively to share concerns and solutions around resource constraints, cost, and technological lift that DHB should take into consideration when building out implementation timelines.

Members:

- Members: All PHPs, 3 AMH Tier 3 practices, CCNC, and 3 CINs
- Selection process: For the AMH tier 3 practices, we are looking for practices that are not associated with a CIN. For the CINs, we are looking for a large, medium, and small CIN (size being based on the number of members served).

Kick-off meeting:

- Date: Early December 2023 (Day and time TBD)
- Goal: Review current timings of the interfaces, identify gaps from the proposed solution, determine resource constraints, and gather recommendations on considerations for solutions by March 2024.
- **Before convening of the workgroup, DHB will provide a template for the PHPs to populate information on their current transmission timings for various AMH interfaces.**

Discussion

For Discussion...

- In-Person AMH TAG Meetings
  - Are you interested in resuming in-person AMH TAG meetings in 2024?
  - What cadence would you like to attend in-person AMH TAG Meetings?

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 2023 Meetings
Tuesday, December 12, 2023 4:00-5:00 PM

Potential Upcoming AMH TAG Topics

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