North Carolina Department of Health and Human Services (DHHS)

Advanced Medical Home Technical Advisory Group (AMH TAG) Meeting # 9 (conducted virtually)

October 27, 2020

Attendees:

AMH TAG Members	Organization
C Marston Crawford, MD, MBA	Pediatrician, Coastal Children's Clinic – New Bern, Coastal Children's
David Rinehart, MD	President-Elect, North Carolina Academy of Family Physicians
Rick Bunio, MD	Executive Clinical Director, Cherokee Indian Hospital
Gregory Adams, MD	Member of CCPN Board of Managers, Community Care Physician Network (CCPN)
Ruth Krystopolski, MBA	Senior Vice President of Population Health Atrium Health
Amy Russell, MD	Medical Director, Mission Health Partners
Kristen Dubay, MPP	Director, Carolina Medical Home Network
Joy Key, MBA	Director of Provider Services, Emtiro Health
Tara Kinard, RN, MSN, MBA, CCM, CENP	Associate Chief Nursing Officer, Duke Population Health Management Office
George Cheely, MD, MBA	Chief Medical Offier, AmeriHealth Caritas North Carolina, Inc.
Michael Ogden, MD	Chief Medical Officer, Blue Cross and Blue Shield of North Carolina
Michelle Bucknor, MD	Chief Medical Officer, UnitedHealthCare of North Carolina, Inc
Thomas Newton, MD	Medical Director, WellCare of North Carolina, Inc.
William Lawrence, MD	Chief Medical Officer, Carolina Complete Health Network
Jason Foltz, DO	Medical Director, ECU Physicians, MCAC Quality Committee Member
DHHS:	
Kelly Crosbie, MSW, LCSW	Director of Quality and Population Health, DHB
Shannon Dowler, MD	Chief Medical Officer, NC Medicaid
Krystal Hilton, MPH	Associate Director of Population Health, DHB

DHHS Consultants: Accenture (Garrick Prokos, Opeyemi Babajide, Priska Ndege); Manatt Health (Edith Stowe, Sharon Woda)

Opening Remarks (Dr Dowler)

- Excited to be back with this AMH TAG.
- The goal a year from now is to be able to say that NC has strongest Managed Medicaid of any Medicaid program in the country. We have amazing leadership pushing us to do things differently and a state full of engaged providers and partners who are "in it to win it;" this drives change that the whole country might emulate.
- During the pause on Managed Care launch we continued work and AMH was a big part of that – we scrutinized how we could make AMH better.
- Overall, we are looking for a balance of taking the best of what we had before with some revisions, creating a strong product with beneficiaries at the center and ending up with the best care for the people of NC.
- Be careful we're not burdened by the "what ifs" that can prevent us from landing things and driving progress. We are going to be live with this in July. It's a scary time for all of us. Let's focus on the "how to's" not the "what ifs." The impetus is on us at NC Medicaid to provide oversight of Managed Care and to listen and be part of what the field is experiencing, providing rapid feedback.

Agenda (Kelly Crosbie)

- Pre-Managed Care Launch AMH Timelines
- AMH Program Streamlining
- AMH Program Incentives and Practice Supports
- PCP/AMH Assignment
- AMH Quality Measure Set
- AMH Payment Model
- AMH Contracting/Oversight
- Next Steps

Please refer to the November 20 AMH TAG Meeting #9 slide deck available on the AMH Website.

Take homes:

- When the TAG last met in November 2019 there were some proposals on the table. Some of those proposals are being finalized now and others have changed since then. DHHS spent time in July and August talking to many of the TAG members, and September working with PHPs.
- AMH model was always aimed at building infrastructure, equipping practices with data and support to do more advance population health, and better population outcomes. Considered how best to advance those aims.

AMH Timelines (Kelly Crosbie): slide 6

Kelly Crosbie reviewed timelines.

AMH Program Streamlining (Kelly Crosbie and Garrick Pokros): slides 8-13

Take homes:

- DHHS heard a lot of feedback about burdensome process reporting and non-aligned requirements across PHPs; also got feedback on the need for a "care management" definition. DHHS took this feedback and worked on streamlining.
- DHHS focused on streamlining how it holds PHPs accountable. The expectation is that the same reduction of burden will pass down to providers.
- DHHS will provide PHPs with a standardized form (Risk List) to pass information to AMHs and back. This same information will populate the Care Management Report that PHPs will send to DHHS. The Care Management Report is designed to allow DHHS to track care management penetration across populations and other priority items like health equity.
- The Data TAG will launch again shortly and focus on reporting.
- For the Care Management definitions, bear in mind that care management includes both complex and rising risk.

Questions from AMH TAG:

- **Q:** Is the requirement to provide information on a weekly basis flexible for providers?
  A: DHHS will take it back.

