Advanced Medical Home Series
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5:30-6:30pm

Presenters:
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Hugh Tilson:
Good evening and thank you for participating. This is the first in the Advanced Medical Home, known as AMH series of informational sessions put on by Medicaid and North Carolina AHEC to support providers during the transition to Medicaid managed care. As a reminder we also put on the fireside chat webinars the first Thursday of the month on managed Medicaid and the third Thursday of the month we discussed clinical quality issues. NC DHB and NC AHEC partnered to ensure health care providers across all 100 counties have the information and support they need to adapt to and thrive under Medicaid managed care. It will provide additional educational webinars like these and virtual office hours across a variety of relevant topics. In addition, we have AHEC support coaches to provide 1:1 assistance to practices. As you can see, tonight we will provide an overview of AMH policy and AHEC coaching. Let me run through a couple of logistics. If you need technical assistance with anything please email us at technicalassistanceCOVID19@gmail.com. I want to let you know we will have time for questions at the end, but to remind you that everyone other than presenters are going to be muted. The way you can ask questions is by using the Q&A feature on the black bar on the bottom of the screen. It's the Q&A feature or if you are dialing in you can send an email to questionsCOVID19webinar@gmail.com. We've learned in the past that our presenters will address your questions during the presentations. I encourage you to wait until the presenters are through with their presentations to submit your question. If we can't get the questions we will send them to Medicaid so they can respond or incorporate those into subsequent webinars. The slides are available on the NC AHEC website, there is a link in the Q&A. We will record the webinar and add the recording and written transcript to these slides on the AHEC website probably first thing tomorrow morning. Let me turn over to Kelly.

Kelly Crosbie:
Thank you so much. Hello, my name is Kelly and I am the director of quality and population health in North Carolina Medicaid. Welcome and thank you very much for coming tonight. Tonight is the first in a series that is kicking off our advancement medical home coaching program. Who do we think should be here tonight? Primary care physicians, office managers and administrators for primary care offices, clinically integrated networks, accountable care organizations, prepaid healthcare plans, technology companies, analytics companies that support primary care offices and Advanced Medical Home care companies, QI companies that support Advanced Medical Homes.

There are a lot of folks we think are interested but the primary focus of this entire coaching program is to help our primary care medical homes get ready for the Advanced Medical Home program. Tonight you're going to have an overview of the Advanced Medical Home program. This might be repeat information for many of you. We're going to go back and start with what is an Advanced Medical Home and what are the requirements? Then we are going to talk about programmatic changes we are rolling out prior to launch. The exciting stuff, we are going to talk about the AHEC coaching program which includes these webinars and coaching. Really, thank you for being here tonight. We know your time is precious. And thank you to all the primary care physicians that provide services, high-quality services to Medicaid beneficiaries.

These are our speakers. I just introduced myself, and I'm joined by two incredible colleagues, Carol Stanley and Krystal Hilton. It's possible we will get a drop in from our own chief medical officer Shannon Dowler. With that, I'm going to turn things over to Krystal.

Krystal Hilton:

Thank you Kelly. As she shared she did a general overview of what we will be discussing but I want to walk you through our agenda. We will be starting with the Advanced Medical Home overview, followed by key policy updates, and sharing options for the AMH practice transformation. This webinar, tools that will be published as part of it, and the practice supports with the AHEC coaching. And some efficiencies for NCQA-PCMH certified practices. Followed by what's next and now is the time. Followed by Q&A. We are hoping we will be comprehensive enough but we offer an opportunity for your questions as well.

The design and intent of the Advanced Medical Home is to offer practices a larger role in managing the health outcomes and costs for patient populations. Several core and guiding principles of the Advanced Medical Home are to preserve the broad access of primary care services. To strengthen the role of primary care in care management, care coordination and quality improvement. And the Advanced Medical Home also offers incentive for practices to be more focused on the cost and quality outcome with increasing accountability over time. Along with the Advanced Medical Home, the expectations are high in areas of penetration rate where we see 22% expectation versus the current 10%. That the care is located in a community-based fashion. As well as addressing the continuum of care needs from high-risk to unmet social needs. One last note in regard to the Advanced Medical Home program, is that it launches concurrently with managed care.

