Roles and Responsibilities of Clinically Integrated Networks and Other Partners
November 1, 2018

Jaimica Wilkins

(Slide 1) Good morning and welcome everyone. Thank you for joining today's webinar entitled Roles and Responsibilities of Clinically Integrated Networks and Other Partners. This is the fourth in our series of trainings focused on the Advanced Medical Home, or AMH. AMH will launch when North Carolina transitions its Medicaid program from a fee-for-service structure to managed care beginning in November of 2019. This webinar will provide an in-depth look into the areas where Clinically Integrated Networks, or CINs, may be able to provide support to AMHs including augmenting staffing, assisting in the provision of care management, providing data management and analytic support, and facilitating contracting with prepaid health plans or PHPs. Today's presentation will be delivered by Jonah Frohlich and Adam Striar from Manatt Health, the State's technical assistance provider for the Medicaid transformation. For additional background on the AMH program, we encourage you to visit the AMH webpage, which contains slide decks, recordings from previous webinars, the AMH provider manual, FAQs, or Frequently Asked Questions, information on future trainings, and other resources. The AMH webpage link is in the back of this presentation, and can also be located by Googling NCDHHS Advanced Medical Home. We thank you for your continued engagement in this important effort, and we hope to see you at future webinars. I'm now going to turn this over to Jonah and Adam, so they can walk you through the remainder of the presentation. Thank you, and enjoy.

Adam Striar

Thanks, Jaimica. And thank you to all the attendees for again making time in your busy schedules today to attend this webinar. The AMH program and care management more generally are a very important part of the State's Medicaid transformation. And we just really appreciate all of your continued engagement on this. So, just to introduce myself. My name is Adam Striar. I'm a manager here with Manatt Health. And I am joined today by my colleague Jonah Frohlich, who's managing director here. So, today we will plan to take an in-depth look at what were are referring to as Clinically Integrated Networks, or CINs and other partners, and the role that these organizations will play in the AMH program. CINs and other partners are a wide range of organizations that will be able to assist AMHs in meeting the AMH tier-free requirements. The State has intentionally provided AMHs with broad flexibility around how to most effectively use CINs and other partners, but our goal for the webinar today is really to help AMHs and CINs understand how these arrangements might actually look in practice, and what are some of the key functional areas that AMHs are likely to need the most assistance in.

(Slide 2) So, here's just an overview of what we're going to cover today. So, we'll start off by providing some context with a just brief high-level overview of North Carolina's Medicaid transformation and the AMH program. We'll then spend just a little bit of time outlining how care management responsibilities are shared between prepaid health plans or PHPs, AMHs, and CINs, which we think will be important background information for understanding the

remainder of this presentation. But the bulk of today's session will really focus on the role of CINs and how they can assist AMHs in fulfilling their program obligations. Here, we'll talk about some of the key functions that CINs are likely to be able to assist AMHs with, and as Jaimica mentioned earlier, these fall into three main buckets. So these include Care Management. So this includes things like supporting staffing and helping with the actual provision of Care Management in the practice setting, and also helping practices develop clinical protocols for delivering care management themselves. This also includes data management and analytic support.

So, this involves things like assisting practices with risk scoring and stratification, accessing and using admissions discharge and transfer fees, or ADT fees, and helping to aggregate and add value to these various data sources that AMHs will gain access to through the program.

And then, finally, the third bucket is contracting. So, DHHS recognizes that AMHs having to contact and negotiate AMH payments across a number of different PHPs may be cumbersome, so we'll explore in this section some of the ways in which CINs may be able to help with this task. And then finally we'll conclude with a handful of use cases. Here, we'll basically provide some hypothetical examples of different types of practices and how they might choose to utilize a CIN or other partner to fulfill a range of functions based on the practice's organizational structure. Time permitting, we'll then follow that up with some Q&A. So, we encourage you at any time during this presentation to enter questions into the Q&A box in the bottom right-hand corner of your screen. And then, just to wrap up, we'll outline some key next steps and direct you to some other training resources that we have available on the State's website.

(Slide 3) Okay, so let's just take a brief step back here and take a high-level look at the role of care management in North Carolina's Medicaid transformation, just to provide a bit of context for today's discussion.

(Slide 4) So, robust care management is really a cornerstone of the State's managed care transition. And in establishing a framework for delivering appropriate care management, the State really started from a core set of principles that you see here. So these include that Medicaid enrollees should have access to appropriate care management. That care management should involve multi-disciplinary care teams. That local care management is the preferred approach – and this is one that we're really going to key in on today, and we'll come back to that in a moment. That care managers should have access to timely and complete enrollee-level information. That enrollees will have access to programs and services that address unmet health-related resource needs. And that care management will align with statewide priorities for achieving quality outcomes and value.

