North Carolina's Care Management Strategy under Managed Care – CCNC Summary

Advanced Medical Homes

Overview

- In first few years, Department will maintain a leadership role in the design and implementation of AMH program
- AMH design to include commitment to maintaining high participation rates by providers to preserve access, allowing for sufficient time for providers to prepare for payment changes and providing support to providers during transition.
- Technical Advisory Group will be created to advise the Department on program design and provide feedback on implementation

Tier structure (see table at end)

- Statewide standards to be established for practice eligibility for each tier. Over time, requirements may evolve.
- Practices will apply to Department for tiers and Department will certify individual practices meet AMH requirements, even if part of a CIN. Providers may also select to remain in-network for Medicaid without participating in the AMH program.
- PHPs will be responsible for monitoring practices' compliance with tier-specific requirements and have the authority to lower their tier if they see fit.
- PHPs will be required to contract with a minimum percentage of Tier 3 practices in their regions with incentives to contract with more. **Currently considering 80% as minimum threshold.** PHP withholds may be associated with this requirement.
- Tier Highlights:
  - Tier 1 – based on Carolina ACCESS I and will be phased out in year 3
  - Tier 2 – based on Carolina ACCESS II
  - Tier 3 – based on Carolina ACCESS II and CPC+; practices must provide care management and PHPs will pay performance incentives (upside-only) starting in year 1 (p.11-12)
    1. Practices must demonstrate ability to provide care management including risk stratification, medication reconciliation, one week follow-up after ED visits, contact 75% of hospital discharges within 2 business days
    2. Practices must meet legacy CA-II requirements
  - Tier 4 – will launch in year 3

Payment

- All payment arrangements must be guided by Healthcare Payment Learning and Action Network (HCP LAN) Categories 2 through 4

- Four components of payment structure:
  1. Clinical services – PHPs will be required to meet minimum rate floors set at fee-for-service levels of all providers. PHPs and providers can negotiate for higher rates.
  2. Medical home fees – set at the following minimums for first two years. PHPs and providers can negotiate higher rates.
     a. Tier 1 - $1 PMPM
     b. Tiers 2 & 3 - $2.50 non-ABD/$5 ABD PMPM
  3. Care Management fees – non-visit based payments available to Tier 3 practices for providing care management. Negotiated between PHPs and providers/CINs.
  4. Performance-based payments –
     a. PHPs required to offer upside-only performance payments to Tier 3 practices in first two years, though they can offer these payments to practices in lower tiers as well.
     b. PHPs must use the Department's quality measure set but can design their own benchmarking and weighting approaches, subject to Department review.

Quality

- Specifics to come in upcoming Quality Strategy paper
- Measure set to be refined and customized by Technical Advisory Group, especially around pediatrics
- Current thinking on measures:

Measures Category	Sample Specific Measures
Measures Tied to Quality Strategy Objectives	• How people rated their personal doctor • Percentage of individuals with a mental health disorder, substance use disorder or I/DD with a primary care visit • **Childhood immunization status** • **Well child visits in third–sixth years of life** • **Cervical cancer screening** • Follow-up after hospitalization for mental illness • **Comprehensive diabetes care, poor control** • **Medication management for asthma** • **Controlling high blood pressure** • **Medical assistance with tobacco cessation**
Total Cost of Care	*Methodology to be defined in coming year*
Key Performance Indicators	• **Emergency department utilization** • **Inpatient utilization** • **Readmission rates**

Data Sharing

- PHPs will be required to share the following with all AMH practices with further detail to come in the RFP:
  1. Assignment/attribution files
  2. Risk stratification of enrollees

3. Initial care needs screening data
4. Enrollee-level summary information, including care gaps, medication summaries and utilization
5. Quarterly practice-level quality measure performance

- PHPs will be required to provide enrollee-level claims and encounter data to Tier 3 & 4 practices, either directly or through CINs
- Department is considering tying PHP withholds to PHP-AMH data transfer
- Department will set minimum requirements for data specifications for data transfers but PHPs will have several ways they can meet this requirement

Care Management

Priority populations

- Enrollees with LTSS needs – automatically determined as requiring ongoing care management. See below.
- Adults and children with "special healthcare needs"
- Enrollees at rising risk – not defined
- Enrollees with high unmet resource needs (SDOH) – identified from Care Needs Screening
- Other priority groups identified by PHP

Care management process (p.18)

Identification process

- Care Needs Screening – performed on ALL members enrolled with each PHP within 90 days of enrollment. PHPs create their own tools but Department will define standard SDOH questions.
- Risk stratification – PHPs will design their own strategies but Department will ensure that priority populations are being adequately identified.
- Comprehensive Assessment – performed on all identified, priority patients **within 30 days of being identified to determine need for care management**. Some groups will automatically require care management (e.g., LTSS, I/DD, etc.). No mention of what must be included except for standard SDOH items.
- Department exploring providing PHPs with initial data support to facilitate efficient startup of PHP care management activities.

