Advanced Medical Homes Update:

Roles and Responsibilities of Clinically Integrated Networks and Other Partners

Kelly Crosbie, MSW, LCSW

Deputy Director, Quality and Population Health

Contents

Part I:
Overview: North Carolina's Medicaid Transformation and AMH

Care Management Principles

Robust care management is a cornerstone of the State's managed care transition

Care Management Guiding Principles

- ❑ Medicaid enrollees will have access to **appropriate care management**
- ❑ Care management should involve **multidisciplinary care teams**
- ❑ **Local care management** is the preferred approach
- ❑ Care managers will have access to **timely and complete enrollee-level information**
- ❑ Enrollees will have access to **programs and services that address unmet health-related resource needs**
- ❑ Care management will align with **statewide priorities for achieving quality outcomes and value**

AMHs are designed to serve as **a vehicle for executing on this approach in a managed care context**

Local Care Management

PHPs must ensure a robust system of local care management that is performed at the site of care, in the home, or in the community with face-to-face interaction wherever possible

Requirements for Local Care Management

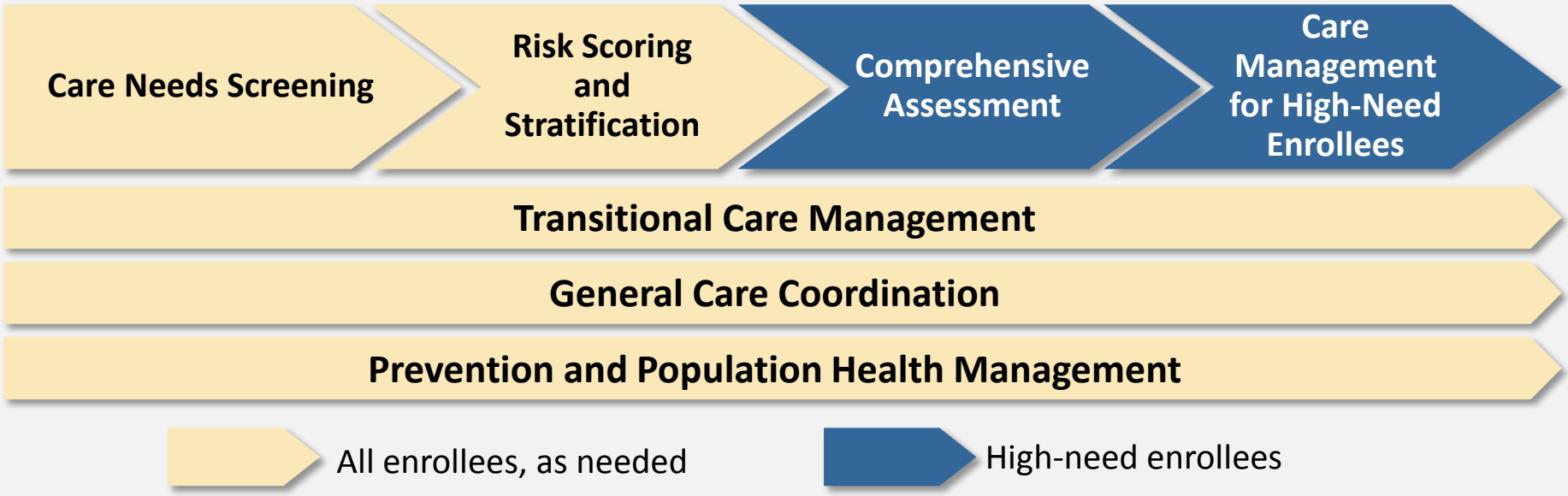
- PHPs must have an **established system of local care management** through AMHs, Local Health Departments (LHDs) as well as care management provided by the PHP that delivers high quality care
- PHPs are responsible for **oversight of local care management**, but can delegate primary responsibility to AMH Tier 3 practices
- If Medicaid enrollees receive care management from more than one entity, the PHP must ensure care plans detail the **roles and responsibilities of local care managers** (e.g., AMHs and LHDs)

