

**AMH Tier 3: High-Transitional Care Management; AMH Frequently Asked Questions**  
**December 18, 2018**

**Dr. Nancy Henley**

(Slide 1) This is Dr. Nancy Henley, I'm the Chief Medical Officer with North Carolina Medicaid.

(Slide 2) Thank you for joining today's webinar, AMH Tier 3 Transitional Care Management and AMH Frequently Asked Questions. This is the seventh in our series of trainings on Advanced Medical Home, which will launch in November of 2019 when North Carolina transitions its Medicaid program from a fee-for-service structure to managed care. This webinar is the third of three webinars focusing specifically on AMH Tier 3. Tier 3 provides an opportunity for primary care practices participating in North Carolina Medicaid to establish a uniform local care management platform by taking on additional care management responsibility at the practice level. In return, Tier 3 practices may receive additional payments from prepaid health plans, which we will refer to here as PHPs. As we discussed in the last webinar, AMH will be required to deliver ongoing management to those who are identified as High-Need. In addition, the Tier 3 AMHs will be required to provide short term transitional care management to patients that have been discharged from hospital or ED or other in-patient and are at risk.

Transitional Care Management in the AMH program has its own distinct set of requirements, which we will focus in the first half of today's webinar. In the second half of today's webinar, we will respond to a handful of frequently asked questions that we have received from the provider community. Today's presentation will be supported by Manatt Health, the state's technical assistance provider for Medicaid transformation. Dr. Emily Carrier, a physician and senior manager at Manatt. Will speak to the Transitional Care Management requirements. And Adam Striar, a manager with Manatt will speak to the FAQs.

For additional background on the AMH program, we encourage you to visit the AMH webpage, which contains slide decks and recordings from all the previous webinars, the AMH provider manual, FAQs, information on future trainings, and other resources. The weblink is at the back of this presentation, or you may simply Google and NC DHHS Advanced Medical Home.

Let's take a look now at what we'll be walking through step-by-step on the agenda today. I'll start off by providing a brief recap of the previous presentations, then I'll turn it over to Dr. Carrier who will walk through AMH requirements around transitional care management, include how practices should identify patients in transition who are in need of care management and required activities. Dr. Carrier will then provide a real life example which shows a scenario in which an AMH should be expected to provide Transitional Care Management to an assigned beneficiary. We'll conclude these sections with some Q&A on Transitional Care Management. If you have a question, we encourage you to enter questions in the Q&A box at the bottom right of your screen at any time.

Following the section on Transitional Care Management, we'll spend the second half of our webinar on several frequently asked questions about AMH. These will focus on a range of topics, including attestation, certification, working with clinically integrated networks, or perhaps other partners in the data requirement. We'll conclude with some key next steps and let you know about other training.

(Slide 3) Let's move on now to take a look at the Care Management approach.

(Slide 4) For those of you who have attended previous webinars, you've certainly seen this slide before. The slide provides an overview of the universe of Care Management functions that the state envisions under managed care, and shows how the state will ensure those High-Need individuals, and those transitioning out of in-patient care will receive appropriate local care management. The care management process that you see in this diagram is divided into three separate categories. Yellow arrows are functions that will generally be performed by the PHP. Blue boxes will generally be performed by the Tier 3 AMH. And the cross-hatch boxes will be shared responsibilities between the PHP and the AMH.

The top row of this diagram displays the process for flagging High-Need individuals and routing them into appropriate care management. We focused on this section in our last presentation. But I'll briefly recap the key elements here. The first component in the top left is the Care Needs Screening, which will generally be done by the PHP within 90 days of enrollment. This will screen all enrolled members for things like chronic or acute conditions, behavioral health needs, medications, and unmet health related resource needs. The second component is Risk Scoring and Stratification. This will generally involve each PHP using proprietary methodology to assign a risk score to each member. This data will then be transmitted to Tier 3 AMHs or to their CIN. Tier 3 AMHs will then be required to take this information in, and use it to stratify their own patient panels.

The third component is Comprehensive Assessment. This is a more in-depth person centered assessment of a beneficiary's health and non-health related needs. This leads to the actual deliver of Care Management but for patients identified as High-Need, on the far right. This top row is what we focused on over the previous two presentations. Running simultaneously with the top row activities, there's a set of Care Management related pathways for individuals not identified as High-Need by practice risk stratification. These include Transitional Care Management for individuals that are discharged from in patients at your hospital, and we'll focus on that during our presentation today.

Then we have General Care Coordination for all patients that are between different care settings and last, the various Prevention and Population Health Management efforts.