Most of the information I will be sharing particularly is refresher information. Please forgive us for that but we wanted to have an opportunity to share this information one more time. I wanted to start with practice eligibility requirements. Most of note is the eligibility requirements are the same as those for Carolina ACESS. That is where North Carolina Medicaid enrolled providers, primary care services will be eligible and some examples of those practices are single and multi specialty groups such as general practice, family practice, internal medicine, gynecology, pediatrics, psychiatry and neurology.

Also as part of her refresher, through AMH care management, practices can choose and base their choices on the level of responsibility for providing care management. That responsibility also comes along with different levels resulting in per member per month payment where option one, AMH would have the primary responsibility for care management which would be done through individual practice level or contracting through a clinically integrated network with the result in higher PMPM. The second option is where they would coordinate with the PHP approach and that would have a lower per member per month payment.

Within Advanced Medical Homes there are three distinct tiers where AMH practices would align based on their level of shared responsibility with the PHP. Tier three is the highest level of responsibility and this is delegated responsibility where the AMH is actually performing the care management responsibility through in-house or the CI ends as I shared in the earlier slide. Within tiers one and two the PHP retains that primary responsibility and that will offer the AMH the

opportunity to integrate with multiple PHP and those could have different approaches to care management. When we discussed fees, all tiers share the medical home fee of $2.50/$5. And the PHP offers incentive programs for all three levels. A difference with tier three is that new care management rates will be introduced.
Care management requirements, again, a refresher. Risk stratification of impaneled patients. Care management is to be provided for all high need patients. There is a provision of short-term, transitional care management, medication reconciliation to impaneled patients who were discharged from the ED or in an inpatient setting. There also must be an active access to ADT fee and the Advanced Medical Home must receive claims, claim data fees, and meets state designated security standards for the storage and use. I hope I didn't move too fast. I didn't want to belabor all of the refresher information. Now let's turn over to Kelly who will review our key policy changes.

Kelly:
Awesome. Thank you so much, Krystal. Hopefully none of that was new information. Folks are very familiar and in fact probably tired of us talking about practice requirements and care management requirements and technology requirements and the payment schedule for AMHs. We actually have a 12 series session on the basic AMH training requirements posted on our website. I think one of the next sessions we should make sure you know where all the advanced medical tools are. Lots of training. There is lots of information and make sure folks know where those are. What I'm going to do now is review some current policy changes. As you recall, prior to COVID, at the end of 2019 managed care was suspended. Throughout most of 2020 all of us obviously have been, especially physicians in your teams, have been supporting individuals in a community during the COVID pandemic. Most of our work in the department has been focused on responding to the public health emergency. We have had time to also work with key stakeholders including Advanced Medical Home technical advisory group. But also just talking to key informants in the field about what was and wasn't working in 2019 as we started to implement the program. We got a lot of feedback on potential ways we can improve the program. Here is where we landed. I'm going to go through some of the key policy changes that we are implementing prior to launch.
Here is a refresher, I think this is really important. We have gone through this at fireside chats. This is just an overview of the pre-managed-care launch time frame. Right now fireside chats are happening and we have launched the AHEC webinars for AMHs. Everything I talked through will be in the updated AMH provider manual released in January. Practice support, that one-on-one coaching will start in January. And here are some key managed-care dates. PHP open enrollment begins mid-March. We are encouraging, the date is not on there, but we encourage all providers to be enrolled in networks in mid-February. That is not necessarily an AMH specific timeline but it's important for all providers. What is really key and we talked about this at fireside chat is making sure you're in networks when PHP open enrollment happens. Last week you heard a lot about PHP auto enrollment. We got a lot of questions. Then you heard about PCP assignment. We got a lot of questions on that, too. April 1 cut off date is important. You really want to be in PHP networks by then. Obviously sooner than that of course but that is when PHP auto enrollment happens. I'm not the expert, I'm just walking through the dates. There are experts on PHP enrollment who aren't me. One of the things I really want to point out is when our glide path starts. What is the glide path you ask? Our glide path incentive payments are another support we're going to give to AMHs. They begin April 2021. Open enrollment for health plans ends mid-May and auto enrollment for PHP begins mid-May as well. Of course you know the standard plans launch July 1, 2021. I encourage you to look at the posted webinars from last week that walk through and answer some questions on PHP auto enrollment and PCP assignment.
Let's talk about some of the AMH program changes. Like I said we had a lot of time to think about what was working and that. We had time to get great feedback from our technical advisory group and we were really looking at ways to streamline the program. For a lot of reasons, right? We want the

