Population Health under Managed Care:
Care Management & The Advanced Medical Home (AMH) Program

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Population Health: Care Management

- **Under managed care, PHPs (plans) will have responsibility for the care management of enrollees.**

NOTE: PHPs will have other Population Health & SDOH responsibilities. Today's focus is on Care Management/AMH.

*The PHP contract will define standardized PHP care management responsibilities**

PHP Care Management Responsibilities

***SDOH COMPONENTS**

- Screening—4 standardized SDOH questions
- Stratification—"High Unmet Resource" Population Group
- Care Planning: Address Unmet Resource Needs
- Quality: Measurement of Screening Rates, Referrals, Closed Loops, Outcomes (in later years)

Under the AMH program, primary responsibility for comprehensive assessment and care management passes from PHP to practices when practices certify into higher AMH "tiers" (see next slides)

Advanced Medical Home Overview

- The **Advanced Medical Home (AMH) program** will:
  - Build on the strengths of today's North Carolina's primary care infrastructure as the State transitions to managed care
  - Offer a range of participation options for providers
  - Emphasize local delivery of care management
  - Offer the opportunity for providers to be rewarded for high quality care by aligning payment to value
- **Care management will be a shared responsibility of practices and PHPs, with division of responsibility varying by AMH "Tier"**
- **The AMH Program will launch concurrently with managed care, with a State certification process for practices launching in Summer/Fall 2018**

Four "Tiers" in the AMH Program

- **Practices will apply to DHHS to participate in the AMH program, and practices' AMH Tier status will be recognized by all PHPs .**

AMH Tier	Summary
1	• Based on Carolina ACCESS I standards • **Will phase out after 2 years**
2	• Based on Carolina ACCESS II standards
3	• Based on Carolina ACCESS II standards **PLUS demonstrated care management capabilities at practice or system level to serve all Medicaid beneficiaries** • PHPs must contract with a substantial proportion *(% to be set by state)* of certified Tier 3 practices in each region in which they operate
4	• **Will launch in Year 3 of managed care** • Care management capabilities as in Tier 3 • Will capture "advanced" alternative payment arrangements

Certification Requirements by Tier

- Practices will be eligible to participate in AMH if they meet current requirements for Carolina ACCESS.
- DHHS will certify practices into Tiers prior to initial managed care contracting with PHPs.
- Practices will be required to choose between Tier 1, 2 or 3.
- Clinically integrated networks (CINs) will be permitted to "batch attest" on behalf of their member practices for entry into Tier 3.
- The **Tier 3** practice attestation process will assess practices' readiness to perform care management functions at the site or system level:
  - Risk stratifying all patients in their panel;
  - Providing targeted, proactive, relationship-based care management to all higher-risk patients;
  - Providing short-term or transitional care management;
  - Providing medication reconciliation support to targeted higher-risk patients;
  - Ensuring patients with emergency department visits receive a follow-up interaction within one week of discharge; and
  - Contacting at least 75% of patients who were hospitalized in target hospitals, within two business days.

Four AMH Payment Types

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 between PHPs and practices
Performance-Based Payments	• Payments based on performance against AMH measures

Payment Model by Tier

- **DHHS will require PHPs to adhere to standard payment models by Tier**

AMH Tier	"Clinical Services Payments" (FFS)	Medical Home Fee	Care Management Fee	Performance Based Payments in Years 1-2
1	✓	✓ - CA I	N/A	Optional
2	✓	✓ - CA II	N/A	Optional
3	✓	✓ - CA II	✓ - Negotiated between each AMH/CIN and PHP	✓
4 (Year 3 +)	*Alternative Payment arrangements may change the balance or merge the components of the payment components, including by decreasing FFS*			✓

AMH Quality Measures

- DHHS will require PHPs to monitor the performance of AMHs in all tiers and calculate performance-based payments based on a set of quality measures
- DHHS will develop a set of Core AMH quality performance measures aligned with North Carolina's Quality Strategy (forthcoming)
- The core measure set will include (at a minimum) measures in the following categories:
  - Measures tied to Quality Strategy objectives
  - Total Cost of Care
  - Key Performance Indicators
- PHPs will be responsible for monitoring the performance of AMHs in all tiers
- PHPs will be responsible for using the core measure set to design performance-based programs and payments

AMH Data Sharing

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

All AMH Tiers

- Assignment/attribution files;
- Results of PHPs' risk stratification
- Initial enrollee-level care needs screening data;
- Enrollee-level summary information;
- Practice-level quality measure performance information

AMH Tier 3 and 4

- Timely enrollee level claims & encounter data feeds (DHHS to standardize format(s))

To receive feeds, Tier 3 and 4 AMHs will need to demonstrate:

- Appropriate health information technology
- Data privacy and security processes

Any Questions?

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