(Slide 5) So let's take a look at the types of Care Management performed by Tier 3. As we described on the previous slide, the AMH model envisions two different types of Care Management. So we have the Care Management for High-Needs enrollees. This only for patients identified as High-Needs by the PHP's needs training and risk score, or the AMH risk stratification at the practice level. High-Need Care Management is characterized by

longitudinal, ongoing Care Management. And it is guided by a care plan developed by the patient's care team, along with patient and family members and so-forth, that is maintained in the clinical system of record, to inform ongoing Care Management. The other type of Care Management envisioned under AMH, and this is where we'll focus today, is Transitional Care Management. This should be made available to all empaneled patients who have an emergency visit or who are discharged from hospital or other in-patient settings and who are at risk of readmission or other possible poor outcomes.

Transitional Care Management is characterized by short-term Care Management coupled with medication management. A key note here is that these types of Care Management have different requirements under the AMH program. Today's program will focus on Transitional Care Management for folks who are interested in learning more about High-Need Care Management, we encourage you to visit the AMH homepage for previous webinars.

I'll turn it over now to Dr. Emily Carrier who's going to walk us through all the Transitional Care Management requirements.

(Slide 6) Dr. Carrier

**Dr. Emily Carrier**

Thanks. Hi everybody. So, I'll start off by walking through the requirements for Transitional Care Management and we'll keep talking a little bit about how it differentiates from the High-Needs Care Management, and then we'll go through an example and do some questions.

(Slide 7) So as a reminder, you've going to see a lot of similarities in terms of the processes of High-Needs Care Management. The key distinction to keep in mind is that this is something that's being delivered on a time limited basis and the idea is to reduce risk of, for example, something like a hospital readmission, or another avoidable adverse outcome. This is something that any patient could potentially get, regardless of what type of practice treats them.

So, for patients who are in a Tier 2 Advanced Medical Home, for example, this is something that PHP would be, the health plan would be responsible for. For patients who are in Tier 3 AMH practice, the AMH potentially working with a CIN or another partner would be responsible for providing this service. And, this is though, if your practice is thinking of becoming an AMH, this is something that's important to think about. This would be one of the core functions that you would deliver either yourself or working with a partner. So this isn't something that you would be required to deliver for all patients, and we'll talk a little bit more about which patients might need it. But it is, or for every transition between care setting, but it is something that you are required to cover for patients who you think need it in transitions that are coming off of ED visits, inpatient admissions, or institutional admissions. And the idea is that the patient is someone who you, in your clinical judgment, and again, we'll talk more about this in a second is at high risk of readmission or another poor outcome. So if someone has really low risk and they're coming off of one of these transitions, they don't necessarily need transitional care

management. So you know, you have an otherwise healthy 12-year-old who sprains an ankle in soccer practice, and they go to the ED, then you have no reason to think that anything bad will befall them. That's not something that's going to trigger the full transitional care management requirement, although you should offer whatever your standard care coordination services are to that patient.

(Slide 8) So let's talk a little bit more about sort of which patient and kind of what their requirements for any AMHs practice would be. So the one thing to think about is that in some of our previous conversations, we've been focusing on high-needs care management. So this isn't necessarily the same population of patients. The patients who get transitional care management don't need to be high risk generally in your initial kind of risk assessment and risk stratification process. These don't necessarily need to be the people who really lit up whatever your algorithm is. Thinking about which patients need transitional care management might be a separate process, but again, similar to your approach service stratification for high needs, this is something where the state is not seeking to prescribe how you should identify the patients who need transitional care management.

But the state does ask that you have a system for how you identify these patients. This system does not again, as with high-need risk stratification, you don't have to go out and buy a software packet. You don't have to, you know, follow some mathematical approach. You can include, you know, you can make clinical judgment an important part, but it needs to be systematic in some way similar to the risk stratification, you know, the sort of common sense question that we ask is if someone who was new to your practice came in and wanted to know about it, would they be able to understand what your system is. And if they looked at some examples, would they be able to see that you followed the system as you described it.

So that's kind of how we think about, you know, the idea that it needs to be systematic. We do ask that you flag certain types of conditions and certain elements of transitions in developing your system. So we ask that you think about the frequency of duration and acuity of visits to resource-intensive studying. So if you have someone who is frequently admitted to the hospital or hits the ED all the time or whose admissions are very extended or there is something about the nature of the visit that should trigger concern, we would want those to be included, and then there are particular types of discharges that again, we think would probably raise flags for transitional-care management like acute behavioral event, NICU discharges, or there are probably other examples that you could think of, and we'll talk through one example when we go through our real-world example in the next couple of slides.

