



November 2020 Managed Care Launch
Fireside Chat: Advanced Medical Home

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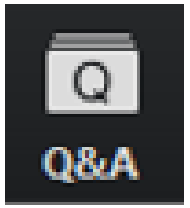
Advanced Medical Home Topics

AMH Refresher
What Counts as CM?
PHP Accountability for CM
Reporting Requirements
Readiness
Practice Support
Engagement
Payments
Quality Measures
Countdown to Launch

Logistics for today's COVID-19 Forum

Question during the live webinar



Technical assistance

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POLL #1

REFRESHER: Advanced Medical Homes

Goal: provide a pathway for practices to have a larger role in managing the health outcomes and cost for their patient populations

Guiding principles

1. Preserve broad access to primary care services for enrollees
2. Strengthen the role of primary care in care management, care coordination and quality improvement
3. ***Provide clear incentives for practices to become more focused on cost and quality outcomes, increasing accountability over time***

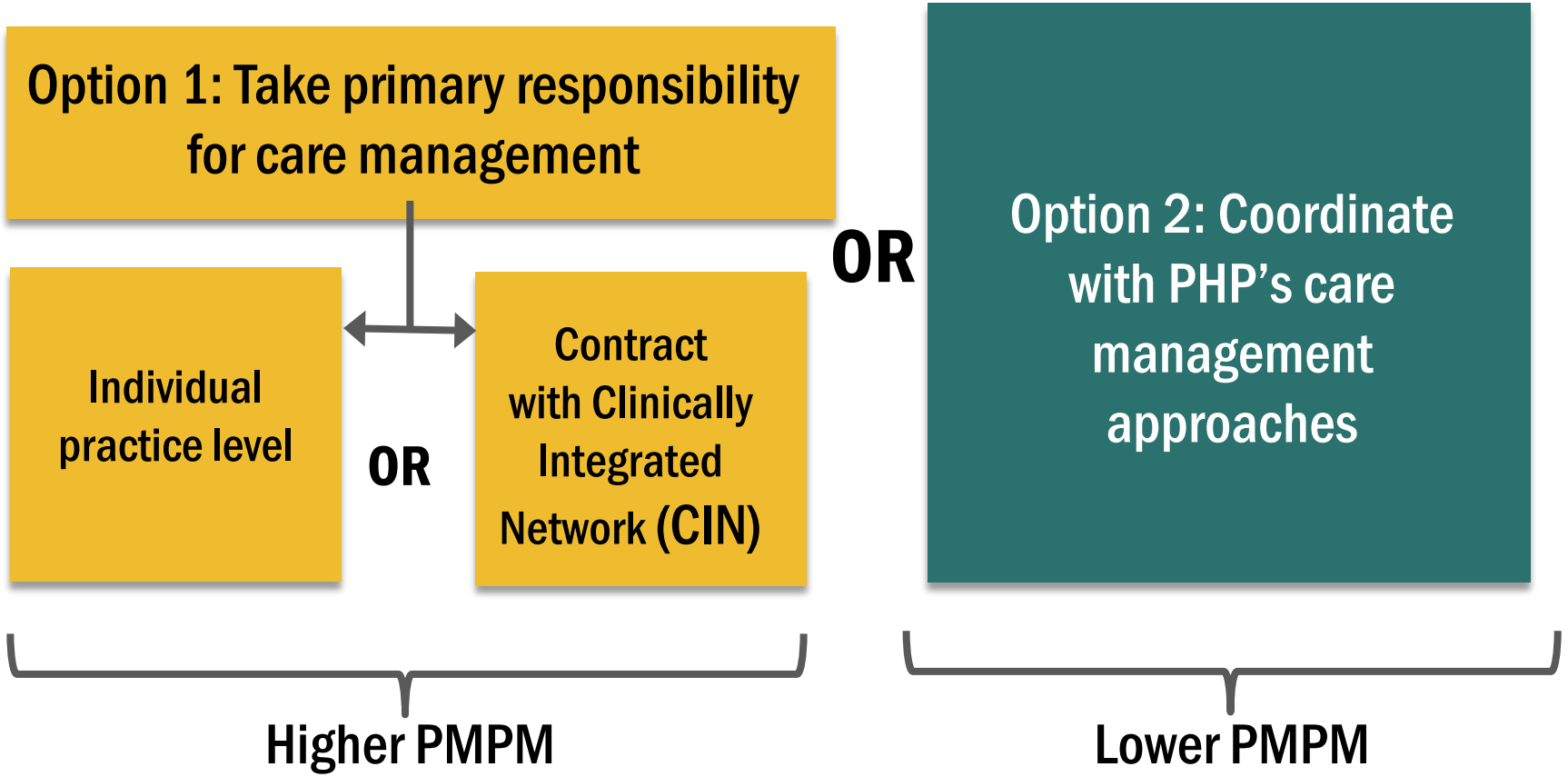
Expectations are high:

- Penetration rates are much higher than current
- Location of care is designed to be highly community-based
- Need to address the continuum of care needs from **rising risk** to **high risk** to **unmet social needs**

AMH program represents an opportunity for providers to fund population health investments critical to a VBP environment!