The AMH program is intended as a minimum initial framework for which PHPs and practices innovate around payment and delivery models to support local care management

Part II:
Roles and Responsibilities:
PHPs, AMHs, and CINs

Care Management Approach

The State has developed a process to ensure that high-need individuals and those transitioning out of the hospital will receive appropriate, local care management

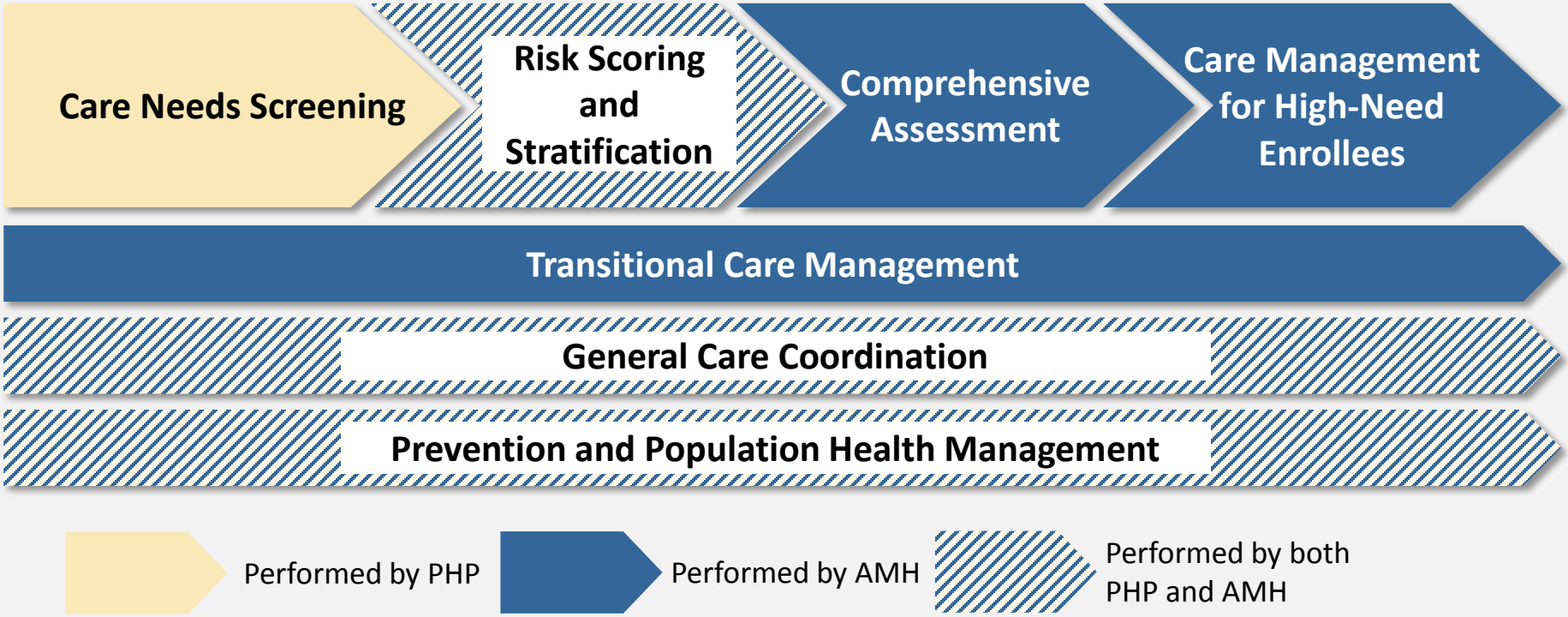


- **PHPs must also implement processes to identify priority populations, including:**
  - Children and adults with special health care needs*
  - Individuals in need of long term services and supports (LTSS)
  - Enrollees with rising risk
  - Individuals with high unmet resource needs
- **AMHs are required to use methods that identify priority populations "to the greatest extent possible"**

*Including behavioral health, substance use, increased risk for chronic conditions, and foster care populations

Care Management Approach: Tier 3

Tier 3 AMH practices are responsible for a range of local care management functions; CINs/other partners can assist practices in fulfilling some or all of these responsibilities



Note: AMH Tier 3 practices will have broad flexibility in determining how CINs/other partners can help meet Tier 3 needs

What are CINs/Other Partners?

