Transcript for Advanced Medical Home Webinar Series | AMH Refresher
May 13, 2021
5:30-6:30 pm

Presenters

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Hugh Tilson
My watch says 530 so let's go ahead and get started. Good evening everyone and thank you for participating in this evenings webinar for Medicaid providers. This webinar is part of the advanced medical home AMH series of informational sessions, put on by North Carolina Medicaid and North Carolina AHEC support providers during the transition to Medicaid managed care. This is the last AMH webinar we're going to do before launch, as reminder. We'll also put on the back porch chat webinars on the first and third Thursdays of the month to discuss hot topics in Medicaid managed care. Tonight, we're discussing prepping for managed care launch. I'm Hugh Tilson I'll be your moderator tonight. I'll turn it over to Kelly Crosbie, in just a couple seconds but first let me run through some logistics, if you need technical assistance, you can email us at technicalassistancecovid19@gmail.com. You can adjust the proportion of the speaker slides by dragging the double gray lines between the slides and the speakers. You can also adjust your video settings to hide people who aren't speaking. To do so click on the up arrow for the pulldown menu to the right of the stop video button on the black bar on the bottom of the screen, select Video Settings scroll down toward the bottom of the page. Then click the hide non video participants box. We'll put these instructions in the q&a For your convenience, we'll take questions after you've heard from our presenters. Everybody, other than our presenters is muted and the chat function is turned off, there are two ways you can submit questions or make comments. One is using the q&a feature on the black bar on the bottom of the webinar screen, or if you're dialing in. Send an email to questionscovid19webinar@gmail.com, we've learned in the past that your presenters will often address questions during a presentation, encourage you to wait to present as you're through their presentations before submitting a question. We'll send all of our questions to Medicaid so that they can incorporate them at FAQs or respond directly as is most appropriate. One of the quick technical thing and that is that we've experienced some technical difficulties, and a couple of zoom webinars lately. We're coordinating with Zoom to understand what happened and how to be sure it's addressed. We hope that we've addressed them we hope that everything's going to be okay. But in the meantime, if you have any problems hearing any of the speakers, please dial into the webinar using one of the two numbers that are on this slide, and we'll post these in the q&a For your convenience as well. Our slides are available on the AHEC website, there's a link to them also in the q&a, we'll record this webinar and we'll add the

recording to and a written transcript of it with the slides on the AHEC website as soon as possible probably tomorrow morning. So now, Kelly, I'll turn it over to you.

Kelly Crosbie
Awesome, thank you so much, hi everyone thank you so much for coming tonight, as you said, this is our final Advanced Medical Home webinar prior to managed care launch on July 1. My name is Kelly Crosby and I'm the Director of Quality and population health in North Carolina Medicaid. Tonight, I'll be speaking, as well as Taylor Zublena and Garrick Prokos will be the main speakers for tonight, but as always we'll be joined by Brenda and Gwen who will be helping facilitate questions, and you never know when Dr. Shannon Dowler our CMO may come by as well.

Next slide please. We have a bit of a hodgepodge agenda tonight because we really wanted to spend some time focusing on some key things that you know we wanted to reinforce prior to launch. But we also wanted to spend some time talking about quality as it relates to advanced medical homes, we've talked about quality and other settings so far, particularly the fireside chats, but we wanted to spend some specific time today talking about quality and the quality measures for advanced medical homes. So we're going to cover the managed care timeline and auto assignment. We've had some frequently asked questions in this space, we want to hit some high notes there. We're going to talk about data tonight, this is probably the most important slide,Garrick is going to talk about the most important slide he's gonna remind you, if you're an advanced medical home, when you start to get data. June is a huge data month for you. You may not feel it if you're a provider but you're clinically integrated network will feel it. There'll be ingesting massive amounts of data on your behalf, but you as a provider may be ingesting it yourself. If you're not using a clinically integrated network, there's some really big dates in June. So we wanted to go through that timeline of dates again so it's fresh in your mind and when you'll be getting all the different data you need to begin providing care management on July 1. Taylor's going to spend the bulk of the time of today's agenda, talking about the quality measures and then I'll give a quick update on the incentive programs posts are in the glide path payments in particular, and we will try our very best to leave as much time as we can for questions. All right, next slide please.

So let's talk about the managed care timeline again. Next slide. You guys should have seen this slide so many times and it's evolved now it's prettier and brighter and I like it a lot, but we are actually sort of on the latter half right now if you look at the teal area, auto enrollment is this weekend. That is plan auto enrollment members who have not selected a plan will be auto enrolled into health plans this weekend so it's a huge date for us. And tonight, what we're going to talk about a little bit, is that what happens afterwards. Right, so folks get enrolled in plans, and then plan start auto assigning them to advanced medical homes in primary care practices. So that's why we wanted to really highlight the data that you'll be getting in June once folks are assigned to you, but also what members might experiences they get assigned to practices and they want to make choice. Let's look at the next slide. We're getting a lot of questions about what happens in this really key period of auto enrollment to a plan and auto assignment to an advanced medical home or primary care practice. There are two links on here hopefully you've