And just a reminder of how AMH fits into all of this. AMHs are really designed to serve as the vehicle for executing on the approach that I've just described in the management care context. The State recognizes that many of these features already exist as part of the State's Carolina Access program, which is the State's existing primary care case management program and fee-for-service Medicaid. So, AMH really exists to build on this program's successes with an eye toward moving closer to achieving each of the principles that I've just outlined.

(Slide 5) And so, as I mentioned on the previous slide, local care management is a key principal of the State's managed care transition and it's something that we'll touch on throughout this presentation. In keeping with this under managed care, PHPs are required to ensure a robust system of local care management that is performed at the site of care in the home or in the community with face-to-face interaction wherever possible. The reason for this is that there is a significant body of evidence that patients prefer that care management be delivered locally using care givers that they know and trust, and also that these types of programs lead to better health outcomes.

So, what are the requirements on PHPs around local care management? So, in addition to the care management provided directly by the PHP, PHPs must also have an established system of local care management that delivers these services through AMHs and through local health departments. PHPs are responsible for oversight of local care management but can delegate primary responsibilities for this down to AMH Tier 3 practices. PHPs need to ensure that the majority of their patients are receiving local care management. And, again, AMH is really the vehicle for executing on this, and PHPs will be able to use this program structure to pass a significant amount of care management functions down to the practice level.

And, finally, if Medicaid enrollees receive care management from more than one entity, the PHP is required to ensure that care plans detail the rules and responsibilities of each local care manager. So, for example, if a patient has been flagged as needing care management from both an AMH and through one of the State's local health department programs, it's the responsibility of the PHP to ensure that rules and responsibilities between the two are clear. And one key note here is that the AMH program is really intended as a minimum initial framework for which PHPs and practices can innovate around payment and delivery models to support local care management. The State really does encourage PHPs and practices to develop innovative ways to deliver better care management to patients and come up with new payment models and other ways to help support this, as long as practices and PHPs are complying with the minimum State requirements.

(Slide 6) So, with that little bit of background on the managed care transition, let's talk a little bit about how care management roles are divided between PHPs, AMHs and CINs and other partners.

(Slide 7) So, what this slide here does is provide an overview of the universe of care management functions that the State envisions under managed care and shows how the State will ensure that high-need individuals and those transitioning out of the hospital will receive appropriate local care management.

So, just to walk through this quickly. The care management processes that you see in this diagram are divided into two categories. So, the yellow arrows that you see here are components of care management that need to be provided to all enrollees. And those blue boxes that you see up in the top right-hand corner, those are provided to high-need beneficiaries only. So it's a key distinction there. Ultimately, these responsibilities will shared

in a structured way between PHPs and AMHs, and potentially also with a CIN, in different ways, depending on the tier level of the AMH.

So, just to walk through each of these required elements quickly. The first requirement in the top left-hand corner is the care needs screening. So, these are required by federal regulation and are generally done by the prepaid health plan. This basically involves a set of standardized screen questions for each patient. They have to be completed within 90 days, and the results of these must be shared with any AMHs that are contracted with the PHP. These screening are required to test for things like chronic or – screen for things like chronic or acute conditions, behavioral health needs, medications, unmet health-related resource needs, and a number of other things.

The second component of this top row here is the risk scoring and stratification. So this includes taking the results of that initial care needs screening and identifying a number of priority populations and different risks strata. So the priority populations include children and adults with special healthcare needs, individuals in need of long-term services and supports, enrollees with rising risks, and individuals with high unmet resource needs. And in addition to that, PHPs and AMHs will separate patients into different risks strata.

Coming out of this is the comprehensive. And these will only be performed by individuals that are identified by the risk score as being high need. So, this is really a more in-depth person-centered assessment of the beneficiary's healthcare needs, functional needs, and their accessibility needs. And this is really intended to help the care team make decisions about the type of care management that the patient needs and help to inform the care plan.

Finally, leads to the actual delivery of care management for patients that are identified as high need, with, again, with specific services informed by the care plan that was developed in the previous step.

So, that top row there again is for high-need care management. But simultaneous with this are a set of ongoing care-management-related pathways for individuals that are not identified as high need. So, this includes transitional care management for individuals that are discharged from an in-patient stay or from an emergency room. It includes general care coordination for all patients between different settings of care. It also includes various preventive and population health management efforts.