Practices that choose to work with CINs/other partners will have the freedom to choose any CIN that meets their unique needs

Types of Practices

- Employed physician groups – employed directly by health system or faculty practice plan
- Independent group practices – single or multi-specialty group practices, community clinics, and Federally Qualified Health Centers (FQHCs)
- Local health departments (LHDs)

Types of CINs

- Hospitals, health systems, integrated delivery networks, Independent Practice Associations (IPAs) and other provider-based networks and associations
- Care management organizations and technology vendors

Practices must consider whether their in-house capabilities are sufficient to meet AMH Tier 3 requirements and how CINs/other partners may support them

How Can CINs/Other Partners Help AMHs?

CINs/other partners can offer a wide range of capabilities but practices will need to determine their precise gaps and needs

CINs/Other Partner Services May Include:

1. Providing **local** care coordination and care management functions and services
2. Supporting **AMH data integration** and **analytics tasks** from multiple PHPs and other sources, and providing **actionable reports** to AMH providers
3. Assisting in the **contracting process** on behalf of AMHs

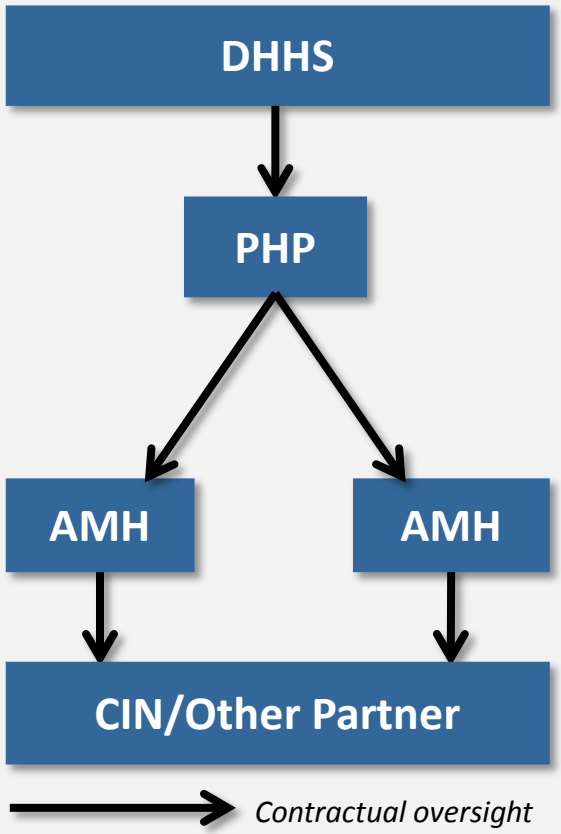
Although the majority of AMH Tier 3 practices may elect to contract with CINs/other partners for support, practices are not required to do so

AMH Accountability for CINs/Other Partners

Tier 3 AMH practices are ultimately accountable to PHPs regardless of whether they delegate care management responsibilities to CINs/other partners

AMH Tier 3 Considerations

- AMH Tier 3 Practices must ensure **proper oversight of contracted CINs/other partners** to ensure that patients are receiving required care management services
- The **State will not have oversight of CINs** (e.g., they will not certify CINs, validate their capabilities, etc.)
- For AMH Tier 3 practices that partner with CINs, the **State will certify individual practices as AMH Tier 3** rather than the entire CIN