(Slide 9) So one key element of the approach to transitional care management is using ADT feed, and this is something that we talked about also for high-risk care management. So this is the same slide that should be familiar to those who were on that call. This is a required element of high-needs care management, but the ADT feed is also a way for your practice to identify if patients, who again aren't part of, haven't previously been flagged as high-risk and aren't in your ongoing high-needs care management system, have a transition that needs transitional care management. And again, this is just a reminder. As of June of this year, if you are a hospital

or physician or NP who has an HR, you need to be connected to NC HealthConnex which is the HIE to be getting payments from our Carolina Medicaid NC Health Choice, and they're planning to provide access to all NE AMHs that are participating in the HIE, they're planning to provide access to ADT information at no additional charge. But if you are going to be an AMH and you have another channel through which you prefer to get your ADT information, you're welcome to use that as well.

So once you have the ADT Feed, what do you need to do about it? So people often ask about, you know, how quickly they need to respond to an ADT alert. You don't need to respond to all ADT Alerts in real time or near real time, but you are required again, you know, using your clinical judgment to develop a process and to develop a system to determine which notifications merit a real time on your real time response and to insure that that response occurs in the time frame that you think is appropriate. And again, the idea is if we were, if someone was new to your practice and came in, would someone in your practice be able to explain what the system is and sort of give examples so that an observer could see that your system was followed. And this is another area where if your practice doesn't have the capacity to watch the ADT feed, the system or the CIN or another partner could potentially be helpful.

(Slide 10) So let's talk about the elements of transitional care management. These are sort of what you need to do to support patients that are in transition. So as with high-risk care management, there are required elements that are a part of transitional care management. There is some overlap, but there are some differences, and again, it's important to note that the patients you encounter in transitional care management might be different from the people, they might be people who you don't have a care management relationship with because they haven't been deemed high-risk overall. So one element is insuring that a care manager is assigned to manage the transition if the person doesn't have an existing care manager. And different, again, a team-based approach is fine. We'll talk more about that in a second, but everyone should have a care manager assigned to them.

You need to make sure that the clinical handoff goes smoothly if the patient has follow-up appointments, or if they need to have, you know, work with a specialist to resolve an immediate problem, ensure that those handoffs go well, ensure that you have a copy of the discharge plan from, if they were discharged from the EHR in-patient setting and whatever information that plan is, something that your conditional care management takes into account. Medication reconciliation is going to be important for members that are coming out of a hospital. For example, we'll talk more about that in a second. And then, we do expect that the assigned care manager should follow up rapidly. Again, rapidly is something that we would expect practices to sort of use their clinical judgment and have developed some kind of protocol for determining the appropriate timing and format of outreach.

It doesn't mean that everyone needs to have a next-day visit in your office. It just means that you need to use your judgment and your knowledge of your patient population to develop an appropriate approach and that the process should be systematic in some way to ensure that practices, that patients don't end up falling through the cracks. But if your practice felt that

telephonic outreach was appropriate for some patients and in-person contact were required for others and had kind of a system for differentiating between those two groups and could show that each group got the type of follow-up that you felt was appropriate, that would be totally fine. And then lastly, once the transition is over and everyone has kind of settled into whatever their new normal is, this would be a time to conduct a comprehensive assessment and make sure that if someone hasn't had it, make sure that they have one and if they have had it, make sure that it's up-to-date. And then, just as a reminder, this does include a number of elements in turn making sure that you have a good handle on the patient's medical and non-medical needs, including the priority unmet health-related resource needs of housing, food, transportation, and personal safety. And this is the kind of thing where, based on this experience, you might decide that the person should have their overall level of risk reclassified, or you might decide that it's fine to keep them in whatever category they were in prior to this transitional care need.

(Slide 11) So just talking about medication reconciliation, again this is something that I think we've talked about in the past. This should be a familiar concept to most. So this is something where we want to ensure that the patient has the most accurate possible list of all their medications and make sure that people have been mindful of any possible adverse medication interactions and minimize risk. So the idea is that someone on the care management team would compare the list of current medications against whatever the person was getting in their ED or hospital institutional setting and make sure that, you know, anyone else on the care team at another facility is aware of the medications and really just make sure that you've done any kind of needed de-duplication or de-conflicting if you have medications that shouldn't be used together. And this is something that you can do coming out of any care transition.