REFRESHER: Advanced Medical Homes

Allows practices to choose:



REFRESHER: Advanced Medical Homes

Option 1: Tier 3

- PHP ***delegates primary responsibility*** for care management to the AMH
- Practices will have the option to **provide care management in-house** or **through a CIN/other partner** across all Tier 3 PHP contracts

Tier 3
- Medical Homes Fees Remain the Same ($2.50/$5.00)
- PHPs must offer incentive pgms
- NEW Care Management Rate

Option 2: Tiers 1 and 2

- PHP ***retains primary responsibility*** for care management
- **Practices will need to interface with multiple PHPs**, which may employ different approaches to care management

Tiers 1 & 2
- Medical Homes Fees Remain the Same ($2.50/$5.00)
- PHPs must offer incentive pgms

Care management will be a shared responsibility of practices and PHPs, with division of responsibility and payment varying by AMH "Tier."

This applies to all plans a practice contracts with and their attributed members.

REFRESHER: Advanced Medical Homes

Option 1: Tier 3 Practice Requirements

- Risk stratify all empaneled patients
- Provide care management to **all** high-need patients
- Provide short-term, transitional care management along with medication reconciliation to **all** empaneled patients who are discharged from the ED or an inpatient setting
- Demonstrate **active** access to an ADT
- **Receive** claims data feeds and meet State-designated security standards for their storage and use

Option 1: Tier 3 PHP Oversight

- PHPs ***must*** verify that AMHs can meet Tier 3 requirements looking for evidence of:
  - Care management policy,
  - Assessment/care plan tools,
  - Care management workflows,
  - Risk scoring methodology,
  - Staffing plans/job description,
  - Care management documentation system,
  - Technology system capable of capturing and using encounter data, member data, ADT data
- ***PHPs are responsible for on-going oversight***

AMH Streamlining Aims

To ensure that AMHs have sufficient data to support their care management efforts, PHPs will be required to share data on attributed enrollees

In response to feedback, DHHS looked at ways to simplify the AMH program and focus on outcomes in lieu of process.

Changes are designed to:

- Shift the focus from individual care management processes to penetration rate of care management in the population and outcomes
- Streamline oversight of care management
- Provide clarity on what “counts” as Care Management for tracking purposes

POLL #2

What Counts as "Care Management"

ALL levels of care management—ranging from high intensity (e.g. care plan development and frequent face-to-face encounters) to low intensity (e.g. infrequent, telephonic contact)—should be reported as CM encounters.

"Counts" as care management

- In-person (including virtual) visit with care manager or member of care team; could include delivery of comprehensive assessment, development of care plan, or other discussion of patient's health-related needs
- Phone call or active email/text exchange between member of care team and member (e.g. to discuss care plan or other health-related needs); must include active participation by both parties; unreturned emails/text messages do NOT count
- Phone calls to set up appointments with providers that are three-way calls between care team, member and practice staff to arrange care visits

Does NOT "count" as care management

- Care manager leaves a voicemail with member or sends unreturned email/text message
- PHP/care manager sends mailer to member
- Phone calls between practice front desk staff and either the member or care team to schedule care visits
- Scheduled in-person visit to which the member fails to show up

PHP Accountability for Care Management

DHHS looked at how to reduce burden associated with multiple requirements for PHPs while maintaining oversight.