program to be successful. You all are really important to us. We want you to be successful. And also, we are in the midst of a public health emergency. With that in mind we are trying to figure out ways we can streamline the program. Here are some big conceptual changes we made. We are trying to shift, anywhere where the program is hyper focused on process or collecting data on process, we are trying to shift away from looking at individual processes for an overall penetration rate. I will talk more about that in a minute. We worked with PHP's to simplify reporting, reporting that PHPs have to report to us and therefore that you have to report to them. We looked at ways to streamline reporting. We also wanted to be crystal clear for that reporting, what we considered as counting for care management. I will walk through these all now.

In program streamlining we looked at ways to reduce burden associated with multiple requirements for PHP's while we still maintain oversight. Why does that matter? Why does it matter what we impose on PHP's? Because we totally understand those requirements then flow down to Advanced Medical Homes. Previously our Advanced Medical Home program had penalties for PHP's for failing to complete very specific care management processes-- like doing care plans and comprehensive assessments. Those are still critically important, don't get me wrong, but that's not what we want to focus on. We are no longer going to have penalties associated with making sure that folks are meeting timelines for care plans and assessments. Instead, as I mentioned, we're going to measure overall penetration. Penetration of care management and care management defined in a singular way. So we expect this reduction in oversight for our part, ours to PHP's should flow down to providers.

Super quickly, this is a process flow, for folks who love to look at processes, we wanted to streamline reports. So we actually worked on two very specific templates. One is called the risk list and the other is the care management report. The most important one to you is the risk list. PHPs are required for those of you who are program junkies. They are required to send on patient risk lists to all AMHs. You have to restrainify your patient panels in order to provide management. We have found a uniform way that PHPs can share the risk lists down to practices and that form actually becomes the way that practices can send information back up to the PHPs, who then populate our care management report that comes back to us. We try to sleep streamline an efficient process with minimal reporting requirements. The risk list and care management will both be posted by January. We just reviewed them a few weeks ago with our AMH technical advisory group data subcommittee. We really want the date of folks to be looking at this. They are the ones who will be pulling this information from your care management documentation systems. Again, the goal here was to simplify the number of data elements, to simplify the reporting structure.

We also said, okay, if we are going to be measuring penetration of care management, if we have to send reports on people who are getting care management, what counts as care management? We didn't want different PHPs or different AMHs to define care management differently. We aligned on these specific definitions. In particular what counts in particular in terms of interaction? I won't go through everything in the slide. Essentially we are talking about a patient centered engagement between a care manager or another member of the care team and a member who is getting care management. It could be in person including virtual, we consider that in person, a phone call, active email exchange, phone calls to help coordinate care for the individual. Those things count as care management. Again, you'll see the things that don't count as care management. The whole point of this was to try to streamline and standardize. When we are reporting things on the uniform templates, we are all counting and recording the same thing. That was the boring administrative stuff that is the kind of administrative efficiency that we are trying to bring to the program.

We also looked at new program incentives and supports. One of which is tonight. More support. Really, really again, we mean it, we don't want to be bureaucrats, we don't want to collect lots of data. My folks do a whole lot of reporting, so we wanted to streamline as I mentioned. We really do want the continued high-caliber access to high-quality care that we have excellent care management. We thought about ways we could reduce admin burden but also provide programs and incentives and

support. We will talk about a new payment stream for practices in the run up to the launch, so the three months up to launch, a way we can infuse more cash to AMHs. We have emphasized the importance of data exchange to support tier three so that glide path that we'll talk about ensuring our AMHs are data enabled and ready for launch on day one. We will also talk about what this is, practice coaching support that the department is working with. We standardize the quality measures and have added protections to the care management rates.
The first thing that we are instituting is something called a glide path. It is more complicated -- is not complicated but it starts to get complicated when you talk about it and people ask questions. It's this essentially: if an AMH tier three can prove they are ready to launch, the three months up until go live they will get a care management payment. Not for the provision but the preparation to prepare for care management. That rate will be $8.51. It will be paid to the tier three practice level, just like you get your $2.50/5 we will add $8.51 per member per month for that rate for up to three months. If you meet the following criteria. You are tier three. You have met tier three,. You have contracted with at least two PHPs. We really want you to contract. And you can successfully complete a data exchange with those two PHPs. Those back criteria will be explained in more detail in a future session and we will also post it. We will post the guides on how you go into Tracks, you will do your out of station in Tracks. Just like you did for tier three, you will do that for the glide path payment. So the payment will be at the individual practice site location level. It will be a PMPM per month. You can get a payment in April, May and June. Again that is in response to all the feedback we heard about practices saying this is a lot of effort. It's a lot of investment in the program. So we want to help with financial support for practices prior to launch.
Tonight, AHEC coaching. We have spent, Carol help me, you can help me, I am messing up-- I think we started planning back in 2019.