(Slide 12) So I'll also talk a little bit more about, we've been making a lot of references to the care manager or the care management team who is doing all of this work. So I'll talk a little bit about care manager training and qualifications, and again, this is something where there's an overlap between the approach for transitional care management and the approach for high-needs care management. The staffing requirements for these teams are essentially the same. So if folks have been involved in the high-needs care management webinar, this should look very familiar to you, but just as a reminder, these are individuals or teams working together who are going to be accountable for active ongoing care management that goes beyond just what happens in your own practice or your own office. So this can be a team, but the team needs to have at least one person who's kind of the team leader who has the minimum credential of RN or an LCSW credential that allows them to work independently, and the idea is that this licensed staff member would oversee the more clinical aspects of care management.

So for example, the medication reconciliation task we talked about earlier might be an appropriate task for that licensed individual to perform, but other staff members who are on that team could go ahead and participate in many of the other tasks that we've talked about like getting the discharge plan, making sure that all the information has gone to the right people, scheduling aftercare appointments, things like that. And the care manager does not to be physically imbedded in the practice, but they should need to be, they should be able to do

local, that is, they can provide face-to-face interaction whenever possible. And it had questions about what happens if a patient declines to engage in care management. So in this case, if you offer care management to someone who you feel is an appropriate candidate for it, but the patient declined, you should still, the AMH should still assign a care manager and do the parts of the care management that don't require the patient to participate directly.

For example, reviewing their utilization, looking at their medication lists and things like that to make sure that if there are any serious safety threats that are, show up there, you can identify them and act appropriately and to make sure that, you know, to the degree that this kind of work can inform the interactions that they have between, with the enrollee and their clinician over the next couple of weeks or months, that the clinician can at least take advantage of, you know, that kind of work. So for example, maybe they don't want to engage in care management, but maybe, they have a follow-up visit with their clinician, you know, six or eight weeks later, at least, the clinician will have the benefit of the care management work, like sort of care manager's work, and they can kind of incorporate that into the clinical interaction.

(Slide 13) So care team, we've talked about how they don't have to be imbedded in the practice. This is something where the practice, you know, this is a lot of different tasks that the AMHs Tier 3 practice will be expected to provide. Some practices may want to work with a CIN or another partner to provide this care management, and there are different ways, there are different roles that they could play. So one example and so, this sort of runs through, they can participate in really most of the areas that we've talked about over the last couple of slides. So for ADTs, we talked about how not all practices may have the resources to sort of watch an ADT feed all the time.

This is something that a CIN could potentially play a role in by aggregating ADT feeds that help to pull out those particularly high-risk alerts that need a real time response. It is particularly important for transitional care management. They might be providing staffing, especially if an AMH is a smaller practice for whom hiring an FTE care manager doesn't make financial sense. A CIN or another partner may be able to supervise some options for care managers that are located in a community who can have that local or face-to-face interaction, but not be full time employed by the practices. And they can also do some of the work potentially around developing the methodologies for identifying which patients are at risk for readmission or other bad outcomes and would be good candidates for transitional care management, or they may have tools that can allow you to streamline the process. Even if your practice develops the approach, the CIN or the other partner can have tools that can help you apply the process faster and more effectively using potentially alternative data sources if that's something you want to do. So that's kind of a conceptual overview of how transitional care management might work and the players who are involved.

(Slide 14) Let's talk through a real-life example of how an AMH might provide transitional care management to a patient.

(Slide 15) So in this example, we have our Tier 3 AMH, and they have elected to partner with a CIN or with another partner to support them in their local care management work. And the way

that they've arranged the partnership, the AMH has decided that what they want to do is do the care managing and the local care management with help from the other partner, but they want to really lead the transitional care management action. And the role they want the CIN or the other partner to play is to do the data aggregation, watch the ADT feed, and get the high-risk alerts and sort of feed it into the, you know, work with the practice workflow, responding, and then do kind of higher level care planning with the AMH and supporting the multi-disciplinary local care management.

(Slide 16) Now we have a patient who is enrolled in a standard plan, and she's chosen the Tier 3 AMH as her primary care provider. And so this is someone who is maybe not someone who would necessarily trigger recognition as high-risk at her baseline. She is, you know, eligible for Medicaid because of her income, and maybe, she's generally a healthy person. Maybe in the past, she's someone who had a history of opiate-use disorder, and maybe, when she had her kids, she stopped using, and she hasn't had a relapse since. She's not on meth or anything else. At her baseline, she's pretty stable, but because of her history, always kind of in the back of your mind and in the back of her mind, you want to make sure that to minimize her risk for relapse because that's something that she and her family really want to avoid. So this is someone who you wouldn't necessarily, you know, worry about all the time, is she going to be in the hospital. You wouldn't, you know, necessarily categorize her as high-risk for ongoing high-risk care management, but she's someone who you would think about if, you know, she had a difficult transition.