Changes to DHHS oversight of PHPs:

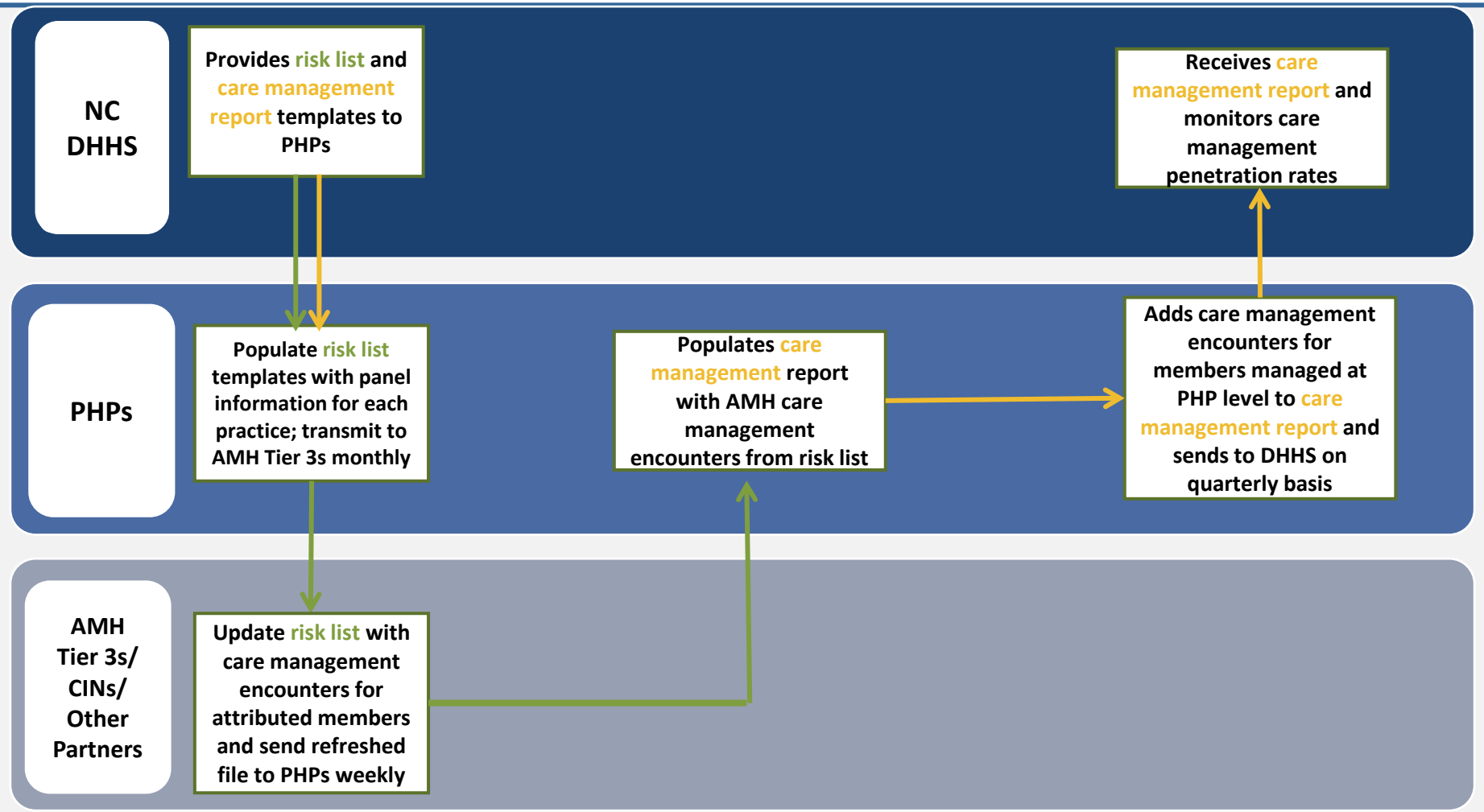
- DHHS had previously planned to impose liquidated damages on PHPs for failure to complete individual care management process requirements:

  (1) Failure to develop a Care Plan that includes all required elements
  (2) Failure to complete a Comprehensive Assessment
  (3) Failure to develop a Care Plan for members with LTSS needs
  (4) Failure to meet minimum transition care management requirements

- **PHPs will no longer be subject to liquidated damages associated with these individual care management process requirements.** DHHS **will** measure total penetration of care management in each PHP's population using the standardized reporting data (see next slides).

- DHHS **expects** that oversight provisions in provider contracts will be similar to those in the contract between DHHS and PHPs to minimize administrative burden.

Working Together to Care for Our Beneficiaries: Reporting Requirements



AMH Tier 3 Readiness

DHHS will implement a new $8.51 PMPM payment stream to AMH Tier 3 practices as much as 90 days prior to the launch of Managed Care to support costs of Tier 3 implementation.

Tier 3 Glide Path Payment Eligibility Criteria

1. AMH Tier 3 within NC Tracks
2. **Contracting completed** with at least two PHPs
3. **Data exchange testing successfully completed** with at least two PHPs

Practice must attest to this in NC Tracks

DHHS will release additional details on the above criteria prior to launch.