(Slide 8) Okay, and so this slide describes the delineation of the responsibilities that I just walked through between a Tier 3 AMH and the PHP. So, the yellow boxes again are performed by the PHP. The blue boxes are tasks that would be performed by the Tier 3 AMH, and those cross-hatch boxes are those that are shared responsibilities between the PHP and the AMH. So, in this example, the Tier 3 AMH is responsible for a range of local care management functions, some of which the CIN or other partner that they choose to contract with could potentially help with the fulfilling. So, again on the top left, you have your care needs screening. This is something that's going to be done by the PHP generally.

Moving on to risk scoring and stratification, so this is something that's actually going to be shared between the PHP and the AMH under Tier 3. So, PHPs are required to employ their own risk stratification based on the results of the care needs screen across all of their members. But in addition to that, Tier 3 AMHs will be required to combine risk scoring information that they receive from the PHP with clinical information at the practice level, and use that to assign a risk score to their entire patient panel. One note on this is that AMHs don't necessarily need to purchase risk stratification software or other technological tools, but at minimum they need to have a process for ingesting this PHP risk for and applying clinical judgment to that, to assign a score across their whole panel.

In Tier 3, the comprehensive assessment in the actual provision of care management will be performed locally by the AMH. And, again, this, as in the previous slide, will be informed by the risk stratification and will, with the comprehensive assessment feeding into the care plan and helping to guide the actual provision of care management.

Transitional care management is another item that will be owned by the Tier 3 AMHs. Again, this is for patients that have recently been discharged from the hospital. And in this Tier 3 AMHs are required to have protocols in place to respond to ADT alerts and other data feeds to ensure that patients leaving the hospital receive appropriate follow-up care.

And then finally we have general care coordination and prevention and population health activities, which will be shared between the PHP and Tier 3 AMHs. PHP will continue to serve in a care coordination role through their provision of data to AMHs, but AMHs will handle the bulk of the day-to-day care coordination activities. PHPs will also continue to operate prevention and population health initiatives for all of their members, and AMHs will continue to offer various preventive services, as have been required under the Carolina Access program. One final thing to know on this slide is that AMHs will have broad flexibility in determining how CINs and other partners can help meet their Tier 3 needs. And that's something that we'll talk about in more depth throughout the rest of this presentation.

(Slide 9) So, what are CINs and Other Partners? CINs and Other Partners can come in a number of different shapes and sizes, but the basic idea is that they are any organization that the AMH designates certain AMH core functions to. Practices that choose to work with CINs or other partners will have the freedom to choose any CIN that meets their unique needs. And choosing the appropriate CIN or other partner is going to depend significantly on the type of practice, since there are a wide range of practice organizational structures that serve the Medicaid program in North Carolina. So, these include employed physician groups. These are, you know, doctors that are employed directly by a health system or by a faculty practice plan. It includes independent group practices. So, these are your single- and multi-specialty groups. Community clinics, FUHCs, etc. And you also have your local health departments, which of course serve a very unique role in North Carolina's delivery system but are also permitted to serve as AMHs.

And then finally, you have your independent solo practitioners, who provided they have the capabilities in place are more than welcome to participate at an AMH Tier 3 level. So, for each

of these different practice types, it may be most efficient for them to work with a different type of CIN. So, practices that are affiliated or employed by a large health system may just wish to work with that health system and use its existing care management capacity. Other organizations, like integrated delivery networks or IPA's may also be able to offer care management capacity for practices that are not affiliated with a large system. In addition to that, you also have care management organizations and technology vendors, so organizations such as CCNC and similar organizations that can fulfill some of these roles if a practice wants to participate in Tier 3, but does not necessarily want to become affiliated with a large system.

(Slide 10) So, how can CINs and other partners help AMHs? Long story short, there are a number of different ways that CINs can help, depending on the specific needs of the practice. So, a first key functional area that they can assist in is the actual, on-the-group provision of local care management and coordination. The second area is related to data and analytics. So CINs can help integrate and analyze the wide-range of data that AMHs are going to receive from PHPs, and they can also help pick that data and help to produce reports and other outputs that provide information that's actually useful and actionable for practices. In third, they can also assist in the contracting process by helping practices negotiate care management fees, performance incentive payments, with PHPs in certain instances. And one final thing to note here that applies throughout is that the State anticipates that the majority of AMH Tier 3 practices will elect to contract with a CIN or other partner for support, but we really want to stress that they are not required to do so. If a practice feels that it has the necessary in-house capacity to do AMH Tier 3, they're not required to work with CCNC or any other CIN or other partner.

