TRANSCRIPT OF CONTRACTING WITH AMH PRACTICES WEBINAR
MAY 30, 2019

Dave Moran

Welcome everyone. Thank you for joining today's webinar. My name is Dave Moran with Webex, and I will be your organizer for today's webinar presentation on Contracting with AMH Practices. Today's presentation is the 7th in a series of nine provider education modules that are planned on Medicaid Transformation. Notification on additional provider education modules will be forthcoming and posted to the Medicaid Transformation website. There are just a few housekeeping rules before we get started. If you experience technical difficulties during the Webex session, please message the Webex producer using the Q&A panel. We will also be holding a Q&A session at the conclusion of today's presentation, and we encourage you to submit written questions at any time during the presentation using the Q&A panel at the bottom right of your screen. Please type your question into the text field and hit "send". Please keep that dropdown as all [panelists]. Also during the presentation, all participants will remain in listen-only mode, and as a reminder, this event is being recorded for rebroadcast.

With that, we invite you to sit back, relax, and enjoy today's presentation. And we'll now turn it over to Edith Stowe, Senior Manager at Manatt Health Strategies, to make opening remarks. Edith, you now have the floor.

Edith Stowe

Good afternoon and welcome. The purpose of today's webinar is to providing contracting guidance and reminders to Advanced Medical Homes, or AMHs, especially those participating in AMH Tier 3, as you consider network participation with PHPs. In the next few minutes we're going to review state-defined AMH contracting guard rails, including those that cover payments and standard terms and condition. And we're going to provide an overview and reminders of the expectations on practices that have attested into AMH Tier 3. And discuss some strategies to ensure that you meet your obligations prior to Medical Managed Care launch, starting in November of this year.

We have team members from the North Carolina Department of Health and Human Services on hand to both present today's webinar and help answer your questions that we receive throughout the presentation. Those experts include Kelly Crosbie who is the Deputy Director of Quality and Population Health at North Carolina Medicaid, and Lynne Testa, who's Senior Program Analyst with North Carolina Medicaid.

So I'd now like to introduce Kelly Crosbie, who will walk us through

today's presentation. Over to you, Kelly.

Kelly Crosbie

Hello, good afternoon, this is Kelly Crosby. As Edith said, I am the Deputy Director for Quality and Population Health with North Carolina Medicaid. So today we are going to be walking through some additional information for Advanced Medical Homes. Specifically, this webinar is focused on contracting information for practices. If you could go to the next slide please.

The objective of today's webinar is to clarify DHH's expectations for how Advanced Medical Home practices and PHPs, that's our Prepaid Health Plans, will contract ahead of Managed Care launch. These are our really important takeaways from today, so hopefully you'll see how we cover these points.

First, the Advanced Medical Home program, or the AMH program, represents significant new statewide investment in primary care. It's really important to us. We've really doubled down on it, we think it's important, and so we hope that the program and the contracts you're seeing represent that new investment.

Second, we at the Department are closely monitoring the rollout of the AMH program to ensure fidelity to the AMH program design.

And third, in order to have an AMH contract in place for managed care go live in November of 2019, AMHs need to do a couple of things. Tier 3 specifically need to make decisions about how your practice are going to meet the AMH Tier 3 requirements by Managed Care Launch. We'll review those again later in the presentation. Also, everyone needs to ensure that your contract contains the required Advanced Medical Home terms and conditions. And thirdly, everyone needs to understand relevant Managed Care timelines, so you can make good contracting decisions. Next slide.

This is a slide covering all of the Advanced Medical Homes currently in North Carolina that have attested through North Carolina Medicaid to being either a Tier 1, 2, or 3. Again, this presentation focuses *heavily* on Tier 3, but we do still have providers who are Tiers 1 and 2. So right now, we have 2,776 practices, and about 1,500 are Tier 3, so about 50 percent on average. So an estimated 81 percent of all the beneficiaries in managed care are going to be attributed to Tier 3 practices. Which means that the care management will be happening via the Advanced Medical Home at the provider level. And if you look across the different regions of managed care, we have really good coverage in terms of number of practices who are Tier 3s, as well as number of beneficiaries

who are enrolled in Tier 3s across all six regions. Next slide.

