Transcript for Medicaid Managed Care Fireside Chat
November 5, 2020
5:30-6:30pm

Presenters:

Shannon Dowler, MD Chief Medical Officer
Kelly Crosbie, MSW,LCSW Director of Quality and Population Health
Krystal Hilton, MPH Associate Director of Population Health
Jaimica Wilkins, MBA, CPHQ, ICP Senior Program Manager, Quality and Population Health

Hugh Tilson

Thank you for participating in this evening's webinar for Medicaid providers. Tonight's webinar is the second in a series of informational sessions put on by Medicaid and AHEC to support providers during the transition to Medicaid managed care. We'll put on the fireside chat webinars on the first Thursday of the month on Medicaid managed care. And on the third Thursday of the month, Tom Wroth president of CCNC will join us to discuss relevant clinical and quality issues. We look forward to seeing you at all of these. NC DHB and NC AHEC have partnered to ensure that health care providers across all 100 North Carolina counties have the information and support they need to adapt to and thrive under Medicaid managed care. This collaboration will produce educational webinars like these and virtual office hours across a variety of relevant topics. In addition, partnership will make AHEC practice support for coaches available provide one on one assistance directly to practices. Tonight, we're focusing on advanced medical homes. I'm Hugh Tilson, I'll moderate this webinar. You can see we've got a great panel of presenters, including Shannon Dowler, the chief medical officer and Kelly Crosbie, the director of quality and population health, Krystal Hilton, Associate Director of population health and Jaimica Wilkins, Senior Program Manager, quality and population health they know a lot and we're looking forward to hearing what they have to say. For I turn it over to Dr. Dowler though, let me run through some logistics if you need any technical assistance, email us technicalassistancecovid19@gmail.com. Next slide, please Nevin.

Also want to say We're gonna have some poll questions tonight. So we're going to keep the poll open for about 20 seconds, so please be ready to respond when they come up. For most of you, it'll just process through but for some, the responses may remain on the screen, you need to click the red button to minimize the results to clear them off your screen. If they remain on there. We'll also have time for questions at the end. And so just as a reminder, everyone other than our presenters is going to be muted. So if you're on the phone, you can submit questions to the Gmail account, which is questionscovid19webinar@gmail.com. That's questionscovid19webinar@gmail.com. If you're on the webinar, use that q&a feature on the black bar on the bottom of the screen. We've learned from past webinars the presenters will often address your questions during their presentations. I encourage you to wait until they're through their presentations before submitting a question. And we'll coordinate with Medicaid to make sure that if nothing is directly responded, they have that so they can respond down

the road. Lastly, we'll record this webinar and we'll make the recording and transcript available on the NC AHEC website tomorrow. Shannon, let me turn it over to you.

Dr. Shannon Dowler

Excellent, thank you. It's great to be with everybody for a fireside chat. I can't believe that we're actually in November. But we are. And so we're actually using our fireplace at our house these days. We have a ton of topics to cover tonight around advanced medical homes, that I think are going to be very helpful for all of you. We do want to take your questions. So we're going to try to go through the material pretty quickly so that there's time to really do some interactive questions and answers, because I have the a team on the call tonight with all the answers to your AMH questions, but hopefully we're gonna answer a lot of them as we go through. Next slide.

So we're gonna kick it off with a poll question. So I know some of you are tired. You've had long days, but we really like these poll questions. They help us understand where you are at this moment. So question one, Nevin. Nevin, can you throw up the first poll question? All right. So the practice you're affiliated with. So whatever practice you're affiliated with, are you? Oh, it went to the results, at least on my screen, and I don't see a way for people to put in their answers. There we go. The practice you're affiliated with? Are you tier three, and do you plan to stay that way? Are you tier one or two? And you plan to stay that way? Are you tier three and thinking you probably should be a tier two before we go to launch? Are you a tier two and think you should probably be a three before you go to watch? Are you saying What? What's a tier? I have a TR. So where are you right now, in your practice? Bring up about 15 seconds and then he's going to tell us what you say, Oh, nice, very nice. We've got a lot of people. For those that are watching the recording later and can't see this that are tier three and plan to stay that way. Very few people answered that they're planning to downgrade or upgrade. But we have a shocking number of people who think that having a TR is going to be good enough so lots to learn tonight. Next slide.

And this is a refresher. So this is a very basic for some of you that are tier threes and have been plugging along but it never hurts to go over the basics. The goal of our medical homes is to provide a pathway for practices to really have the ability to impact outcomes and costs of care and use it to use our existing infrastructure to take care of our patients. We want to keep broad access to primary care services. We know it's critically important in any Medicaid population, it's critically important in all populations. But for us, we really want medical homes to be strong. And so that strength by investing in primary care happening on the ground and in the practices, we think we're going to have improved care coordination and really have meaningful benefits to the beneficiaries. This is very different than what you see around the country in managed care programs. This is one of the amazing innovations of North Carolina, people are watching to see how it goes. So they're going to be incentives to help you keep your patients engaged in care, having the best outcomes possible, and accountability will increase over time through managed care. The expectations are high. So we want care management to happen at a higher level than it is today. We want it to be really community based care management. This is really important to

us. We don't want it to be a nameless, faceless person in some other state that's doing the care management for your patient. And we also want to continually address the continuum of care, we want to capture those people that are rising risk, they may not be high risk right now. But they're on their way to being high risk, we want to catch them early, get upstream. So this is a really important fundamental piece if you're an advanced medical home to get you ready for value based payments, which will be here before we know it. Next slide.