Care Management for High-Need Populations

- Care planning (p.20) – completed for "high-need" patients **within 30 days of comprehensive assessment** and updated when patient circumstances or needs change, and at least annually.
- Comprehensive Assessment also to be re-administered when patient circumstances or needs change, and at least annually
- Regular face-to-face visits with a care manager who is based locally, when possible

- Addressing unmet resource needs – local community-based resources, offering in-person help securing services to improve wellbeing, access to housing specialist and medical-legal partnerships.
- Other required components include medication reconciliation, follow-up on referrals, peer support, self-management

LTSS

- Standardized comprehensive assessment tool
- Person-centered care plans for all enrollees who need LTSS
- Specific requirements for care management ratios and staffing standards

Transitional Care

- All enrollees with a transition will receive some level of transitional care management
- Certain higher-risk transitions will trigger higher-touch transitional care management
- Clinical handoffs, medication reconciliation, scheduling of follow-up visits and contact with assigned care manager **within 48 hours of discharge (2 business days)**

Disease management

- PHPs will offer DM programs that align with NC Quality Strategy (white paper to come)

Care Manager Staffing Requirements (p.21)

- Department is setting baseline expectations for care manager training and qualifications and will vary based on population being managed.
- Department will place parameters on how PHPs will structure care management, with incentives on using local care management.

OB Care Management and CC4C

Overview

- PHPs will assume responsibility for high-risk pregnancies and at-risk children. All funding related to provisioning these programs will be included in the capitation payments to PHPs.
- PHPs will be required to contract with LHDs for both programs for first two years.
- Department will play a clinical leadership role in the continuation of the programs. Technical Advisory Group will have large role as well.

Pregnancy Medical Homes

- Required to meet continuing standards of the program, including no elective deliveries before 39 weeks gestation, reducing the C-section rate, completing a Department-specified high-risk screening on each pregnant Medicaid enrollee and integrating the plan of care with local care management and cooperating with open chart audits.

- Payment:
  - PHPs will be required to continue the current incentive payment structure in the first year of managed care ($50 for completed risk screening, $150 for completed postpartum visit).
  - Department will work with PHPs to build on this structure for the years following.
  - Current rate increase for vaginal deliveries to be converted into the permanent fee-for-service rate floor.
- Practice support – stated that it will continue but no elaboration

OB Care Management

- PHPs required to contract with LHDs for OBCM for first two years of managed care (right of first refusal). Payment level will be similar to current level. If LHD refuses, PHP is responsible for providing local care management.
- PHPs will be responsible for procuring an electronic documentation system
- If LHD underperforms, PHP may terminate its agreement with the LHD
- After two years, LHDs may compete with other care management entities to provide these services.

CC4C

- PHPs required to contract with LHDs for CC4C for first two years of managed care (right of first refusal). Payment level will be similar to current level. If LHD refuses, PHP is responsible for providing local care management.
- PHPs responsible for very medically complex at-risk children – same as current?
- Children in foster care will be carved out for first two years and will receive CC4C in current system during that time.
- PHPs will be responsible for procuring an electronic documentation system
- If LHD underperforms, PHP may terminate its agreement with the LHD
- After two years, LHDs may compete with other care management entities to provide these services. PHPs will have an incentive to contract with LHDs to meet minimum requirement for local care management staffing.

Advanced Medical Home Tiers

AMH Tier	Managed Care Launch Year	Design in Years 1 and 2 of Managed Care: Practice Requirements	Primary Responsibility for Care Management	Medical Home Fee (paid by PHP)[8]	Care Management Fee (paid by PHP)	PHP Performance Incentives to Practices	Design After Year 2: Vision
Tier 1	1	Carolina ACCESS I requirements	PHP responsible; must coordinate with practices	$1 PMPM	None	None required, but PHPs encouraged to begin offering performance incentive payments based on AMH measures	Tier 1 will be phased out after two years
Tier 2	1	Carolina ACCESS II requirements	PHP responsible; must coordinate with practices	$2.50 (most enrollees) or $5.00 (members of the aged, blind and disabled eligibility group) PMPM	None		• State may modify Carolina ACCESS II requirements based on feedback • The Department will continue to set minimum medical home fees based on Carolina ACCESS II; practices can negotiate higher rates • PHPs will offer AMHs performance incentive payments
Tier 3	1	Carolina ACCESS II plus select CPC+ care management requirements	Practices responsible; AMH practices may arrange that care management functions will be performed at the CIN	$2.50 (most enrollees) or $5.00 (members of the aged, blind and disabled eligibility group) PMPM	Negotiated between practices (or CINs on behalf of practices) and PHPs	PHP must pay performance incentive payments to practices if practices meet performance thresholds on standard AMH measures, which may include total cost of care	• State may "raise the bar" on Carolina ACCESS II and customize the CPC+ -based care management requirements • State will continue to require both medical home fees and care management fees • PHPs will offer AMHs performance incentive payments
Tier 4	3	*Will launch after Year 2*					• Practices responsible for care management as in Tier 3 • PHP payment models will need to meet state thresholds for amounts that the practice potentially owes or foregoes annually based on performance.