seen them as part of our provider, fact sheets that we published at Medicaid, we published these a little while back. There's a two parter fact sheet. The first part is health plan auto enrollment information that's on hotlink, so when you go to the website that will take you right to that fact sheet, and the second part two is specific to AMH PCP auto assignment. So it tells you everything from what the auto assignment algorithm is how you can find out who's assigned to you and how you can help people change. So when we think about EMHs we thought about two kind of critical buckets of information that our advanced medical homes need to know. The first is the orange box, that's the most important thing to us, individual people, individual people may come through your practice, and they may need to be reassigned to you, maybe, hopefully, if auto enrollment works well if auto assignment works well everybody who's assigned to you will remain assigned to you and everything will be just fine. That's that's our goal, right, but there will be lots of instances where people realize they wanted to pick you and they're not assigned to you, or there might be individual errors. So when members come to you, we want you to remember that members have 30 days in which to request a change in assignment, they can go directly you can help them, or they can go directly to the health plan to ask to be assigned to you, and it's pretty quick. We're publishing some new guidance in a couple of days just a little bit more on this particular item. And remember, members can change without cause one other time in the year so they can change choice for you without cause. But they can also change any number of times, with cause if they make core cause reason they want to go to another primary care practice. So that's kind of the first bucket of things we're really concerned about that you know how to help members get reassigned to you. It shouldn't be hard, you should be able to call the health plan on their behalf, help them fill out a form, it does go to the health plan doesn't go to the DSS and the health plan can help reassign them to you. The second big bucket of things that we want to talk about is the green box. So Garricks going to talk about the data in just a minute. And this is kind of the mass, the mass practice list you're gonna get either as an advanced medical home or is the CIN. So some of our CIN are quite large. So CIN will be ingesting data in practice lists that could be 30,000 60,000 70,000 members, so your CIN is going to be looking at this list, they're going to be seeing if they have errors or concerns and they'll be working with the health plan so there might be some noise in that space so we expect some of that kind of mass. Mass. Clarifying of panels to go on. We hope it's not a lot, right, but we imagined that's kind of the other space that we're looking out for. And the one thing I would say is just have, have patience. Every everything's going to be okay. We really want to make sure members get to the right place. There's a lot of protections in place during the crossover period. Members can always see any in network PCP and get paid, it's not an issue reassignments can be nice. It doesn't have to be a big issue. But these are kind of the two big places we wanted to just pay attention to. There's a blue box on there to just let me talk about the blue boxes for a minute. You know, a member can, you can help the member to call their health plan, or fill out a form, and get a change of auto assignment for their health plan, but also remember that members can also call the enrollment broker, but they should call the enrollment broker if they're also changing their health plan, so they may have been assigned to a health plan that you're not participating with. They can call the enrollment broker, pick a health plan you're participating with and pick you as their PCP. So remember, help them call the enrollment broker if they want to change their plan, and also their PCP, but if they're in the right plan and they just need to get reassigned to you, please

contact the plan. All right, next slide. So, this is the really really important slide, which is when you're going to get really important data prior to lunch, and I'm going to turn it over to Garrick.

Garrick Prokos
Thanks Kelly. Good evening everyone, so as Kelly mentioned what we're going to review on this slide are the key data elements that you're going to be receiving from the health plan sending to the AMH tier threes are the CINS and as Kelly mentioned, the beneficiaries who did not select health plans during open enrollment are going to be auto enrolled into a health plan this weekend and as a part of that process if they didn't select a PCP during open enrollment, they will be auto assigned a PCP by the health plan, and then what you'll see here on the top line is on June 4 the PHPs will send AMH tier threes, or the CINS beneficiary assignment files for your assignment so it will contain all of the beneficiaries who either selected you as a PCP during open enrollment, or they were auto assigned to you by the health plan, and that will include a different eligibility data, and that information is available on the DHB website in terms of the different data elements but that will start moving on June 4 to inform you all of who all has been assigned to your AMH, tier three. The next thing that comes, are the claims history files. So these are professional claims and encounters institutional claims and encounters dental claims and pharmacy claims and encounters and these are the 24 months history claims files, and those will start coming one week after you receive your beneficiary assignment files, so that will have all those in all the information the claims information for beneficiaries you received on that beneficiary assignment file. In addition, one week later as the PHP start stratifying beneficiaries and identifying beneficiaries for care management, you will start receiving the patient risk list. On June, 18, so that will start coming down to you. And then, one week after that on July, or two weeks after that rather on July 2 you will start receiving the pharmacy lock in information for beneficiaries who have been assigned to you. And so that is whether the beneficiary has been locked into a pharmacy or prescriber that type of information. And then finally, on July 9 we're kind of reversing direction here where the Amh tier threes or CINs, you all will start sending information back to the health plans on the patient risk list. And as you'll see here in the frequency I did want to highlight for the patient risk list. Going back to the health plans for the first eight weeks of launch the AMH tier threes who have been delegated to follow up with transitioning members to manage care should be sending the risk list to the health plans on a weekly incremental basis, and then outside of that eight week window, you will you will start sending that on a monthly basis, so this gives you a very high level of all the data that you or your CIN will start receiving up until and then right after launch for beneficiaries that have either selected you or been auto assigned to you by the health plan. And if Kelly if you have nothing else to add, I think we're moving on to the quality measures.

Kelly Crosbie
We can definitely go into the quality measures we've got some great q&a coming in, and hopefully we'll live some of those up for the group. At the end, but we will turn it over to Taylor to talk about the advanced medical home quality measures.