So let's say in this scenario, this patient, she's in a motor vehicle collision, and she has an injured leg. She gets taken to the Emergency Department, and let's say she is diagnosed with a non-operative fracture. She's got a non-operative, you know, fracture, and she's sent out with instructions to be immobilized and follow up with Orthopedics, and she has a lot of pain and swelling. And when you or your CIN practice or the CIN partner sees this alert, you think this is patient who I'm concerned about. Because this is a patient is at risk, depending on how she does her pain management, of either having a lot of untreated pain, or potentially being at risk for relapse due to self-medication. So, this is something ...

(Slide 17) So here's sort of what happens that ED admits a patient goes to the EC, that triggers the ADT alert, that goes to the CIN and then in terms of the AMH practice, the AMH practice using the sort of identification process that they've developed with the CIN and that's supported by the CIN recognizes this isn't someone who's normally on our radar as needing Care Management but given our special knowledge of here and our relationship with here, we know that she would benefit from some outreach right not to help support her.

And so the care manager reaches out to the patient to make sure that her needs are being met at home, that she's doing okay, you know, she's not struggling to much with either the pain or because she's immobilized, but still trying to sort of take care of herself and her family, and she's not feeling overwhelmed, and they help talk her through some safe pain management approaches, and make sure that she's feeling kind of supported, and make sure that she's feeling supported, and have someone that she can reach out to, and that she's feeling in a good



place with her pain management, and not feeling like she has to rely on opioids in a way that she feels like would be risky, or increase her chance of relapse.

So that's kind of the way that the, you know, Transitional Care Management could work. This is someone who is high risk all the time, but needs some extra help getting through this transition to keep her on the right track and avoid an outcome that neither the patient nor the practice wants.

(Slide 18) So, that's our example. Um, so this is the time that we have for questions about Transitional Care Management. Just as a reminder, we're going to have a general Q&A, or a general review of Frequently Asked Questions on number of the topics that we've talked about over the last couple of webinars. But if people have questions about specific aspects of the Transitional Care Management that we've just discussed, feel free to type them in. And some of them, we'll be able to answer today, and others will go into a future Frequently Asked Questions, either on a future talk, or on the website.

So one question that we got – "Is the practice to support patients in transition for the ADT seats encompass all facilities, or just facilities that we're on staff at, because the HIE isn't necessarily covering 100% of facilities. So the idea is that the practice should support all patients, patients in transition at all facilities in their catchment area. And so the ADT should be able to give you most of those and if there are facilities that are in your catchment area that aren't covered, you may need to do some outreach to them. This is if a patient for whatever reason, they're traveling, or on vacation or they're in another state or something like that, you know, you wouldn't be expected to be aware of them necessarily.

I think we have another – do we have ... let's see if we have other questions about Transitional Care Management and folks are welcome to send in questions late, and we'll try to address them in a future FAQ. And if not, I'm going to turn it over to Adam Striar who is going to run through the FAQs for those topics which we have previously discussed. So thanks, Adam.

### **Adam Striar**

(Slide 19) Great. Thanks Emily. Hello everyone. So I'm just going to spend a little bit of time walking through a handful of Frequently Asked Questions that we've received from providers and other stakeholders over the course of rolling out this program. The state definitely recognizes that the AMH program may seem complex, and we really want to make sure that we're being responsive where there are particular points of confusion. So I'm just going to walk through some questions that we've spelled out on the slides, but we definitely encourage participants to write in any additional questions that you may have into that chat box in the right hand border of your screen, at any time throughout the presentation, and I'll make pauses throughout and try to respond to as many of those as I can.

(Slide 20) Okay, so the first question is, am I allowed to attest for a Tier 3 now if my practice does not have the required capabilities in place today? And what happens if I attest the Tier 3 by January 31, 2019, but don't have the capabilities in place by the time Managed Care

launches? So, just to respond to that first question, attestation indicates that a practice will have the required capabilities in place by the launch of Managed Care, which is scheduled again for November 2019 and not necessarily by the time of attestation. So here the state definitely understands that many practices currently do not have the necessary capabilities in place to do Tier 3, but plan to either invest in these capabilities during the coming year in house, or plan to work out some sort of a contract with a clinically integrated network or other partner to help support some of these activities. And these activities are totally fine from the perspective of the state. And we strongly encourage any practices that are on the fence or maybe not sure if they're going to have the capabilities in place in time to attest by that January 31<sup>st</sup> deadline. That said, any practices that fail to meet this deadline are going to have opportunities later on to come into the AMH program at different point in time.