So you really have two options, you can take primary responsibility for care management as a practice, and you get a higher per member per month payment. You can do it at your individual practice level. Or you can do it in partnership with your clinically integrated network. Or you can say you know what, I think I really want to use the PHP's care management approach. I'm happy with a lower pmpm because my practices and equipped to do that, no, no harm, no foul, whatever is the right thing for your practice, there's a lot of respects responsibility with option one, it's a lot of work. If you're not ready for it in year one, it's okay, use your PHPs. And then you can always upgrade later. Next slide. So another way to look at these two options, option one is that tier three, that's where the PHPs are saying we're going to trust you medical home, to do all the care management that your patient might need, you're going to have to provide that care management in house or as I said, through a CIN or other partner, you're still going to get your medical home fees, but then you're going to also get the care management right on top of it. And you're going to hear more about that. There will be incentive programs tied to this, that will be coming as well. Or you can say option two, I'm going to be a tier one or two practice, we're going to let the PHPs have responsibility for the care management, we're not ready yet. And we want you to be ready, we want you to build the infrastructure, we want you to get there. But it's okay if you're not there yet, and just raise your hand and say, you know what I'm going two right now. That means you'll interface and interact with the PHPs. And they might have different approaches to care management. And you have to work with all those different approaches to get the best care for your patients. It's really a shared responsibility between the phps and the practices to make sure that care matters what's happening for the right patients. Next slide. I think I'm going to turn it over to Kelly, who is one of the original, original thinkers and dreamers and designers of this advanced medical home concept to tell you a little bit more about what it means to be tier three.

Kelly Crosbie

Thanks, Shannon. So this is the final refresher slide. So Shannon already walked you through. There are three types of medical homes, there are requirements to be a medical home, you are a primary care provider, you have to provide a complement of primary care services. Tier three really is the next level. So this slide is about that tier three part. A tier three part really is that care management component. So what does that mean? What does it mean to do tier three care management on the left hand side of your screen, as you're looking at it, it really means simply you can risk stratify all your patients, you can decide who needs what kind of care management and how much you can provide care management to this patient. So you have things like a multidisciplinary care team, you can provide care management, you can also provide transitional care, which we know is incredibly important. So you can help people transition between settings, you can demonstrate to give access to data like ADT feed. So you know when people are discharging from hospitals, and there's some pretty stiff technology requirements. To

do a really good job with care management, you need to be really empowered with all the data that we could give you to be able to manage everything from risk stratification to active management of the case. So because tier three requirements are pretty high, the PHPs before they contract with you as a tier three, they're going to want to validate that you can do those things. So that's pretty reasonable. We ask them to verify those things before they contract. So So what does that verification look like? It does vary slightly between PHP s but we'll talk about standardization in that area a little later in the slide.

But in order to verify that you can be a care manager PHPs are going to do things like they're going to look for your care management policy, they're going to look for your care management assessment, the workflow tools that you have, how you can do risk stratification, what's your methodology, they're going to look for your staffing plans, your job descriptions, your staff training, they're going to look at your documentation system, and they're going to check out your technical abilities. So they're going to see if you can ingest data, and populate and maintain a care management system. So it's, it's pretty important that you can demonstrate those things. So next slide.

So that's kind of the refresher. So a lot of the rest of this presentation is going to talk about how we are before launch, we've streamlined the program. So we spent the summer talking to a lot of stakeholders. And we really appreciate that feedback. So we talked to providers and AMHs. And they're clinically integrated networks. And we looked at ways we could streamline the program make it a little bit easier and a little more standard prior to launch, we really want folks to have the support to be able to become a tier three, if that's what they want to be to do really solid care management for all the reasons that Shannon said, this is kind of an entry level way to get some funding to set up infrastructure to be able to take higher levels of risk and become, you know, take higher levels of value based models in the future. So these are kind of some of the things that we're going to talk about, these are the themes. So we're going to start looking at processes. So we sat down with the PHPs. And we said, Here, management is not about measuring processes. So we're going to be really crisp about what we measure, we're going to measure simply things like care management penetration, just so you know how much care management is provided. And we're really going to look at some of the measures that we talked about at the end some of the outcomes we expect in primary care.

We're going to talk a little bit about how we're streamlining oversight, both from a reporting perspective, but also some auditing perspective. So we'll talk about that towards the end of the slide deck. Um, but one of the most basic things we're going to do is we're going to agree on what we consider care management. So if we're going to count care management. And we're going to talk about how much penetration we have in the field and we're open to measure it. Let's talk about consistent ways we use tools to report it, but also even defining what we see as care management across PHPs. So back to Shannon, I think she has another poll.

Dr. Shannon Dowler

All right, next slide. All right, we got a poll question. This one's an important one. This is about care management. What do you think counts as care management? So Nevin, can you launch our poll question, here we go. So this is one where you can choose as many of them as you think are accurate. And we want to know what you think should count as a care management service. And our next slide, spoiler alert, we're going to tell you what counts. And trust me, there'll be lots of follow up on this because it's about learning to speak the same language together. And so but but we are interested, in your opinion on what do you think counts right now as a care management interaction? Or what should count in the future. So take a second and look at all these options face to face meetings, telehealth meetings, leaving messages for patients a phone call, a touch base in the office, a phone call by the front desk about an appointment, mailing information to a patient, completing a social determinants of health screen. Nevin what did the people say? All right, great. You guys are good. All right. So for those of you watching the recording, you're gonna have to wait for the next slide to get the answers. Sorry. Next slide. Kelly, tell us about what counts.