Carol:
Yeah.

Kelly:
We have been very excited about this for a long time. We are very grateful for partnership with AHEC that we can provide webinars but in practice coaching as well. Some folks are getting coaching and support from CINs and some aren't. We want coaching available to folks who need it to be able to meet the tier three requirements. Carol will talk about coaching requirements later.
This is a new flexibility that we actually went over a few fireside chats ago. Two fireside chats ago. You actually get a Medicaid bulletin coming out on this soon. We talked about it last week as well. Starting at launch we are going to allow PHP additional flexibility on member assignment policies. The goal is better matching between members and the actual primary care office they are actually seeing. I know that can get complicated for people. Sometimes people go to multiple primary care practices. But the whole purpose of this is, first we always require that PCP auto assignment looks at the current assigned physician. And if there is claims history with the current assigned physician, within a defined time period, the member will be assigned to primary care. It's about keeping members aligned to the primary care practice they are seeing. If there is no history of visits with the assigned PCP, PHPs will look toward another primary care office that the individual has the treatment relationship with and then assign. Again, I encourage you to watch last week's fireside chat because we go through this in painstaking detail. But the two principles are, how can we maintain actual treatment relationships and family treatment relationships? Not all PHPs will take up this flexibility. At a minimum, PHPs are required to assign members to currently assigned primary care offices. But they do have the flexibility now to dig deeper into claims. But again, please visit the webinar. Please look for the Medicaid bulletin coming out because we get asked about this assignment flexibility a lot.

We have worked hard to standardize the AMH quality measures. This year we took a hard look actually at PHP measures. We actually streamlined PHP measures. We are still going to measure a lot of things, we have been measuring a lot of things with the impact of the public health emergency on our quality performance. You all have been working incredibly hard on things like Keeping Kids Well campaign and getting them in for immunizations. Again we are super grateful for all that. But we really took the time to try to simplify overall measurement for PHPs and AMHs. We started out in the place where we had a measures set, PHPs could take from and add to the measures set. We ended up with five measure sets. That's not helpful. It's not helpful for administrative burden or from a QI perspective. We need folks focused on a concentrated set of measures. What you will see here is our final measure set and we think these are measures the primary care can impact. Some are quite tricky, we admit. Some of them are tricky in terms of data collection-- things like diabetes control. Blood pressure control. Depression screening and follow-ups. These are tricky things, but stay tuned. We will talk about support in the future about how AHEC can help with data collection or better clinical data collection. The point of this slide is that we are really excited about having a streamlined standardized set of AMH measures. These are the measures that will be tied to incentive programs that you would engage in with the PHP. There it is. A little note on the bottom, because this is really important, PHPs are also required to share a total cost of care measure with the AMH. We are actually working on the methodology, because you are experts. You know it's tricky. There is deftly a requirement. In addition to quality measures you have information on total cost of care.

In the payment world, I want to talk about incentive payments and sorry, this is a heavy slide, but essentially all we are saying is for measurers, you know quality measures happen on calendar year. PHPs will launch mid-calendar year. They will launch in July. Some of them are going to kick off performance right away in that half of 2021 and we are delighted about that. PHPs are required to start, the latest date they can start is for calendar year 2022. Many of them are choosing to start at the tail end of 2023 which is really exciting.

This is a big one on payment. One of the things we tracked closely with PHPs and providers in the field are care management rates. One of the things we published fairly early on in the contracting process was rate methodology for determining care management rates, just to use as a guide or to give as much information as we could to the field about our thinking and what went into the rates we were paying PHPs. And as you will see that in the $8.51 we are paying for the glide path. We saw all kinds of ranges of rates. We have also seen rates tied to performance. That is one of the things we want to not have any more. One of the things we finalized is guaranteed care management fees. PHPs cannot place care management fees at risk based on any measure. Performance, penetration of care management, quality performance, because care management is that prospective payment that allows you to have a population-based model that helps you manage care management and that needs to be a stable, a stable amount each month. I already mentioned that measure set, that is for the payments. It just is. It's not part of one, it is the measure set. Okay? And remember, incentive payments are required for tier three and strongly encouraged for tier 1 and tier 2.