- **Q:** Are AMHs being held to a specific penetration level for care management?
  A: No. There is no penalty/liquidated damage on PHPs for "how much." However, we know that our capitation rate assumptions say that about 22% of the population will receive care management and we want to track against that as a dashboard indicator. We also want to be able to perform deeper dives into the data if we need to.

- **Q:** Does telehealth count as "face to face"? Is "face to face" the only category being tracked?
  A: The PHP contract still contains an expectation that the majority of care management is delivered locally.

AMH Program Incentives and Supports (Krystal Hilton and Kelly Crosbie): slides 15-17

Take homes:

- There will be a new funding stream to support the glide path to Tier 3. DHHS heard the challenges about staff, infrastructure and being ready for Tier 3 and looked for a way to create more support. Glide Path Payments (slide 16) are a new idea since the pause.
  Note that this is a different use of the team "glide path" from the November 2019 proposal, which meant a 90 day "hold harmless" period after Managed Care launch. This "glide path" will be before launch. Practices will be eligible for payments if they complete contracting as a Tier 3 with 2 or more PHPs and complete data testing.
- AHEC supports will be available to practices in network with at least 1 SP and PHPs can refer practices for assistance (slide 17).

PCP/AMH Assignment (Kelly Crosbie and Dr Dowler): slide 19

Take homes:

- One PHP approached DHHS with a desire for more flexibility on PCP auto-assignment and DHHS has spent a lot of time and thought on it, including through Executive Review Committee yesterday.
- Not all the specifics are landed but DHHS will be making the change that PHPs may select a different provider for members who are not engaged in care defined by minimum time periods (see slide 19). This does not affect people who select their practice.
- The rationale is that people in the ABD category are by definition not healthy and well and really should be seen in the medical home at least once a year. For non ABD, at 18 months can make the argument that the patient is not being served. DHHS wants to make sure people are being engaged and come in for preventive care.
- This is not a dramatic change but does have the potential to cause some disruption. DHHS is using as many channels as possible to encourage practices to see and engage their patients. The flu shot is an opportunity. Telehealth counts. A Medicaid bulletin article ("Managing your Primary Care Assignments") was just published on this issue: https://medicaid.ncdhhs.gov/providers/medicaid-bulletin
- More information to come, including how beneficiary notification will need to work.

Questions from AMH TAG:

- **Q:** How does this affect smaller practices that provide specialized services to other practices (e.g. SUD)?
  A: Comes down to the practice and PHP to work out.

- **Q:** Could the minimum lookback periods be longer given COVID?
  A: DHHS discussed this but telehealth counts, and it is reasonable to expect a check in.

- **Q:** Does telehealth count as "face to face"? Is "face to face" the only category being tracked?
  A: The PHP contract still contains an expectation that the majority of care management is delivered locally.

Quality (Kelly Crosbie): slide 21

Take homes:

- DHHS has streamlined the SP measure set and has therefore streamlined the AMH measure set
- DHHS is being firmer than previously that PHPs must use this measure set (without changes) for AMH performance incentives.
- Some measures listed have new specs – will be updated in the forthcoming Tech Specs that DHHS will release.

Questions/comments from AMH TAG:

- **Comment**: The chlamydia screening measure is difficult to manage solely as an AMH.

Response: Thanks for the feedback. AMH will get credit whether the screening happened at the AMH or not.

AMH Payment (Kelly Crosbie): slides 23-25

Take homes:

- Slides 23-24 contain year 3 AMH payment policies and a timeline for performance incentives.
- DHHS re-debated whether to set a care management rate floor. DHHS is NOT setting a rate floor for a variety of reasons. One reason is that AMH populations are different (e.g. well children vs complex adults). DHHS wants to provide flexibility.
  Guidance on how the cap rate was built up for care management (on AMH website) still applies.

Contracting and Oversight Policies (Kelly Crosbie): Slide 27

Take homes:

- Slide 27 contains final policies (mostly unchanged since November 2019).
- DHHS acknowledges that NCQA auditing is an issue. DHHS has begun work with NCQA to find a way through.
- Guidance on how the cap rate was built up for care management (on AMH website) still applies.

Questions from AMH TAG:

- **Q:** If an AMH Tier 3 wants to move to Tier 2 voluntarily, does there need to be a notification period to PHPs to make sure they cover the care management?
  A: On November 3, 2020, DHHS published a NC Medicaid Bulletin article on the downgrade process, which can be found here, *Modified NC Tracks AMH Tier Attestation Tool Available*.
  Need to think more on the question.

Overall Comments and Next Steps

- DHHS is working through the timeline for PHPs to revise their AMH Tier 3 contracts – will need to occur before field resumes or re-contracts.
- Data sub-committee is being scheduled.

There were no public comments.

The meeting adjourned at 2:25 pm.