Payments will flow to practices in the same way as current CA II Payments. Qualifying practices will receive $8.51 PMPM direct from NC Tracks for each month in which they meet the conditions shown at left, up to three times.*

***In addition to COVID enhanced rates if applicable**

To reinforce the importance of AMH Tier 3 data exchange, DHHS is also adding a new liquidated damage (enforceable after launch) on PHPs of $1,000 per occurrence for failure to transmit a beneficiary assignment file or claims to an AMH Tier 3 practice (or CIN/Other Partner) within the Department's published data specifications

AMH Tier 3 Practice Support Resources

NC AHEC will offer practice support and education aligned with the AMH program in partnership with DHHS.

AHEC practice supports will include:

AMH Practice Coaching

- Starting in January, AHEC coaches will work with individual practices to accelerate adoption of Tier 3 standards and facilitate transition, starting with a standardized assessment tool
- Available to primary care practices who are in network with at least one Standard Plan
- PHPs may refer practices that need assistance meeting AMH standards

Education

- AHEC will offer webinars, tip sheets, bulletins and other mass communications on the AMH program
- Education will be geared toward all interested Medicaid practices

First webinar: December 10, 2020. Registration information will be posted to https://www.ncahec.net/medicaid-managed-care/

Patient Engagement with Medical Homes

DHHS will allow PHPs additional flexibility in PHPs' PCP/AMH assignment policies for "dis-engaged" members.

Existing Policy in Standard Plan contract (p. 126):

- When a member does not select an AMH/PCP at the time of enrollment, the PHP will assign an AMH/PCP.
- The PHP's methodology for assignment must include the following components, in this order, to the extent that the information is available:
  1. **Prior AMH/PCP assignment**
  2. **Member claims history**
  3. Family member's AMH/PCP assignment
  4. Family member's claims history
  5. Geographic proximity
  6. Special medical needs
  7. Language/cultural preference
- In contract year 2, DHHS may direct the methodology to include AMH status.

Flexibility:

- For Step 1 of the assignment methodology, PHPs may look at prior AMH/PCP assignment together with claims history at the assigned PCP/AMH (Step 2).
- PHPs may set a lookback of claims in prior 18 months (non-ABD) or 12 months (ABD) with assigned PCP.
- If a member has a prior AMH/PCP assignment but has **no claims history** with the assigned AMH/PCP within the lookback period, the PHP *may* assign to another AMH/PCP, following components 3-7.
- **There will be a cap on % of a provider panel that can be moved.**
- **There are always beneficiary choice protections.**

Four Medical Home Payment Types Exist

Payment Type	Description
Clinical Services Payments	• Fee-for-Service
Medical Home Fees	• Payment for coordination with PHPs, similar to today's Carolina ACCESS fees • *Will be set at Carolina ACCESS levels for 2 years*
Care Management Fees	• Payments available to Tier 3 practices for assuming significant care management responsibilities • Fee levels negotiated directly between PHPs and practices *DHHS does not have insight into these arrangements*
Performance-Based Payments	• Incentive Payments based on performance against AMH quality measures

AMH Tier 3 Payments

The Department is finalizing several policies regarding Year 1 AMH Tier 3 payments:

1. **There is no care management fee rate floor, although in November 2020 DHHS made the suggestion of what a floor *should* be.**
2. **Guaranteed care management fees that cannot be put "at risk".**
3. **Timeline for Changing payment terms**
4. **Limited AMH Measure Set for Tier 3 Performance Incentives**

*Note: PHPs will NOT be subject to liquidated damages for failure to contract with all AMH practices

POLL #3

AMH Final Quality Measures

PHPs will be required to use only these measures to develop AMH performance incentive payments in Year 1.

Updated AMH Measure Set

- Adolescent Well-Care Visit
- Childhood Immunization Status (Combination 10)
- Immunization for Adolescents (Combination 2)
- Screening for Depression and Follow-up Plan
- Well-Child Visits in the First 15 Months of Life
- Cervical Cancer Screening
- Chlamydia Screening in Women
- Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)
- Controlling High Blood Pressure
- Plan All Cause Readmission-Observed to Expected Ratio

Pending Measures

PHPs will be required to share **total cost of care** data with practices at a later date.

What's Good Enough? What Are The Benchmarks?