Taylor Zublena

Thank you everyone. So in this slide, and to continue on with the availability of data, all of the continuing flights that I'll speak about tonight are available through three, these three different sources as well as our link at the bottom of the page and the link is for the quality management and improvement with web pages product transformation, the Medicaid quality strategy is the overarching document that outlines the goals and aims and objectives and interventions that we've established to assure and monitor innovation improved quality through managed care. The Annual Quality Report was just posted as well in April, and it provides a historical evaluation and comprehensive on the supportive navigation for improving the health and outcomes for the beneficiaries. It was three to four years through 2019 and it provides a great historical perspective and really the basis for deriving the Advanced Medical Home measures, the standard plan measures in the future tailored plan measures as well. And keeping in mind provider burden and national alignment so that's a great source to see really the level set of where we are in North Carolina, Medicaid, where we need to improve aware of bright spots, and I'll continue on with some of those when we talk about the historical measures. And lastly on this slide, the quality measure technical specifications. That's down to the meticulous level of numerators and denominators, who's included in the measure. And again, all of the measures in the majority in the Technical Specifications document are naturally nationally aligned and where they're customized their significant detail as to how we derive those measures. So I wanted to point back to both of those three sort all of those sources as we go through the following slides because there's a lot of dense information that we'll review tonight, and then as a reminder, since this is refresher conversation, February 14 Fireside Chat goes over the same information. So if you'd like to hear it verbally after tonight there's tonight's transcript as well as February 14 and these written documents to reference as well. Next slide please.

And so what we have on this slide is the advanced medical home measures that it is a consolidated set and it really points towards a subset of standard plan measures, which are targeted for what's most applicable and actionable and primary care as well as the mindfulness and measure and provider burden and alignment as I was mentioning with state and national standards of care. So you'll see a focus on the domains of prevention and early intervention through well child checks and immunizations which are pretty standard appropriate screening such as cervical cancer and chlamydia screening women, and chronic condition management and prevention of advanced disease through appropriate management with prevalence and significance of chronic conditions such as higher prevalent conditions in North Carolina, such as hypertension and diabetes, as well as utilization measures, and I'll go over the historical reference for these slides or for these measures in subsequent slides. So there are 11 measures in this total set, and we'll continue on the historical reference on the next slide please. Next slide please. Sorry, placeholder. And so for the Annual Quality Report just to give a background of the historical perspective on these measures, It's a comprehensive report as I was saying, and accountability and level setting for quality measures that are really driven towards the quality strategy aims and goals, better care delivery, healthier people and communities and smarter spending, and the measures that are within the Annual Quality Report and really are driven through the quality strategy are organized by the aims and goals, and were developed through extensive networking and taskforce with the Institute of Medicine Institute of Medicine

and consulted through the Medicaid NCAC Quality Committee, internal consulting as well through the Medicaid quality and Health Outcomes Committee, and certain certainly alignment with the CMS adult child, and Behavioral Health Core sets as well as the maternal health course that. So the measures for the Annual Quality Report are from years 2015 to 2019. We haven't yet received for 2020 to be able to evaluate that, but that will be in the upcoming annual policy report which should be out within the next year as well. We're going to continue that. And so just as a reminder, the measures that are within the Annual Quality report that's posted our claims and survey based and there's a lot of emphasis in moving towards hybrid and clinical methodology as measures continue to advance and evolve, but largely what you'll see through the advanced quality, or excuse me the Quality Report, our claims and survey based. Next slide please.

So, to go into the measures themselves where you see the highlights are the Advanced Medical Home measures, and a few things of note on this slide, some of the measures have changed by the National measure steward NCQA, so where you see well child visits in the first 15 months of life. And third, fourth, fifth and sixth years of life. Those measures have changed and evolved into what you saw a few slides prior being W30 which is well child visits within 30 minutes of life. And then there was a shift to include ages three to 21 years old to be more inclusive of children ages seven to 11, as well as adolescents so you'll see some measure changes there, but historically speaking, these are the measures, adolescent and well child visits that we have historical performance on. And so for other measures on this slide you'll see the performance largely for preventative care immunizations and well child checks have been in line with national medians. And just to clarify, when I say national medians, it's with like Medicaid product lines. In other states, not with commercial product lines. And so you see the you'll see through the in your party report as well where there's the star reference we indicate whether it's within a standard deviation of the national median there's a two line effort there, where we need to have some improvement where you see adolescent well child visits, it's below the national median so certainly underscores significant improvement that's needed there other measures that you see on the slide where there isn't a star reference or a comparison, that's due to either data completeness or the age range and availability of that data. So you'll see a diamond or notification there and we get the actual rate, but you'll see largely for preventive care and immunizations were in line with national medians, where we need to improve would be follow up after hospitalization for mental illness and I will say if you're able to reference the Quality Report, seven days a little bit harder to really get this performance rates but by 30 day we are much closer to the national median for those measures. So next slide please.