(Slide 11) One other important thing to consider is that Tier 3 AMH practices are ultimately accountable to the PHP regardless of whether or not they delegate care management responsibilities to a CIN. So, if a CIN is not fully equipped to provide required care management services or to undertake certain analytic tasks, or do anything else for an AMH, that's really on the AMH to ensure that it's fulfilling its obligations. The PHP won't necessarily have any oversight of the CIN. So, it's really up to the AMH Tier 3 practices to ensure that there is proper oversight of these designated entities to ensure the patients are continuing to receive required care management services. It's really important to note here that the State will not have oversight of CINs and will not certify CINs, validate their capabilities or provide any kind of a list of CINs for AMHs to choose from. The State's role here is really limited to overseeing PHPs through managed care contracts and ongoing oversight and certifying individual AMHs – certifying that individual AMHs are eligible to participate. All other oversight through any AMH program is really going to occur through contracting arrangements that flow down from the PHP to the AMH and ultimately to the CIN.

(Slide 12) So, in this section, I'm just going to talk briefly about one of those three key functional areas the CINs may be able to help in, and that's in supporting the actual provision of care management.

(Slide 13) Just to quickly refresh on this slide, which again highlights the key functions that are shared between PHPs and practices under the AMH model, Tier 3 AMHs are responsible for performing a comprehensive assessment. From that they're required to develop a care plan and provide care management for all high-need beneficiaries. They are required to provide care management for patients in transition. They also share responsibility with the PHP for risk scoring and stratification, general care coordination, and preventive and population health management.

(Slide 14) So, within that first care management bucket, CINs can support AMHs in a number of ways, and that's through helping with staffing, helping to develop protocols for or actually doing the comprehensive assessments and helping to develop care plans. They can also assist in managing transitions between different care settings. So, on the staffing point, we think this is really going to be one of the most important ways that CINs will be able to help practices through augmenting staffing and helping practices ensure that they're meeting all of the staffing requirements. We think, you know, just to recap the Tier 3 staffing requirements, practices are required to have licensed, trained local care management staff that work closely with clinicians in a team-based approach for high-need patients. They're required to assign all high-need patients a care manager with minimum RN or LCSW credentials that's accountable for ongoing active-care management. And they're also required to assign patients identified as high-risk for an admission or other poor outcome with transitional care needs to a local care manager. And, again, we think it's likely that a lot of particularly smaller practices won't necessarily be able to support these staffing requirements in-house. And that's really where a CIN can come in.

So, how specifically can CINs help here? So, for practices that are employed or affiliated with a large system, the health system may have staff or other infrastructure that can be used to help support the delivery of care management. So, these types of practices may look to work with their parent organization and really leverage that infrastructure that's already there. For independent practices, this may mean contracting with a care management vendor that provides access to mobile local care management staff. Again, it's not a requirement of the AMH program that care managers be imbedded in the practice, but there does need to be some element of local care management there. Or, it could mean contracting with a CIN that can provide access to remove, on-demand care management staff that supplements the practice's local resources. So, the key point here is that the state has established certain staffing requirements to ensure that patients receive robust local care management. That practices ultimately have a lot of flexibility in determining how they actually implement that, and that's with or without the help of the CIN.

(Slide 15) CINs may also be able to help with performing comprehensive assessments and developing care plans, which, again, AMHs are required to do for all high-need patients. So, on the comprehensive assessment, there are certain requirements around how they must be conducted. So, they have to contain specific elements, so they have to screen for a number of items, including a beneficiary's immediate care needs, any medications, any physical, intellectual or development disabilities, behavioral health conditions, and a number of other

things. They can be performed as part of a clinician visit, or separately by a team led by a clinician with a minimum RN or LCSW credential. They have to be reviewed by the care team. And also must include protocols for situations where patients might be at immediate risk.

Care plans are really – come out of the comprehensive assessment, and are intended to guide the provision of care management for high-need patients. So, these need to be developed within 30 days of that initial comprehensive assessment. Have to be individualized and person-centered and developed using a collaborative approach. They have to incorporate findings from in addition to the comprehensive assessment, the PHP care needs screening, risk scoring from the PHP and the practice. And in addition to that, the AMH must also develop a process for updating the care plan on an ongoing basis.