This is just a remind, high level, of our Advanced Medical Home managed care timeline. So currently, we are in the contracting phase. So as you recall, grandfathering from Carolina Access to Advanced Medical Homes happened back in September. In October of last year, through February of this year, practices were making decisions around what *type* of Advanced Medical Home they wanted to be, if they could meet Tier 3 contracting standards, and therefore what is ____ at the state level to wanting to become a Tier 3 provider. In February we also announced who our PHPs would be, and which regions they would cover. And since then, so since about mid-February until now, we have entered the contracting phase. So PHPs are contracting with Advanced Medical Homes, and in some case their CIN partners. So that is ongoing currently, and we are all moving towards an 11-19 launch. We'll get a little more granular with some of these timelines a little bit later in the slides, so you can make some informed decisions about the contracting process.

So let's talk about those three objectives. So the first thing that we wanna remind folks is, the Advanced Medical Home program represents significant new statewide investment in primary care. So let's break that down a little bit. If you go to the next slide.

Again, the Advanced Medical Home is really built off of the current Carolina access program. That's our long-standing high quality medical home network and care management program here in North Carolina. So, our goal was to retain all the foundational elements of Carolina Access program, but raise the bar for Tier 3 practices. And also simultaneously increase investment to fund those improvements in the program. So, it was do more, but here's some more funding in order to do more.

So, if you look at Carolina Access, it had very standard, basic practice requirements. Everything from after-hours care to number of hours to be open a week, the type of primary care services that has to be provided. All of that's the same. So, all tiers 1, 2 and 3 have those same practice requirements. Where we've raised the bar is for Tier 3. So, some of the really new important practice requirements for Tier 3 is the risk stratification of all empaneled patients and for those that meet criteria for care management. Those individuals get a comprehensive assessment, they get care management. The practice is able to create and maintain a care plan for those beneficiaries. Beneficiaries who need short-term transitional care, transitioning between levels of care can get that. That includes medication, reconciliation and management. And the

practice is able to access that real time Dave Moran is on discharge and triage information or transfer information so they know what's happening between settings of care. So, that's really kind of the bulk of the new Tier 3 requirements.

Penetration should change. We've covered this in earlier sessions as well. Currently, the state funds a certain amount of care management penetration. We're able to touch a certain percentage as the population for the amount of money that North Carolina's been able to invest in the model. Our partner CCNC does wonderful restratification to identify payments for care management.

As we transition to the Advanced Medical Home program, we are expecting a significantly higher portion of the population will receive local care management. So, in order to do that, we've invested more funding into the model. So, practices should expect more. We've invested more money in the system through the PHPs. So, practices should have, they should feel access to more care management resources. That could be or doesn't have to be a care manager embedded in your practice. But certainly, more care management resources for you as a Tier 3 practice, and more patients should have access to more care management as well.

And lastly, let's talk about the delivery of the services. Historically in Carolina access practices have received $2.50 for non-ABD members and $5 for ABD members as part of their monthly medical home fees. That's the same. And the practices who wanted to belong to the CA2 program, the Carolina Access 2 program would contract with CCNC who would provide statewide care management for members who needed care management.

So, again, medical home fees stay the same when we move over to the Advanced Medical Home program. For tier 2 practices, the care management now happens at the PHP level. So, tier 2 does everything a medical home needs to do and the broad overarching local care management happens through the prepaid health plan. But Tier 3, that's where Tier 3 practice is in the driver's seat for that additional care management, there's additional care management funding for the practice for them to be able to do care management.

So, kind of those functions that we covered in Advanced Medical Home, kind of the new functions that are around care management, as well as the new funding. We're gonna break that down a little bit more in later slides, but first some decisions need to be made. But again, the point of this that we are really investing in new care management requirements

and putting additional funding and investment into the Advanced Medical Home program. If we go to the next slide.

Another one of our objectives is to remind you that we are closely monitoring Advanced Medical Home rollout. So the map that we showed you earlier was a map that we'd been tracking since last October. There's some dashboards that go with it as well. We've been tracking everything from grandfathering through at a station to understand the penetration of which practices were opting in and out just to get a sense of how the program was rolling out and how beneficiaries would be impacted. We will continue to do that, if you look at the next slide.