Adult measure then again the highlight for these are for the advanced medical home measures, cervical cancer screenings prevention, chronic disease management, let's see, down through on the right side of your slide where we're mostly aligned with national medians, cervical cancer screening we are below the national median but there have been your year over year improvement so there's much, much more to improve. There, you'll see in the bottom and I didn't reference it in the prior slide so forgive me for the admission screening for depression and follow up. That's a little bit more of a difficult measure, nationally, where we're trying to drive this route through managed care and improvement is utilizing screening in, in primary

care, at the point of care and then what is the referral pattern and follow up. So it is the CMS, adult and child in behavioral health core measure. That should be proved, improving year over year but wanted to point that out, that we don't have a comparison data because there was a struggle nationally to really get it deriving the data completeness, but significant efforts through health information exchange agencies, as well as working through the PHPs and in advanced medical homes, to look at appropriate screenings, how to appropriately capture that and improve follow up plans. Next slide please. And lastly, maternal health measures. Not as much in the primary care space but looking at maternal health significantly access to prenatal care, timeliness of care and postpartum. If you'll see the star for timeliness of prenatal care. Due to the ability to measure that we appear to be below the national median but once include a few more pregnancy related codes. We were actually able to find that we are closer to the national median and the methodology behind that closer find is within the annual quality report as well. So it's is quite interesting to see, due to the measure limitations we look to be a bit lower, there's certainly some improvement to be made and where we want to stress improvement of that through managed care and beyond. But if you look for the Annual Quality Report there's much more in the maternal health space to show where we have significant improvements. Next slide please.

And so I won't read this last slide, line for line but to have some key takeaways from the historical performance reports, extensive review comprehensive through the Annual Quality Report and really used as the basis with all of our internal and external review and looking at national standards, and certainly keeping in mind, point of care through primary care as well, where we have our bright spots where we excel in North Carolina, historically, where we need to drill down further, a little bit more of a root cause analysis to see how we are away from national medians, what that means what interventions we need to tie to that to support improvement of that in population health and quality, and looking at the implications for providers and patients on the bottom of your screen, you'll see. We're using all of that in mind, to develop targets that we'll go over in the subsequent slides to see where we can drill down to those root causes and provide more equitable care, what are the problem areas and how do we support improvement of those. Next slide please. And so this really to look to see when the measures start and capture of it so for the predominant volume of measures they follow a calendar year of measurement which overlays the contract here so it's slightly off so using this slide as kind of a pictorial reference to show a standard plan launch the first star that you see on the left side of your screen, coming up very quickly on July 1 And how we're using that sort of half measurement year, and back claims and data that you'll be receiving to see what's the care to date, where it was our runway to continue with quality from that point on, and then looking at calendar year 2022 is really where the clock starts so to speak, where there's data completeness, the prepaid health plans have access to a full realm of data and the ability to capture those measures according, according to the measure standards. Measure stewards, and taking that into year three, so the first two years of data quality capture and measurement as really QA structural, we're looking to see to make sure we have quality improvement where we can, and we'll go into those incremental targets in the next slide, but then really having a firm hold. By the start of plan year three, and where with holes can apply scheme where we

have more completeness of data to have a good picture of where we need to drive improvements in the future. Next slide please.

And so, as I was alluding to in the prior slide of data, developing targets. This is just to give a general overview of how we're wanting to drive improvements for quality and quality measured targets. So to explain here for the first few years of managed care. The department benchmark will be at 5% relative improvement over the prior year performance so in the example on this slide given if plan A has 1000 women who qualify for chlamydia screening, in 2019, 500 got a screening so that's 50% performance for the next measurement year, we would want the health plan to screen and additional 25 women to achieve that 5% increase over baseline. And so if we go to the next slide please. There's a visual representation to really show this improvement. So rather than aiming for national median for some of these measures, out of the gate, we're wanting a 5% increase to allow actionable achievable, but continued stress improvement over the next few years, so if you're looking from 2019 to 2022, you'll see the blue icon represents 10 women that received their screening and increase, and so their health plan performance in this example goes from 50% 500 out of 1000 in 2019, to 59%, which is 590 out of 1000 in 2022. So showing that to show the visual representation of incremental improvement over the next few years. Next slide please.

And so also as important as we're trying to have overall incremental improvement is the stress and importance and significance of health equity. And so, the definition for disparity and how we're using this measurement is to identify quality measures with significant disparities and as we're defining it as greater than a 10% relative gap in performance between a subgroup and a reference group. And this is extracted from the health care quality and disparities report by AHRQ. So an example for this evening if Health Plan B provides flu vaccines to 65% of all eligible patients, but then broken down by race, 70% of their white patients received the flu vaccine, while only 60% of their black patients received the flu vaccine. This is identified and notice noticed as a discrepancy and the disparity that we, that would be a focused improvement area for the health plan. So, if we can go to the next slide, please. And so I think I've already covered that in the prior slide but just to reiterate disparity targets with the 10% will need to be reduced by 10% year over year so rather than having just a one off year, we want to see a 10% reduction to then eliminate that disparity, so that if the flu vaccine for Plan B 65% of patients 70% of white patients receive it. 60% received the flu vaccine we want to see that reduced year over year so that it improves health equity. And the example you're given was for race, but other areas of health equity and stratification that we are looking at to identify disparities and equitable outcomes and improvements are, race, ethnicity, age, language disability status and geography as well. So really looking at the subgroups to full groups to see identify and to identify disparities across the state. Next slide please. And so this is just a visual representation to really capture that to show incremental disparity targets, and where we want to see the reduction year over year, so that by that disparity is no longer identified as a disparity. And next slide please. So for the third managed care year and beyond. The department will adjust the benchmarking methodology as needed based on information gathered in these first two years ago we're really looking closely to analyze the data and see where improvements are needed and disparities identified, and I will hand it back over to Kelly.