Kelly Crosbie

So what counts as care management. And as you can imagine, there was a lot of thought that went into this. And we did go to a lot of experts. So things like folks who credit care management agencies, the Care Management Association in America, like how it's defined, but we do want to acknowledge something that's really important. So care management in our system is not just about folks with incredibly complex medical needs, not at all. The system that we've built today is really looking at folks who have high unmet resource needs, who are writing risk, far up to people that have very complex medical needs, right, and lots of hospitalization. So we need a care management model that's very flexible. We need a flexible care management team. And we need to be flexible at what we consider care management. Essentially, things that count as care management really is active engagement with the member, it can be any member of the care team who has an in person, including virtual visit, we talk about the care goals, the needs, the barriers, you do an assessment, you do a care plan, it might be active phone calls, or active text messages between a care team member and between the member, it might be phone calls, where you're triaging with a member to get them set up with an appointment. So really is just active engagement doesn't have to be it doesn't have to be a community visit doing a care plan, but it really is those moments of active engagement. They may be brief, they may be lengthy, but things that don't count. I think there's a little common sense here. Things that don't count are things like leaving a voicemail or sending out a mailer. Or unfortunately, those times that you do set up appointment members unable to attend. But again, we're trying to be fairly flexible about what counts is care management. Really what's going key here, though, is we're trying to be consistent. We're trying to set up a flexible model and a consistent way. So what one, PHP costs care management, all PHPs cost care management, so providers have a lot of consistency across their plans, or across PHP, excuse me. So next slide, please.

So remember, I told you that we really looked at streamlining. So the first place we needed to start was how are PHPs accountable to us at the state for care management? Because we know things flow from the top down. So one of our first goals in thinking about reduction of burden was how can we at the state reduce burden on the PHP. So again, some of the easing of burden passes down to AMH's. So the

first thing we did is, you know, we have a lot of SLA. So we have a lot of requirements around how timely care management should be, and processes that it should include, like doing an assessment or even a care plan. We used to have liquidated damages. So financial penalties for PHPs, for getting those things done. So we're relaxing, those things still matter to us, right. We do want members to have assessments and care plans. But we're not going to tie financial penalties to those because those aren't the most important thing, right? The outcome to the most important thing. So we're relaxing those liquidated damages on PHPs. So we will measure something very simple. We're going to measure total penetration for care management. And so we expect that, again, that simplification where we're not measuring every little process of care management, but we are generally measuring overall penetration, how much and who's getting care management it's really important who's getting care management. So that's it.

Yeah, jump in. And this is one of the places where we heard from the field, guys are killing us, because the PHP is want us to provide all this information. And they say it's because you're making them require all that information, which was true. So so we work through it. And we really, really streamline the amount of things we're asking for from the phps, so that they will unburden you with the practice. Yep. So that's our last bullet. That's our expectation. So we're easing up. We're requiring much less things at this date. And so that's what we expect to flow down to the field. So the next slide is probably the most dense, I'm not going to go through it in the whole way. But really, what this is demonstrating is, in order to Cat Cat capture that penetration, that idea of who is getting care management, we've standardized the definition of care management. But we've also standardized the process flow and reporting. So reporting, we want it to be standard. So we are passing down templates to the PHPs templates for how they get patient data to practices and templates for how they collect patient data from AMHs. backup to PHP is backed up to the state. So we'll actually have a whole presentation on this. But the thing that you really want to take away from this slide is we've created two specific templates, we would like PHPs to use to pass down patient level data to to AMHs. And there's one report that we would like AMHs, to to put information on to send back to phps, who will then send it on to this date. So again, the theme here is standardization of reporting, simplification of reporting from us to to PHP, too AMH's. Right, next slide, please. And this, I'm going to turn this over to Krystal Hilton. And she's going to tell you about one way that we're investing in a MHS prior to launch.

Krystal Hilton

Thanks, Kelly, we do understand that it will be an incredible amount of effort and cost to implement tier three to implement tier three. So we are provide an opportunity for financial support, we are looking to have a 90 day prior to launch opportunity for practices to qualify for financial support, there'll be three distinct opportunities. And the qualifications are fairly simple, that you would just have to contract with at least two CHPs, and also successfully test for data exchange with them, with that criteria, please note that it this financial assistance is in addition to any COVID enhancements that are potentially applicable. Now share with Jaimica an opportunity for additional practice support.

Dr. Shannon Dowler

And if I can jump in real fast Krystal and just focus on that, that readiness again, this is significant. This is a big lift, and we're talking we're gonna spend millions of dollars in those three months ahead of time for the AMHs that are ready to go and want to start getting that payment early. So then on day one of go live, you're ready to go and you're ready to be held accountable by the PHPs. And so this is a great opportunity. There's no such thing as free money, right? You got to do stuff for it. But it's hopefully the things you're going to be doing anyway. So we're just getting it to you ahead of time. It does require a couple things to happen first, and we'll talk about timeline a little later.

Jaimica Wilkins

Yes, happy to talk about the AMH tier three practice support resources. So next slide, Nevin. Thank you. So NC AHEC will offer a two prong approach with practice support via AMH practice coaching and education via webinars and tip sheets, etc, that are aligned with the AMH program in collaboration in partnership with the department. So what does AMH practice coaching look like? I'm so glad you want to know. It looks a lot like what AHEC has always been doing and is so good at and most recently has been with our keeping kids well program in working one on one with individual practices to ensure that they can implement interventions to improve their well child visits to immunization. Similarly, starting in January AHEC coaches will work with individual practices to accelerate adoption of the tier three standards and facilitate transition. They will use a standardized baseline assessment tool for tier support to create the established baseline and then customize for the extended AMH coaching. The AMH practice coaching is available to primary care practices who are in network with at least one standard plan PHP, and the PHP may refer practices that need assistance meeting AMH standards. There's also a self referral process where AMH practices can complete an informational application and send to AHEC. In addition, in the future, there will be a Do It Yourself advancement toolkit that AMHs can use to maintain and improve their processes through coaching. As well as after lunch there will be some rapid cycle improvement for tier maintenance.