Okay, we have some guard rails during this contracting phase. Remember, we talked about the contracting phase started in February. We know it's at various levels all over the state. So, we get a lot of feedback from practices. That's really helpful in terms of the base contracts folks are getting, the contract negotiating process. How contracts are being more formalized over time. So, we know there's a lot happening in the contracting phase right now. So, know that we are monitoring activities and we're also providing additional guidance during that rollout and contracting phase. This is a living process. We are evolving, pivoting, being flexible as we need to be as are the PHPs and we do provide additional guidance if we need to.

So how are we holding PHPs accountable? So, first it's important for you guys to know that we are in continuous communication with the PHPs. We talk to them very routinely and in some cases almost every day. And understanding the evolution of AMH contracting is an ongoing conversation. We have reinforced a lot of messages with our PHP partners in terms of making sure that practices and their CINs are aware of care management fees and required performance based incentive payments. We are establishing reporting requirements for the program prior to launch and also after launch.

So, as we've said in previous sessions, we want to collect pretty robust data, so we understand how the care management dollars are being reinvested in the community. And we are ensuring that PHPs are contracting with every Tier 3 practice. Remember, there's very limited exceptions. There may be times when an AMH and a PHP cannot reach agreement. We will know about those, we will understand those, we will talk with PHPs about this, but the expectation really is that 100% of AMH Tier 3s are contracted at the Tier 3 level.

We're also monitoring the market. Besides PHPs, there's a whole market around Advanced Medical Homes and CIMs and practices. So, we are

either now or will shortly be doing things like reviewing contracts. So, we do routinely review and the contracts that PHPs are writing with Advanced Medical Homes and PHPs are negotiating with clinically integrated networks or other care management partners of AMHs.

So we are looking for things that we'll cover in other slides about the AMH requirements, the incentive payments are there, that care management payments are there. In July, we'll begin monitoring contracting at the practice level. So, one of the reports that we actually get from PHPs is a practice level contracting update. So we understand at the site specific NPI level which practices have signed contracts. We can check if all the appropriate rates are in place and we can check how many patients are attributed to those practices. So, we understand and contracting while this is happening.

As I mentioned, we, of course, are monitoring the payment amounts made from PHPs to AMHs. We know we're investing significant amounts of money and we really want to ensure that the money is flowing down to the community level. Again, practices should feel more support and we should have more beneficiaries having access to care management services.

We will be using, remember I said we're gonna be collecting a lot of data. We'll be using that data to assess the quality and the quantity of local care management. So, everything from just understanding how many people get _____ for care management, how many folks actually engage in care management. We'll be getting data at that level. And of course we'll be tracking things like utilization, as well as the quality outcomes at the practice level.

We also engage, as much as we possibly can and always open to more, working with stakeholders. Many of you are either a part of or very aware of our public meetings, they're public. We've _____ Medical Home Technical Advisory Group. That is a group made up of PHPs, CINs, provider representatives where we talk about very specific AMH areas to get stakeholder feedback, advisory feedback. In the last three meetings, we've been talking a lot about this contracting process. They actually reviewed this slide deck and a lot of what we're covering today is based on feedback from that advisory group about what is happening in the field where the pain points for providers and how can we better educate and inform providers of what's happening – our oversight of this process and what they can expect. So, part of that advisory group is this very presentation today.

Of course we meet with other provider associations. We talk directly

with providers, with PHPs, as I said. We meet with them very routinely. And always, we will talk in this presentation about other ways to give us feedback. We really appreciate on the ground feedback so we understand what's working and not working, so we can pivot and try to improve things. Okay, next slide.

So, the last thing we wanted to cover was contracting the steps to be prepared for AMH to go live. This is the longest section. Okay, so – next slide. Here's some steps to prepare for managed care go live. So, AMH practices need to take three steps. The first thing is, you need to make a decision about how your practice is going to meet program requirements by November 1st, by managed care launch. We'll break that down. Two, as a practice, you need to ensure that any contractor getting contains the required AMH terms and conditions. We've gotten a lot of feedback in that area and this is really developmental. So know that we are working with PHPs, they're being very responsive, but there may be contract in the field right now that you're looking at that don't have all of those. It is a work in progress. Those contracts can and will be updated. And three, the third step that you need to take is, again, we're gonna do our best to show you the relevant managed care timeline. There's a lot of differing concerns in the field about what the real managed care timelines are, but we're gonna do our best here to give you a better sense of the timeline so you can make an informed decision about when and how you contract.