Part III:
CIN Capabilities: Care Management

Tier 3 Care Management Responsibilities and CINs/Other Partners

CINs/other partners may support practices in the delivery of local care management

Potential ways that CINs/other partners can support AMHs

- Local staffing support
- Performing Comprehensive Assessments and Care Planning
- Providing same day outreach and managing care transitions

Staffing

CINs/other partners can help Tier 3 AMHs meet specified local care management staffing requirements

Tier 3 Local Care Management Staffing Requirements

- Have licensed, trained local care management staff work closely with clinicians in a team-based approach for high-need patients
- Assign all high-need patients a care manager with minimum RN or LCSW credentials who is accountable for active, ongoing care management
- Assign patients identified as high risk for admission or other poor outcome with transitional care needs a local care manager

Potential CIN Delegated Responsibilities

- Provide local care management staff and other infrastructure through a health system, integrated delivery network or other care management partner
- Provide access to remote, on-demand care management staff to supplement local resources

Comprehensive Assessments and Care Planning

Tier 3 AMHs will be required to conduct a Comprehensive Assessment and develop a Care Plan for all patients identified as high-need

Tier 3 Comprehensive Assessment and Care Plan Requirements

- **The Comprehensive Assessment:**
  - Can be performed as part of a clinician visit, or separately by a team led by a clinician with a minimum credential of RN or LCSW
  - Must be reviewed by the care team
  - Must develop protocols for situations where patients are at immediate risk
- **The Care Plan:**
  - Must be developed within 30 days of the Comprehensive Assessment
  - Must be individualized and person-centered and developed using a collaborative approach
  - Must incorporate findings from the PHP Care Needs Screening/risk scoring, practice-based risk stratification, and Comprehensive Assessment
  - Must include a process to update the Care Plan

Potential CIN Tasks

- Perform and assist in protocols and the development of the Comprehensive Assessment
- Provide tools for practices to streamline administration of assessments
- Identify and aggregate actionable data that can be used to inform Care Plan development
- Perform or assist in the development of the Care Plan using local CIN care managers
- Develop workflows for updating the Care Plan on an ongoing basis
- Update the Care Plan on an ongoing basis

Same Day Outreach and Managing Transitions of Care

Tier 3 AMHs must support patient care transitions in real or near real-time

Tier 3 Patient Care Transition Requirements

- Implement systematic, clinically appropriate care management processes for responding to high-risk ADT alerts
- Provide local care management for patients in transition that are identified as high risk

Potential CIN Delegated Responsibilities

- Develop clinical protocols for responding to high-risk ADT alerts
- Develop transitional care management protocols and provide staffing support
- Provide local on-demand care management capacity for ADT events that require real-time or near real-time responses

Part IV: CIN Capabilities: Data Management and Analytic Support

AMH Data Flows

PHPs Data Flows to Practices

- **PHPs must share the following with <u>all</u> practices:**
  - Beneficiary assignment information
  - PHP risk scoring and stratification results
  - Initial Care Needs Screening information
  - Quality measure performance information
- **PHPs must share the following with <u>Tier 3 practices</u>:**
  - Encounter data

Other AMH Data Flows

- AMH Tier 3 practices will be required to access **Admission, Discharge, and Transfer (ADT) information***
- All practices should **collect and process relevant clinical information** for population health/care management processes
- AMHs are encouraged **to share protected health information safely and securely with members**

Note: PHPs and AMH practices will be responsible for complying with all federal and State privacy and security requirements regarding the collection, storage, transmission, use, and destruction of data