Kelly Crosbie

All right, thank you so much Taylor, I'm sorry, I was working on question responses so the last thing we wanted to go over before we highlight some, some questions, we've answered a lot in the chat, but I think it would be good to live, some of them actually, even though we've answered them in writing to live, some of them up because there's some recurring themes. And before we get to that I just want to talk really quickly just to give an update on some of our incentive programs. So if you go, go to the next slide please. The first is just an update on our healthy opportunities screening assessment and referral payment. As of May 13 we've had a little over 4000 claims. We still have a decent proportion of denied claims but our paid claims is growing. And you all know that we had a system issue that has been fixed. Some of it was on our side, but the one thing that I will say if you're an FQHC please build a separate claim or for for the G code, the G 9919 code, separate from your, your T code, or the claim will deny, if both are on one claim. The other issues were our issue internally about the way that the billing was set up so we're asking providers to please rebuild. And the vast majority of the rebuild claims you're going through just fine, no problem. So a lot of the old denials are just the legacy denials for when in claims refers deny. We've had a lot of questions around. Will this code continue with the health plans after July 1 we have been talking with the health plans, and I'm going to show you on the next slide we've been analyzing the data. I'm not sure. I don't know I don't have a crystal ball about how this will look after July 1 there's definite interest. What I can say is there's absolutely definite interest from all of us and making sure that we are screening more folks for them at research needs absolutely, that we are following up or closing the loop on those making good referrals and making sure people get the resources that they need. And it's, we've had a lot of feedback about paying for screenings that are positive right so just the act of screening is really important. So there's just a lot of interest in making sure that we're screening, getting people the resources that they need. And I think the question is just, is that a billing code, is it making is it somehow enhancing. This is a population health approach for advanced medical homes, it's part of screening as part of that reimbursement. So I, we are definitely analyzing the data that we're seeing, getting lots of feedback please continue to give us feedback about the right way for us to keep to keep this going. Certainly as part of your population health workers and advanced medical home, but go to the next slide just to share a little bit of data with you again we have a very small amount of claims, but this is where we're seeing the vast majority of the claims and those highlighted counties, the orange part of the the claims that are that are paying and the blue are the ones that are denying don't focus on that as much as focus on the circle that's that's where the counties are where we're getting claims, and the circle is how many claims we're getting so we're seeing preponderance of billing from specific counties. And thank you to everybody who is sending in the zip code, the zip codes are incredibly important. So we know from this that we're seeing causative screens, we know the areas where people are screening, but we have zero sense out is how many negative screens, we know we know that we know that's a deficit. But we do know that on the screens that we are seeing, we know they're positive and the biggest areas we're seeing positive screenings are in food and our housing and utilities measure so.

Kelly Crosbie

This is such a powerful data, we're grateful to you all for using the code and for building with this he codes, and we'll continue the analysis as claimed turnout on this through July, and we will be exploring the right way to continue to incentivize you all to to screen and close the close the loop and get people the resources that they need. Next slide please.

Ya'll should be very familiar with this slide. We're sending so many settings it's the glide path payments and on the next slide I'm going to share some exciting data that you may have seen in a back porch chat or a fireside chat but this is the attestation portal, You've all seen it, you need to attest if you haven't, you haven't already, if you already have, this is not for you, so this might just be for five people on the call. If you haven't tested for a glide path payment, please do so if you meet the requirements you need to test for each specific Amh site. So you have to pick the NPI close location code of your site, you need to attest for glide path payments you need to attest for the two health plans that you finished contracting with in the two health plans you've finished all the data integration testing with, please pick the same two health plans for both choices. If not, the system will send us an error once in human error, but it'll send us in. So please try to match or don't try but match the health plan you test with with the health plan you contract with, and that way the payment will go through without a hitch. But go to the next slide please. Here's here's how it's looking though, right, this is very exciting. Um, we have the most. We've certainly had the biggest month of adaptations in. In March, for the April, April, May, June, massive amounts so thereafter, smaller amounts of providers less than 100 new attested in April, and in May so far, vast majority of providers who had tested were approved we were able to validate we told you that we validate with the health plans that you really did finish your contracting and testing. We also have instituted a reconsideration process, so far all 100% of providers who ask for reconsideration were approved. Most of the reconsiderations are due to just errors, and people errors, or we do have the COVID hardship, so we do have some some practices who obviously have been responding to the public health emergency or were serving as a, as a source for testing or vaccinations and so they were unable to get to their attestation in on time to meet the deadline so, but all reconsiderations were approved. We are now at. I'm sure we've exceeded 78% of our AMH tier three providers have attested in been paid for the glide path payments. The deadline for the final payment that the June payment deadline is tomorrow. If you've attested already this does not apply to you but if you've not yet and tested. Tomorrow is the deadline for the final payment for June. And then we allow another week for reconsiderations so if somehow you missed the May the April, or the March deadline, any of the deadlines, and you want to use the reconsideration process please look at the bullet in the bullet and tells you what can qualify you for reconsideration and how you just need to give us some document and proof that you do indeed have to contracts, and you have finished testing providers have had no trouble getting that kind of documentation, either from their CIO, or from their health plan, and again we appreciate all the work of the providers their CINs and the health plans and been great partners in helping us get documentation and validate all the attestation so it's been a tremendous amount of work from everyone and we're very grateful, but we're also credibly excited that we're able to provide incentive payments to so many of our tier threes. So you'll just see a hot link there for the bullets. And then the next slide I think are just resource lights, and then we can do questions so I'll show you the resources. One more time, we always show these, please go to the events

medical home webpage, there's just tons of resources up there if you go to the next slide. These are hot links for all three glide path bulletins, we try to publish a new one every month just to remind folks about the process the deadlines and the reconsideration process. And then we like to put the link at the bottom for all the training resources, we have around the AMH each model. And I think that's the last.