Now we'll move to education. So what is education? What it looks a lot like what we're doing now, webinars, tip sheets, bulletins and other mass communications on the AMH program. Some of the information that will be included is how AHEC can help you and the benefits of AMH practice coaching, as well as an active engagement framework. The education will be geared toward all interested Medicaid practices. And the first webinar series for the AMH webinars will begin on the second Thursday, December 10 2020. And we encourage you to go to the link as you see it on the screen and register for the series that will add to our first Thursday webinars and our third Thursday webinars. So now you'll have a one two three series of webinars to register for. We look forward to sharing more information with you about that. Some of the AMH webinar topics we brainstorm will include care management, knowing your data and your in panel patience as well as the tier support tool, what it looks like and how to use it and best practices from the field as we move forward for improvement. Now I'm going to turn it back over to Shannon to talk a little bit more about patient engagement.

Dr. Shannon Dowler

So one of the things that is really clear is that even though you think PHP is would be happy that I have patients engaged because they're not spending money if people aren't coming to the doctor. The truth is they want the patients engaged, they want them coming in to see you they want them especially to be seen by their medical home, to be getting preventive screenings done to be getting labs as appropriate to have chronic diseases be managed, but also the prevent things like flu shots. So we have been asked by the PHPs and have spent the last year talking through how to create an opportunity for members who are not engaged to be moved from a primary care practice.

First thing I should say is that if a beneficiary states where they want to go for their medical home, that is not changing. So beneficiary choice is paramount. Number one most important. So when it's time for that enrollment, and the beneficiaries get to pick their practice, you want them to pick you and you want to ask them, Hey, don't forget to pick us because no one's going to mess with it if they pick you as the medical home. But for some people who really aren't engaged in care, they're probably not going to call and set up who their primary care provider is going to be either. And so PHPs are going to be allowed to have a look back period at claims and see who is not actively engaged in care that they really like to see engaged in care. So if they age, blind or disabled population, they can go back 12 months and there are no claims at all for that patient. No telephonic claims, telehealth claims, flu immunisations, no claims for that practice met beneficiary, they're going to have the opportunity to move that patient to a different medical home, that is going to be able to engage the beneficiary. If they're not ABD or age blind and disabled, it's going to be an 18 month look back. We wanted to make sure that we didn't hold it right at a year. Because a lot of times you can't even come in for preventive health events right of the year. I know that for my own teenagers, it's sometimes hard to get them in anyway. But we wanted to give it that year and a half timeframe to make it a little bit more generous for the folks that aren't age blind and disabled, there are going to be some protections in there, there'll be a limit to the number of beneficiaries that can be moved as a percentage of a panel, they're going to be beneficiary provisions of their choice. So beneficiary choice is paramount. So we'll give you more information about this as those guardrails are finalized. But this is the time right now, over the next couple months, where you really, really want to be engaging your patients. We've been talking about this the last two months on our webinars, make sure you're getting your people in. And this is, this is one of the reasons why we want them to stay with their medical homes, that they're meaningfully engaged their medical homes. So things you can do to help with that is there's phone lists, calling patients asking them to come in, or just communicating about what plans are accepting and when they do the open enrollment, who they should pick and how to join so they can stay with your practice. Next slide. So on the topic of money, I'm going to turn it over to Krystal to talk about all the different ways that you get paid to be a medical home.

Krystal Hilton

So this has served as a bit of a refresher, hopefully, for many people, and it's just sharing how what the current four types of medical home payments that currently exists, there is the build services or your fee for services, fee for service payment. And then there are the medical home fees, care management fees,

as well as our performance based fees. This these are, these have been tests around for a little bit. So they should hopefully be a little bit familiar for everyone. Next slide, please. But we will move on into discussing some critical policies that the department finalizing regarding AMH tier three payments, we want to explore options to get the best case management rates available. And to make sure we were making clear investments in the infrastructure in the field. The first of the policies, which we have four key policies. The first is looking at the fact that we have no care management rate four, we did spend some time in rigorous debate on whether or not to impose a rate four but how are we settled on no rate four, and I wanted to allow the negotiation process to be able to generate some of the best rates possible.

Secondly, that we are guaranteeing the care management fee, which means that that will not put them at risk for performance or other metrics, other things, but the negotiated fee would be the fee that will be paid out. Our third policy area that we're looking at, is looking to ensure that there is more level of transparency, there are time frames, that if the PHP wants to make any payment changes, they have to submit those changes into us. And they have to be approved and then implemented within at least 90 days prior to full implementation. That last policy area that we're looking at that we wanted to make sure that in that line of transparency, that we had clear performances incentives and there were clear measures that would support those performance incentives. So we have landed on a specific set of measures. And these other measures that are based on the performance payments from Sorry, could only based on this measure set. They can be used with tier one and tier two, if applicable, how and they can also be used to with the other value based arrangements. But for tier three performance incentives, this standard set is what we are what that PHPs must utilize. Like to share back with Shannon, I believe we have a poll coming.

Dr. Shannon Dowler

All right, Nevin, throw a poll question at us. So we're gonna shift into quality measures. I know this is a topic that can trigger some of you. So I want you to answer honestly, when you see your performance on a quality measure, what's your gut instinct? Do you react to it and say, Wow, we're killing it? Or Oh, we can do better? Do you question it? Do you say that data is not right? I know we're better than that. Do you really just sort of push it away? It's not your problem. The Quality Manager handles it. Are you really out of the loop? And not even sure that you have quality data? Or do you go into despair of the darkest kind, another quality measure? So where are you Nevin? Where's everybody? When we asked this question? Um, nice. So that's, that's good. I've spent a lot of years working with physicians on the quality space. And oftentimes, the the second choice if I question the data is a real problem and some of our metrics that we're going to talk about in a minute, there are some issues around getting the the data as accurate as possible. And you can believe we're well aware of it. You've got a team that's committed to getting this data right, next slide.