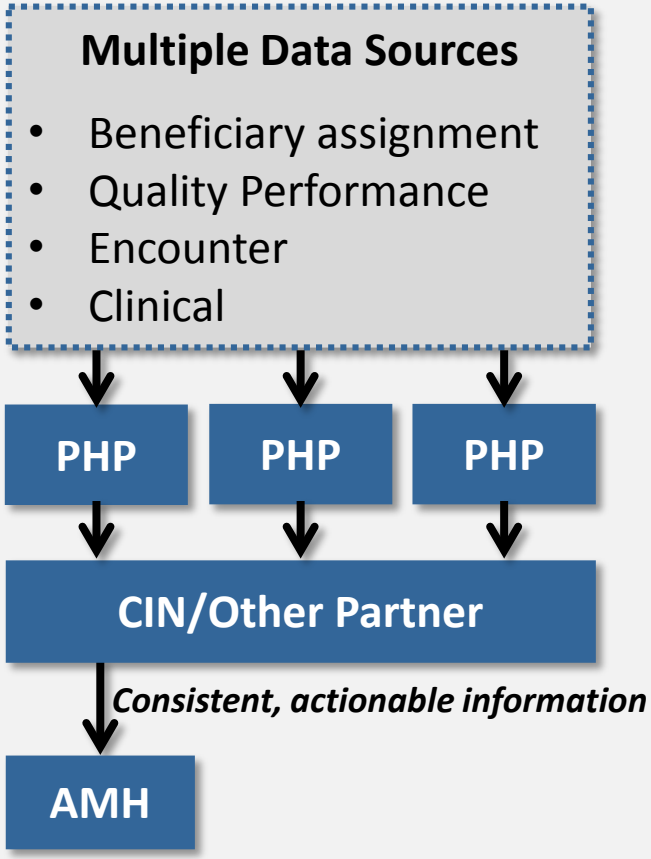
*Tier 1 and 2 practices will not be required, but will be encouraged to access ADT information

Potential CIN/Other Partner Data and Analytics Support

CINs/other partners can support AMHs in processing multiple data flows needed to support care management and related functions

Potential CINs/Other Partner Support

- Assisting with **risk scoring and stratification**
- Accessing and utilizing **ADT information**
- Compiling data for **comprehensive assessments and care management**
- **Receiving**, **aggregating**, and **transmitting**:
  - Beneficiary assignment data
  - Quality performance data
  - Encounter data
  - Clinical data



Assisting with Risk Scoring and Stratification

Each PHP will conduct risk scoring and stratification for all members and perform initial Care Needs Screening*

AMH Tier 3 Risk Scoring Requirements

- Use PHP assessments to inform delivery of care management
- Use a consistent method to **assign and adjust risk** status
- Use a consistent method to **combine risk scoring information** from PHPs with clinical information to score and stratify empaneled patients
- Identify **priority populations**
- Ensure entire care team understands basis of **risk scoring methodology**
- Define the **process of risk score review** and validation

Potential CIN Delegated Tasks

- Assist in defining process for risk score review and validation
- Adjust risk status for each assigned patient based on risk scoring data from multiple PHPs
- Assist in educating care team on risk scoring methodology
- Perform or assist in identification of priority populations based on risk scoring
- Incorporate risk-stratification findings into the Care Plan, once a risk level has been assigned to a member
- Use analytics to develop more detailed risk assessments and customized care management approaches

** See Appendix B for more information on required data sources.*

Accessing and Utilizing ADT Information

CINs/other partners can help Tier 3 AMHs access ADT data through a health information exchange (HIE) or other source

AMH Tier 3 ADT Requirements

- Track empaneled patients' ED and inpatient utilization by **accessing real- or near real-time ADT feeds**
- Implement a **systematic, clinically appropriate care management** process for responding to high-risk ADT alerts

- AMHs and their CINs/other partners are encouraged to work with NC HealthConnex or other ADT sources including the North Carolina Healthcare Association

Health Information Exchange (HIE):

A secure electronic network that enables the safe and secure transmission of protected patient health information between authorized health care providers.