Updated AMH Measure Set

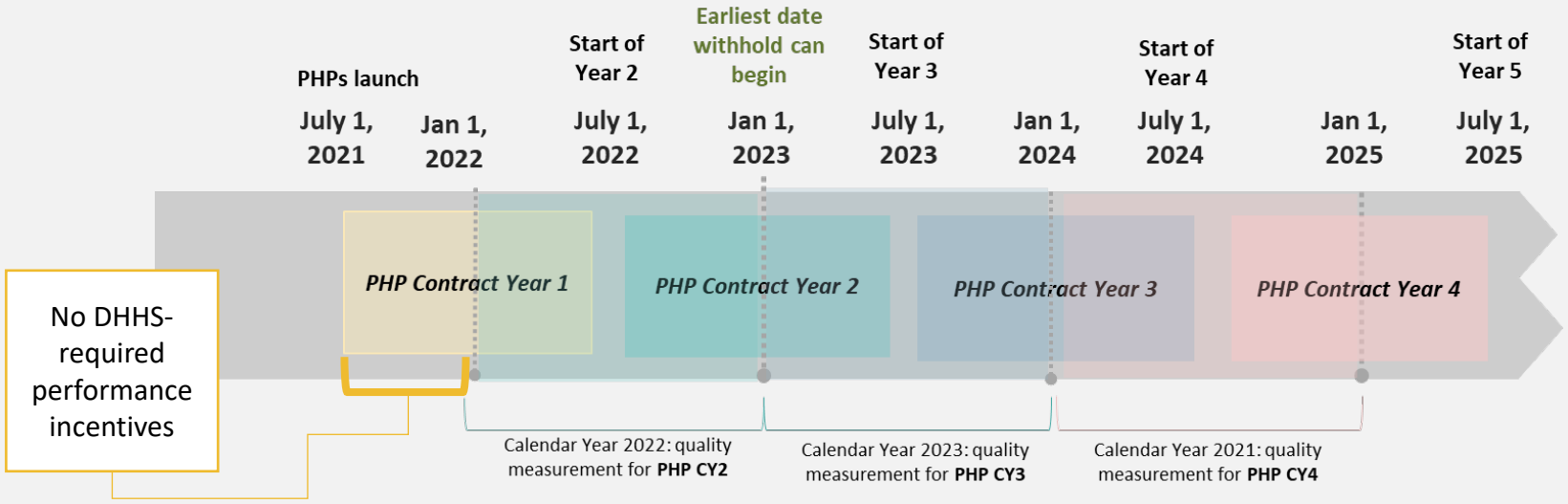
- Adolescent Well-Care Visit
- Childhood Immunization Status (Combination 10)
- Immunization for Adolescents (Combination 2)
- Screening for Depression and Follow-up Plan
- Well-Child Visits in the First 15 Months of Life
- Cervical Cancer Screening
- Chlamydia Screening in Women
- Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)
- Controlling High Blood Pressure
- Plan All Cause Readmission-Observed to Expected Ratio

Below National Average
At National Average
Above National Average
No rate information

AMH Tier 3 Payments (cont.)

Performance Incentive Payments

Year 1 Performance Incentive Timing—Due to differences in PHP contract year and quality measurement reporting period timing, **Department-required incentive programs, including performance incentive payments for AMH Tier 3, will start six months after managed care launch (at the latest).**



AMH Oversight and Performance Standards

DHHS is moving ahead with policies that promote streamlining and transparency.

Contracting and Oversight Updates

1. **Tier 3 contract audits**—For year 1, PHPs may **not** condition Tier 3 contracts on audits or other monitoring activities that go beyond what is necessary to meet AMH Tier 3 standards (e.g. NCQA Complex Case Management)

2. **Timeline for corrective actions and AMH Tier "Downgrades:**
   - PHPs **must allow** AMHs and CINs/Other Partners at least **30 days** for remediation of non-compliance with AMH Tier 3 standards before pursuing a downgrade.
   - **Practices may "self downgrade" using the process on the AMH website.**
   - DHHS is **NOT** implementing he 90-day "hold harmless period" because Glidepath moved IN FRONT of launch.

3. **Oversight processes transparency**—PHPs **must** share their oversight processes and notice to the AMH of **any actions** taken against that AMH's contracted CIN/Other Partner.