The last thing is oversight and performance standards. The reality is, and we have talked about this before, that PHPs are at risk, they are delegating care management to practices. They are required to have NCQA accreditation by year 3 and there are very heavy requirements. So how do we put some kind of guardrails around that to help new AMH that are just getting off the ground in year 1? The first thing is for tier three, both for contracting and for ongoing oversight for PHPs, no audits or oversight of tier three can be on anything above and beyond tier three requirements. Tier three requirements are rough. I admit they are. Not easy. We can't lay our NCQA accreditation or any other conditions above either for that AMH contracting process or afterwards for the audits.So timeline for corrective actions [Indiscernible] downgrades. Again this is something we workshop in our technical advisory group, obviously being a tier three has massive responsibilities both for the provision of primary care but also care management. Sometimes, AMHs struggle to meet performance standards. We're going to expect PHPs to have an oversight process. We do want them

to have at least 30 days for remediation of no compliance before they pursue a downgrade. We expect this to be a partnership. That is what we have heard from PHPs. This is a partnership. If an AMH is struggling, we want PMH to help. We'll help as much as we can, we'll ask AHEC to help. We want members to be taken care of and have continuity of care. The goal is never: you're not doing well, I'm going to demote you to tier 2 and take away your patients. We don't want that. I don't mean your assigned patients, I really mean the folks you're care managing. At least 30 days for remediation. We expected to be active in partnership and again we have the option of supporting that in any way we want to. And we really want to support the partnership of PHPs and AMHs. Practices may choose to self downgrade. You might decide now you could go on Tracks and say I need some time, I need another year to think through if a tier three is right for me. You can go to Tracks at any time a downgrade to tier 2. We've had a lot of conversations, I think a really important conversation that needs to happen in a thoughtful way as well, especially in the midst of after launch. Again, we don't want tier three to raise her hand and say, I am done, transition all my care management patients tomorrow. We need a thoughtful process around that. Tier three may choose at any time to say this isn't for me and work for PHPs to tradition their patients to someone else who seek care management. We are not going to do the 90 day whole harmless period. We were going to have the first 90 days as a hold harmless for all Advanced Medical Homes. Instead we are doing the 90 day glide path period upfront. Infuse money, we're going to help folks get ready prior to launch rather than have a hold harmless period. It has the potential to harm patients or not have the highest caliber of care. We would rather try to do financing and upfront with coaching and infusion of cash. Rather than a hold harmless period after launch. We do require PHPs to be transparent. After you sign the contract with them, they need to say this is exactly what our oversight and audit process is going to look like. These program updates are final now, we have posted them on the AMH website. We will make sure you know where the website is. It's on the AMH page. Again we really want you contracting with PHPs as soon as possible. We really want you completing that prior to February 1. You want to be included in provider directories so members can choose you during open enrollment. We really want you to be contracted so you can get the glide path in April. And we encourage everyone to participate in the AHEC coaching program. Now I'm going to turn this over to Carol.

Carol Stanley:
Great. Thank you so much, Kelly. That was such good information. First I want to say on behalf of all of AHEC we are really excited to be part of this transformation. And we look forward to working with practices and continuing our work with North Carolina Medicaid. You all have really done some exciting work, especially in the past few months with making some efficiencies and making some changes to make the experience better for the practices. I am here to tell you about the four tenets of AMH education.
I'm going to go through all four of these. The four tenets of AMH education are the AMH webinar series. The 1:1 AMH coaching from AHEC. The CINs and PHPs are your partner in doing the AMH work. And then there is some existing information and resources you have at your fingertips. I'm going to go through each one of these separately.
Obviously you all are aware of the webinar series which you are tapped into at this point in time. You are listening to the first webinar, and we have a series of six going on through the end of May. We have sequenced these webinars in a way that enables your practice to assess what you're currently doing, establish a baseline and really work toward these different kinds of milestones to take you to the highest tier achievable for your practice. One of the things I want to mention about these webinars, they are recorded, the transcript is available to you. We also provide the slide deck, it was posted to our website earlier today. So, if all of you from your practices cannot participate in every webinar, I would recommend you have someone designated within your practice to download those slides and maybe conduct an in-service and share the information with each other as time permits.