So PHPs are going to be required to only use A set of measures developed for the AMHs for incentive payments in year one. So it's a defined set that you see in front of you. Now, these measures are things

that are areas where we're doing well, areas where we have opportunity, and areas where we're really not doing well. And it also includes some that we're not really good at measuring, because we want to get better at measuring these things in the most accurate way possible. Next slide. So when we look at how we're doing now, if it's red, it means we are below the national average. And it doesn't look great for us. Adolescent well care visit. That's a big one, immunizations for adolescents. That's a big one. This is kind of part of this issue of engagement with your beneficiaries. This is why we need you to be engaged with your beneficiaries. well child visits in the first 15 months of life. Cervical cancer screening, which I will myself comment on is one of those optics metrics, which I can't stand because of the cervical cancer recommendations now are different. And so it can be very difficult to get that accurate plan all cause readmission. observed to expected ratio. We're also below on that. We are at the national average on the childhood immunization status, recombination 10, which I'm pretty impressed by because that's a really hard metric to get to. That's a testament to how strong our medical homes for children are around the state. We actually are above the national average at chlamydia screening for women, and we want to keep it that way. So that's when we're focusing on because the downstream long term costs and impacts of undiagnosed chlamydia are significant. And then there are a few of them that we haven't been measuring. And so we need to learn how to measure and find a better way to measure. And the team's working really hard to make sure that we're getting the clinical data, as well as the claims data that we need to do these measurements. Next slide. Kelly, talked to us about incentive payments and timelines.

Kelly Crosbie

How exciting, no, this one's it's a little more simple. And it looks right. So PHP is go live in July of 2021. And for all you measure nerds out there, that's right in the middle of an annual measure cycle. So really, PHP aren't required to start incentive payments based on that measure set until measure year 2022. So calendar 20, calendar year 2022. Um, but some PhDs are choosing to start incentive programs right away right at launch, which is really exciting. So they are only going to use that six, the first six months of calendar year 2021 and develop their incentive programs off of that which we we applaud, we think that's really wonderful. But again, at a minimum PHPs have to insert those incentive programs for calendar year measures 2022. So on the last slide, I'm going to tell you one more standardization. So I get all the fun ones tonight, it's about standardization. So Nevin, if you could go to the next slide. This is the last one. So we talked about standardization in terms of we all care management, the same thing, we're all going to use the same reports. Um, and this is the last one. So PHP is are going to oversee tier threes, they just are, they're going to assess if you can be in tier three before they even contract with you. So we wanted to set some guardrails around what that oversight process has to look like. So the first thing is for tier three audit, so when they audit you when they're trying to contract with you and your time, the standard for what they measure to you must be tier three requirements in the first year, it can't be NCQA accreditation standards. Even though health plans have to be accredited in year three, we understand that complication. But for year one, if you are adhering to the tier three standards, you're good to go. And that has to be the standard that all PHPs use. The next thing is we wanted to put some guardrails around corrective action First, we want to take it to make sure that we had a corrective action process for many tier threes or the CINs that are supporting them, this might be kind of new. And so we that doesn't mean we want members care to fall through the cracks, it just means we want to have kind of a continuous quality improvement approach here. So at a minimum, we really want PHP to

allow CINs and AMHs to have at least 30 days to remediate errors or issues when they're not able to perform to tier three standards. So we don't want immediate downgrade, like there's some some underperformance and and immediately the tier three loses their contract or they're downgraded to it. So we wanted to say let's let's have at least 30 days to remediate significant issues and let's work collaboratively to improve the program and not come at it from a penalty mindset.

Um, this is a reminder that practices can self downgrade if you say you know what, I attested to a three but as I'm working on a three I decided I would like to use this year to get some AHEC coaching a coaching program and then I just want to be a tier two across the state for year one. That's perfectly fine. The Medicaid bulletin and I think that came up Monday, actually talks about the new tracks functionality that we have. So there's a portal already on tracks for AMHs. We have new functions. In tracks, so you can go down across all of your sites and downgrade yourself to a tier two, and that becomes your maximum tier at this date. So that's published in Monday's Medicaid bulletin. Um, we had explored a hold harmless period. So we explored the idea. Um, back in 2019, we explored the idea of the first 90 days kind of being a hold harmless period, where we're where AMHs could not be put under corrective action or downgraded. But instead, we kind of flipped it, we started so that 90 day readiness period where we're doing the care management rate for 90 days prior to launch, to fix up time to hire and invest in get ready prior to launch, rather than this 90 day after the fact hold harmless. And the last thing, we expect PHPs to be transparent, so in their oversight processes. So when you sign a contract with a PHP to be a tier three practice, they need to tell you this is our audit process. This is our oversight process. This is what it's going to look and feel like. And they need to share that with practices. So practices network...

All right, next slide. So this is just kind of a reminder about oversight in general. And there's and there will be some dependencies on the end of this slide to talk about measures. But Shannon really shared with you that AMH set, it was very important for us to keep that crisp and manageable. We all know we can only work on so many things at one time. Um, but this is kind of a reminder that we will be working with PHPs on a broader measure set. So these two slides just kind of go over some of those measures. Many of these, the PHPs over responsible for reporting to us, although we will calculate them ourselves as well. But some of them just population based measures that we'll track. So for example, the first four, they're really around care for children and adults. So some preventative care, and some chronic care measures PHPs will be responsible for reporting this to us. Those arc measures is avoidable utilization measures for adults and children will continue to measure the state from a population level. On the next slide. The next slide is the list of all kind of the behavioral health or integrated care measures. A lot of them are in the opioid, opioid space or prescribing around anti-psychotics follow up after mental health hospitalization. PHPs will be responsible for those and you'll see a long list of maternal health measures as well. maternal health, pregnancy and birth outcome measures. PHPs are absolutely responsible for all of those, they'll report to them to us and will actually monitor them as well, we'll calculate them ourselves at the state. So it's just a reminder that the AMH measure set is a very important measure set. It has required incentive payments, as Chris will talk to you about but it is not the only measure set that we have for PHPs. And so I think with that and turning it back to you to Shannon.