DHB Will Monitor (in addition to AMH Measures)

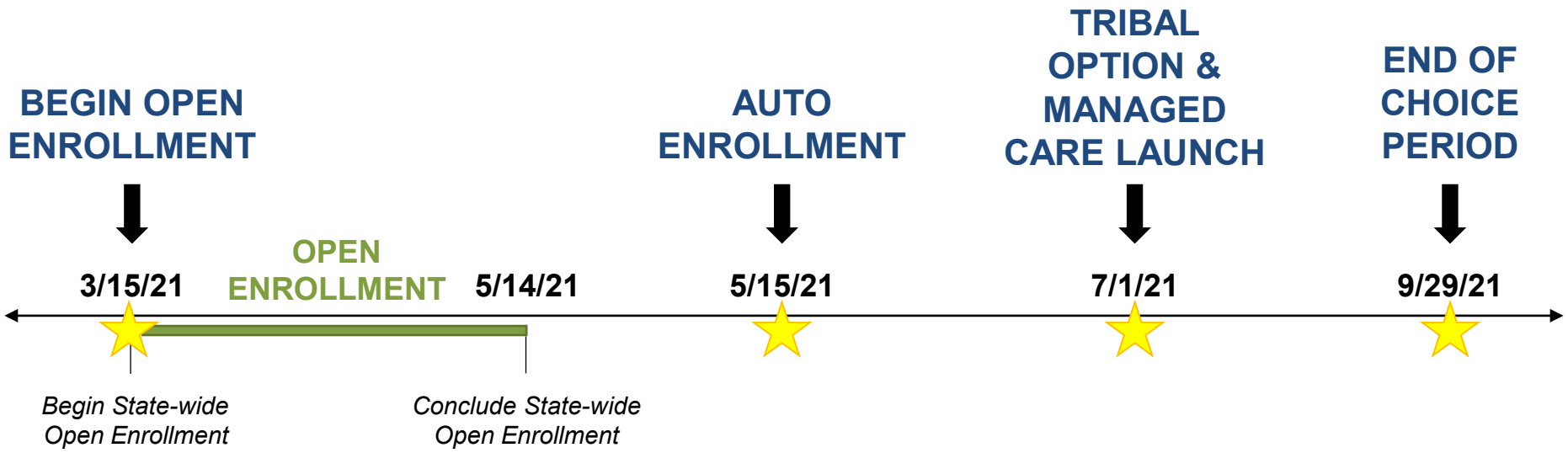
- Percentage of Eligibles who receive Preventative Dental Care
- Total Eligibles Receiving at Least One Initial or Periodic Screen (EPSDT)
- Flu Vaccines for Adults
- Hemoglobin A1c (HbA1c) Testing (HA1C)
- Avoidable Utilization
  - PDI-14: Asthma Admission Rate
  - PDI-15: Diabetes Short-Term Complications Admission Rate
  - PDI-16: Gastroenteritis Admission Rate
  - PDI-18: Urinary Tract Infection Admission Rate
  - PQI-01: Diabetes Short-Term Complication Admission Rate
  - PQI-05: COPD or Asthma in Older Adults Admission Rate
  - PQI-08: Heart Failure Admission Rate
  - PQI-15: Asthma in Younger Adults Admission Rate

DHB Will Monitor (in addition to AMH Measures)

- Use of Opioids at High Dosages in Persons Without Cancer
- Use of Opioids from Multiple Providers in Persons Without Cancer
- Concurrent Use of Prescription Opioids and Benzodiazepines
- Use of First Line Psychosocial Care for Children and Adolescents on Anti-Psychotics
- Follow-Up After Hospitalization for Mental Illness (7- and 30-day)
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
- Medical Assistance with Smoking and Tobacco Use
- Low Birth Weight
- Prenatal and Postpartum Care (both rates)
- Rates of Screening for Pregnancy Risk
- Contraceptive Care: Most & Moderately Effective Methods
- Contraceptive Care: Postpartum
- Rate of Screening for Unmet Resource Needs

POLL #4

Time Keeps on Slipping…Into the Future



Upcoming Webinars

1. **Clinical Quality Webinar (Women's Health)**
   Nov. 19, 2020 @ 5:30 PM

2. **Medicaid Fireside Chat (Tribal Option & Beneficiary Attribution)**
   Dec. 3, 2020 @ 5:30 PM

3. **AHEC AMH Webinar Series #1**
   Dec. 10, 2020 @ 5:30 PM

Registration information will be posted to
https://www.ncahec.net/medicaid-managed-care/