Next we have the AHEC one-on-one Advanced Medical Home coaching. This is something I'm a little biased towards obviously. It's very exciting, what we have across the state. We have nine regional AHECs and among all the AHEC we have more than 30 practice support coaches, these coaches are very impressive. And often many of them were practice managers previously. We have a number who are certified content experts for patient centered medical homes. There are a number of standards with the AMH tiers that resemble patient centered medical homes. We also have a number of coaches with experience in coding. They really know how to roll up their sleeves and work elbow to elbow with practices and of course during this pandemic, many of them are doing virtual coaching from the desktop and that has been effective as well. I just want to go through some criteria for being able to have one of our AHEC coaches work with you and partner with you to help advance your practice toward the AMH tier you are reaching towards. For one thing, you must be in at least one Medicaid PHP network. And not currently actively engaged with AMH support from one or more CINs, the clinically integrated networks we are wanting you to partner with. And you also must meet one of the following criteria. Either a tier two AMH or tier three and needing to be an essential practice and when we use the term essential practice, we are talking about the independently owned primary care practices. FQHC, RHC, and local health departments with primary care. There is another group with tier 2 or tier 3 health system or health system owned practices that might be located in medically under resourced communities. Be on the lookout for the AMH coaching from our AHEC coaches, which will be opening up for applications mid-January. If you tap into our webinar on January 14, we will have the instructions during the website on how to request AHEC coaches to help you through the AMH tier standards and getting to the point where you want to be.
The third bucket tenant is to partner with your CINs and Medicaid health plans to maximize available resources. This is very important, if you think about it, your workflow redesigns are going to include your CINs. Also the Medicaid health plans. It's very logical to think about partnering with these entities so you can be well prepared for when Medicaid managed care goes live July 1.
Some of the other existing resources that you have at your fingertips, and we encourage you to check these out. One is the North Carolina Medicaid AMH provider manual. As Kelly mentioned earlier, that is going to be updated and released in January 2021. Most of the information is very valuable and will help guide you through meeting the standards. Also available to you are previously recorded AMH webinars. It is a series that gives you the nuts and bolts of each of the tiers and how to attain the tier level you want to. These were recorded in 2019 and most of the information is still up to date. Also, you have at your fingertips our AMH policy papers, various memos and more. If you see below there is a website link for you to go to and access all three of these things. I want to reiterate something Kelly said and also Krystal. This is hard work. This AMH meeting the standards, it is hard work, but if you think about it and pause for a minute, look at what has been accomplished since March during the pandemic. I think everyone on this webinar has had to do workflow redesign. Meaning you've had to think about PPE for your staff and clinicians, you have had to think about how to conduct telehealth visits that you may not have done before. There are many things, even thinking about redesigning your waiting area in your practice and seeing well visits in the morning and sick visits in the afternoon. You know how to do this work. It's going to be successful, so just think about those skills you have applied in workflow redesigns during the pandemic and apply those same skills to being the best AMH you can. We will get this and we will be successful.
As I mentioned, coming January 14 of 2021, available for download is a newly developed AMH tier support tool. This is something we are very excited about. At AHEC we had a number of our coaches develop an assessment tool that practices can use to pretty much assess your current state when it comes to the AMH standards. It also will help you develop your own work plan and work closely with a AHEC coach if you would like. Also, embedded within the tier support tool, it will indicate which standards you may already be needing just by being a patient centered medical home through NCQA. There are some standards that mirror each other, so you can really see some efficiencies through that. Also, we have, coming January 14, the next webinar. We will have a tutorial from our

coaches on how to use the tier support tool and assess the current state of your practice. This tool was pilot tested by coaches across the state. We were able to work out some of the kinks and do some cycles ourselves with developing the tool. We are pretty excited about that. And then, also practices who meet eligibility requirements starting with January 14 can apply to work with an AHEC coach, and I don't think I have mentioned, the coaching is available at no cost to practices. I think that wraps it up for me. I am going to hand it back over to Krystal.