So, let's look at that first item a little bit. So, next slide. The first thing, again, we're focusing on what we need you as a practice to do to make a decision about how your practice will meet program requirements by managed care launch. So, let's look again. We've done trainings on this, that's where you've seen these, but Tier 3 practices are responsible for care management functions included in that out of station process that we talked about that started last October actually. So, remember, high level, the our care management process starts with the care need screening that is typically performed by the PHP. But anything that's stripped or anything that's blue is the responsibility of a Tier 3 practice. That's risk, _____ stratification, comprehensive assessment, care management, transitional care management, general care coordination among services and prevention and population health programs. So, again, those fundamental Tier 3 functions. Let's see, next slide.

Tier 3 practices are required to perform these activities. So, that's high level. Last slide was high level to the process. These are some of the very particular items of what we mean by care management that we talked about in an earlier slide. First is, you'll have a patient panel. So,

you need to be able to risk stratify your patient panel. We've had a lot of questions here about how complex that needs to be. Let me remind you that PHPs will be using their own risk stratification methodology. That information will be shared with an AMH Tier 3 or their CIN. You'll get that information across four or five PHPs. So, part of risk stratification is just looking across those lists using your knowledge as their medical home provider to make decisions about which patients would benefit most from care management and specific types of interventions. Of course, some of you may have CINs that have very sophisticated analytics to do their own risk stratification, but some sort of risk stratification must be done.

Next one is kind of obvious, Tier 3s need to provide care management to high need patients. Now remember, high need patients, we've defined that. So high need patients, don't think of it in the classic high cost, high risk, high need kind of way. Obviously, those are always patients that you look out for, but we are looking at high need patients in a new way, rising risk, high end resource needs. So, not just kind of the most expensive or the folks with the most number of hospitalizations. Excuse me for one second. Sorry, I needed to get a drink of water. Okay. So, practices need to be able to use the risk scores to identify those patients that need care management and to provide that care management. For patients that do get care management, practice has to perform a comprehensive assessment. Next slide.

Okay. After the comprehensive assessment, the Tier 3 practice or their partner will have to develop a care plan. So, the care plans – this is, this is obvious if you do need care management – it should incorporate findings from the screenings, the risk scores that you get from your plans or you get from your own vendor, and it has to be a thorough assessment, and it has to have very concrete goals, interventions. It should be whole person, so you should be looking at medical, educational, social, all sorts of needs. And, so it should be a good comprehensive care plan. That really is care management in a nutshell, right? Find the patients, do an assessment, and do a care plan. Okay. In addition, all Tier 3s are required to do that short-term transitional care management for classic things, right? Coming out of an inpatient, coming out of an ED, but going between levels of care, as well. And part of that, too, requires good clinical knowledge, right? You need to get your ADT information, or hospital information, or transition of care information, and make good decisions on patients who need outreach, and the level of care management and the types of care management interventions as individuals would need. A big one that we talk a lot about is being able to receive claims data feeds. So, again, you as a

practice need to receive claims information, or you CIN needs to be able to receive claims information. Why? Claims information really has two vital functions, right? Claims information is typically used in restratification methodologies. So, your vendor may use it to do restratification for you. But in addition, that claims information is, is, should populate short-care management documentation system, so you can find out other services that the, your member is, is getting, medications that they're getting, so you can help coordinate among those medical services that would show up in a claim. Okay? Next slide.

So, what on earth is a CIN or other partner? Remember, the term CIN or other partner, that's a very DHHS term, because we were trying to find a way to describe the fact that those functions that I just went through, especially that, that final claims, claims, getting claims and storing claims and using claims, but it's pretty sophisticated. It could be costly, and not all practices are necessarily wanting to take in-house. So, practices may use CIN for things like technology services, as I just described. They might use it for administrative support. So, helping to collect data that needs to go to health plans for reporting purposes, that's a really important administrative function the CIN can help with. Maybe the CIN can provide clinical staffing resources, so they might provide psychiatric or medical consultation or nurse consultation or pharmacy consultation or a community resource guide. Or, they might actually provide the full complement of care management staffing that a practice might use. And, of course, we're hearing a lot that CINs are working to negotiate on behalf of groups of practices with PHPs for care management rates, incentive programs and the like. For us, CIN is very generic. It can include hospitals, health systems, IPA's, integrated delivery networks, care management organizations, tech vendors. We're very agnostic. There's no specific deed to this definition. We're saying AMH Tier 3s, we want you to be successful, and please work with the agencies that can help you be successful and meet Tier 3 requirements. So, how are we seeing that, that look in the market right now, if we can go to the next slide.