And just to answer the second half of that question, practices are always free to change their status to Tier 2 at any time between January 31<sup>st</sup> and the launch of Managed Care without any penalty. So if a practice attests to Tier 3 but for whatever reason they don't think they're going to have the Care Management capacity in place in time, those practices will have the opportunity to drop back down into AMH Tier 2 or out of the AMH program entirely, with no penalty whatsoever. On a related note, some folks have asked us if this can be done through NC Tracks, so going in and changing Tier status from 3 to 2. Unfortunately, NC Tracks currently does not have this capability, but the state is working on developing a solution to this, to allow practices to switch their Tier status downward. So, again there's plenty of time to consider this, and this is something that could be done later on in 2019. But if you feel that you have incorrectly attested to Tier 3, we encourage you to reach out to the state. Using the contact information in the back of this webinar.

And finally, we remind you that if a practice chooses to change to a Tier 2 status, CHPs are actually required to contract with that practice at a Tier 2 level. Tier 2 again is essentially equivalent to the Carolina Access Program in terms of both practice requirements and then payment amounts. So if a practice decides that it just wants to keep doing what it's doing and receive those same \$2.50 and \$5 medical home fees, they will be able to secure those contracts, if they decide to go ahead and drop down from Tier 3 to Tier 2.

Okay, so I'm just going to pause there for a moment and see if we've gotten any additional questions. So when question that we got was, why make people attest by a deadline that is known to be flexible. This seems counter intuitive. So this is totally a fair question, but I would answer that we, we really want to, our goal here is to maximize contracting with Tier 3 AMHs and PHPs at the start of Managed Care. We really want PHPs to have a good feel for what Tier 3 providers are out there in order to plan out their Care Management and population health strategies, and also to help the state plan out and plan for the rest of this rolling out program.

Okay, so I'm going to go ahead and move along to the next slide

(Slide 21) So the question is, does Tier 3 attestation guarantee a practicing contract with each PHP in our region? So this is on a related note, this is something that we've gotten many questions about and something that the department realizes is very important to practices that

are considering attesting to Tier 3. So in response to this, the state has actually just released new guidance on this topic, which basically outlines the department's expectations around Tier 3 contracting and clarifying situations in which it would be acceptable for a PHP to decline to contract with a certified Tier 3 AMH. So I'll basically just walk through the contents of this guidance now, but we've also placed a link to this guidance at the end of this presentation, so we encourage folks to go ahead and look into that if you're interested in more detailed information on this topic.

So the state's general expectation is that PHPs will contract with all Tier 3 certified practices at a Tier 3 level. And so this means including all of the required contract terms placing Care Management responsibility on the AMH but also including all of the Tier 3 payments, so those Care Management fees and performance incentive payments, in addition to the regular medical home fees. The reason behind this is that the state created Tier 3 ... the reason why the state created Tier 3 to begin with is that it's a major goal of the Medicaid transformation to have the greatest possible proportion of Care Management delivered locally. AMH Tier 3 is really the primary way that this is going to happen. The state in general wants all practices that are right to take on these responsibilities to have the opportunity to do so.

That said, in the guidance we also outline two scenarios that the state will accept as reasons for not contracting with Tier 3 AMHs. So the first is when the PHP and the AMH practice are not able to reach an agreement on AMH payment amounts. So these again are the Care Management fees which are negotiable and the performance incentive payments. So, for example if a practice thinks that it needs a particular level of Care Management fee that is not in line with what other practices in the market are receiving, the PHP would be permitted in the situation to decline to enter into a Tier 3 contract with that practice.

In the second scenario that the state would permit is if the PHP determines through its own auditing process that the state certified AMH practice lacks the required capabilities set by DHHS for Tier 3. So if for example, a PHP determines that an AMH doesn't have the capabilities in place to take any claims data, or if they can't do risk stratification, if they don't have the necessary staff to do face-to-face local Care Management, the PHP would be permitted to decline to enter into a Tier 3 contract with that practice.

The state is actually not going to review each and every contract between PHPs and AMHs. Instead what it will do is closely monitor the overall progress of contracting between PHPs and AMHs through reporting requirements on PHPs. So essentially what the state is going to do is require that PHPs report on contract Tier levels and per member per month amounts across all of their contracts. And the state will be able to determine through these reports whether or not PHPs are maybe unfairly excluding certain Tier 3 practices from contracting. So the plan is that that will provide some layer of protection for certified Tier 3 AMHs and they go out into the market.