Krystal:
Thank you, Carol. Sorry for the pause. Okay, I am rounding out the information portion of our presentation. We are really, really excited to take some of your questions. So I will be doing a little repetition, that is my role tonight. Repeat and refresh. But as Kelly shared earlier tonight, Medicaid launches July 1, 2021. In many areas that feels like tomorrow. So, we really want to continue to help set each of you up for success by offering support for your practices.
First, for those who are aligned with CINs, you have support from your CIN. Please note that your CIN, you are in partnership with your CINs. They are positioned to help their assigned AMHs prepare for managed care launch and function optimally. For those not aligned with CINs you are able to utilize the resources such as this webinar series and other items that Carol shared in her part of the presentation. We would like to kind of put in a shameless commercial reminder that you can get started by attending our next webinar in this series. It focuses on the AMH tier support tool. It will help you to fully understand the practice support tool itself, and the one-on-one coaching model. Please join us January 14 from 5:30 to 6:30, and there is a link where you can register on the AHEC website. I am turning it back over for the Q&A portion.

Hugh:
Thank you, Krystal. I am happy to do that. It has been fun watching the Q&A's that have been submitted and answered. You should be able to see a bunch of answers to submitted questions. Just as a reminder, if you have questions use the Q&A feature in the black bar on the bottom of the screen. If you are on the phone you can send us a question, let me repeat that, questionsCOVID19webinar@gmail.com. Let me run through a couple of these. One is a statement but I will read it. **A weekly list report from AMH to PHP doesn't sound "minimal." It sounds like a manual process that will be very time-consuming. Looking at the name on the risk list and marking every contact we have with the patient is burdensome**. I will just relay that and see if you have a response.

Kelly:
I think it illustrates a need for us to probably have a more attentive process. We go through at a high level at the sessions because we don't want to get into the weeds but I think that is a great question. Let me tie it to something else someone asked in the chat. We actually got a question on the data standards for AMH tier three's and I posted those as a response in the chat. There are some pretty heavy duty data standards for AMHs to be able to do standardized EDI transactions, I'm speaking above my technology level, to be able to share massive amounts of claims and beneficiary information with some frequency to adjust and share. Actually posted that in the chat for all those requirements for tier three. One of the things we are doing in particular with that risk list and one of the things we actually worked on with the technical advisory subcommittee last year was more standardization. So our claim and member files are standardized, but PHPs are required to share a lot of information with AMHs. Things like patient risk lists, screening information, and so what we did was survey our technical advisory group around what they want to further standardize because they have been ingesting five different types of risk list from five different PHPs. So standardization of the risk lists was one of the asks. We do expect AMHs and technology partners to be able to inject these not manually, to be able ingest them and process them, and I think there is a policy thing here I

want to highlight. The risk lists are for information and for help for the AMHs. AMHs are also required to do their own restratification. That is not me saying ignore the PHPs risk list, it's helpful information to help you to be able to stratify the patients who need care management. I am merely saying there is not an expectation that that is the only list you are using, that you're hitting everyone on the list. It is a bit of information to plug into your stratification process. But I do think, one of the things we are doing now, sorry this is a long answer, we are querying our CINs because for most but not all AMHs, the scenario where they're using CINs to ingest and produce these reports back out. So, we are getting feedback right now. Take a look at the risk list and elements. How hard is that going to be for you to ingest and how hard is it going to be to calculate? Is it going to be easy to query the care management systems and populate and send it back to PHPs every week or is it going to be hard? We are trying to dig into that to know that. The goal is that AMHs will have the technology ability to ingest and query their systems to populate, so it doesn't have to be a manual process but I totally appreciate your comment. We are doing due diligence to understand how efficiently the systems that AMHs might use, how officially they could ingest this. I think it is a path forward without everyone having to ingest five different risk lists, to spit back out five different care management reports to PHPs. But the goal is to continue to work to streamline and that is why the data tag is really important in guiding us on better data ingestion and reporting. I welcome that feedback and I appreciate it. There was a really important question, can I snag it?
It was something I had anxiety about and I knew someone would flag it. In the timeline there is an important distinction, please look at the webinars and please look at the fireside chats that have been done, and the information coming out for Medicaid. Because those dates around contracting are really important, the deadline for getting into the provider directory is actually in February. Members open enrollment, when members go in and look at the provider directory to choose which PCP they want or which plan they want, that is in February. After open enrollment closes, Medicaid will auto enroll members to plans. Part of the auto enrollment is looking at who their PCP is. So will try to find a plan that has their PCP. So that deadline to get into that is April. You want to be in that book in April so when people get auto sent a plan it will be based on the fact that you are their primary care physician. Someone asked for clarification. The dates are February and April. Forgive us for messing that up to begin with.