So, there are a number of things here that CINs we think could be really helpful with. Number 1 is performing and assisting in protocols and in the development of the comprehensive assessment. So, this could mean, you know, the CIN helps with the development of an assessment tool, or they could do the actual delivery of the assessment and provide staff on site to do that. They could provide tools for practices to streamline administration of assessments. So, this could be something like a technological tool that helps a practice identify the right questions, or help them streamline entry and storage of these assessments into their EHR. CINs may be able to identify and aggregate actionable data that can be used to inform care plan development. So, PHPs will be passing a lot of different data elements to the AMHs. CINs can really be helpful in thinking about how to make sense of that and aggregate it into a form that's actually helpful to providers. They can perform or assist in the development of the care plan using local CIN care managers. So, this would be providing actual staffing. They can also help with developing work flows for updating and developing the care plan. So, not necessarily providing care management staffing, but helping the practice develop a plan to update the care plan on an ongoing basis using its own care managers. And then, finally, just providing staffing for assisting and regular updates to the care plan. The key takeaway here is that, you know, there are a number of different avenues through which CINs might be able to assist with comprehensive assessments and care planning.

(Slide 16) And then, finally, CINs and other partners can help AMHs deliver transitional care management. So, again, this is for when a patient is discharged from the hospital. And just a refresher on the transitional care management requirements in AMH, Tier 3 AMHs are required to implement a systematic, clinically appropriate care management process for responding to high-risk ADT alerts. They're also required to provide local care management for patients in transition that are identified as high risk. The key thing here is that in general, practices will need to be able to respond to these events in real time or near real time. And this is something that may be a challenge for smaller practices or practices that have limited care management functionality in-house. And CINs can help here in several ways, so they can again help with developing clinical protocols, they can help develop transitional care management protocols and provide staffing support. They can help with responding to ADT alerts and helping to connect to those ADT feeds. They can also help with providing local, on-demand care

management capacity for actually responding to these ADT events that require those real-time responses or near real-time responses.

Okay, so, now I'm going to turn it over to Jonah Frohlich, who's going to walk us through some of the other ways that CINs can help Tier 3 AMHs be successful. All right.

Johah Frohlich

(Slide 17) Thank you, Adam. So, in this section, we will be reviewing the role that CINs may play in providing Tier 3 AMHs with data management and analytics support.

(Slide 18) So, first, let's just review data flows in the program. So, there are a number of data flows that AMHs will need to be accountable for and support from the PHPs. So, first of all, PHPs must share with all practices information related to beneficiary assignment to them, risk scoring and stratification results, initial care needs screening information that Adam reviewed, and quality measure performance. PHPs must share encounter data as well with Tier 3 practices. AMHs will have other data flows that they will need to be accountable for integrating into their workflows. They'll be required to access admission discharge and transfer information, or ADT data, from hospitals that their patients are being admitted to. And all practices should collect and process relevant clinical information for population health management and care management processes. They're also encouraged to share protective health information safely and securely with their members, that those members can have access to their own information to support their care needs. Now please note that PHPs and AMH practices will be responsible for complying with all federal and state privacy and security requirements regarding collection, storage, transmission use and destruction of data.

(Slide 19) Now, CINs and other partners can support AMHs in processing multiple dataflows needed to support care management and related functions. CINs may support Tier 3 practices in a number of ways. First, they can assist with risk scoring and stratification processes, both incorporating information from PHPs and enhancing them in their risk scoring process. They can support access and utilization of admit, discharge and transfer information from hospitals. Assist with the compilation of comprehensive assessments for care management. And they can support the receipt, aggregation and transmission of beneficiary assignment information from PHPs, quality performance data and counter and claims data from PHPs and clinical data.

From the diagram on the right, here you can see that those multiple data sources will be coming from multiple PHPs that the AMH may be contracting with. And the CIN partner can support that AMH by aggregating data from the various PHPs that they contract with, integrating it and providing consistent and actionable information to the AMH that they're supporting. CINs can also support risk stratification and scoring methodology. Each PHP will be conducting a stratification and scoring methodology for its members, and the performance of additional care screenings however.

(Slide 20) AMH Tier 3 risk scoring requirements that CINs might support include using PHP assessments to inform delivery of care management using a consistent method to assign and

adjust risk status. Using a consistent method to combine risk scoring information from PHPs with clinical information to score and stratify their empaneled patients. Identifying priority populations, ensuring the entire care team understands basis of risk scoring methodology that may be received from multiple PHPs. And defining a process for risk score review and validation. And CINs might support AMHs in a number of ways. They can assist in defining processes for risk score review and validation. They can adjust risk status based on information that they receive and help aggregate from the multiple sources we just described. They can assist in educating care team members on risk-scoring methodology so they can help interpret reports that they might get from PHPs. They perform or assist in identification of priority populations based on risk scoring results. They can assist in incorporating risk stratification findings into the care plan once a risk level has been assigned to a member. And they can support the use of analytics to develop more detailed risk assessments and customized care management approaches and care plans.