So, there are a couple different options, contracting options, for how AMHs can work with CINs and PHPs. We wanted to give a lot of flexibility. Some practices want to build all of Tier 3 functions in-house, other do not. So, here are some contracting options as we are seeing them play out in the field. If you look at 1, we, DHHS, we contract with the PHP, who contracts with the Advanced Medical Home, who then contracts with the CIN or other partner, that's a pass way. What we were seeing most commonly is Option 2. We are, we are contracting the same, DHHS is contracting with PHPs, and they in turn are contracting

with CINs on behalf of Advanced Medical Homes. So, we're seeing a lot of that right now. And, in the third scenario, some, again, DHHS contracts with the PHP, and some AMHs are full service, so they're doing everything, the technology, all the care management, and they're not using a partner. So, we're seeing all of these options. Again, 2 is kind of the most common of what we're seeing, and the message here is, regardless of how you're contracting, your practice is still responsible for meeting Tier 3 requirements. And, so, if you are working with a CIN, you need to think about how the CIN is informing you of how they're performing those functions, and you need to know how well they're doing on your behalf, but more importantly, on behalf of the members in your practice. Okay?

So, the next slide, slide 16 – we are also getting a lot of questions, and we understand that the market is developing in North Carolina. This new Tier 3 model is new, obviously, managed care at this global of a scale is new to us. So, we anticipate that changes, practices are going to change the type of arrangements they have with CINs as other partners, for a variety of reasons. We know things will change over time. People will find CINs that they would prefer to work with for a variety of reasons. Or, a CIN might just be a glide path for that AMH to develop capabilities in-house. There could be a myriad reasons. But again, the AMH should be in the driver's seat and make those kind of decisions themselves around how they want to change contracting relationships or not. So, when folks attested to be a Tier 3 with the State, we had a free text field, where folks could say what CIN they wanted to work with. That is not a – you're not beholden to that in any way. So, a lot of practices didn't know the CIN they wanted to work with, or they put who they thought they might want to work with. That is, that is in no way an obligation or a requirement, so, if you attested to working with a particular CIN, that is up to you. We would urge you to please check the contract that you have already signed with the CIN, because you may have obligated yourself to something in that contract, but at the State, there's no obligation for you to work with any CIN that you may have attested to work in your attestation process. You're not even required to notify DHHS of the change. PHPs will be tracking affiliations, so they will be tracking the CINs that AMHs are working with, and part of their reporting is actually to get that information back to us. So, you're not required to re-attest or to change anything. So, change in whatever ways makes sense to you as a practice.

Okay, so the last thing I want to say is, let's talk about the payments – the next slide. So, let's recap those payment requirements one more time. Payment for Tier 3 requirements has to be met under any of those three

contracting options. Okay? So, remember we talked about 1, 2, 3 contracting options? Let me remind you of the Tier 3 payment models. Medical home fees, $2.50 and $5.00. That's a floor. You can always try to negotiate higher medical home fees. On top of that is the care management PMPM fee. We're paying the PHPs a care management fee. They in turn need to pay Tier 3s a care management fee. And PHPs are required to include non-risk-based, performance-based incentive contracts on a discreet set of measurements. Obviously, these are floors, right? So, if you as a practice, or a group of practices working with the CIN, negotiate higher medical home fees or risk-based performance incentive programs, that's perfectly fine, if that's what you want. Otherwise, these are, these are mandatory – these are floors for us. Okay.

In Options 1 and 3 – remember those two contracting arrangements that we talked about, which are PHP directly to an AMH? The PHP has to pay medical home fees and care management fees directly to the practice, if the PHP's contracting directly with you. So, no practices – you can negotiate care management fees directly with the PHPs, the PHP must provide you with information on what that care management fee would be, if you want to contract directly with them for care management services. In Option 2, again, where the PHP is working with the CIN on your behalf, the CIN can arrange those fees, they can receive those fees and disburse them to you, with your consent. As long as that's something that you arrange as part of your contract with the CIN, that's fine. I hope what we're emphasizing here is, know your options. We are flexible. But make sure that you are getting all required fees in any of the contracts that are being negotiated with you as a direct practice or with your CIN. Know the flow of funds, know the rate floor DHHS has set. Just be informed as you are negotiating these contracts, or the CIN is negotiating them on your behalf. Okay? Next slide.