Yes. Y'all have been entering questions in the chat function here, you can always send questions to Vorinda thank you, and we try to follow up with FAQs, if we don't get to any questions live. I think I'm going to turn it over to you for questions but I just, I think there's just a few I want to lift up that we were answering live. We got, got a lot of questions just around how to fix auto enrollment and auto assignment issues, again I encourage folks to please look at those two hot links in the earlier slide that talk all about auto enrollment and auto assignment, and how to help members who, who want to change their plan how they can go back to the enrollment broker to change their plan. If they want to change their PCP or they can go back to the enrollment broker, they want to change their plan and their PCP or they can go right to the health plan if they just want to change their PCP assignment. All of those are detailed in the auto enrollment and the auto assignment bulletins that we share their their fact sheets so I think they're fairly readable, I think. So we have a lot of those questions. There was, and feel free rest of the folks to turn your turn your Taylor come back and Garrick come Vorinda and Gwen in when I feel like we got. Trying to remember should have written it down. Oh, this was another big one. I meant to put on this site and forgive me I did it, but remember if you're, if you're a tier three, you're getting boatloads of data from your health plan never went through that just boatloads of data, right, if you're in tier two or tier one, you're still going to get an out tribution list from your health plan. All right, you're not going to get a big ole file, like the tier three does that you'll get a patient list it is probably in your health plans patient portal, patients told you how to pick it up if they didn't, please find out how to pick it up, but also the nctracks portal will continue to produce your patient panel list, it will have your panel for Medicaid direct and your panel for each health plan so will be one consolidated place. Again, if you're tier three and you're getting boatloads of data, your care management system should be showing if your patient panels are they, they should just be doing all that work for you, but for tiers one and two. Again, your health plans will give you a list and their patient portals. And also, you can go to the nctracks if you're the office administrator, go to the nctracks site after every every second check right you get a new patient panel. And so around mid June, you'll get your patient panel that shows you who your Medicaid direct patients are and all of your patients assigned across each health plan, and they're always we get lots of feedback on the patient panelists, we're grateful for it. You should see very soon, at what already came out. Excuse me. We put out a fact sheet on how to use the patient panel list, or it's coming out next week, I can't remember. Forgive me for that, but we have a lot of questions so we tried to put together a nice fact sheet, we did, and the great provider team did that too so just questions on how to read that patient playlist. So I think those are the two areas the one hit, but there are a lot of questions on here, but team I don't know before you just go through them, were there any that you wanted to raise up Garrick and Taylor in particular in your set that you thought oh that's a good question you'd like to raise it up yourself.

Hugh Tilson
Well then why don't I just start at the top and we can go from there. Well the assignment files contain the PHO and subscriber ID.

Kelly Crosbie
I Garrick you if you don't know Garrick I don't know, so we might have to take that load back.

Hugh Tilson
All right, we're working through an issue with one of the PHPs for some reason they think we are not taking new patients we have taken all the steps they instructed, but so far no resolution. When they auto enroll patients, to the plan, but they show us blocked. We also have reached out to our CINS well the, as well as the ombudsman.

Kelly Crosbie
I'm going to put, I just put my email in response to that, we will log you in our help desk ticket for follow up I assume other people are following up on this to be perfectly honest with you if it was logged at the ombudsman someone's following it up, but I'm happy to add, add your question to the queue too for our observer. So I just put my email there.

Hugh Tilson
What is the requirement of AMH three and quality reporting back to PHPs, will it be supplemental files, full, ECQM other.

Taylor Zublena
The metric, it's measures specific so most of them will be utilized through claims administrative data, if there are clinical measures, that's where we encouraged the connection use of HIE but the plan should be able to extract the data needed according to the measure stewards if there shouldn't be in a cent. We're trying to really limit the data that has to be manually pulled from the advanced medical homes and trying to automate that and do that, according to the measure steward. Hopefully that answered your question.

Kelly Crosbie
We are also, its in early stages, we, what we, what we don't want is a lot of administrative burden. And you know we've talked to a lot of practices and CINs and truthfully, a lot of people are, because there are there in Medicare shared savings plans, or they've been in a risk based or shared savings agreement with like BlueCross BlueShield North Carolina for for several years. They're used to producing quality --. That's pretty new for Medicaid. And so we are trying to work with the health plans in the Health Information Exchange to to work on really leveraging the Health Information Exchange to pull extracts from the Health Information Exchange to try to reduce the amount of reporting that providers will have to do so. We're working on it, it's certainly not going to be perfect in day one but we're trying to align across health plans. So, to do what we can to reduce administrative burden we appreciate their partnership, and we appreciate the partnership with the HIE.

Hugh Tilson

Thank you. What if our hospitals employed specialists don't take patients health plan that we are contracted with make it hard to do a quality job with outcomes if they aren't participating, plus so many social determinants of health, it's quality effort is more around standardized screening processes, it's easier to takes help from someone to guide us.