Accessing ADT Information: Opportunities for CINs/Other Partners

AMHs and their CINs/other partners are encouraged to work with HIEs to establish data use agreements to enable data sharing

Potential CIN Tasks

- **Facilitate access to an ADT feed** for the AMHs' assigned beneficiaries
- Develop systems and process to **incorporate ADT information** into the AMH's electronic health records (EHR) and/or care management systems
- **Develop workflows and alerts** to facilitate follow-up and outreach for member in need of care management based on ADT alerts
- Incorporate ADT information into **risk stratification and risk-scoring** processes

Transferring, Accessing, and Aggregating Other Data Sources

CINs can help Tier 3 AMHs manage and create actionable information from PHP claims and other data sources

Potential Delegated CIN Tasks

- Acquire, process, manage, standardize and securely store claims data from **multiple PHPs**
- Support the creation of **Comprehensive Assessments** and **Care Plans**
- Perform analytics to develop **targeted care management approaches**
- Provide **actionable information** to care managers

AMH Data Flows

- Beneficiary assignment data from PHPs
- Quality performance data from and reporting to PHPs
- Encounter data from PHPs
- Clinical data from other providers

Part V:
CIN Capabilities: Contracting

General PHP Contracting Requirements

PHPs are required to contract with all AMH Tier 3 practices located in each PHP Region

PHP Contracting Requirements

- PHPs will **not be required** to contract with Tier 3-certified practices **at a Tier 3 level** if they are unable to reach mutually agreeable contract terms

- PHPs must **accept Tier 3 certified practices into their provider networks at a minimum Tier 2 level** if they cannot reach agreement on Tier 3 contracting terms

Contracting Roles of CINs/Other Partners

Subject to applicable laws, some CINs may help AMHs negotiate Medical Home Fees, Care Management Fees, Performance Incentive Payments, and payment terms and reimbursement rates*

CINs/Other Partner Considerations

- AMHs should **discuss contracting options with potential CIN partners**, and **seek legal counsel to clarify** any potential antitrust or anti-kickback concerns
- **AMHs may designate CINs to receive their payments** for Medical Home Fees, Care Management Fees and Performance Incentive Payments **services directly from PHPs**
  - The Department will not establish funds flow parameters between AMHs/CINs/PHPs

Note: PHPs may perform evaluations of the CIN if the AMH contracts with a third party to provide any of the Tier 3 care management required services

** Medical Home Fees have state-prescribed floors but can be negotiated up by mutual agreement between the PHP and the AMH*

AMH Tier 3 Contracting: Negotiating Care Management Fees

Tier 3 AMHs will need to consider care management responsibilities, regional cost variation, and other factors when negotiating Care Management Fees

Overview of Care Management Fees

- Tier 3 **involves PHPs passing care management responsibilities down to the practice level**; additional costs associated with these activities are intended to be covered by Care Management Fees
- The State **has not set minimum payment amounts for Care Management Fees** paid to Tier 3 practices by PHPs; these will be negotiated between PHPs and AMHs
- **AMHs are ultimately responsible** for any commitments made to a PHP

Potential CIN/Other Partner Tasks

- Subject to applicable laws, AMHs may choose to delegate contracting for Care Management Fees to CINs/other partners
- AMHs that delegate contracting should understand and set terms/conditions for funds flow; example up-front questions include:
  - *How should the Care Management Fees be shared between the CIN/other partner and the AMH?*
  - *What must AMH practices do to meet Care Management and Performance Incentive Payment milestones?*

** Medical Home Fees have state-prescribed floors but can be negotiated up by mutual agreement between the PHP and the AMH.*

AMH Tier 3 Contracting: Performance Incentives

PHPs must offer Performance Incentive Payments to Tier 3 AMHs

Tier 3 Performance Incentive Guidelines

- Payment arrangements must be guided by the **Health Care Payment Learning and Action Network (HCP LAN) Categories 2 through 4**, which reflect varying levels of value-based payments*
- For the first two years of the program, PHPs must offer **these incentives on an "upside-only" basis**. Practices will NOT be at risk of losing money (i.e., "downside risk") if they do not meet specified performance targets
- Practices and PHPs may negotiate arrangements that include downside risk, **but PHPs must also give practices the option of upside only**
- Incentives must be **based on the State-approved AMH quality measure set***