That leads me right into – make sure that any contract you're looking at contains all the required AMH terms and conditions. So, that's the second thing. First thing was, make sure that you know the program requirements and you figure out how you're gonna get 'em done. Are you gonna do 'em? CIN's gonna do 'em? Combination of both? This, when you're looking at contracts, make sure they contain all the required AMH terms and conditions. As I mentioned before, we're trying to do that on our end, too, but typically we see base contracts, we approve base contracts. But as contracts go into the field and providers or CINs negotiate this contract, they can, they can change and grow. So, you, please, look at the contract and make sure it has the right terms and conditions. So, on this slide, we have the summary of the terms and

conditions for all Advanced Medical Homes. So, they're basic things that you should know as an AMH. You have to have a patient medical record. You have to use cost or utilization reports that the health plan is going to send you. The health plan should send you a monthly enrollment report, so you need to use that. And you have to do your basic primary care coverage services, right? Thirty hours a week, 24/7. So that should be in all, all contracts, for all levels of AMHs. Tier 3, again, I think we've gone through twice now, all the different Tier 3 functions. Everything from restratification, the whole care management process, and ways to get care management data, like encounter data, member data, other types of data that you as a Tier 3 are responsible for getting. So, again, we are closely monitoring the contracts, CIN contracts as well as PHP to AMH contracts, but please, look for those things, as well. Today's presentation has the full list of terms and conditions at the end of the contract. Okay? Next slide.

So, upcoming Medicaid milestones. I think everyone knows the big dates by now, right? The big dates: On November 2019, Regions 2 and 4 will launch, and in February 2020, all regions, the other four regions will launch. So, all regions will be live by February of 2020. So, between here and November though, there's some important dates that you should know about. Okay? All right. We get a lot of questions about this. So, we really want you to understand that critical points for beneficiary enrollment and PCP selection, as well as auto assignment ahead of go live. We are getting very close to what we call soft launch, or open enrollment period. Members have a 30-day open enrollment period. So, around the end of June, soft launch will open, and that's where beneficiaries will get notification, they'll get information on here is everything that's happening in managed care. You can call an enrollment broker and make a choice of plans. Typically, unfortunately, many beneficiaries don't typically use that benefit to make a choice of plans. We hope we do really great marketing and education, so lots of members become very active in the choice of plan that they pick. So, they can at that point go to the enrollment broker, starting at the end of June, through September, speak to an enrollment broker, go online, and choose a plan. We know that beneficiaries will choose a plan based on the plan that has their provider, the providers that they're used to seeing, especially their primary care provider. So, for many primary care practices that we talked to, that's an important date for them. They want to know that they are, they are in a, in a network when beneficiaries make choices. Know this, though. In terms of our projections, we're not expecting right at the end of June for lots of beneficiaries to be going out and, and, and making choices of plans. This is a process. It will take time, and so, there is time. But just know, that's

an important date. It officially starts at the end of June. Okay.

Once we go through open enrollment, we've allowed folks to make a choice, we will do auto assignment. The vast majority of our beneficiaries will be assigned to a plan based on an auto assignment algorithm rather than choice. Again, just because many members historically don't necessarily choose. We hope they do. We really hope they do. But, if not, we will have an auto assignment process. Auto assignment privileges geography, right? So, obviously beneficiaries have to be assigned to a plan in their geography. So, in many, so beneficiaries, some beneficiaries will have four plans, and some beneficiaries will have five plans. We have two regions that have five plans, right? So, we have to pick a plan that's in the region. But again, that's, that's pretty easy.

The second thing though is that we do look at historical provider relationships. So, we've had a lot of concern around beneficiaries being moved from their current primary care provider. So, the algorithm privileges historic primary care relationships. So, know that when people are sent to plans, we look for a historic primary care relationship. So, that happens, again, mid-September. So, for all the folks who haven't chosen, they'll be auto assigned.