(Slide 21) Now CINs and other partners can help Tier 3 AMHs access admit, discharge and transfer data through a health information exchange, an HIE, or other sources. Now these health information exchanges are a secure electronic network that enable the safe and secure transmission of protected health information between authorized healthcare providers. And it is in Tier 3 AMH, providers will be required to track empaneled patients ED and in-patient utilization by accessing real or near real-time ADT feeds. And by implementing a systematic and clinically appropriate care management process for responding to these high-risk ADT alerts and notifications. An AMH's met use CINs, now their partners to health access information by connecting with an HIE like North Carolina Health Connect or other ADT sources including the North Carolina Health Care Association or directly from hospital partners.

(Slide 22) Now AMHs and their CIN partners are encouraged to work with these HIEs to establish data use agreements, so that data might be safely and securely shared across parties. In this case, a CIN might provide an AMH Tier 3 provider in a number of ways. They might support and facilitate access to an ADT feed. The AMH's assigned beneficiary, as we just described. May develop systems and processes to incorporate ADT information into the AMH's electronic health record or other care management systems that they're using. They can support the development of work flows and alerts to facilitate follow-up and outreach for members in need of care management based on ADT alerts and notification, and they can incorporate ADT information into risk stratification and risk scoring processes.

(Slide 23) CINs can also help Tier 3 AMHs manage and create actionable information on PHP claims and other data sources. So, specific tasks that CINs may fulfill and be delegated on behalf of AMHs include acquisition, processing and management standardization and securely storing claims data from multiple PHP sources. It may also use that information and additional workflows to create comprehensive assessments and care plans. They can use information from these variety of sources to develop analytics, to develop targeted care management approaches for high-risk and high-need patients. And they can use that information to provide more actionable information to care managers and providers who are caring for beneficiaries. AMH dataflows include, as we've mentioned, beneficiary assignment information or from PHPs,

quality performance data, from and reporting to PHPs claims and encounter data from PHPs and clinical data from other providers.

(Slide 24) In the final section, we're going to turn to contracting, and the role that CINs may play in supporting the contracting process between PHPs and AMHs.

(Slide 25) Now, if you were participating in other previous webinars, you'll note that PHPs are required to contract with 80% of all AMH Tier 3 practices located in each PHP region at the Tier 3 level. PHPs will not be required to contract Tier 3 certified practices at a Tier 3 level if they are unable to reach mutually agreeable contract terms. Though this would count against a PHP's 80% contracting requirement. However, PHPs must accept Tier 3 certified practices into their provider networks at a minimum Tier 2 level, if they cannot reach mutually terms on Tier 3 contracting requirements.

(Slide 26) Now, this is very important, subject to applicable laws, some CINs may help AMHs negotiate medical home fees, care management fees, performance incentive payments, and payment terms and reimbursement rate. And there are many different ways that AMHs and CINs may work together to negotiate and support this contracting relationship, and the State is flexible with respect to how these relationships develop. There are a number of considerations that AMHs should take, as they consider the role that CINs play in this contracting process. First, they should discuss contracting options with potential CIN partners and seek legal counsel to clarify any potential anti-trust or anti-kickback or other legal concerns they have about arrangements. And now AMHs may also designate CINs to receive their payments from medical home fees, care management fees, and performance incentive payment services directly from PHPs. The Department, however, will not establish funds flow parameters between AMHs, CINs and PHPs. It's up to those three parties to define those funds flow parameters. Note also that PHPs may decide to perform evaluations of CINs if the AMH contracts with them and provides any of the Tier 3 care management required services under that arrangement.