Kelly Crosbie

Oh boy, they were, I think there are there are a couple things that I mean first. First is about the if your hospitals employed specialists don't take the patient's health limit they're contracted with so that's a really tricky one, and and I am not, I'm not, I'm not Jean, y'all know Jean by now. Jean Holliday. She manages the network adequacy and you've probably seen Jean and lots of presentations talking about network adequacy. And I would say that it is a big change for us. We're going into place where, you know it's Medicaid open network to different kinds of networks and different kind of referral relationships, and I think it's going to be bumpy for a while, you may have to change your referral patterns to in there, in network specialists, because as long as health plans meet network adequacy, they don't need to have every specialist or every primary care and network, we might want them to, but they don't necessarily have to do that. So it might be bumpy for a while to develop new referral patterns if the specialist you're used to working with or even a specialist in your in system is no longer in network with a health club and so that that will that will definitely be a change for us, I think, you know it's very hard to, you make an excellent point about when you think about improving quality and outcomes for people addressing social determinants of health or unmet resource needs, is, is we all know, we've all seen the statistics about 70% of the issue healthcare is determined by 70% of things that have nothing to do with health care 80% So I think what what we've tried to do the transformation design is kind of plant as many leavers as we can for health plans and providers to be able to address unmet resource needs. There's probably lots of other presentations that go through some of those leavers that we've put in the system, but just in a really basic way in the Amh model itself. It starts with the screening, health plans are required to try to screen every single person. And we wrote, and they are required to use mandatory standardized questions around and that resource needs who were identifying those needs, and they're required to provide care management to those individuals, also our AMHs a matrix are required to do assess for these unmet resource needs. And we are saying, go ahead and use your Medicaid care management dollars to help individuals who may be medically well and healthy. But go ahead and use your care management dollars to help them find the unmet resource needs they use, they need in the community. And we've provided a lot of flexibility for health plans to invest some of their dollars in resources that are non medical, we have the pilots we're actually piloting a lot of non medical services which are very exciting, and we hope that gives us a lot of evidence to say, Hey these work these improved outcomes we need to figure out a way for Medicaid to buy more of these things. So, your point is well taken, and I don't mean to go on and on but I think we're, we're pushing the boundaries here in North Carolina with how we're trying to maximize the Medicaid dollar to to pay for address unmet resource means but completely agree. We totally were on board with you that that is 70 80% of the issue and we need to find out ways to, to address unmet resource needs if we're gonna improve outcomes. So those of you you have a lot of hard questions here.

Hugh Tilson

I know there was a kind of related one which should help plans accommodate HOSAR payments, otherwise why do they talk about social determinants of health. This is an example of health plans not providing the same services traditional Medicaid.

Kelly Crosbie

That is a, that's a really good question and I didn't mean to do the health plans a disservice I said they're thinking about it. I think they and we are thinking about it in a really good way, I think. I think we're trying to think about how do we use that screening, and the this, hopefully the success in the data. But how do we leverage it, maybe differently, because maybe it's not a fee for service payment. Maybe it's part of the care management rate, so you have the flexibility to do it as a practice pulling that data address things but it doesn't have to be a fee for service build right, so I don't mean to say like, they don't want to cover it. That's not what I need to say at all. I think we're trying to say what is the best way. Were we able to infuse a little bit of dollars in the system get people used to a new process and what works, it's almost like a little test what worked and didn't I mean we hear repeatedly. Why did you make us do you new process to screen people and then not pay us for negative screens. I think that's totally legit. And so I think that's something we need to figure out so I think, I think we are trying to explore the best way to continue to support practices to screen and refer.

Hugh Tilson

Thank you. Got a question about our health plans picking up health equity payments.

Kelly Crosbie

I would say in their current form no, and that's the easy answer right. And I would, I would also suggest that you please go to the AHEC website look at some of the backwards chats look at the Medicaid bulletin that explain the health equity payments. And I would just say, those were one time Medicaid payments, organized and constructed in a very specific way that does not mean that the health plans will absolutely not find ways to support us equity. This was just a very specific one time payment that's all.

Hugh Tilson

Other questions about how will the glide path be distinguished or show up on the RA

Kelly Crosbie

Garrick, I don't know if you're there, but there's actually different messaging on the array, I don't have it handy right now but your RA will actually say that you got to glide up payment, or if you got a health equity payment remember the health equity payments went at once. There's a, there's a remittance advice that says you got a health equity payment and then there's remittance advice and so you got to go. But we can get an FAQ out that specifically kind of like cuts and paste what you were meant to -- so.

Hugh Tilson

How about this one we've been approached about changing from our current --, if we do this or decide to leave our CIN altogether and do this ourselves, should we wait until after go live so we don't disrupt our patient assignments.

Kelly Crosbie
Well, patients are assigned to you as a practice, so they're not assigned to CINs at all, they're assigned to individual practices. I think the timing of when you change your clinically integrated network, if you decide to cause that's your choice I think probably has probably the timing of it probably has a lot to do with how you contracted with health plan. So if, if your health plan is by virtue of CIN and contract, we don't want you to lose your contract right you need to maintain that contract through lunch with the CIN and so that's really hard to answer, not quite knowing the structure of the CIN and contract that you have with the patients are assigned to you I think we would say if your contract with the CIN now and that helps you be a tier three, it'd be fantastic if you knew how the next. When you ended that contract the very next day you could maintain your care management services for your member if --CIN

Hugh Tilson
This one is their process when a practice needs to dismiss a patient, as the practice have to get authorization from the health plan. If there is a process, can you please describe it.