The third thing that happens then about seven to 14 days later is health plans will auto assign beneficiaries who haven't picked a PCP or Advanced Medical Home to an Advanced Medical Home. Again, in that algorithm, the PCP has to privilege historic provider relationship. When we send member eligibility files to the health plans, a little after 9/16, we'll auto assign, and we'll send them their members. We will send an eligibility file with all of their members. That information will include who their assigned primary care provider is. At that time, we will also be sending them tons of historic claims information. So, again, they'll auto assign, but it will be based on the historical assignments between patient member beneficiary and the primary care or Advanced Medical Home. Then a month later, we launch. So, we'll be tracking all this really carefully. But we want you to note the dates. So, as you think about contracting and you think about maintaining your patient panels, know some of these dates. All right.

The last thing that we wanted to share with you is our huge list of documents that we have out there on the Advanced Medical Home program. If you could go to the next slide, please.

So, we have a, a specific, we have a, a home page, as well as some, some related pages around Advanced Medical Home. So, you'll see some of those up top. We have the Medical Home page, we have the training

page, and we have tons of everything from the Advanced Medical Home policy to trainings, to guidance documents. So, there's a lot of stuff out there. So, right now, we are going, I think I'm going to turn things back over to Edith, right? Edith?

Edith Stowe — Yes, this is Edith Stowe again. We've had some excellent questions, as you've been talking, Kelly. So, I'm going to tee up a few of those for you to answer. So, the first one is a payment one. We talked about the performance-based incentive payment, and the question is, does the performance-based incentive payment have to be in addition to the Medical Home fee and the care management fee?

Kelly Crosby — Yes, it does. Yes. These are separate payments, so there's, there's actually, how many payments? Five payments? There's, you get paid for your normal office visit, right? So, you're gonna bill your CPT codes and get paid for an office visit. You get your normal Medical Home fee, 2.50 and 5 that you're always used to getting. You get a care management fee, and then, yes, you have to be eligible for an incentive payment on top of all of that. We have about 12 measures. They are broken down by adult measures and child measures. We think primary care can impact those measures. Health plans have to develop performance incentive plans on those measures. They have no downside risk. But it is definitely a separate, above and beyond, the Medical Home fee payment.

Edith Stowe — Great. We had some excellent questions about Tier 3 and CINs. So, one question we saw is, is there any State policy that would prevent an AMH practice from working with more than one CIN or other partner?

Kelly Crosby — No, there isn't. This is really, it's about Advanced Medical Homes in the driver's seat. You know, we've, we've issued some guidance, because we, what we want to do is make sure that Advanced Medical Homes get to choose what makes sense for them. The goal has always been for – to think about administrative burden and to provide _____. There's five different plans. You have a panel that's not just five types of Medicaid, but other patients, and, for us, we think the CIN, if you use one, is a way to help with all that administrative burden of five Medicaid plans and even all your other payors. So, we've given guidance to ensure that no Advanced Medical Home feels pressured to choose a particular CIN, especially pressured by the PHP to pick a certain CIN. But it's really up to the practice if they, if they choose somehow to split their patients or their work across CINs. Again, you have to look at the – we're not a party to any contract that a Medical Home may send with a CIN. We're not a party to it. So, those, you know, have your attorney look at this agreement, and, and, and, before you decide about signing anything. But

there's nothing, nothing on our end that kind of limits how practices contract with CINs. Nothing from the State.

Edith Stowe Great. Okay. Two-part question about claims data. First part, can you just clarify what the requirement is for PHPs to share claims data with AMHs in the different tiers.

Kelly Crosby We have two papers, and they're probably on slide 21. We have two different data papers. I'm gonna start high and then quickly get to your answer. In both papers, we talk about the types of data that have to be shared with all tier practices. And probably the three biggest things I think of are eligibility information. So, who's your patient panel? Care needs screening results and GAP reports. So, when your, your patients in your panel are missing important milestone visits, you get a GAP report. If you're Tier 3, you also have to get claims data. Claims data has to come on a monthly basis. That's probably the next biggest thing to add. There's some other things, too, like ADT feeds, other information that a Tier 3 has to get, but it is monthly encounter information on all the eligible members belonging to the AMH. So, that's the, that's the claims information that you'll get.

Edith Stowe And then, the second part claims data is the question is, if you have a Tier 3 practice, is the PHP required to share the claims data directly with anyone, any CIN that the AMH designates, or are there more restrictive rules about where the claims data has to go.