(Slide 27) So, we're going to focus here on Tier 3 AMH contracting negotiations of care management fees. So, Tier 3 AMHs will need to consider care management responsibilities including regional cost variation and other factors when negotiating care management fees. Tier 3 involves PHPs passing care management responsibilities down to the practice level. Though additional costs associated with these activities are intended to be covered by care management fees that are negotiated between a PHP and an AMH. Now, the State has not set minimum payment amounts for care management fees paid to Tier 3 practices by PHPs. These will be negotiated between PHPs and AMHs, and CINs may play a role in negotiating those care management fees on behalf of AMHs. AMHs, however, are ultimately responsible for any commitments made to a PHP. So the type of task that CINs might play in supporting this arrangement is, subject to applicable laws, AMHs may choose to delegate contracting for care management fees to CINs. AMHs that delegate contracting should understand and set terms and conditions for a fundsflow. Example up front questions may include, how should the care management fees be shared between the CIN and the AMH? What must AMH practices do to

meet care management and performance incentive payment milestone? What must CIN partners do if they perform any of those requirements?

(Slide 28) Now, we also need to consider the role that CINs can play in supporting the negotiation of performance incentive payments. For all AMH Tier 3 providers, PHPs must offer performance incentive payments to those Tier 3 AMHs. There are a number of guidelines for the establishment of those incentives. First, payment arrangements must be guided by the Health Care Payment Learning and Action Network, or HCPLAN Framework Categories 2-4. Those categories reflect varying levels of value-based payment.

In the slide deck that will be provided on the AMH website, Appendix C has more information on this HCPLAN Framework. For the first two years of the program, PHPs must offer these incentives on what's known as an upside only basis. That means that practices will not be at risk for losing money or being exposed to what's called downside risks if they do not meet specified performance targets. If they don't make those performance targets, it means they will not be able or eligible to receive additional upside only or bonus or incentive payments during that contracting period or contracting year.

Practices and PHPs may negotiate arrangements that do include downside risks, but PHPs must also give practices an option for upside only. PHPs may not mandate that AMHs enter into downside risk arrangements in the first two years. And incentives must be based on state-approved standardized AMH quality measure sets. So, in terms of the role that the CINs can play in negotiating and supporting these arrangements, again, subject to applicable laws, CINs may support negotiation, management and monitoring of performance incentive contracts across multiple PHPs. They can help AMHs understand performance incentive payment terms and potential risks and benefits associated with different arrangements, and they may assist practices in choosing performance reporting measures that the State publishes.

(Slide 29) And in this final section, we are going to cover use cases. Now these are three generalized use cases, and they are obviously variations on each of these themes. But we wanted to provide an overview of some general use cases that may exist in the community and may pertain to you.

(Slide 30) For this first scenario, we have a practice that's affiliated with the health system. And then you have limited practice based care management functionality, but significant care management functionality at the health system level.

So, in this instance, the health system if they're an authorized administrator of the practice will complete the practice attestation. And they'll negotiate medical home, care management, incentive arrangement, and rate with the PHP, and they may negotiate technology vendor contracts to support other aspects of their AMH Tier 3 requirements. They may also employ local care managers and deploy those across the care management practice site and at affiliated sites of care. Those care managers will be responsible for working in partnership with the primary care practice and providers and care team, managing and performing

comprehensive assessments, developing care plans, ensuring patients receive care management and general care coordination.

In this case, the primary care practice would lead the care teams and determine strategies for population health management working with the health system, informing AMH risk scoring and stratification with clinical information and other information they have. They'll consult with care managers on clinical protocols, and manage patient empanelment. And in this scenario, the health system may engage with one or more technology partners, and those technology partners may aggregate and update PHP risk stratification and scoring information. They may aggregate claims and other information form PHPs, monitor and integrate ADT events and alerts into care management workflows, and aggregate and provide other actionable information from other dataflows to support analytics, reporting and other IT-related functions such as population health management.

(Slide 31) In the second case, this use case has a large-size independent practice. It's not affiliated with an institution or another health system. It has some but not all of the necessary Tier 3 care management requirements and functionality in-house. In this use case, the primary care practice may decide to negotiate its own fees, medical home, care management, performance incentive and reimbursement rates directly with the PHP. The office administrator completes the practice attestation for Tier 3 and submits that to the State. If the clinical staff provides most local care management, including the assessments, care plans, ensuring patients receive care management and care coordination, it may lead care teams to determine strategies for population health management, inform AMH risk-scoring stratification, and develop clinical protocols. And in this case, the primary care practice may work with the CIN to support many of the IT components of the Tier 3 program. So it may integrate updates from PHP to support risk stratification and scoring, integrate claims information from those PHPs. Monitoring, integrating ADT events in the care management workflows. Aggregating, providing actual information from other dataflows to support reporting analytics and population health management functions.