APPENDIX

FINAL Adult AMH Measures

NQF #	Measure ID	Measure Name	2016 Rates %	2017 Rates %	2018 Rates %	2019 Rates %	Steward	Definition
1768	N/A	Plan All-Cause Readmissions	18.24	18.22	-	-	NCQA	Assesses the rate of adult acute inpatient stays that were followed by an unplanned acute readmission for any diagnosis within 30 days after discharge. As well as reporting observed rates, NCQA also specifies that plans report a predicted probability of readmission to account for the prior and current health of the member, among other factors. The observed rate and predicted probability is used to calculate a calibrated observed-to-expected ratio that assesses whether plans had more, the same or less readmissions than expected, while accounting for incremental improvements across all plans over time. The observed-to-expected ratio is multiplied by the readmission rate across all health plans to produce a risk-standardized rate which allows for national comparison. https://www.ncqa.org/hedis/measures/plan-all-cause-readmissions/
32	9768	Cervical Cancer Screening	52.44	49.83	46.47	43.82	NCQA	Assesses women 21–64 years of age who were screened for cervical cancer using either of the following criteria: • Women age 21–64 who had cervical cytology performed every 3 years. • Women age 30–64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years. https://www.ncqa.org/hedis/measures/cervical-cancer-screening/

Adult Measures Continued

NQF #	Measure ID	Measure Name	2016 Rates %	2017 Rates %	2018 Rates %	2019 Rates %	Steward	Definition
18	2706	Controlling High Blood Pressure	-	-	-	-	NCQA	Assesses adults 18–85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90 mm Hg). https://www.ncqa.org/hedis/measures/controlling-high-blood-pressure/
0039		Flu Vaccinations	-	-	-	-	NCQA	The percentage of adults 18 years of age and older who self-report receiving an influenza vaccine within the measurement period. This measure is collected via the CAHPS 5.0H adults survey for Medicare, Medicaid, and commercial populations. It is reported as two separate rates stratified by age: 18-64 and 65 years of age and older. https://www.ncqa.org/hedis/measures/flu-vaccinations/
0418/ 0418e	N/A	Screening for Depression and Follow-Up Plan	-	-	-	-	CMS	Percentage of patients aged 12 years and older screened for depression on the date of the encounter or 14 days prior to the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the eligible encounter. http://www.qualityforum.org/QPS/0418
2950	N/A	Use of Opioids from Multiple Providers in Persons Without Cancer	-	-	-	-	PQA	Percentage of patients aged 12 years and older screened for depression on the date of the encounter or 14 days prior to the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the eligible encounter. http://www.qualityforum.org/QPS/0418

Adult Measures Continued

NQF #	Measure ID	Measure Name	2016 Rates %	2017 Rates %	2018 Rates %	2019 Rates %	Steward	Definition
0027		Medical Assistance with Smoking and Tobacco Use Cessation						The three components of this survey measure assess different facets of providing medical assistance with smoking and tobacco use cessation. The results of this measure represent the percentage of smokers/tobacco users who answered "Sometimes," "Usually," or "Always" to this question. The rates presented deviate from NCQA's methodology of calculating a rolling average using the current and prior years' results, since only the current year's results are available. https://www.ncqa.org/hedis/measures/medical-assistance-with-smoking-and-tobacco-use-cessation/
		Advising Smokers and Tobacco Users to Quit	-	-	72.2	77.9	NCQA	Adults 18 years of age and older who are current smokers or tobacco users and who received cessation advice during the measurement year.
		Discussing Cessation Medications	-	-	44.4	48.1	NCQA	Adults 18 years of age and older who are current smokers or tobacco users and who discussed or were recommended cessation medications during the measurement year.
		Discussing Cessation Strategies	-	-	47.2	49.0	NCQA	Adults 18 years of age and older who are current smokers or tobacco users who discussed or were provided cessation methods or strategies during the measurement year

Adult Measures Continued

NQF #	Measure ID	Measure Name	2016 Rates %	2017 Rates %	2018 Rates %	2019 Rates %	Steward	Definition
33	509	Chlamydia Screening in Women (Total Rate)	58.19	58.2	57.86	57.22	NCQA	The percentage of women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year. https://www.ncqa.org/hedis/measures/chlamydia-screening-in-women/
731		Comprehensive Diabetes Care					NCQA	Assesses adults 18–75 years of age with diabetes (type 1 and type 2) who had each of the following: • Hemoglobin A1c (HbA1c) testing. • HbA1c poor control (>9.0%). • HbA1c control (<8.0%). • HbA1c control (<7.0%) for a selected population. • Eye exam (retinal) performed. • Medical attention for nephropathy. • BP control (<140/90 mm Hg). https://www.ncqa.org/hedis/measures/comprehensive-diabetes-care/
59	26	HbA1c Poor Control (>9.0%)	-	-	-	-	NCQA	
575	8662	HbA1c Poor Control (>8.0%)	-	-	-	-	NCQA	
3389	N/A	Concurrent use of Prescription Opioids and Benzodiazepines	-	20	16.02	14.86	PQA	The percentage of individuals ≥18 years with concurrent use of prescription opioids and benzodiazepines for ≥30 cumulative days. (Excludes patients in hospice care and those with cancer or sickle cell disease.) https://www.pqaalliance.org/assets/Measures/PQA_Opioid_Core_Measure_Set_Description.pdf