Kelly Crosby Yeah, I mean, again, this is a good example of the AMH being in the driver's seat. Obviously, we're talking about sharing PHI, so it's a big deal, right? So, the AMH has to ensure that they have the right agreements with whoever they determine they want to, to either house or analyze the, the claims data on, on behalf of them, right? So, an AMH may determine that they've, they're using a CIN to store the claims data, analyze it for restratification, and, and populate the care management platform. That's their choice who they use. And they are responsible, obviously, for having the appropriate data use agreements in place for those business associates so they can have proper storage and use of the PHI. But that's, again, that's, as long as HIPAA is followed, we have appropriate data use, and BAA agreements in place, that's really up to the practice.

Edith Stowe Great. I think last question before we transition. Can you offer any more advice or thoughts to providers who might be considering doing Tier 3 essentially without a CIN? Contracting directly with a PHP? What are the major things that they need to bear in mind?

Kelly Crosby

Hmm. You know, probably the most – when we talk to practices, 'cause we have spoken with some practices who feel really like they want to do this themself, and typically, it's a practice that's already doing some of this maybe for other payors, or has a really large Medicaid population size, feels comfortable with data and technology. Folks aren't necessarily telling us they, they're uncomf – I mean, they feel good about getting a patient, a risk, a patient list from health plans, they feel good about getting. A risk to stratified list, so they know patients who are high risk, in certain high-risk categories. They feel good about having a care manager, hiring a care manager, and getting consultation from, from other multidisciplinary team members. I think it's the technology component, which is being able to get an eligibility file and a claims file, to be able to store it appropriately and correctly, and to be able to ingest it and use it somehow. So, that's probably the, the biggest thing we're hearing from practices on. That's probably the most, probably the most expensive, and the most, the most challenging thing. It's not shall we do care management itself, but it's being able to correctly accept, store and utilize data, which is, which is what we want, right? We want data in from practices, but that's kind of the, if a practice asked me, I would say that's the part look really carefully at, like, how you think you want to do that, or, and if that, if, who might be able to help you do that, now or in the future. And we talk to a lot of practices, too, I'm gonna throw this out there, we don't talk about it very much, but, practices to want to do a glide path, and that's so fine. There are other tiers. You can be a Tier 1 or a Tier 2. You still have to do the same practice requirements, but the PHP does your care management. Or Tier 3 is always open. You will never, you can never not be a Tier 3. And so, some providers need to take more time to evaluate their options, or to build capacity in-house, and that is perfectly fine. You can – if you're not a Tier 3 by November 1st, no big deal. Become a Tier 3 by February 2020, or June 2020. That's fine.

Edith Stowe

Great. Let's fit in one more. This is a question about options for practices to access ADT fees and, in particular, does the HIE provide that option.

Kelly Crosby

It does. And I, I know that probably all the folks on the phone, because of session _____ because of just, that's, that's, you, you, you see the value of it free as a practice, or connected to the HIN have signed some level of arrangement with the HIE, and those varying levels of arrangements. They do have a process by which they can share ADT information with practices, and, we've worked with them around the way that they share that, so that is an option, and I encourage you as a prac – I'm not the HIE, and so I don't want to misrepresent them. But

they certainly have that functionality. We have said that in our paper, they're a good source to go to. There are other sources, too. We're not trying to privilege any particular source. But, please, since you're probably a member, talk with them about ADT options, because they certainly have them.

Edith Stowe — Great. All right. So, I think at this time I would like to now transition to Lynn Tester, to cover future opportunities for provider engagement.

Lynne Testa — Thank you, Edith. Next slide, please.

As we've stated in earlier webinars, the Department values provider input and feedback, and is making sure stakeholders have the opportunity to connect through a number of venues and activities. Some of the ways that you can participate include registering for regular webinars, conference calls, meetings and conferences, providing comments on periodic white papers, FAQs and other publications, keeping up to date on the regular updates to our website, which we have indicated here on this slide, and sending your comments and questions and any additional feedback through the Medicaid Transformation e-mail. Know that providers will receive education and support during and after the transition to managed care. Next slide, please.

Two remaining webinars scheduled in the coming weeks will cover topics on clinical policies and help the opportunities in Medicaid managed care. In addition, there is a link to the PHP meet and greets and virtual office hours, schedule on the right side of this slide. Providers are encouraged to visit the Medicaid websites often, and to look for upcoming events and webinars advertised through special bulletins and NCTracks provider announcements. We do appreciate your joining us today, and this concludes today's presentation. Thank you.

[*End of Webinar*]