Roles of CINs/Other Partners

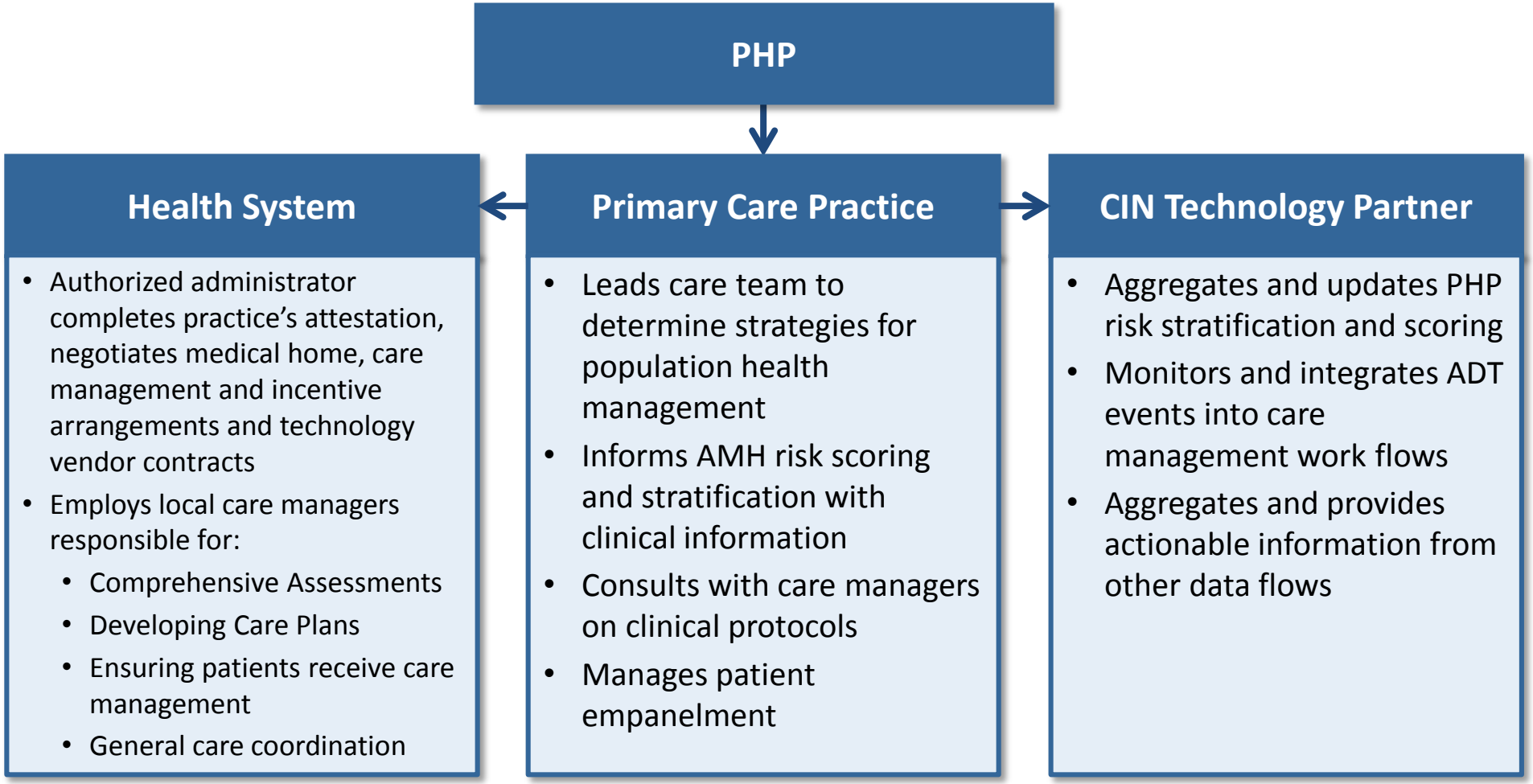
- Subject to applicable laws, CINs may support negotiation, management and monitoring of performance incentive contracts across multiple PHPs
- CINs can help AMHs understand performance incentive payment terms and potential risks and benefits associated with different arrangements
- CIN's may assist practices in choosing performance reporting measures