Dr. Shannon Dowler

All right. Time for our final poll question of the evening, Nevin. All right, this is a question that I'm just curious about. Right now, your practice plan, your strategy for contracting with PHPs? Is your plan to contract with all of them if they offer you fair contracts, contract with most of them if they offer fair contracts, contract with only a few of them, contract with only a couple of them? Or maybe you don't realize you're supposed to be contracting with PHP right now. Or you just don't know what your strategy is. We're really interested to hear what your practice strategies are, we've heard a lot of different ones. So while you're answering that, I will say my bias is from the beneficiary standpoint, I would hope that you contract with all of them, because they all offer you equally fabulous contracts. Because we want our patients to have choice and to be able to go where they want to go. So we don't want to make them have to pick and choose maybe change their primary care provider because they're not accepting the plan that they chose and other things. So Nevin what did people say what's the strategy? Nice. So that's great. So 68% of you are saying that, you know, offer me a fair contract. And I'll contract with every one of you if that's fabulous, that's our goal. All right.

Next slide. We're wrapping it up for questions. Oh, we're, we're gonna wrap it up quickly now. So we get to your questions. So time is moving fast. Open enrollment begins March 15. And then before you know it, we're going to be going live. What does that mean? It means you got to be doing stuff now. So I've been mentioning the last two months about getting your provider information updated. So make sure you're working with your practice manager to make sure all your information and tracks is accurate so that when we do the the member access will, they'll be able to see they'll see your practice, they'll see who's in it and we have it as perfect as possible. That was a lesson learned from last time. So November and December is a great time to make sure your information is all correct. It's also time to get those contracts done. We the plans have to have a certain amount of time from when you sign a contract to before you get into the system and we want you in the system when open enrollment begins so that your patients know who they can pick to stay with you as a provider. So it's really important that all this work is happening ahead of time, and that you're not waiting till the last minute. Next slide. Jaimica do you want to talk a little bit about the upcoming webinars?

Jaimica Wilkins

Yes, absolutely. So upcoming with our webinars, we're having our third Thursday webinar for the clinical quality updates around women's health, which will include topics around HPV vaccine, family planning, waiver, clinical policies around women's health, and the breast and cervical cancer control program. Then, for the first Thursday, fireside chat on December 3 2020, we will talk about travel option and beneficiary attribution. And then we will kick off our AMH webinar series on the second Thursday, December 10 2020, at 5:30pm, just like our first and third Thursday, and we'll talk about the topics that I mentioned before in the previous slide. So we highly encourage you to go to the registration link, and register for the AMH survey, the AMH series of webinars and the other two webinars if you're not already on the first and third Thursday series.

Dr. Shannon Dowler

We love having you there. Because then we can answer your questions. But we do have recordings available. So that's also there. I'm sorry Jaimica did I interrupted you saying something else?

Jaimica Wilkins

No, I was just going to turn it over to you for update.

Dr. Shannon Dowler

Okay. All right, great. So just a few moments of personal privilege, when I have a captive audience, there are a few things I just want to make sure you know about so much is happening, it's hard to keep up with all of it. So flu shots, were way behind we are past performance we were in October of last year. So overall, our flu uptake is lower than it should be. And this is big, obviously, because of the twin demmick, risk COVID rates are going up, I think today we posted our highest number, again, we keep hitting our highest numbers. So really as much as you can engage your members to come and get their flu shots, ideally with you, because then that's a claim. And that shows they're engaged with you. But if not somewhere we really need flu shots. Next, click. This is something really big and exciting. Many people have had great ideas of what Medicaid should cover or suggestions around the coverage. And it's sometimes been hard to figure out where to go. We have a new easy button on our website. And it's called stakeholder request coverage form. And it's a forum you can complete to say, Hey, why don't you cover the service? Obviously, you should. And it allows you to tell us why we should do something differently than we are. We're really open to feedback. And we want to hear what you have to say. And we're trying to make it easier for you to get that information to us. Because frankly, you're the ones on the frontlines doing all the work, we need to know what you need. All right, here's the fun part. So all my experts on the phone, turn on your cameras so we can see you and Hugh are you going to moderate all of the questions?

Hugh Tilson

Well, I will do my best. We have a lot of questions. Start with a question that says How do I know what Tier I am? How can I figure that out? How can I verify what Tier I am,

Kelly Crosbie

You can actually verify an NC tracks, you know actually tell you if you go in and you do a tier. But here's a rule of thumb. If you were Carolina axis one or two, you are an H one or two, we made it really easy. And the only way you're in tier three is if you actually went in and you clicked on all of your sites in tracks and you would test it to tier three requirements. And that's what makes you a tier. But you can actually go to NC tracks and check all of your sites and check all of your your status at all of your sites. Like I said, there's a bulletin journal that published on Monday, that tells you how to go into tracks and change your change your status, use the same, use the same information to go in and check your status. So that'll that'll be the link in Monday's bulletin.

Hugh Tilson

I got lots of questions in here about the intersection of AMH and CINs. So can you first of all talk about the intersection and what you think about that the specific question that started this is can the presenters mentioned that CINs may be managing this for their practices providing two three requirements for them, etc?