I'm going to pause right there and see if we have any other questions. Okay, so one question that we've gotten is, if a practice wants to remain as a Tier 2 AMH, would they still need to contract with CCNC? And so the answer to that question is no. There's no longer, at least within

the AMH program, there's no longer going to be a requirement to contract with CCNC. Practices are more than free to continue to work with CCNC if they're happy with the services that they provide. But that is by no means a requirement and practices are free to work another CIN or other partner or take on these enhance Care Management responsibilities in house. That said, for patients that remain in fee for service, practices that want to continue to get that Carolina access to medical home fee, again only for fee for service patients would actually still need to contract with CCNC.

Okay, so I'm just going to move on to the next question in the slides.

(Slide 22) So the question we have here is can an individual PHP perform its own checks of whether my practice meets Tier 3 requirements? And so the answer to this question is yes, PHPs will be permitted to access Tier 3 practices as part of the initial contracting process. Both prior to Managed Care go live, and then on an ongoing basis. So essentially, PHPs after PHP awards in early February, these PHPs are going to receive a list of practices that are certified by the state to do Tier 3 in each region. PHPs will then be able to use this list to do audits of these practices prior to entering into Tier 3 contracts and also will be able to, after these contracts have been executed, continue to do ongoing oversight and ensure that practices are meeting their obligations.

Activities that PHPs are permitted to do include conducting onsite reviews, telephone consultations, documentation review, and then other sort of virtual or offsite reviews. PHPs can also perform evaluations of a CIN or other partner, instead of or in addition to the AMH, if the AMH has decide to work with the CIN or other partner. So if a practice says to a PHP that it's working with a Care Management vendor or with a parent health system to fulfill the Tier 3 requirements, the PHP would be able to conduct checks if with that contracted entity instead.

That said, there are some guardrails that the state has put in place around what PHPs are allowed to do in terms of oversight. So PHPs are not permitted to lower the Tier level of an AMH practice location associated with the same organizational NPI or tax ID without an assessment of each individual practice location. So here we remind you that AMH at this station and participation in the program is at the NPI location level. So what this means is that organizations with more than one location under an NPI have to attest separately for each location. But the upside of this is that the state really views these locations as distinct, for the purposes of the AMH program. And PHPs can't make decisions that apply to one location based on findings against another, even if that's within the same NPI.

PHPs also cannot lower the Tier level of an AMH practice location based on a different PHPs findings or if a different PHP has reclassified a practice. PHPs can't change an AMHs certification status with respect to other PHPs. What this means is that the state is really the final arbiter of practice certification status. So if a practice is reclassified to a lower tier by one PHP, that's not going to change the practice's overarching certification status with the state. Or impact the practice's ability to contract with other PHPs.

And finally, PHPs are not permitted to reclassify practices to Tier 1. Tier 1, we remind you again, is only for practices that were grandfathered in on the basis of being in Carolina Access 1. So no new practices are going to be permitted to enter this Tier.

So I am going to pause here quickly. See if we've found any additional questions. So on the question around whether PHPs are required to contract with all Tier 3 AMHs. We've gotten the question – I thought it was 80 percent. Is it 80 percent or 100 percent? So, the answer here is really the intent of the program, of the department's policy is to get as close as possible to 100 percent contract with all certified Tier 3s. The state is really only going to permit these two reasons why a PHP may decide not to contract, and those again are if the PHP and the AMH can't reach an agreement on price. Or if the PHP determines that the AMH does not meet the required Tier 3 capabilities. We know again that the department has just released new guidance on this topic. Again, this is, we've placed a link to this guidance in the back of this presentation, so we encourage folks to go and check that out. It's also located on the AMH home page.

Okay, just in the interest of time, I will continue moving on.

(Slide 23) Okay so the next question is, what if the PHP concludes that my practice does not meet Tier 3 requirements. And so, as I alluded to on previous slides, if the AMH is not able to perform the activities associated with AMH, uh, with their AMH Tier, the state will permit the PHP to change or really lower the Tier status of the AMH, and to stop making applicable AMH payments to that practice. So, for example, this would mean for a practice being reclassified from Tier 3 to Tier 2, the PHP would actually be able to cease making those Care Management fee payments, and performance incentive payments. Since they've being reclassified to Tier 2, those \$2.50 and \$5 PMPM medical home fees would continue to be made.

For practices that are being reclassified, the state will require the PHPs send advance notice to the practices. Just a final note here is that this discussion of reclassification really only applies to AMH. And for any other aspects of underperformance not related to Care Management or other AMH functions, such as fraud or negligence, PHPs and the state would follow their usual processes.

And just moving on to the next question...