** See Appendix C for HCP LAN Framework and categories.*

Part VI:
CIN Use Cases

CIN/Other Partner Use Case 1

***Scenario*: Practice affiliated with a health system has limited practice-based care management functionality**



CIN/Other Partner Use Case 2

***Scenario*: Large-sized independent, unaffiliated practice has some but not all of the necessary care management functionality in-house**

PHP

Primary Care Practice

- Office administrator completes practice's Tier 3 attestation
- Clinical staff provide most local care management, including:
  - Comprehensive Assessments
  - Developing Care Plans
  - Ensuring patients receive care management
  - General care coordination
- Leads care team to determine strategies for population health management
- Informs AMH risk scoring and stratification
- Develops clinical protocols
- Negotiates Medical Home Fees, Care Management Fees, And Performance Incentive Payments

CIN/Other Partner

- Aggregates and updates PHP risk stratification and scoring
- Monitors and integrates ADT events into care management work flows
- Aggregates and provides actionable information from other data flows

CIN/Other Partner Use Case 3

***Scenario*: Independent, unaffiliated practices, FQHCs, LHDs that have minimal primary care, care management functionality in-house**

PHP

Primary Care Practice

- Office administrator completes practice's Tier 3 attestation
- Care team develops population health management strategies
- Supports AMH risk-scoring and stratification with CIN partner
- Consults with and advises care managers on clinical protocols
- Manages patient empanelment
- Ensure patients receive care management

CIN/Other Partner

- Provides local care management including:
  - Comprehensive Assessments
  - Care Plans
  - General care coordination
  - Clinical protocols in consultation with practice
- Negotiates Medical Home Fees, Care Management Fees, And Performance Incentive Payments
- Aggregates/updates PHP risk stratification scoring
- Monitors and integrates ADT events, claims and other information from other data flows into care management processes

Part VII:
Q & A

Part VIII:
Next Steps

Overview of Upcoming Events

Recent/Upcoming AMH Webinars

- **November 15, 2018:** AMH Tier 3: Patient Identification and Assessment
- **December 3, 2018:** AMH Tier 3: High Need Care Management
- **December 18, 2018:** AMH Tier 3: Transitional Care Management
- **January 10, 2019:** IT Needs and Data Sharing Capabilities*

*new data brief coming out mid-January

For more information and to register for these webinars, visit the AMH webpage: https://medicaid.ncdhhs.gov/advanced-medical-home

Additional Information

Questions?

- **Email:** Medicaid.Transformation@dhhs.nc.gov
- **U.S. Mail:** Dept. of Health and Human Services, Division of Health Benefits
  1950 Mail Service Center
  Raleigh NC 27699-1950

AMH Webpage

- https://medicaid.ncdhhs.gov/advanced-medical-home

White Papers, Manuals, and FAQs

- *UPDATED*: NC DHHS, North Carolina Advanced Medical Home (AMH) Program Frequently Asked Questions, October 18, 2018
- North Carolina Advanced Medical Home (AMH) Program Data Strategy in Support of Care Management, October 4, 2018
- NC DHHS, Becoming Certified as an Advanced Medical Home: A Manual for Primary Care Providers, August 28, 2018
- NC DHHS, "Data Strategy to Support the Advanced Medical Home Program in North Carolina," July 20, 2018
- NC DHHS, "North Carolina's Care Management Strategy under Managed Care," March 9, 2018
- NC DHHS, "North Carolina's Proposed Program Design for Medicaid Managed Care," August 2017