Kelly Crosbie

Yeah, I read a read of most of the questions. So there were definitely a lot of questions around CINs. So just a couple points about CINs that I think will address most of the questions. As Shannon said early on, it being an AMH can be challenging. Most AMHs are joining together in clinically integrated networks. And most clinically integrated networks are offering a care management platform. They're offering analytics. They're offering the ingestion of all the data that PHPs are sending. They're creating quality reports. you're offering care management infrastructure, even care managers who are consultants for care management so they can offer the full complement of services. AMHs are not required to use them, but many are choosing to because that's smart. AMHs just have to negotiate those contracts with CINs. So fees go to AMHs. These the medical home fee, the care management fee, those are for tier threes. And tier threes can use those care management fees, for example, to purchase the support of a CIN. Many CINs are also negotiating contracts for their collectives of AMHs with PHPs. So that's great, like a lot of them provided us a value added service to but but really, that's something that you know, the choice you make as a practice, if you want to work with the CIN, and the deal that you negotiate with them. So I saw a lot of questions about how much do I have to pay us a CIN, can they take my whole career management fee, that really is what you negotiate. And, and we can't name all the CINs in the state. But we, I will say that we have a mixture of hospital based physician networks, right? CINs and we also have independent CINs. And they all have different arrangements with practices underneath them. And so we, we we support use of CINs, but we don't get into the weeds of what those arrangements look like.

Hugh Tilson

I think you might have answered this. But if if our practice is part of the CIN, do I sign an individual contract?

Kelly Crosbie

I think that's happening in a lot of ways, right? So many AMH's are signing a contract with a CIN and the CIN is contracting on their behalf with with PHPs. But we've seen it other ways to where each individual AMH is signing a contract with a PHP and then also with the CIN and again, this is where I'm not an attorney, I don't pretend to be an attorney. You know, that's that's an I we can't get into those things. So I would just say there's a variety of arrangements, providers are enrolled in Medicaid, and they need to

be enrolled in the PHP's network. But there's a lot of flexibility in how that contracting can work between an AMA a CIN and a PHP, whatever works best for the practices is what we support.

Hugh Tilson

Got some questions from ob gyn not sure if it should be or could be an AMH or a tier three or can talk about specialists as part of AMHs including ob gyn?

Kelly Crosbie

I can but want to let anyone else want to jump in I don't I don't want to hogthe floor. You can be right. I mean, if you're an OB that is currently an enrolled primary care provider, and in North Carolina that is that, you know, AMH means something specific about primary care, right, going in and enroll as a Carolina access provider. So you agree to provide this list of primary care services and lab works and screenings. And you also agree to access standards. We have obs who are Carolina access primary care providers. So we think that's great. So it's kind of like good attract, look at the requirements, go to the AMH website and look at the requirements to be an AMH regardless of tier just to be an AMH, the primary care practice requirements are laid out there ob certainly are one of the practices that can do all that. And that's kind of your choice if you want to do all that.

Hugh Tilson

So a couple more CIN unrelated questions, is the data exchange from the CIN into the PHP or from the practice to the PHP? Is that a direct link? Or is it all through the CIN?

Kelly Crosbie

Again, it's kind of one of those, it depends on how you do it. But but this is I would say, by far, this is the most a common situation we're seeing, PHPs have to use standardized file formats from this state, to deliver claims information and also beneficiary demographic information two to AMHs. That's a lot of a lot of data is a lot so mostly images are saying hey, CIN do it on my behalf. So most of the data exchange those huge tranches of claims data and member eligibility and demographic data, by and large most of that is going from the PHP right to the CIN. And what the CIN does is they package it beautifully. They packages in in the care management documentation system, they package it in reports that AMHS can use so that's kind of a value out of a CIN.

Hugh Tilson

One last CIN unrelated question is will AHEC coaches be reaching out to practices that are part of a CIN.

Kelly Crosbie

Krystal, Jamaica?

Jaimica Wilkins

All right, practices are able to practice are encouraged. That is they are working with the CIN they may not initially want to work with the AHEC coaches, they will want to get some services and get some coaching from their CIN. However, if they do select to work with CIN, sorry decide to work with AHEC and they are affiliated with CIN and they will definitely be able to do so.

Hugh Tilson

Sounds great. A couple questions about payment levels, PHPs are trying to pay too low on the AMH levels, what can we do?

Kelly Crosbie

We, we, you know, you know, Krystal shared that we, we debated kind of the rate floor. And we actually talked to quite a few folks in the field about the rate floor. So, um, I will say that there are folks who have been able to negotiate really great rates and something I'm not, I don't do that. And again, I'm not an attorney, not pretending to be one. But I will say that we've tried to enable you with a little bit of information. So one of the things on our AMH website is, it's a rate of rate discussion. So we actually give you information about how we develop the care management rate, we pay the PHPs. So a lot of people found that very effective as they were thinking through kind of their, their negotiating approach with PHP. So looking at that, um, that's where we get the 851 care management fee that we're paying you pre launch, by the way, right. That's where the 851 comes from. But but I do think it is kind of a is a reminder, the contract from us to the PHP says PHP need to contract with 100% of tier threes. So I think that's important for you to know. So important leverage, but also think like, and I'm a believer, right? Primary care is really important. And if you're a practice that seeing a lot of Medicaid, you are needed, in that PHP network, you are needed to meet their hundred percent tier three requirement, you're needed to make their network adequacy requirement, you're needed, you're needed, under value. And so um, and that was probably not really solid negotiating material. But I guess I would remind folks that like, don't settle, you don't like, there's a lot in that contract that says you need to be contracted with so I would say don't settle.