(Slide 32) And finally, we have a scenario of an independent, an affiliated practice, an FQHC, local health department, other primary care practitioner that have minimal primary care management functionality in-house. And in this case, subject to applicable laws, we'd envision that many of these practices will use and work with a CIN and have them support the negotiation of medical home fees, care management fees, performance incentive payments, and reimbursement rates. That CIN would provide local care management, including care assessment, plans, support general care coordination and clinical protocols. They may support the aggregation and updates of PHP risk scores, information from PHPs, including claims and encounter information. It may monitor and integrate ADT events, and other information to support analytics reporting and population health management. At the primary care practice, an office of administrator would still complete the attestation of Tier 3 and a care team would develop population health management strategies with their CIN partner. They would support and inform the AMH risk scoring and stratification process with that partner, consult with and

advise care managers on protocols, manage patient empanelment, and ensure that patients receive care management working in concert with their CIN or other partner.

(Slide 33) So, at this stage, I'd like to turn to our question and answer period. And I recognize we only have about five minutes for this part of our program. And we have quite a few questions. I'd like to make sure that we have at least a few minutes to respond to those. We'll categories each of these questions that we have and then we'll respond to them in the Q&A page that's listed on the AMH website. Adam, were there a couple of questions you wanted to see up here first, please?

Adam Striar

Sure. Thanks, Jonah. So, we received one question, Will the new Medicaid patient portal being rolled out be limited to a specific CIN, or available to all AMHs? And, so, I believe you're referring to NC Tracks there, which is the portal that AMHs will use to go in and attest for AMH. So, this portal is actually only available to practices and authorized office administrators. There's currently not any functionality where a CIN can go in and attest on behalf of one or more AMHs. So, even if a practice plans to join up with a larger CIN, they'll still need to – the provider will either need to go in directly or have their office administrator go in an attest to AMH Tier 3 track. Do you have one you wanted to respond to, Jonah?

Jonah Frohlich

Yeah, there's a question about CINs and that they're requesting exclusive alignment now, before awards have been granted to PHPs. And the question states that it feels premature and any advice on that. There's still many unanswered questions. Now the State doesn't really want to enter into the negotiation process between AMHs and CINs. The State however has really put forth the principles of having a unified care management platform. You know, in the case of a Tier 3 provider and a CIN partner, it would be very difficult, I think, for a – and especially for a smaller practice to work with multiple CINs. And who would have likely multiple different care management platforms and care management providers that would support the care team. So, I think it's really important for all the AMHs to consider all of their options, and really think about what is the best option for them that would create that unified care management platform.

Adam Striar

Yeah, and on a related note, there's another question that we received. If you find that you have joined the wrong CIN and want to switch to another, will patient stability be maintained during that process by maintaining their medical home, even if they may have different PHP contracts? And, I think it's the same general answer there is that is really the purpose of the medical home is to own all aspects of a patient's care delivery. So, if a practice wants to change CINs, it's really up to the AMH practice to ensure that there is still continuity of care for the patient. The practice really will need to make sure that all dataflows coming from the PHP are redirected to the correct CIN, if that's an arrangement that you have in place. You'll also need

to make sure that all fundsflow issues are sorted out, but at the end of the day, it is the responsibility of the medical home to ensure that the member is receiving needed services.

Jonah Frohlich

(Slide 35) Thanks, Adam. I note that we're a minute away from the end of the webinar, so, just – in terms of next steps, I want to make sure everyone is aware we have dates for upcoming webinars, on November 15th. We'll begin a series of three webinars on Tier 3 requirements and doing deeper dives into these. The first will be on the 15th of November, on patient identification and assessment. December 3rd we'll cover AMH Tier 3 high-need care management requirements. And December 18th, transitional care management. And on January 10th, the final plan webinar in this series, at least, IT needs and data sharing capabilities.

(Slide 36) For more information about this, you can go to the AMH website, at Medicaid.NCDHHS.gov/advanced/medical/home. Now we'd encourage everyone to please sign up for these and share information about these upcoming webinars with your partners. If you have any questions, please feel free to e-mail us at Medicaid.Transformation@DHHS.NC.gov. You can send a letter, for those who still do that, to the Department of Health Services, Division of Health Benefits, 1950 Mail Service Center, Raleigh, NC 27699. Please visit the AMH website. As I mentioned before, there's a number of white papers, manuals, and frequently asked questions that you can access there, including these webinars, recordings of these, plus the slides. This slide deck will be available shortly after the conclusion of this webinar. And there are a series of appendices that are included in this deck that we referenced that you are absolutely encouraged to review, to get a deeper understanding of the program requirements. Thank you very much for your time today. We greatly appreciate it. Have a terrific rest of your day.