Kelly Crosbie
That is a rough, rough, rough, rough question we get it a lot. I think it's a very fair question, until we've answered it I'm gonna try to stay true to the answers, we've had so far. Obviously practices have their own policies and procedures in place for how they work with patients, and that is not is not Medicaid policy, that's the practices individual policy, we do hope to things we do help. We do hope that with the care management, dollars and the care management program that practices are better equipped and better financed, to help patients with barriers to care. And we also have said that if you want to dismiss a patient from your practice please work with the health plan. Because what we don't want are people who are not linked to a medical home or or who are linked to you still in the system, but you're no longer in an active relationship with them. We want to help them find a practice that best fits their needs and that might mean you if you can't help them with your care management and your resources or your policy said look, we've, we've done everything and now we need to dismiss this patient, please work with your health plan because we want very much to ensure that we're able to meet every member's needs and get them connected to a practice that maybe there's a better fit.

Hugh Tilson
Got this comment for Amh work some of the PHPs are doing transition of care work to see if you're doing transitions of care work and clinics are doing TCM, seems like a lot of duplication of work.

Kelly Crosbie
Great question. Next, the next step Back porch chat which will be for looking at the date there'll be a backward chat really soon on transition of care. And we had, as you know we have the

AMH sessions here a while ago talking about transition of care. I think we've tried very hard not to duplicate efforts around transition of care because that's really really confusing for members. But the reality is is that sometimes the first and best and easiest point of contact is from a health plan to a health plan, for example. So the health plan might to help with a data facilitation or warm handoff to the advanced medical home, it's easier for us as a state to pass member lists of crossover we have the high need crossover member list we've identified a subset of members, we consider very high risk and we want to make sure they're okay during the transition, we pass this along to the health plan, it's a data transfer and they pass those down to advanced medical home so it's not a lot of duplication on the same number. Sometimes it's just passing data on, or the health plans, the first best person to grab the data and then pass it down to the ah but, um, the other thing I would say I'm a social worker, can you ever do too much transitional care work, really. You can bombard a person, you should never bombard a person right. But I do think it's incredibly important that we do everything within our power to make sure our most vulnerable folks get transitioned really well. In this system, so it's okay, I can live with a little bit of duplication.

Hugh Tilson
Just got a message that the next back porch chat is May 27 with Dr Dowler, put on your calendars. Thank you. Yep, we're just about out of time, let me see if I can find. How about this one practices receiving enhanced payments must complete a practice survey following the health equity initiative, when will we be receiving the survey.

Kelly Crosbie
Do you know? I'm sorry, we'll have to get back to you. I've seen it, know when they'll go out.

Hugh Tilson
How about this, what about the HIE, what if he can't provide data to the CIN and that is needed to meet some of the quality measures, or the state waive those measures until the HAA can successfully move data, we have to do manual chart reviews.

Taylor Zublena
That's a hard one, it varies measure by measure but I think historically that's where we have the administrative measures, measures that so until we can get to that more clinical NVCQM extraction of measures its administrative so utilizing those claims and point of care, again, to minimize the manual chart audit to really try to move away from that systemically, but were most of the measures followed administrative until we can get to that hybrid methodology.

Hugh Tilson
So I think we're just about at a time, the questions are either I think things we've already answered or specific to a particular practice or comments. I guess here's one we have well DHHS provide COVID-19 training as needed by the COVID-19 amendment for Amh delegates.

Kelly Crosbie

Good question. I think that's TBD, just for folks who don't know, obviously because of the, all of us, because of the public health emergency over the past year we have. We've all done things quite differently and we've asked our care management entities to do things differently. So we've asked our health plans to think about the public health emergency, and how that means they should deliver care management differently, everything from thinking about how they target care management differently, tried to do better outreach for testing and vaccines, deploy care managers, a little bit differently. So we've asked them to think through that, and to kind of give us their plans for how they really want to help manage things well. Because of that we've also asked them to think about helping the field right now, most of the care management will be delivered in the field by beds medical homes and their care and partners. So we've asked the health plans to describe the changes they're making trust, how they're going to train the field on the changes they're making to their care management model, and on some best practices, things that the field might want to consider, so they can tailor and target their care management programs during the public health emergency. So, I think it really the answer really is TBD because we're actively working with the plans now on what that flexibility might look like and how they might want to train, train providers so the goal is not to be burdensome. But the goal is to say let's all think smarter, and the health plans do have a responsibility as our as our kind of primary vendor for managing care partner for managing characters to think smart, and to train, the train the field on how to be smart and nice care management. So, I think, again, don't want to be emotionally burdensome and if there are ways we can work collaboratively, we are all for that.

Hugh Tilson
Now, I think we're out of time unless there's a question you see that you want to respond to before we go, while you're looking at that, let me just thank all of our participants for joining us tonight and Kelly, thank you and your team for just a great content rich presentation that's great and timely information so thank you for this and for all the all are doing back over to you,

Kelly Crosbie
Just thanks everyone for coming. Thank you for all the questions sorry we didn't get to them all tonight, but we will follow up with them I think most of them we have answers to. But thank you all for joining us. Thank you so much for supporting the advanced medical home program, and we look forward to all of us collectively getting through the launch successfully, and then coming back to some more trainings, After, after lunch so thank you.