Hugh:
Kelly, any other questions you saw you want to respond to? We have a couple more that have come in. You know what you want to communicate.

Kelly:
I think we got a lot of questions about the glide path. A lot of folks are wondering can we further clarify what it means for the testing? What does it mean to do technology testing? And we will. Absolutely. In one of these sessions we will clarify that, as well as published guidance. That is something we will clarify. We just wanted to alert you that the glide path is coming. **The other thing is we are getting questions about the attestations for glide paths. Can CINs attest?** And the answer is probably not. The attestation will be much like attestation for tier three. You will go into Tracks, and Yupp. I get a glide path payment. It is a system of record which triggers things like payment. The system of record needs to know you did meet the glide path requirements and you can get paid.

Carol:
I just wanted to mention several people have asked about the NCQA accreditation requirement. That applies to the PHPs, not to the AMHs.

Kelly:

There is no requirement currently, no plans to have a requirement for AMHs to have PCNH accreditation. Health plans have to have health plan accreditation by year three. But there is no North Carolina requirement for AMHs to have accreditation of any kind.

Hugh:
We have a question, **if we have already contracted with a PHP in 2019 do we need a new contract with the new standards and changes?**

Kelly:
PHPs, they are working now on rolling those changes out. They are updating the contracts and already current contracts that are signed in the field. That's going to take a while. But they are working on it. I will do an edge case. Sometimes we get an edge case. Someone may say, I've signed a contract where my care management fee is at risk, is it okay if I want to keep it? Yes, totally yes. I'm saying that is not the model and that is our protection that is not at risk, but if that is something you are choosing because you really want, for whatever, a variety of reasons that's okay. That's just an edge case example I wanted to give. Yes, the PHPs will be updating their contract, it will take time. We have to approve their new contracts, they have to get them in the field. They are scrambling to contract with so many providers. Itt will come. That's why we put the policy updates out, here they are. PHPs will be working on contract updates with you. I think one other thing that came up in the questions is, I'm going to try to say this clearly, the new program requirements are not changes to the tier three requirements. In terms of, when you attested to be a tier three, you attested to a set of services and functions and staffing and technology requirements. Those have not changed. Someone asked about that. I just wanted to try to be clear about that. We are not asking you to go in and reattest as tier three. The tool on the coaching is the same as in 2019. What we have tried to streamline is basically things that are essentially contract terms, performance measures, rates, those are not what it means to be tier three. What it means to be a tier three has not changed.

Hugh:
Follow-up question, **can the new 2021 care management fees be negotiated to a new rate due to the low rates in the last contract?**

Kelly:
Of course. I am not an attorney, I cannot advise you on contractual matters. But by all means.

Hugh:
Do the payments go directly to the AMH tier 2 practice if working with a CIN or to the CIN?

Kelly:
The care management payments or glide path?

Hugh:
It just says due payments.

Kelly:
Let me clarify the best they can. The glide path payments go directly to the practice. The tier three practice, just like the practice gets the$2.50/5, just like the $8.51. Prior to launch will come directly from PHP to the AMH. That is how the payment will go prior to launch. After launch, it's up to however you have determined the contract. You will get your medical home free from the PHP, your $2.50 and five dollars remain the same. Folks have entered into different arrangements for where the care management fee goes. Does it go to the practice who pays the CIN or does a go to the CIN on

your behalf? Same thing for incentive payments. Do they go to you or your CIN who distributes them to practices? Those are your contracting decisions.

Hugh:
We are out of time. Let me thank you and your team for this great information. And thank everybody for joining us tonight. I will turn it back over to you Kelly for any final words you want to provide.

Kelly:
Seriously, I cannot thank you enough for so many people for coming when you are all very busy. For sitting through some of the same information. For asking really excellent questions. I think your questions help us make the program better. Your feedback helps us make the program better. Your questions help us make the program better. Please use the excellent AHEC coaches. I guarantee they will help you. Thank you for joining us.
[Event Concluded]