Dr. Shannon Dowler

And a lot of it's a lot of work. You know, we're asking you to do a lot of work as a tier three. And you have to build that infrastructure and invest and that should be valued.

Kelly Crosbie

It is. Yeah. Oh, and one other thing, too, because if this came up too, I don't mean to jump the gun, but that the whole issue about care management fees at risk. So sometimes we saw middlin rates, um, that were a risk, right. So here's your rate unless you underperform. And if so, then we're going to cut it. I mean, that's a really key takeaway from what Krystal said. And a big change for us is that no, care management rate is a guaranteed revenue, we put information out there about how much we think it should be. And it needs to be guaranteed revenue for you.

Hugh Tilson

Um, couple questions about signing up this year versus last year. So you initially said patients would be assigned to us if we are their historical FOC? I guess, if historical medical home, but at the end, you mentioned patient may have to change AMH if their preferred doc does not contract with the PHP, which is it? are patients governed by PHP or AMH? Who wins the patient?

Dr. Shannon Dowler

So there's our December webinar, this is a huge answer. It's actually an incredibly complicated algorithm for this attribution and our December webinar, we're going to be talking about the tribal option. And we're gonna be talking about this in great detail. So I would say tune into it because there are a lot of complexities to it, patient choice is really important. But the patient if they choose you, and you're not in network for their plan that they chose, there's a problem, because they're going to need to go with an in network provider. And so that's why as many plans as you can contract with less chance that isn't happening. But we're going to go into a lot of detail to help you understand how that attribution is going to work.

Hugh Tilson

Related, maybe question if patients signed up last year for their PHP plan, would they have to do so again?

Dr. Shannon Dowler

Yeah, we're the we're with open enrollment, we're kind of it's so long since the last round, we're having them redo everything. It's It's been a long time since the last time we had open enrollment and the world's a different place. So yes, but this is a great opportunity for for AMHs and practices, to really touch base and connect with your members, make sure they know how much you value them as part of your team. And to ask them to select and go on and go on and enroll in select you

Hugh Tilson

Getting questions about where to find the slides in the recording and just remind everybody that'll be on the NC AHEC website, and I'll try to post that in the q&a.

Dr. Shannon Dowler

Um, I saw a comment earlier about slowing down. And it's hard, there's so much information that we want to share and we're excited about it. And it's, um, the recording will be available though, so you can listen back through it and there gonna be a lot of sessions coming up as well. We're gonna kind of flood you with information and so that you feel ready and impowered to go into this managed care world.

Jaimica Wilkins

And most importantly, Shannon, I think that we, we try to get through it quickly so we can have time to answer your questions, which is a very valuable part of our webinar.

Hugh Tilson

I'm sorry, Hugh, oh, no, no, no, no problem. Questions about connecting with NC notify. Nc health connex to share data. And is that going to be adequate? And will there be a fee and you talk about ways to provide the data and whether NC health connex can serve in that capacity?

Kelly Crosbie

Yeah, tier threes are required to have a source of ADT information. Admission discharge in transfer has got that wrong. And NC notify is absolutely an option that definitely counts check. If you're getting NC notify through the HIE, that's great. There are there are other ways to get it to. So again, this is typically a value add that CINs can can bring. And they can they can get connected on your you know your behalf to get the NC notify information or from another ADT source.

Hugh Tilson

So we're just about out of time, let me just read a couple of these one is can be considered having an entire evening devoted to how mental health fits into standard plans, and AMH, much discussion about tailored plans. But that would be a good future topic. Thanks to all the presenters, we're lucky to have you at the helm for your great effort of our great state. Thank you for that. The link for the recording. I'll go ahead and do that right now. And then Shannon, you have access to the questions. Is there something that you see that you want to make sure that you're asking? You're

Dr. Shannon Dowler

I'm looking for, there's so many questions. I know.

Krystal Hilton

Shannon? Good. I was gonna say while you're looking through Shannon, do you want to chime in about the behavioral health mental health? We are considering that as a topic for our third Thursday webinar in December?

Dr. Shannon Dowler

Great. Um, yeah, so if so if you have a question in here, we're going to get to all the questions. So you're going to get an answer. We've got someone on the team who goes through all these questions and make sure an answer gets to you if it wasn't answered in the webinar. And so some more information coming. I'd love that idea about behavioral health, we're actually in our women's health next month, no, in two weeks, it's in two weeks, or the third Thursday, we're focusing on women's health and actually a large part of that around behavioral health. And so Dr. Carrie Brown from DMH is going to be on that with us talking about women's behavioral health and women's health. So we are trying to work behavioral health into a lot of the things we're talking about.

Hugh Tilson

So I think we're just about out of time. Let me thank all of you for participating. Reminder, I did try to post the link to the ncahec.net is the website where these will be I don't have the specific link available right now. But we can get that out to everybody. Shannon, thank you and your team so much for just incredible information. And let me turn it back over to you for some final words before we sign off.

Dr. Shannon Dowler

Um, you know what, they are amazing. And they've put together an amazing program. And they're experts. And they're available to make this go well for you. And so just know that the team at DHB really wants us to be successful. We want to be the leading managed Medicaid state in the country, because we're going to do it differently. And we're going to do it with a very patient centered primary care focused approach. And we're excited because we know we can do that in North Carolina. So thank you all for doing what you do every day and taking care of the 2.2 million and climbing beneficiaries in North Carolina. And if maybe we get Medicaid expanded this year. Wow. It'll be even more. So. Thanks for being here tonight. And joining us, Hugh, as always, thanks for emceeing and we'll look forward to seeing you in a couple weeks on our next webinar.

Hugh Tilson

Take care everybody, be safe.