(Slide 24) So the question is, if our practice enters Tier 3, how can we be assured that we will receive adequate reimbursement from PHPs for performing Care Management? So this is a concern that the state has heard from a number of providers considering participating in Tier 3, but we really feel that this recent guidance that I just mentioned sort of gets to the heart of this issue. So in this latest guidance, the state clarifies that it is expecting that PHPs will contract every Tier 3, except in those two specified instances that I mentioned. So what this does here is it will really provide PHPs with strong incentive to enter into contracts with Tier 3 practices that adequately fund Care Management capacity. And as I mentioned before, the state will also be monitoring the Tier level of contracts in each region across Tier 3 practices and the dollar

amount associated with those contracts. To really insure that PHPs are not excluding Tier 3 practices in ways that are in conflict with spirit of the AMH program.

Okay, I'm just going to just move on now to the next question.

## **Part VII: Appendix**

And just to switch gears a little bit here, one question that we've received a number of times. If my practice decides to contract with a CIN/other partner, can we designate funds to flow directly to them from the PHP?

We've heard a lot of feedback from practices but they are concerned about having to take on that extra step of routing image payments from the practice back to a CIN or other partner that may be really doing the bulk of the care management for them. So we just like to clarify here that Yes, AMHs are permitted to designate CINs or other partners to receive any AMH payments. So again this includes medical home fees, and negotiated care management fees and performance incentive payments that the Tier 3s will receive.

AMH has to consent to any funds being redirected to a different entity but the State really does not wish to stand in the way of these types of arrangements. The State is not going to establish any kind of funds flow parameters between AMHs, CINs and PHPs.

Okay, I'm just going to move on to our final question here, then we should have a minute or two for any final last minute questions.

So, switching gears again, Will PHPs and Tier 3 AMHs be required to use a specific data source or HIE services for ADT-based alerts?

The answer to this question is No. The State is not seeking to impose restrictions upon where practices obtain their HIE services. So practices are really free to use any HIE of their choosing and can access ADT information in any way that makes sense for them. The State recognizes that many practices have relationships or arrangements that are already in place to ingest ADT information in different ways and it doesn't want to stand in the way of these types of arrangements.

That said as Emily mentioned earlier state law requires providers who receive state funds so these are providers who are enrolled in Medicaid or NC Health Choice in PHPs to connect with NC HealthConnex which is the State's current statewide HIE. And one benefit of participation in HealthConnex is that it will provide AMHs with access to an ADT feed at no additional cost, but so this option is always going to be there for practices that are considering doing Tier 3 and thinking about how they're going to access ADT information. But as I mentioned providers will have alternative options for HIE services. This is one area where the State feels that working with the CIN or other partner may be really helpful to Tier 3 practices. These organizations may be able to do a number of different things to help the AMHs. This can include helping them to

ingest ADT information, helping them compile it to produce reports that are useful and actionable and helping practices develop work flows to respond to these ADT lawyers.

Okay, just a couple of minutes left. I just want to give folks a chance to type in any last questions. I'll try to get through a couple more here before we wrap up the day.

Okay, so one question that we've gotten here. We have two different locations under the same Tax I.D. and same NPI do we need to attest the Tiers separately one for each location?

And the answer to that question is Yes. Practices will enroll in the AMH program at the NPI location level. So, if you are in practice with an organizational NPI and you have multiple locations within that NPI each of those locations is actually going to have to go in and attest to Tier 3 separately.

As we mentioned earlier this also flows down to PHP oversight of AMP practices. And PHPs are really required to treat each of those locations as distinct AMHs for the purposes of oversight and monitoring. And on a related note, we've had some questions about whether NPIs organizational NPIs will be able to batch a test by for all locations under a single NPI and unfortunately NC tracks currently does not have that capability, so practices will actually need to go and view a separate at the station for each of their location.

Okay, with just about one minute left I think this is a good place to stop. So, just a reminder to folks that we really encourage any practices in participating in Tier 3 to go in and complete that at the station by January 31<sup>st</sup>. As a reminder we encourage folks who are – who may be have confusion about this issue of Tier 3 contracting to review this latest guidance that we've put in the back of the slide deck and any additional resources that you may find useful on the AMH homepage.

As reminder to folks we also have another webinar upcoming on January 10<sup>th</sup>. This one is really going to get into the weeds on IT needs and data sharing. In the AMH programs so that may be of interest to lots of folks and here we've just laid out our contact information so if you have any questions about the program you can write into the [Medicaid.Transformation@dhhs.nc.gov](mailto:Medicaid.Transformation@dhhs.nc.gov) email.

As I mentioned earlier, there's also the AMH homepage which contains a whole host of training and other resources that may be of interest to folks.

So, thanks again to everyone for taking the time to participate in today's webinar and we hope you all have a really wonderful holiday.