FINAL AMH Pediatric Measures

NQF #	Measure ID	Measure Name	2016 Rates %	2017 Rates %	2018 Rates %	2019 Rates %	Steward	Definition
1388	520	Percentage of Eligibles Who Received Preventive Dental Services (PDENT-CH)	**60.23**	**60.77**	**60.76**	**62.22**	CMS	Percentage of individuals ages 1 to 20 who are enrolled in Medicaid or CHIP Medicaid Expansion programs for at least 90 continuous days, are eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services, and who received at least one preventive dental service during the reporting period. https://cmit.cms.gov/CMIT_public/ReportMeasure?measureRevisionId=735
38	8760	Childhood Immunization Status (Combination 10)	32.81	34.16	30.29	35.02	NCQA	The percentage of children 2 years of age who had a four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and nine separate combination rates. https://www.ncqa.org/hedis/measures/childhood-immunization-status/

Pediatric Measures Continued

NQF #	Measure ID	Measure Name	2016 Rates %	2017 Rates %	2018 Rates %	2019 Rates %	Steward	Definition
1407	12927	Immunization for Adolescents (Combination 2)	15.62	21.67	28.89	31.55	NCQA	Assesses adolescents 13 years of age who had one dose of meningococcal vaccine, one Tdap vaccine and the complete human papillomavirus vaccine series by their 13th birthday. https://www.ncqa.org/hedis/measures/immunizations-for-adolescents/
1392		Well-Child Visits in the First 15 Months of Life: 6 Visits or more	59.39	63.52	62.06	65.67	NCQA	Well-Child Visits in the First 15 Months of Life: Assesses children who turned 15 months old during the measurement year and had 0–6 well-child visits with a primary care physician during their first 15 months of life. https://www.ncqa.org/hedis/measures/child-and-adolescent-well-care-visits/
1516	61	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	69.25	69.88	70.14	70.49	NCQA	Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life: Assess children 3-6 years of age who received one or more well-child visits with a primary care practitioner during the measurement year. https://www.ncqa.org/hedis/measures/child-and-adolescent-well-care-visits/

Maternal Measures

NQF #	Measure ID	Measure Name	2016 Rates %	2017 Rates %	2018 Rates %	2019 Rates %	Steward	Definition
N/A	N/A	Percentage of Low Birth Weight Births	-	-	-	-	NCQA	The percentage of singleton births for which mothers had continuous coverage with the same PHP from ≤ 16 weeks' gestation with low birth weight or very low birth weight. https://files.nc.gov/ncdma/documents/NC-Medicaid-Managed-Care-Quality-Measurement-Technical-Specifications-Public.pdf
1517		Prenatal and Postpartum Care (Both Rates)						
	511	Timeliness of Prenatal Care	37.66	36.92	36.37	35.53		The percentage of deliveries that received a prenatal care visit as a member of the organization in the first trimester, on the enrollment start date or within 42 days of enrollment in the organization. https://www.ncqa.org/hedis/measures/prenatal-and-postpartum-care-ppc/
	512	Postpartum Care	59.03	59.36	58.89	68.77		Postpartum Care. The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery. https://www.ncqa.org/hedis/measures/prenatal-and-postpartum-care-ppc/

Patient Satisfaction Measures

NQF #	Measure ID	Measure Name	Steward	Definition
6		CAHPS Survey	AHRQ	The CAHPS Health Plan Survey is a survey that asks health plan enrollees to report about their care and health plan experiences as well as the quality of care received from physicians. HP-CAHPS Version 4.0 was endorsed by NQF in July 2007 (NQF #0006) and Version 5.0 received maintenance endorsement in January 2015. The survey is part of the CAHPS family of patient experience surveys and is available in the public domain at https://www.ahrq.gov/cahps/surveys-guidance/hp/index.html http://www.qualityforum.org/QPS/0006

Social Determinants Measures

NQF #	Measure ID	Measure Name	Steward	Definition
N/A	N/A	Rate of Screening for Unmet Resource Needs	NC DHHS	Assesses the extent to which families have access or have worried about food, transportation, and interpersonal safety.